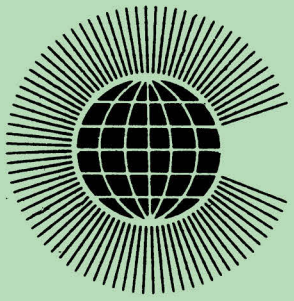
Emerging Issues in Commonwealth Abortion Laws, 1982



Commonwealth Secretariat

Emerging Issues in Commonwealth Abortion Laws, 1982

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and

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I. Introduction

In an attempt to ensure that legal provisions keep pace with medical advances in the field of prevention of unwanted pregnancies, the Fourth Commonwealth Medical Conference (1974) requested the Commonwealth Secretariat to collect information on laws on abortion. The Commonwealth Secretariat circulated a questionnaire to the Member countries of the Commonwealth, and to Associated States and dependencies, to identify their laws and intentions concerning medical termination of pregnancy. The resulting 1977 Survey, published by the Commonwealth Secretariat as a study in Three Studies of Abortion Laws in the Commonwealth analysed the state of the law, as well as evaluations of it and proposals for change in Commonwealth jurisdictions.

The 1977 Survey was presented in that year to Commonwealth Law Ministers' Meeting in Canada and to the Fifth Commonwealth Health Ministers' Meeting in New Zealand. The latter "commended the Secretariat for providing comprehensive background information for governments, and thought that the data should be kept updated on a permanent basis."

The Commonwealth Secretariat has responded to that request by commissioning periodic revisions. Initially a two-year revision was published in the International Digest of Health Legislation, World Health Organisation (W.H.O.) and was reprinted in a monograph by W.H.O. The 1979 Report was based on information that was available as of 1 May 1978. The 1979 Report was distributed to all Commonwealth Ministers of Justice and Health.

This 1982 Report represents the second revision. The Secretariat has again circulated a questionnaire based on information contained in the 1979 Report to Member Jurisdictions to determine the changes that have occurred in the five-year interval since the circulation of the questionnaire for the 1977 Report. This present Report presents the information that was made available and analyses the position as at 1 November 1982 as advised to the Secretariat. The Report is designed to be read as a separate, and self-sufficient document, it does not need to be read in conjunction with previous Reports.

The first 1977 Report was intensively considered by Commonwealth governments Health and Legal representatives at the Medical-Legal Workshops held in Barbados and Malawi and organised by the Medical and Legal Divisions of the Commonwealth Secretariat in 1979. The conclusions of those meetings, contained in Appendix A and B, were presented to the Sixth Commonwealth Health Ministers Meeting in Arusha, Tanzania in November 1980. The conclusions on Medical-Legal Issues were:

MEDICAL-LEGAL ISSUES

General — (a) The Meeting generally endorsed the recommendations contained in the reports of the two medical-legal workshops held in 1979 in Barbados and Malawi. Particular endorsement was given to the following recommendations concerning abortion law and practice.

National — (b) Countries should provide for a jurisdiction to have at least a "developed" law, either by legislation or through an authoritative executive statement of the scope of lawful abortion under existing law.

(c) Laws relating to approved contraceptive measures should be clearly exempted from the scope of laws relating to abortion.

(d) Lawful abortion should include, at the minimum preservation of life and physical and mental health, as determined necessary in good faith by a doctor.

(e) Abortion services should be rendered by adequately qualified personnel.

(f) Consideration should be given to accommodating abortion primarily in laws focusing not upon crime and punishment but upon health and welfare.

(g) Continuing dialogue should be maintained between doctors and lawyers on legislation and medical practice, and on the impact of medical technology upon the relevance and application of laws.

Regional

(h) Regional groups and their secretariats should, within the limits of their resources, support the above activities, taking initiatives as and when appropriate.

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(i) The Secretariat should encourage discussion of issues relating to the medical termination of pregnancy at meetings of Health Ministers and of Law Ministers of the Commonwealth.

(j) The Secretariat should continue to disseminate information on the legal and medical aspects of the medical termination of pregnancy, and to support efforts to establish a medical-legal dialogue on the subject.

(k) The Secretariat should, where possible, provide technical assistance to Commonwealth governments requesting help with the development of their laws on the medical termination of pregnancy.

(l) The Secretariat should, within the limits of its resources, provide support in this programme area, taking the initiative as and when appropriate.

Those recommendations, requiring implementation at the national level are discussed in Sections III and IV of this Report. Section III outlines those countries that have at least "developed" their law (recommendation b) or in some cases advanced it since 1978. Table II of this Report outlines the extent to which Commonwealth governments enable medical termination of pregnancy to perserve the life and physical and mental health of the woman (recommendation d). Section IV discussed the extent to which Commonwealth governments have exempted contraceptives from the scope of laws relating to abortion (recommendation c). Section IV analyses how Commonwealth governments have interpreted their laws to enable the use of the newer medical technologies such as menstrual therapies to the benefit of womens' health (recommendation g). Of particular interest is the response of the Sri Lanka Ministry of Justice in recognising the legitimacy of menstrual therapies before pregnancy can be diagnosed:

"It appears that Menstrual Therapies can be performed in Sri Lanka without violating abortion law where a woman is not proven to be with child."

Section IV discusses what Commonwealth governments have done to enable the delivery of abortion services by "adequately qualified personnel" either by court interpretation or statute (recommendation e). Finally the extent to which governments have accommodated "abortion primarily in laws focusing not upon crime and punishment but upon health and welfare" is discussed in Section IV. Many Mamber countries, especially through their respective Commissions on the Status of Women, recognise that women as well as men have right to health care treatment outside the context of crime and punishment. Of particular interest is the following recommendation of the Report of the National Commission of the STatus of Women in Barbados:

"The service should permit abortion on the sole request of women upto the twelfth week of pregnancy."

Indeed, the Barbados Report stressed, as do other similar Commonwealth Reports, that abortion should only be used as a second line of defense against the prevention of unwanted pregnancy behind the more desirable and cost effective first line of defense of contraceptiion and sex education.

With respect to recommendation h, requiring regional implementation, analyses of laws along a regional basis have been prepared. Such work, "Menstrual Therapies in Commonwealth Asian Penal Law" International Journal of Gynaecology and Obstetrics, 20: 273-278 (1982) was thought significant where there was regional differentiation in the law, notably Commonwealth Asia. Further regional study "Abortion Laws in African Commonwealth Countries" Journal of African Law 25: (1982) was thought fruitful where governments take particular interest in regional Commonwealth practice.

Finally, with respect to recommendation i-l, requesting implementation by the Commonwealth Secretariat, this Report is being presented to the 1983 Commonwealth Ministers of Justice Meeting held in Colombo, Sri Lanka, in Ottawa, Canada, October, 1983 and any Ministerial Meeting for Women and Development. The Secretariat continues to disseminate information on medical-legal aspects of abortion through the Commonwealth Law Bulletin and through a newly-initiated series, Commonwealth Developments in Health Law (See Issue I, July 1981). The Secretariat has supported efforts to establish medical-legal dialogues on this subject based on the Barbados and Malawi models at the Regional meetings of the Health Ministers. Finally with respect to recommendations k and 1, the Secrearíat, under the auspices of the Commonwealth Fund for Technical Assistance is able to provide technical assistance to developing Commonwealth countries requesting help on health-related, as on other matters.

II. The Legal Background: Its Implications

This section presents the legal background for the report. It is based in part on the 1977 Survey, its 1979 update, the Reports prepared for the Barbados and Malawi meetings as well as regional analyses of Commonwealth abortion law. The present Report intends to be readable as a self-contained study. Some references to earlier Surveys will be made where necessary to confirm or refute their observations in light of the subsequent experience, and where necessary to show new perspectives and the direction of new approaches.

The legal background of Commonwealth Abortion law has implications which previously have been undervalued. For example, those countries that maintain their Common or Customary law with respect to this issue prohibit abortion after quickening. Some countries with basic laws, irrespective of how they have developed or advanced them, do not prohibit procedures by one acting on a woman or a woman acting on herself until she can be proven to be "with child". The legal history of Commonwealth criminal law has implications for abortion, prohibiting it only after certain gestational stages have been proven (see Table I) and/or permitting it by specified indications (see Table II). Those Commonwealth countries permitting procedures soon after a missed period are often more accommodating of post conceptive self administered methods than those law permitting abortion by specified indications.

A. Evolution of Commonwealth Abortion Law

1. Generally

Commonwealth abortion laws have been divided into Common/Customary law, basic law, developed law and advanced law. Common law prohibits abortion only after pregnancy reaches the stage of quickening which is normally taken to occur at about 12 or 14 weeks since the last menstrual period. After quickening, the historic English Common law punished abortion as a misdemeanour. Basic law punishes abortion by statute modelled either on the English Offences Against the Person Act, 1861 or on the Indian Penal Code 1860. These two models differ in significant ways. Perhaps the most important of which is that the Indian Penal Code punishes a woman acting on herself or one acting on a woman only after she can be proven to have been 'with child' which is now normally taken to have occurred at about 6 or 8 weeks of pregnancy. The English Offences Against the Person Act, 1861 punishes anyone with intent to abort but punishes the woman acting on herself, only after she can be proven to be 'with child'. Some countries that have adopted this exact model, others have altered it to punish both the person acting on the woman and the woman acting on herself irrespective of whether she is 'with child'.

Developed law recognises either implicit exceptions by case law or explicit exceptions by statute to the basic law prohibitions, in favour of procedures undertaken with the intention of saving the woman's* life or physical or mental health. Advanced laws positively provide for abortions to be done, by presenting terms under which abortion services may be made lawfully available. Although they are not necessarily more accommodating than developed laws, they set the legal scene for conscientious and secure

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* Woman refers throughtout this Report to any female capable of conception, including adolescent women.

performance of medical termination of pregnancy by defining the conditions, locations and, for instance, qualifications for those performing legal abortions.

The evolution has been generally from gestation oriented laws (Common/Customary law) to crime oriented laws (Basic), through laws recognising life and health preserving exceptions to criminal liability (Developed), to health-oriented laws (Advanced) which positively state the circumstances and conditions in which pregnancy may be lawfully terminated. The use of law in health-oriented jurisdictions to direct public resources to family welfare, and to encourage individuals to take their own preventive and protective initiatives in health care, has promoted a vision of law in family health incompatible with crime and punishment. The growth of health and welfare laws has shown signs of refocusing perspectives on abortion. The practice is acquiring a lower profile in the health care setting of several jurisdictions. It is coming to be treated in much the same manner as other comparable medical procedures and as it was at Common law.

ii. Common/Customary Law

Common law punishes abortion as a lesser offence, a misdemeanour, but only after quickening. This misdemeanour was capable of commission by a pregnant woman upon herself, and by other persons on her, but in neither case was there liability if pregnancy was not proven to have proceeded to quickening. Quickening is normally taken to occur about about 12-14 weeks of pregnancy. The Common law position still prevails in Sierra Leone. There is an absence of local legislation on abortion in Sierra Leone. As a result Table II explains that both Common law and the English Offences Against the Person Act, 1861 are applied. It is unclear whether the application of the 1861 Act supercedes the Common law altogether. For example it is unclear whether procedures before quickening which were permissible at Common law are legal in Sierra Leone. It appears that in countries influenced by the historic English Common law standard, procedures performed before quickening are legal unless carried out in violation of other laws on, for instance, the unqualified practice of medicine. Common law offences may be neutralized by Common law defences to liability, notably the defence of necessity recognised in R. v. Bourne (see II A. iv. below).

The Common law position was changed in England as earlier as 1803 where prequickening care by another person was punishable albeit with a lesser punishment than post quickening abortion. An 1837 act abandoned the distinction between a woman quick and not quick with child and indeed eliminated the requirement that the woman be pregnant at all, punishing anyone who acted with the intention of procurring a miscarriage. This historically important quickening distinction was not, however, totally abandoned. The 1837 Act and its subsequent amendment in 1861 continued to punish a woman acting upon herself only when it could be proved beyond reasonable doubt that she was "with child", thereby leaving those methods a woman could employ on herself before she could be proven "with child" unpunishable. This is the situation in England today and in many Commonwealth jursidictions which adopted the 1861 law. Others, however, have changed it making a woman acting on herself, irrespective of whether she is "with child", criminally liable (see Table I).

As the law evolved during the 19th century the "quickening" stage found at English Common law became a "with child" stage found in subsequent English statutory law or at Scottish Common law. It is hard to know when the quickening standard became the 'with child' or pregnant standard as it is

known at Scottish Common law. The first reported case, H.M. Advocate v. Anderson (1927) held that it must be shown that the woman was pregnant for a charge of abortion or attempted abortion to lie. The Scottish Common law position traditionally enabled greater availability of pre-pregnancy care in Scotland than in England prior to the passage of the British Abortion Act 1967. The British Abortion Act 1967 does not supersede Scottish Common law but rather supplements it. So those acting before a woman is proved pregnant are not liable for abortion at Scottish Common law. Thereafter they must comply with the British Abortion Act 1967. This Scottish Common law position was codified in the Indian Penal Code and exists today in India and countries who have adopted the Indian Penal Code (see II A iii below).

Customary law found in many parts of the Commonwealth is similar in many ways in its evolution to Common law. It is the law that is derived from custom in much the same way Common law is derived from the communal practice and attitude. Information on customary or tribal abortion law is sparse but developing. The sparseness is due in part to the general lack of integration of customary law into the colonial law systems. It is only now that countries are beginning to realize its importance particularly in areas concerning the family. As a result countries are moving through, for example, Native Custom Recognition Acts to accommodate customary practices and beliefs.

Since the Native Customs (Recognition) Act, 1963, came into force in Papua New Guinea in 1964 for instance, custom may be invoked in Common law courts of criminal jurisdiction to ascertain the existence of a state of mind, to decide the reasonableness of behaviour and the reasonableness of an excuse. Custom pertaining to pregnancy, contraception and treatment of an unborn may accordingly be invoked upon a charge of abortion with exonerating effect. Similarly, although areas of immunity from observance of the general law will not be recognised, customary belief held in good faith may be found a justification in an individual case for not proceeding with criminal case.

In 1978 the Law Reform Commission of Papua New Guinea addressed more general issues of accommodating customary law in a general way, but it advanced a perception especially pertinent to Commonwealth States whereby customary law is or has been relevant. The perception has distinctive force regarding legal prohibition of abortion, since this often derives much of its validity from religious sentiment and doctrine, and both are invoked to resist liberal reform of such laws. The Law Reform Commission observed, however, that:

> "To punish one people by applying standards and world views of another people is inherently wrong and is fundamentally unjust. We believe no independent and self-respecting nation can tolerate this. A criminal justice system which punished people for things they do not consider to be wrong cannot be effective, respected, and supported."

This is an observation of profound philosophical, jurisprudential and political significance. When applied locally it may entitle individuals to manage their fertility, perhaps by recourse among other means to safe termination of pregnancy, in a manner compatible with their culture and ethical standards. In Papua New Guinea, for instance, Heather McRae has noted that abortion is practiced in most societies, and that among the Kuman people, for instance, it is not regarded as wrong. In Sanguina Wauta v. The State (1978), Prentice C.J. considered that exoneration by custom should apply only to nationwide as opposed to local custom. McRae has argued that

the constitution requires respect for local custom and character. Further problems, although not insurmountable, arise with respect to the application of a customary standard. Questions have arisen as to whether it is the doctor's or woman's custom that is relevant custom, but given that it is the woman's well being that is considered it would seem that the woman's custom is only relevant here. Similarly once it is accepted that the abortion is indicated because of the woman's customary belief, it does not matter where the abortion is performed in an urban hospital or a rural clinic. Perhaps the most difficult is the determination of the criteria by which customary belief is established. For example, are the introduced religious beliefs that have modified customary belief separate or inextricably linked? Such respect for individual and group autonomy is related to developments on the international plane of human rights, which include rights to group participation and to adherence to indigenous cultures and values.

In another part of the Commonwealth, Professor Poulter and his colleagues from the National University of Lesotho found from the Report of the Commission on the Laws and Customs of the Basutos that there was no law or punishment with regard to abortion. Professor Poulter explains that abortion however was practiced. He cites an 1936 anthropological study of the Basutos by H. Ashton explaining that they knew of and used abortiacients. H. Ashton concluded in his study of customary law and indigenous courts, that abortion was a matter which was dealt with by the family rather than the courts.

The Basutos approach to abortion although removed in time and place was similar to that of T.B. Macaulay (Lord Macaulay). While Lord Macaulay drafted the Indian Penal Code in 1837, he wrote that abortion is a family matter and as a result should not be left to criminal law prosecutors who did not have the sensitivities needed for such family affairs. He recommended that it go unpunished, (see II A iii below).

Another approach that has been taken in customary law but not incorporated into modern statutes is allowing for abortion along lines thought permissible in traditional customs, a traditional custom indication. Professor K. Ndeti, a sociologist at the University of Nairobi explained from his observations of six East African tribes that:

> "No woman is allowed to have children until proper arrangements have been made with regard to the conditions of marriage, initiation rites, responsibilities, duties and parental obligation."

Women not respecting these rules face severe social sanctions, but abortion was used in these tribes to relieve unnatural circumstances, such as when pregnancy resulted from taboo relationship or could result is a social or psychological crisis for an individual, family or community.

Common/customary law still prevails in Lesotho and Swaziland. It is however unclear what that law permits with regard to abortion. It might go unpunished as it did under the Basutos. It might also be influenced by Roman Dutch common law. It might also be analogous to the historic English common law standard not punishing abortion until quickening.

iii. Basic Law

Section 58 of the English Offences Against The Person Act 1961 states that:

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

Section 59 provides that:

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

Section 58 establishes criminal liability for a woman procuring her own miscarriage only when it can be proven beyond a reasonable doubt she is "with child". Section 59 establishes criminal liability for supplying or procuring with intent to procure a miscarriage irrespective of whether the woman is 'with child'. These prohibitory provisions provide one of the basic models of Commonwealth abortion law. Many jurisdictions express the language of these sections almost verbatim as their own law. Some jurisdictions, for example, Tonga and Guyana vary from this model by making the woman criminally liable irrespective of pregnancy. These countries however, are in the minority with respect to this issue in the Commonwealth (See Table I). Still other countries for example Papua New Guinea and Cyprus have sections that are entitled 'a woman with child', and then the text continues by saying 'a woman whether or not with child'. These sections have been interpreted in Table I as though the text and not the title is controlling.

An alternative model of Basic law exists, however, in the Indian Penal Code 1860. The Indian Penal Code 1860 is the basic criminal law not only in modern Indian jurisdictions, but also in Bangladesh, Brunei, Sri Lanka, Malaysia, Singapore and in non-Commonwealth Pakistan. Outside Asia this provision exists in the Penal Code of Northern Nigeria and variations of it exist in Commonwealth Malta and Mauritius and in non-Commonwealth Egypt, Kuwait and Sudan. This model differs from the English model in a material particular. The 1861 Act is concerned with "intent to procure the miscarriage of any woman whether she be or be not with child." The Indian Penal Code provides, however, that "whoever voluntarily causes a woman with child to miscarry shall ... be punished ..." (emphasis added).

An explanation to this section states that "a woman who causes herself to miscarry is within the meaning of this section". Reading this explanation together with the section would require an interpretation that the woman acting on herself must be "with child" to be criminally liable. Such a reading would be consistent with section 312 of the 1837 draft which reads:

"Every woman who, being with child, voluntarily causes herself to miscarry, and every person who voluntarily causes a woman with child to miscarry, shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished."

The Indian Penal Code 1860 formula, presents prosecutors with the additional burden of proving beyond reasonable doubt pregnancy of the woman acted upon or acting on herself, as an important element of the wrongful act constituting the crime. The distinction is of more significant modern effect, however, in placing post-coital contraception, self administered suppositories and menstrual therapies outside the reach of the abortion prohibition (see IV A and B below).

The 1860 Code was primarily drafted in 1837 by Lord Macaulay the Chairman of the Indian Law Commission. Apart from minor rewording and the addition of an Explanation to the abortion provision, the 1860 Code did not change the substance of the Macaulay abortion law. Lord Macaulay drafted the 1837 Penal Code with a view toward making the administration of Indian criminal law efficient and rational. He saw a limited role for criminal law, being all too aware of early nineteenth century abuses and arbitrary nature of criminal law enforcement. Lord Macaulay did not believe in legislating private virtue. He thought that the control of private morality should be left to other instrumentalities. He thought that coercive sanctions of punishment should be applied not to what people do to themselves but restricted to preventing people from doing positive harm to other people.

In the notes to the 1837 Draft Code, Lord Macaulay points out that the existence of an abortion law could be used by extortionists to make false charges of abortion. He seriously suggests that the Governor General not invoke it without the greatest of care because:

"With respect to the law on the subject of abortion, we think it necessary to say only that we entertain strong apprehensions that this, or any other law on that subject may, in this country, be abused to the vilest purposes. The charge of abortion is one which, even where it is not substantiated, often leaves a stain on the honor of families. The power of bringing a false accusation of this description, is therefore, a formidable engine in the hands of unprincipled men. This part of the law will, unless great care be taken, produce few convictions, but much misery and terror to respectable families, and a large harvest of profit to the vilest posts of society. We trust that it may be in our power in the code of procedure to lay down rules which may prevent such an abuse. Should we not be able to do so, we are inclined to think that it would be our duty to advise his Lordship in Council rather to suffer abortion, where the mother is party to the offence, to remain unpunished, than to repress it by provisions which would occasion more suffering to the innocent than to the guilty."

One may conclude, therefore, that the Indian Penal Code abortion provision is designed to apply only in the clearest of cases. It applies to women acting upon themselves only when clearly "with child". It applies to others only when women are demonstrably pregnant and where others terminate pregnancy with express intent to commit the crime of abortion.

Despite the prohibitory tenor of the language used in particularly the 1861 English model of basic law, a feature of its expression is repeated use of the qualification "unlawfully" to describe administration, supply or procurement of poison and use of an instrument or other means of procuring miscarriage. The implication that "lawful" administration and use are possible, received recognition probably initially by Lord Macaulay in his 1837 draft, but not repeated in the 1860 Code, by his exoneration of acts "done in good faith for the purpose of saving the life of the woman." In the 1909 Canadian case of Re McCready, Lamont, J. of the Saskatchewan Supreme Court observed of a woman's abortion that "from the evidence before me I cannot say that the operation ... might not have been necessary to preserve her life, in which case it is not unlawful." Positive expression in law that the necessity to preserve the pregnant woman's life renders her abortion lawful brings the law to a more developed level.

iv. Developed Law

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

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

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

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

Expression of the law in a combination of statutes and judicial decisions causes lawyers no difficulty, but the law must be understandable to more than lawyers. For ease of understanding by physicians and others, the law is best expressed in adequate statutes, and a developed abortion law is therefore most usefully contained within the limits of a single enactment. Relatively few Commonwealth abortion laws in fact offer this clarity.

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

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

A comparable developed provision appears in the Penal Code of Kenya, section 240 of which explains that:

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

These provisions may be regarded as making explicit a necessity justification for abortion such as the Bourne decision read into basic law. Its expression elevates a basic abortion law to the level of developed law.

v. Advanced Law

Developed law prohibits abortion in general but gives express recognition to the necessity to preserve the woman's life or health. Advanced law positively provides that abortion is lawful when sought by the woman and when specified indications are satisfied. Such justifications for abortion are not identically contained in advanced laws, but different Commonwealth countries have selected their particular details from various indications. (See II B iii below). Advanced laws often specify how abortion services may be delivered to women seeking them who satisfy statutory indications. The predominate provisions for legal implementation are presented at Table III.

B. Requisite Conditions

i. Generally

Some Commonwealth abortion laws punish abortion only after certain gestational developmental stages (see Table I). Others establish indications for legal abortion (see Table II). The gestation approach, which finds its roots in the English Common law which, as was seen in II A ii above, prohibits abortion after quickening. The Common law position was codified thus enabling acts until the woman could be proven to be 'with child'.

The other approach to evolved by force of statute within the English criminal law and countries with that criminal law system. That approach, now represented in the English Offences Against the Person Act, 1861 as developed by the 1938 R. v. Bourne case permits abortion irrespective of gestational limits only for certain specified indications, namely risk to life or to physical or mental health. Pre-quickening procedures were first prohibited by an English 1837 statute most probably because of the difficulties the prosecution faced in proving pregnancy. Since criminal statutues have superseded the gestational approach, the indication approach has come to prevail in

English criminal law and of those countries following its legislation. An indication approach need not completely eliminate the significance of gestational stages. Abortions in some countries with an indication approach are legally more easily obtainable earlier than later in pregnancy. For example, the Indian Medical Termination of Pregnancy Act, 1971 requires the approval of two registered medical practitioners, where the procedure is to be carried out between the 12th and 20th week of pregnancy, whereas only the opinion of the physician who is to perform the procedure is required during the first 12 weeks.

ii. Gestational Stages

As was seen in II A ii above, Common law punishes abortion as a lesser offence after quickening, normally coinciding with the end of the first trimester of pregnancy. At English Common law post quickening abortion could be justified by the application of the defence of necessity. This defence permits lawful post quickening abortion where it is necessary to save the life or physical or mental health of the woman. This unamended Common law may still prevail in Sierra Leone, Lesotho and Swaziland. The Common law position prevails in Scotland today, although after a woman is shown to be 'with child', abortion in Scotland is governed by the British Abortion Act 1967.

The Common law position to a large extent was codified in the Indian Penal Code, the criminal codes of Northern Nigeria and a variation of it, for instance in the Penal Code of Malta (see II A ii above). The Indian Penal Code differs from the Common law, however, in that it punishes abortion after quickening as a greater crime with a greater punishment. Accordingly, those countries that set gestational stages tend to be those with a Common law position or a codification of that position (see Table I). Those countries that take a gestational approach permit procedures before quickening or before a woman can be proven "with child". The "with child" standard now differs from the quickening standard although initially they were about the same. Formerly, a woman could only be proven to be "with child" at quickening. As techniques to prove pregnancy progressed, pregnancy could be proved earlier on in gestation. Now pregnancy can be proven by reasonably available methods at about 6 to 8 weeks since the last menstrual period. The merits of the gestational approach are that it encourages the health care system to provide services as soon as possible after missed menstural periods, and that it encourages women to seek care as soon as possible after a missed menstrual period.

iii. Indications for Legal Abortion

Common/customary law, basic law, developed law and advanced law all permit abortion for atleast one of the following indications:

(a) Risk to life and grave and immediate risk to the health of the woman (the strict necessity indication).

(b) Risk to the woman's physical or mental health from continuation of pregnancy meaning risk beyond that normally associated with pregnancy (the physical and mental health indications or sometimes known as the therapeutic indication).

(c) Some degree of likely serious physical or mental impairment of a child if born (the foetal indication).

(d) Pregnancy by rape, incest or other criminal intercourse (the juridical indication).

(e) The effect of child birth upon the health and welfare of the woman's existing children and family (the social, socio-medical or socio-economic indication).

(f) Jeopardy to the social position of the woman or her family (the family indication).

(g) Failure of routinely employed contraceptive means (the contraceptive indication).

(h) Pregnancy of an adolescent girl or a legal minor (the adolescent indication).

(i) On request.

Table II contains information on legal indications for abortion as given in the responses to the Commonwealth Secretariat questionnaire. Some of the indications vary with respect to gestational stages. The family indication found in the law of Cyprus, the contraceptive indication found in the law of India and the adolescent indication found in the law of Hong Kong are not tabulated in Table II. Suggestions for other indications include the traditional or customary indication discussed at II A ii above.

Laws expressed in basic form such as those that prevail in Malawi, Sri Lanka and Antigua recognize the strict necessity indication. It is unclear whether such countries with basic law would apply the defence of necessity as interpreted in R. v. Bourne (1938) to allow abortion to save the life or physical or mental health of the woman as their responses to the Commonwealth Secretariat's questionnaire did not mention Bourne. Developed laws such as those that prevail in Kenya, Northern Ireland and Jamaica apply Bourne to recognize the therapeutic indication as well as the strict necessity indication. Advanced laws such as those in Zimbabwe, Singapore and Seychelles recognize most or all of the indications (see Table IV).

iv. Provisions for the Performance of Abortion (In Law and Practice)

In former reports, Table III was called Provisions for Implementation (In Law and Practice). It has now been renamed Provisions for the Performance of Abortion (In Law and Practice) for a specific purpose which is to underscore that it only deals with abortion procedures. It does not deal with any procedures done before the law considers the procedure to be an abortion. So for example in India, the provisions for the performance of abortion would not apply to post conceptive procedures done before the woman is proven to be 'with child'. The same reasoning applies to Scotland where the Common law still applies. As a result the British Abortion Act 1967 would not apply until a woman is proven to be 'with child', the time at which the Scottish common law considers a post conceptive procedure to be a legally prohibited abortion. As a result, those procedures done before a woman is is proven pregnant are contraception and are regulated by general medical practice statutes and not the abortion statute. This fact however is not reflected in Table III because it only deals with those procedures that are considered by law to be abortion. Where it deals with procedures not considered in law to be abortion, it so states, for example Bangladesh.

Table III deals largely with the predominant provisions contained in advanced laws. Some advanced laws do have additional provisions for performance of abortion and they are outlined below. Neither the predominant or additional provisions are discussed at length here because they have been dealt with extensively in former Reports.

Table III deals largely with the predominant provisions contained in advanced laws. Some countries' responses to the Commonwealth Secretariat questionnaire have suggested what the practice is in their country but this is not required by their abortion law. Those countries that are not listed in Table III are those countries whose laws do not have provisions for the performance of abortion and as a result they have chosen not to explain what the practice might suggest.

1. Specified Professionals

Laws may relate the required qualifications of professionals to the demands of the tasks to be undertaken to ensure the safety of the procedures undertaken and, for example, to ensure access (see Table III). Some laws, for example, Singapore require specified qualifications in obstetrics and gynaecology to do abortions up to the 16th week and further specified qualifications between 16 and 24 weeks. Other laws require abortions to be done by a registered medical practitioner and some, for example, the United Kingdom allow nurses to assist in the procedure under delegation of the doctor (see IV C iv below). Still other countries by, for example, Ministerial regulation allow allied health personnel to do very early procedures. For example, Bangladesh allows appropriately trained allied health personnel such as family welfare visitors to do early procedures.

2. Specified Institutions

Some laws do not state where abortions should be done but rather leave it to the discretion of the Ministries of Health. Other laws require a hospital or a liscensed institutions and allow for detailed regulations to establish liscensing requirements. Other laws such as Seychelles require a specified hospital. The purpose may be to ensure the availability of appropriate services for the stage of the pregnancy to be terminated, so that earlier procedures could be conducted in local clinics, and later procedures in more fully equipped central hospitals. This means of regulation also may ensure public availability without prohibitive cost and with public accountability for services rendered.

3. Stage of Pregnancy

Commonwealth jursidictions vary with respect to specifying the stage of pregnancy after which abortions may generally not be performed. Most are silent on this issue and hence allow abortions to be done until viability the point at which common law prohibits any further procedures. Others state a time beyond which abortion can't be performed except in the case of emergency. For example, India says 20 weeks unless immediately necessary to save the life of the pregnant woman. Medical procedures for safe termination become more complex and may require higher levels of available equipment and skill with longer gestation. Accordingly, different provisions may apply to medical terminations of pregnancy at different periods of gestation. For instance, early termination achievable by chemical means may not require institutional care, early medical means may be applied upon an out-patient basis, and later terminations may be permitted only in adequately equipped facilities and/or with attendance of specially qualified personnel.

4. Approval Procedures

Approval procedures vary from the simplest of requiring the approval of the health or allied health personnel performing the proceudre to requiring the approval of an additional practitioner or even 2 to requiring the approval of a committee. The propose of approval requirements found only in advanced laws is principally to supply evidence of a practitioner's observance of legal indications, rather than to serve the woman's health needs.

5. Additional Provisions

Infrequently, advanced laws contain provisions upon matters related to items appearing in 1 and 2 below. These may concern costs of abortion services, aiming to prevent exploitation of desperate women and to assist the equitable availability of services. A tabulation of such provisions includes:

1. Cost provisions.

2. Conscientious objection provisions (in non-emergencies) for health professionals.

3. Reporting requirements.

4. Spousal and parental consent provisions (although these are often governed by general as opposed to specific laws).

5. Citizenship or residency qualifications for non-emergency services.

III. The Present Ground: Legal Reform

A. Statutory Changes and Proposals

1. Generally

Since 1977 relatively few initiatives have been taken among Commonwealth jurisdictions to enact new legislation. Belize, New Zealand and Seychelles introduced new advanced laws; Hong Kong in 1981 introduced changes to its pre existing advanced law. No less impact upon Commonwealth abortion legislation has come from changes brought about in Commonwealth membership. The laws of the newer Member States tend in general to conform to, and thereby to confirm the philosophy of, pre-existing criminal law patterns. The abortion laws of Vanuatu and Zimbabwe, however, present instructive advanced laws. The Termination of Pregnancy Act of Zimbabwe, for instance addresses grounds for abortion, creates an appeal procedure when official permission to terminate a pregnancy is denied, contains an emergency exception from regular authorisation and, for instance, regulates the fees chargeable for abortion services.

The major developments in Commonwealth abortion management have arisen through refinements, clarifications and limitations recognized in existing laws, to create more systematic patterns of delivery of abortion services, and of other associated health services. Some developments have concerned the role of nurses and by inference comparable health professionals, others have distinguished more clearly between abortion and post-coital contraception, and yet others have recognized that menstrual therapies requiring emptying of the uterus may legitimately be available without observance of legislated provisions applicable to abortion.

Accordingly, while the field of abortion legislation cannot be seen significantly to have changed since 1977, the definition of that field has been drawn more sharply, and it has become more clearly differentiated from such related fields as fertility control and woman's health care. Further, within the abortion field, the infrastructure has become more fully established and the role of doctors as initiators but not sole executors of abortion procedures has been judicially clarified.

The commentary which follows identifies a number of areas in which such developments have occurred, considered first regarding particular issues and their implications, and then in the wider context of action and perceptions on the plane of public law and international agreements. Initially, however, distinctive provisions of legislation of States which have been amended or introduced to Commonwealth experience since 1977 will be addressed. This exploration of laws relates to tables II and III below, which record the status as of 1 November 1982 of abortion provisions in all Commonwealth jurisdictions, derived from answers kindly provided in response to questionnaires sent to all member states by the Legal Division of the Commonwealth Secretariat. In addition, an extensive bibliography is presented, to reveal the evolving depth of Commonwealth national, international and comparative literature in this expanding area, and to offer ministries and agencies in Member States a convenient means of access to the literature in order to gain more detailed and comparative information.

ii. Specific Changes

At the end of April, 1981, the Republic of Seychelles enacted its Termination of Pregnancy Act, 1981, which amended its formerly purely prohibitive Penal Code in favour of permitting doctors in defined circumstances to peform abortions. The Act presents an interesting model of legislation for geographically compact, jurisdictions, since it concentrates legal abortion services upon a single, specified hospital, namely Victoria Hospital, Mahe. The Act permits a consultant gynaecologist to perform an abortion at the hospital, if three doctors from the opinion in good faith that continuance of pregnancy would involve risk to the pregnant woman's life, or risk of injury to her physical or mental health greater than if the pregnancy were terminated. Alternatively, their opinion may be that there is substantial risk that if the child were born alive, it would suffer from such physical or mental abnormalities as to be seriously handicapped. The language of the Act shows an origin in Britain's Abortion Act 1967, although the health indication in the 1981 Act is limited to the pregnant woman's physical and mental health, and does not include the health of any existing children of her family, as does the 1967 Act. The 1981 Seychelle Act imaginatively expands upon the earlier Act, however, in permitting account to be taken of the pregnant woman's actual or reasonably foreseeable environment to determine not only risk to her health, but also risk of serious handicap to an abnormal child. This displays admirable sensitivity to the relation between the parental environment and a child's potential to experience relative normality or handicap. The act further allows abortions to be done if the pregnancy is a result of rape or incest.

The requirement of three medical opinions may appear demanding in principle, especially since the three must consult any other doctor in Seychelles who holds a specialist qualification in a field, such as psychiatry, relevant to the health of the pregnant woman. In fact this may not necessarily be an obstacle to prompt termination of a dangerous pregnancy, however, since the three doctors who must form an opinion are the attending physician who proposes the termination of pregnancy, the consultant gynaecologist who is to perform the termination, and the Director of Health Services in the Ministry of Health. If the latter acts speedily and in reliance upon the skill, experience and good faith of the two doctors with clinical and first-hand knowledge of the patient, this approval procedure need not present delay constituting harm to the pregnant woman, such as by postponing the procedure until the second trimester.

The Act replaces the three physicans' opinions by the opinion of a judge when on the balance of probabilities, the judge finds that the pregnancy is the result of rape or incest. It is instructive that the finding should have to be only on the balance of probabilities, since a criminal conviction for these offences would be possible only upon the more demanding standard of proof beyond reasonable doubt. It is evident, however, that the 1981 Act permits speedy formation of a judicial opinion upon medical and other evidence, without completion of forensic investigations resulting in a criminal charge. Medical opinions are also displaced upon judicial determination of the pregnant woman's unfitness for motherhood, for instance on account of her mental, retardation or deficiency.

Pregnancy may be terminated only before the end of the sixteenth week of pregnancy, unless the Director of Health Services is of opinion that there are exceptional grounds for later termination. Since the Director's opinion

is required for earlier abortions, however, the opinion that the procedure is justifiable in itself, and that it is justifiable after sixteen weeks of pregnancy, may become merged into a single assessment. Pregnancy is deemed to have started on the date determined by the Director in his sole opinion, so that a complex biomedical and philosophical dilemma is obviated by an ad hoc administrative ruling, based upon medical and circumstantial evidence.

The Minister of Health is obliged to make regulations under authority of the 1981 Act for certified expression of the medical opinions required before an abortion can be performed, and for presevation and disposal of these certificates. Regulations must also provide for reports to the Director of Health Services regarding abortions performed, and for limiting disclosure of reports required to be submitted. The Act also contains a conscientious objection clause, closely modelled upon the British 1967 provision, permitting a person to object to participation in abortion procedures, if able to discharge the burden of proving such objection in any legal proceedings which may result. The general right of conscientious objection does not apply, however, regarding treatment which is necessary to save the life, or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

The Act's permission of abortions only in the Victoria Hospital and upon three medical certificates has no exception for cases of emergency. If an emergency were to arise, therefore, when certificates could not be acquired and the Victoria Hospital was inaccessible for any reason, a life-saving or health-preserving abortion might be medically indicated, but unavailable under terms of the 1981 Act. The necessity doctrine recognized in the Bourne case might well be available in such a case to provide exoneration for action taken in good faith. This may appear from section 147 of the Penal Code, which follows section 58 of the English Act of 1861 in prescribing the behaviour of "Any person who .... unlawfully administers" a poison or other noxious thing or uses force or other means with intent to procure miscarriage (emphasis added). This implicit recognition of lawful abortion even outside the terms of the 1981 Act is reinforced by the absence from the Act of the provision found in Britian's 1967 Act, which in other regards was used as a model, that "For the purposes of the law relating to abortion, anything done with intent to procure the miscarriage of a woman is unlawfully done unless authorised by .... this Act." (Section 5(2)). The British Act gives statutory recognition to the needs of necessity, when detailed requirements of the Act cannot be observed.

The new advanced law of Belize was achieved through re-enactment of its Criminal Code in 1980. The earlier law permitted abortion only to preserve a pregnant woman's life. The new Criminal Code conforms to modern advanced laws by adding to basic law the provisions that no offence is committed when a doctor acts upon two medical opinions that continuation of pregnancy involves risk either to the life of the pregnant woman or to her physical or mental health, or that of any existing children of her family, greater than if pregnancy were terminated. Termination is also permitted if the two opinions find susbtantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. After 28 weeks of gestation, however, pregnancy is terminable only to save the mother's life, unless it be shown that the unborn child was not capable of being born alive.

These provisions appear to have been derived from Britain's Abortion Act 1967, as is the addition that, in determining risk of injury to health, account may be taken of the pregnant woman's actual or reasonably foreseeable environment. The Criminal Code of Belize also adopts the conscientious objection provision of the 1967 Act, permitting refusal to participation in abortion treatment by any person able to prove conscientious objection, but with an exception where such treatment is necessary to save life or to prevent grave permanent injury to a woman's physical or mental health. The law of Belize includes no other provisions of Britain's 1967 Act.

Zimbabwe's Termination of Pregnancy Act, 1977 was based upon the Report of the [Rhodesian] Commission of Inquiry into Termination of Pregnancy 1976, and enacted against the background of Roman-Dutch Common law. It represents in principle a standard type of advanced law, whose principal deviation from the norm is its rejection of a mental health indication for abortion. Section 3 provides that "No person may terminate a pregnancy otherwise than in accordance with the provisions of this Act," and section 4 permits such termination "where the continuation of the pregnancy so endangers the life of the woman concerned or so constitutes a serious threat of permanent impairment of her physical health that the termination of the pregnancy is necessary to ensure her life or physical health, so as the case may be." This rejection of a psychiatric indication for abortion may be based upon sceptical observations in the 1976 Report, but it raises the question whether a woman's threat of suicide, reflecting that the balance of her mind and may be disturbed, would furnish grounds of abortion due to danger to her life. Other indications for abortion are such serious risk of physical or mental defect in the child as would create permanent serious handicap, and reasonable possibility of conception as a result of unlawful intercourse. The Act interestingly defines "pregnancy" as "an intra-uterine pregnancy where the foetus is alive", so that ectopic or tubal pregnancy can apparently be terminated without having to conform to the Act.

Subject to an emergency exception, procedures may be performed only by doctors in desginated institutions with written permission of the superintendent. Such permission is dependent upon two doctors, not involved in the same professional partnership or practice, certifying appropriate danger to the woman or danger of serious handicap in an abnormal child. Regarding the indication of unlawful intercourse, permission for abortion is dependent upon a magistrate's certification of complaint, of appropriate interrogation of the woman and others involved, and of a finding on a balance of probabilities that unlawful intercourse resulted in the pregnancy. An alleged victim of rape or incest must make an affidavit or other statement under oath to this effect, explaining that the offence could be the cause of pregnancy.

An interesting provision of the Act is that, if an institution's superintendent refuses permission, any person dissatisfied may appeal to the Secretary for Health. Such person may include the woman, a member of ther family and, for instance, her doctor. It will be interesting to monitor whether in fact appeals are taken under this provision their degree of success. No appeal appears possible, however, against the grant of a superintendent's permission. A superintendent receiving medical opinions of indications for abortion must submit them to the Secretary for Health, and the Secretary may obtain any information he seeks regarding an abortion, whether or not the provisions of the Act have been observed, and whether or not the information tends to incriminate the person required to provide it. When there is an opinion that an offence has been committed, the Secretary

for Health shall report to the Attorney-General. The Secretary must also report a finding of professional misconduct to the Registrar of the Medical Council.

The Act has an emergency exemption from prior certification requirements regarding abortion on grounds of the woman's life or health, when the doctor must submit a report to the Secretary for Health within 48 hours of performing the procedure. Further, it provides that, notwithstanding the provisions of any law or agreement to the contrary, no doctor, nurse or other employee of a designated institution shall be obliged to participate or assist in an abortion. The wording is very broad, with no requirement that objection be based on, for instance, conscience, no exception for immediate life-threatening emergency, and no limit to the scope of "assistance." It may be questioned, however, whether this provision would protect refusal based, for instance, upon grounds of endangered woman's race or religion. The Act also governs fees for abortion services, and regulations made under the Act prescribes the same fees as are normally charged for similar medical and institutional services.

The law in force in Zimbabwe was guided by the earlier published Report of a Commission of Inquiry. This same pattern of legislative development occured in New Zealand, whose Report of the (McMullin) Royal Commission of Inquiry on Contraception, Sterilisation and Abortion, published in March 1977, paved the way to the Contraception, Sterlisation and Abortion Act 1977 and related amendments to the basic Crimes Act 1961. The New Zealand legislature did not enact the full recommendations of the Royal Commission in 1977, however and the departure from those initial proposals was part of a vigorous public and professional debate in New Zealand on the issue of abortion. Indeed, at one point the medical profession's non co-operation with the 1977 Act's complex system of authorising abortions was described as a strike. The legislative outcome of further consideration of the 1977 Act was amending legislation of 1978 to alter both the Contraception, Sterlisation, and Abortion Act and the Crimes Act. This legislation introduced measures proposed in the Report of the McMullin Commission but not adopted in 1977, and was recommended by the Abortion Supervisory Committee constituted under the 1977 Act.

The Committee has the task of granting or refusing applications for licences made by heads of institutions, under which abortions may be performed. A full licence authorises abortions in the institution regardless of the duration of pregnancy, and a limited licence is authority for the performance of procedures in the institution only during the first 12 weeks of pregnancy. Every doctor approached about or proposing an abortion must, at the woman's request, refer the case to two certifying consultants (at least one of whom is practising obstetrician or gynaecologist) with a request that they determine whether or not the procedure should be authorised. Only one other doctor need be referred to if the doctor originally approached is a certifying consultant. If they disagree, they must refer the case to a third such consultant. The Abortion Supervisory Committee maintains a list of doctors who act as certifying consultants. Authorisation by two such consultants is required in every case, except when an abortion is immediately necessary to save the woman's life or prevent serious, permanent injury to her physical or mental health.

Abortions may be performed with legal protection against criminal charges only upon legislated indications. The indications under legislation

of 1977 and 1978 amending the Crimes Act 1961 conform to the standard criteria of advanced laws, including the indications of serious danger (beyond that normally attendant upon childbirth) of life or physical or mental health, incest and sexual intercourse with a woman under care or protection, and indirectly, rape. The legislation states that, while not in themselves grounds for abortion, account may be taken in determining serious danger to life or physical or mental health both reasonable grounds for believing pregnancy is the result of rape, and the woman's age being near the beginning or the end of the usual child-bearing years. The Crimes Amendment Act 1978 added the indication for pregnancies of less than 20 weeks' duration that there is a substantial risk that the child, if born, would be so physcially or mentally abnormal as to be serious handicapped.

The detailed administrative scheme constituting and determing the functions of New Zealand's Abortion Supervisory Committee is too elaborate for simple presentation, the original Contraception, Sterilisation, and Abortion Act 1977 running to 46 sections and 26 pages in length, of which 37 sections and 17 pages are devoted to abortion. Among the Committee's duties are to take all reasonable and practicable steps to ensure that sufficient and adequate facilities are available throughout the country for counselling women seeking advice on abortion, to recommend maximum fees for services, to ensure that the administration of the law is consistent, and to ensure the effective operation of the Act. An interesting provision is that in creating a list of certifying consultants, the Committee shall have regard to the desirability of appointing doctors whose assessment of cases will not be coloured by views on abortion generally incompatible with the tenor of the Act, which under section 30(5) include views:

"(a) That an abortion should not be performed in any circumstances;

(b) That the question of whether an abortion should or should not be performed in any case is entirely a matter for the woman and a doctor to decide."

In the Supreme Court of New Zealand case of In the Matter of Margaret Lena Brasted (1979) it was held that doctors' views held before enactment of the 1977 legislation should not be taken into account, since the Act of that year showed both views legally unacceptable, and a conscientious doctor operating under the Act would be expected to apply its own non-extremist philosophy.

The Offences against the Person (Amendment) Ordinance 1981 of Hong Kong introduces changes of considerable significance to Hong Kong's pre-existing advanced law. To the indication for abortion that two doctors are of opinion that that pregnancy involves risk to the woman's life or risk of injury to physical or mental health greater than if pregnancy were terminated, was added two doctors' opinion that there is substantial risk that if the child were born, it would suffer from such physical or mental abnormality as to be seriously handicapped. Further, regarding those pregnant before the age of sixteen, or pregnant by rape or other sexual offences of which they are victims, doctors were empowered to find risks of injury to health by continuation of pregnancy greater than if an abortion were performed. A woman's complaint of a sexual offence made to a police officer within three months of its commission creates a rebuttable presumption that the doctor believed the pregnancy to have been so caused. Nevertheless, a pregnancy of more than 24 weeks' duration may be terminated only if two doctors find this necessary to save the woman's life. The Act also reduces the extraordinarily severe

punishment of life imprisonment for a woman who procures her own abortion from up to life imprisonment to up to seven years' imprisonment and a fine. In contrast, New Zealand's legislation provides a maximum penalty of a fine not exceeding $200.

Hong Kong's 1981 Ordinance goes beyond amendment to the law on abortion as such to introduce the crime of child destruction, based upon the English Infant Life (Preservation) Act, 1929, whose language was read into the 1861 Act's basic abortion law in the celebrated case of R. v. Bourne. It punishes as if for manslaughter whoever, with intent to destroy the life of a child capable of being born alive, wilfully causes the child to die before it has an existence independent of its mother. The exception to this, however, applied in the Bourne case, is that the act causing the child's death was not done in good faith for the purpose only of preserving the woman's life, which the Bourne case interpreted to include preserving her physical or mental health. Pregnancy for at least 28 weeks raises a rebuttable presumption that the child is capable of live birth.

The 1981 Penal Code of the Republic of Vanuatu formerly New Hebrides deals with abortion in a provision which is both simple and sophisticated. Section 117 provides penalties of two years imprisonment for anyone intentionally procuring a woman's miscarriage, including the woman herself, but provides that it shall be a defence to show that the act constituted a termination of pregnancy "for good medical reasons." This clearly includes danger to life or health, both physical and mental, but accommodates the medical implications of fear of serious fetal defect likely to result in handicap of the child born, and also social or socioeconomic factors describable as socio-medical and, for instance, rape and incest. Further, it supposes the medical reasons to have been satisfactory to a doctor, but does not limit such reasoning to doctors. Where no doctor is accessible, it may permit a nurse, midwife or other suitably qualified person acting in good faith to reach an assessment representing a good medical reason. The absence of monitoring procedures to ensure good faith enables courts to determine legality upon the facts of each case, subject to the provision that no prosecution shall be commenced without written consent of the Public Prosecutor. This introduces a potential for administrative monitoring, so that procedures conducted in individual hospitals may be given immunity from prosecution under indicated provisions. The system clearly lacks the certainity and specificity of a legislated scheme, but it has flexibility and an ability to accommodate new perceptions and sensitivities with the concept of medically appropriate treatment.

iii. Proposed Changes

Since 1977 a number of jurisdictions have proposed that their abortion legislation be amended. Barbados, for instance, publicised a draft law, which was not presented at that time. An interesting feature of this Bill is that it would have provided for delegation by doctors to appropriately trained health personnel:

> "The Treatment for the termination of a pregnancy of not more than 12 weeks duration may be administered by or under the supervision of a Registered medical practitioners ...." 4(1) (emphasis added).

A feature of countries which have adopted advanced laws has been the occasional incidence of "black-lash" proposals aimed to reduce the scope of such laws. Perhaps most notable of these, in view of the wide Commonwealth reference to the British Abortion Act 1967, and adoption of a number of its provisions elsewhere, was the Private Member's Bill proposed in the U.K. Parliament by John Corrie, M.P. The proposal was unsuccessful, and attracted vigorous opposition from the medical profession, but it also gained support of some who feared the 1967 Act was being abused. The Bill proposed among other reforms to reduce an upper limit for abortions of 28 weeks gestation to 20 weeks; this was unacceptable, but an amendment to 24 weeks was supported at third reading in the House of Commons.

The Nigerian Society of Gynaecology Obstetrics sponsored a bill seeking to legalise termination of pregnancy if 2 registerd doctors are convinced the life of the pregnant woman is endangered and if there is a substantial risk that the child would be born with a physical or mental handicap. Ironically the present and most vocal opposition came from certain women; and yet the Nigerian Society of Gynaecology Obstetrics sponsored the bill because of its concern of "the increasing number of illegal abortions carried out under inadequate health conditions which lead to a high death rates among women."

In Queensland, Australia, the government introduced legislation in 1980 intended to limit lawful abortion, and was opposed politically and by the medical profession. The Bill limited abortion to women who face death or suicide as a result of childbirth, and to victims of rape or incest, under specified conditions. Considerable controvery was raised by the tenor and detail of the Bill, which was defeated. Similarly in 1978 the Legislative Assembly of the Australian Capital Territory rejected a Bill that sought to prohibit the operation of private abortion clinics.

Despite these restrictive initiatives, however, the general thrust of developments in Commonwealth abortion law has been towards liberalisation. This may be a realistic movement, since even in jurisdictions with restrictive law and severe penalties for breach, there are few signs of criminal enforcement of the law since 1977. Further, in such jurisdictions many signs exist of illegal abortion idenitified in medcial practice in hopsital admissions. Laws appearing restrictive de jure may be liberal de facto because among other things lack of enforcement. Very few prosecutions for illegal abortions have been brought since 1977. Similarly, laws appearing liberal de jure may operate with restrictive effect. Further, not all laws defined in this Report as advanced are necessarily liberal, as the case of Canada may show, since its abortion law omits indications such as rape, incest and fetal abnormality liable to cause severe handicap. Evidence shows that under the advanced laws of Canada, Britain and New Zealand, legitimate abortion requests go unmet, leaving women to the resources of self-help and travel to more accommodating jurisdictions, such as the United States and, for instance, Australia.

These experiences serve to remind readers that this commentary is based simply upon the apparent state of Commonwealth laws. It is not a sociological record or analysis of how individual laws are found to operate. Identically worded laws may have quite different operation in practice, in ways beyond the trained perceptions of lawyers.

B. Judicial and Administrative Interpretations

i. Generally

While relatively little legislation has been proposed regarding abortion, and even less has been enacted, judical and administrative bodies in the Commonwealth have actively influenced perceptions of abortion law in significant ways in the course of the last five years. Indeed, a number of these initiatives are of such profound impact upon the present law, notably in achieving differentiation of abortion from similar medical treatments of women, as to warrant special consideration. This must relate not merely to understanding of existing law, but to the emergence of new issues out of existing law.

Accordingly, the section which follows this will address Emerging Issues, and include a number of issues which are derived from judicial and administrative interpretations of the law. Such issues as the legal difference between abortion and contraception, and the legitimate role which nurses may undertake in executing doctors' orders for termination of patients' pregnancies, have recently been significantly affected by administrative and judicial initiatives. Further, the performance of menstural therapies upon women of reproductive age has become separable from medical treatments which might uncritically appear to be analogous to termination of pregnancy.

The present subsection considers more static aspects of abortion law, addressing such issues as the rights of biological fathers under existing law, and the status in law of the fetus. The decisions have tended to conform to long-standing doctrine in regard to these matters. Judicial determinations have not so much taken the law into new areas, as reinforced its foundations. A further reinforcement exists, for instance, in the proposition that a mentally competent woman cannot be subjected to an abortion without her own independent consent having been given beforehand. This is so self-evident that very few enacted developed or advanced laws state this requirement in express terms. The body of legislation which regulates abortion also punishes criminal assaults, and imposing abortion upon an unwilling woman may be a grave assault indeed.

The issue did arise, however, in the Canadian case of Beasley v. McKellar General Hospital (1981) regarding a legal minor (aged under eighteen) who appeared ambivalent about an abortion for which she was eligible, and which her parents were pressing her to have. With the support of her boy-friend and his parents, (ex parte) litigation came before a High Court of Ontario judge, Osler, J., who restrained the hospital from acting upon her until it was clearly established that the patient was exercising her own free choice in the matter, unaffected by parental pressure. Preservation of a woman's right not to have an abortion is an important value essential for the law to protect. Commonwealth jurisdictions have different provisions, however, regarding mental competence which may be a condition of exercise of autonomy. Similary, the English high court has recently confirmed traditional legal doctrine regarding mature minors. It was held in the case of Re Shirley that a 15 year old girl could give legally effective autonomous consent to an abortion for which she was legally eligible despite her parents' opposition on religious grounds while the result might be different in these two cases, the rationale was the same.

A Canadian case showed that doctors owe patients legally enforceable duties to afford them the health benefits of laws, including those permitting abortion. In Zimmer v. Ringrose (1981), the Alberta Court of Appeal upheld an award of damages to a woman where an unsuccessful sterlization resulted in pregnancy the doctor should have helped the woman to have terminated in accordance with her wishes and the local law. The appeal court observed that:

> "The other aspect of the negligent after-care concerned the [doctor's] failure to provide his patient with reasonable standard of medical and hospital care. Upon discovering that the [patient] was pregnant, the doctor sent Mrs. Zimmer to the United States to undergo a proceudre [i.e. abortion] which could have been performed competently in Edmonton [Alberta] in a hospital setting with medical supervision. Although the hospitals at which the appellant had admitting privileges did not perform abortions for policy reasons, a reasonable practitioner in the [doctor's] position would have referred his patient to a colleague having privileges at one of the city hospitals which acccepted abortion cases. The [doctor], however, made no attempt to secure an abortion for the [woman] in a hospital in Edmonton. As a result of his failure to display the degree of care and concern dictated by the situation, the [woman] underwent a more painful and emotionally distressing experience than was necessary in the circumstances. Her suffering would have been substantially reduced if the [doctor] had discharged his duty by arranging hospital care." (p.226)

This establishes that women have rights to doctors' aid in using the provisions of local abortion law, and that doctors may be held legally negligent in failing or declining to facilitate abortions. Canadian law has no provision for conscientious objection to abortion, but where such provisions exist they often exclude objection in emergency cases, which may result from untreated pregnancies endangering life or health. The case of Zimmer v. Ringrose places abortion provisions within the law on health and welfare, and not just within the criminal law.

The English case of Sciuriaga v. Powell (1979) establishes that women have a right to competently and early done abortions. Watkins J. of the Queen's Bench Division held that the doctor had been in breach of contract in that be failed to exercise reasonable skill and care in carrying out the operation as soon as possible and had negligently omitted to conduct any following-up tests to establish the success of the procedure or to provide any follow-up care. The woman decided to have the child because once pregnancy was established at 22 weeks there was a reasonable risk to her health of having an abortion. The woman was awarded substantial damages for loss of earnings to trial, future loss of earnings, diminution of her marriage prospects on account of her unwed motherhood and pain and suffering.

ii. Spousal Consent

The 1977 Survey noted that "No Commonwealth abortion law requires the biological father's consent to an operation". That position has not changed, and it has indeed been confirmed at national and international levels. The underlying principle has been further compelled by increasing recourse to

artificial insemination by donor. Here, the biological father's indentity is usually not disclosed where it is reliably known. As against that however, improved techniques have made paternity testing in routine reproduction more reliable in positive identification of fathers.

Instances exist in which husband's threats of legal proceedings against doctors and hospitals who propose to terminate their wives pregnancies have deterred abortions (see the Canadian case of Re Simms and H (1979)). Since husbands very often have legal duties to provide their wives with health services, any such threats obstructing abortion indicated on therapeutic grounds could expose the husbands to the threat of legal proceedings, perhaps of a criminal nature. Further, doctors and hospitals accepting women as patients for abortion, but then declining to perform therapeutically indicated procedures, to which the patients have given an informed and autonomous consent when they are adults of competent understanding, would face legal consequences, and perhaps disciplinary proceedings, for abandonment.

No case exists in which a husband has been successful, except perhaps in obtaining a temporary injunction to delay a medical procedure for a very short time, such as 24 or 48 hours, so that the issue may be appropriately prepared and litigated. The cases that have gone to full trial, before the English High Court (Family Division) and, on appeal, before the European Commission of Human Rights, have been resolved against the father's claim. This is the more significant because the Abortion Act 1967, which was in issue in both cases, permits abortion not only upon a therapeutic indication, but also upon social, sociomedical or socio-economic reasons.

The English High Court case Paton v. Trustees of the British Pregnancy Advisory Service (1978) concerned a husband's application for an injunction to restrain his eight week pregnant wife's abortion since the husband's right to have a say in the destiny of the child he had conceived had not been respected. The husband alleged that his wife was being spiteful, vindictive and utterly unreasonable in seeking abortion, and that she had no proper legal grounds for seeking the procedure; he later accepted, however, that the provisions of the Abortion Act 1967 had been correctly observed. The case finally put to the court was that if doctors certifying satisfaction of the legislated conditions for abortion did not in fact hold the views they expressed, or had not come to their stated conclusions in good faith, there would be an issue triable by a court as to the propriety of the abortion procedure, and that in such a case an injunction might be issued to restrain the legally suspect abortion. The judge, Sir George Baker, President of the Family Division of the High Court considered this an academic issue, and observed that:

> "it would be quite impossible for the courts in any even to supervise the operation of the Abortion Act 1967. The great social responsibility is firmly placed by the law upon the shoulders of the medical profession."

Addressing the facts of the case, the applicant's admission that his wife's doctors had apparently acted conscientously and in good faith, the judge concluded that:

> "The two doctors have given a certificate. It is not and cannot be suggested that the certificate was given in other than good faith and it seems to me that there is the end of the

matter in English law. The Abortion Act 1967 gives no right to a father to be consulted in respect of a termination of pregnancy."

The judge further, noted that the Regulations made under the 1967 Act prohibited disclosure of information about abortions, with certain exceptions which did not, however, permit, disclosure to a husband or biological father without the woman's prior free consent. On declining to look behind the issued certificate, the trial judge noted that:

> "not only would it be a bold and brave judge ... who would seek to interfere with the discretion of doctors acting under the Abortion Act 1967, but I think he would really be a foolish judge who would try to do any such thing, unless, possibly, where there is clear bad faith and an obvious attempt to perpetrate a criminal offence."

This sets a high standard of proof to be met by one wishing to challenge a medical decision that abortion is appropriate according to the terms of an advanced law.

The woman had an abortion shortly after the decision in the case was made, rendering any regular appeal moot. The husband appealed, however, to the European Commission of Human Rights, contending that English law violated provisions of the European Convention on Human Rights on, inter alia, his "right to respect for his private and family life" (Article 8(1)). The Commission made a preliminary jurisdictional ruling that the husband's claim could be heard, since he could be considered a possible "victim of a violation of the Convention" due to his being so closely affected by the termination of his wife's pregnancy (Paton v. United Kingdom (1980)). The Commissioners considered the status of a fetus under the Convention (see IV. E.) and addressed the husband's claim to a right to family life rather more briefly. They concluded, however, that the wife's decision and the action proposed by her doctors, in so far as they may have interfered with the husband's right, were justified, because of the necessity to protect the rights of another person (see Article 8(2)), namely the mother herself. She was permitted to prevail in any conflict as to her medical management "being the person primarily concerned in the pregnancy and its continuation or termination." The husband's ancillary complaint about the procedural inadequacies of English law in not affording a right of spousal consultation was similarly dismissed.

The high level of rejection of the husband's assertion of a right to be consulted confirms a priori legal reasoning against a compulsory right not only of veto over abortion, but also of participation in decision-making. It follows that no stranger or third party enjoys a greater legal right of involvement. Some applicants have attempted, however, to assert alleged rights of a fetus to life, so as to prevent exercise of the woman's right to legal abortion. These attempts raise the issue of the present legal status of the unborn child.

iii. Legal Status of the Fetus

The 1977 Survey noted that the status of the fetus is not expressly raised in abortion laws in Commonwealth jurisdictions. Where the issue arises, it is pursued in terms of the general law on status and procedure,

and almost invariably is resolved by denial of legal status of the fetus. In the 1978 case of Paton v. Trustees of the British Pregnancy Advisory Service Sir George Baker, P. summarised the general Commonwealth law in his judgment, observing that:

> "The fetus cannot, in English law, in my view, have a right of its own at least until it is born and has a separate existence from its mother. That permeates the whole of the civil law of this country ... and is, indeed, the basis of the decisions in those countries where law is founded on the common law, that is to say, in America, Canada, Australia and, I have no doubt, in others".

This view, which is consistent with traditional common law jurisprudence regarding both civil law and criminal law, subject to the abortion prohibition itself, received support from the European Commission of Human Rights in the 1980 decision in Paton v. United Kingdom. The European Convention on Human Rights provides in Article 2(1) that:

> "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction ....".

Concerning whether a fetus was included in this formula and so had a protected right to life, the Commissioners noted that no other use of the word "everyone" in the Convention indicated a possible prenatal application, and concluded that Article 2 does not inlcude the unborn. Turning to the question of whether the word "life" included unborn life, the Commissioners determined that a fetus does not have an absolute right to life, since to recognise such a right would place higher value upon unborn life than upon the life of the pregnant woman, so limiting her own right to life which is clearly protected by Article 2(1). Such recognition of unborn life would be contrary, it was observed, to the object and purpose of the Convention. The Commissioners confined themselves strictly to the facts of the case, however, which involved the initial stage of pregnancy, the woman being only eight weeks pregnant, and medical grounds of danger to the woman's life. This accordingly leaves open contrary arguments regarding fetuses of more advanced gestational age, and abortion indicated on other than medical grounds. It was unclear whether a viable fetus may found a more successful claim than was presented in Paton, although exclusion of even a viable fetus from the meaning of the word "everyone" in Article 2(1) may be significant evidence against such a claim.

Sir George Baker P. referred in his 1978 decision to Canada, which was appropriate in light of a number of recent challenges made before its courts to operation of the legal abortion provisions of the Criminal Code. The leading case albeit subsequent to the 1978 Paton decision was in 1979 before the Ontario High Court Dehler v. Ottawa Civic Hospital whose judgment was upheld by the Ontario Court of Appeal in 1980 for the reasons which the High Court had given earlier (Dehler (1980)). The Supreme Court of Canada refused leave for further appeal. The case concerned an applicant's action for injunctions and declarations whose effect would have been to prohibit therapeutic abortions from being performed in certain hospitals in Ottawa. The applicant claimed to act "as representative of those unborn persons or that class of unborn persons whose lives may be terminated by abortion in the defendant hospitals". The underlying concept was that legally protected

persons orginate at conception or shortly thereafter. It was further contended that that persons' lives cannot be ended, under the Canadian Bill of Rights (since superseded in part by the Canadian Charter of Rights and Freedoms) except by due process of law. Therapeutic abortion committees, which have power to authorise abortions under the Criminal Code, have no clear obligation to observe due process of law, nor to hear advocates on behalf of the unborn children.

The court dismissed the claim that the abortion provisions of the Criminal Code violated the Bill of Rights, on the authority of the Supreme Court of Canada decision in 1975 in the case of Morgentaler v. The Queen (1976). Regarding the applicant's status to maintain the action, the court reasoned that no such status could exist, since a representative cannot have greater power to act than the party claimed to be represented, and unborn persons have no power to have proceedings brought on their behalf. A representative cannot confer on those claimed to be represented status or rights which the law does not otherwise accord them. The judge Robins. J. observed that:

> "Since the law does not regard an unborn child as an independent legal entity prior to birth, it is not recognized as having the rights the plaintiff asserts on its behalf or the status to maintain an action. A foetus, whatever its stage of development, is recognized as a person in the full sense only after birth."

The decision drew support from the modern history of Canadian case law, and also the Paton case in England, and the plaintiff Dehler cited no cases supporting his arguments. The decision was also congruent with that of the High Court of New Zealand in Wall v. Livingston (1982), where a member of the public was denied legal standing to challenge on behalf of an unborn child a decision to terminate a pregnancy reached according to New Zealand's Contraception, Sterlisation and Abortion Act, 1977. This renders rather more exceptional a 1979 decision of a Family Court judge in the province of Nova Scotia, in the case In Re Simms and H (1979). The case involved interpretation of the provincial Children's Services Act, however, rather than of underlying Common law principles.

The case arose in the Family Court when a husband, upset at his estranged wife's successful application for therapeutic abortion, applied for an injunction from the provincial Supreme Court to restrain the abortion. The Supreme Court hearing was scheduled for a short time ahead, when the judge in the Family Court would have been unavailable after the day of hearing he was conducting. This hearing concerned not the father whose proceedings were pending in the Supreme Court, but a stranger who was locally active in opposing lawful abortion. She applied to the Family Court for an order under the Children's Services Act, 1976 of Nova Scotia appointing her guardian ad litem of the unborn child for the purpose of representing the unborn child in the proceedings to be brought by the father. The Dehler decision would indicate that Mrs. Simms' position was not superior to that of Mr. Dehler. However the Family Court Judge, bearing in mind the need for a speedy decision, read the provincial Act to apply to an unborn child, and granted the application permitting Mrs. Simms to appear as guardian ad litem in the Supreme Court proceedings scheduled for hearing four days later.

The case may appear similar to others where temporary injunctions have been granted for 24 or 48 hours to permit due preparation of proceedings, the order in this case being intended to cover the 96 hour period up to the High Court proceedings. In the event, the hospital yielded to the threat of litigation and cancelled the therapeutic abortion, so that the High Court proceedings were not pursued. When indeed the wife, having given birth, acted to have the intervenor's guardian ad litem status set aside, the Court ruled the issue moot, and declined to hear the action. The case has raised significant questions, however, not only upon the proper reading of the Children's Services Act, 1976, but also upon whether a Family Court can give status to participate in High Court proceedings. Accordingly, the case may have raised more questions than it answered. It does show an instance, however, of a judicial decision, admittedly of low authority and questionable effect and implications, giving legal status to a guardian on behalf of an unborn child.

Academic opinion considers this Family Court case to have been incorrectly decided and, being at the lowest level of the hierarchy of courts, it does not contribute very much to precedent. In any event, it is likely to be overshadowed by litigation challenging the operability of the Canadian Criminal Code provisions allowing lawful abortion in light of the Canadian Bill of Rights, now the Charter of Rights and Freedoms, which protects life against termination except by legal process. The matter may seem to have been addressed in the Morgentaler and Dehler cases but late in 1981, the Supreme Court of Canada permitted a federal tax-payer to have legal standing to seek a declaration that the Criminal Code provisions violate the Charter (Minister of Justice of Canada v. Borowski). This case may work its way up through Canadian courts during the next few years.

iv. Preparatory and Inchoate Offences

Although "abortion law" centres upon termination of a woman's pregnancy, the law relating to abortion includes supplying and acquiring drugs and instruments intended for unlawful use in achieving abortion. Further, while Commonwealth case-law on abortion itself is relatively sparse, the historic case-law on supplying and acquiring means of procuring abortion is comparatively well furnished, containing precedents on whether or not particular substances or herbs are drugs, and what may be an "instrument ... intended to be unlawfully used or employed with intent to procure the miscarriage of any woman whether she be or be not with child" (Section 59, Offences Against the Person Act, 1861, see below). The historic legal problem arose because instruments so employed were by no means confined to surgical instruments, but included commonplace domestic and household implements capable of insertion into the uterus. Similarly "any poison or noxious thing" (ibid) used with intent to achieve miscarriage, raised problems where ordinarily available poisonous and non-poisonous substances were intentionally consumed, perhaps in the case of the latter in excessive quantities. Although historic English law in particular has confronted a variety of uses of implements and substances supplied by and delivered to persons aware of their potential to be used for purposes of unlawful abortion, and a jurisprudence capable of systematic analysis has emerged, few Commonwealth jurisdictions pay distinctive regard to narrower aspect of abortion law.

It is notable that every few indeed of the responses to the questionnaire circulated by the Commonwealth Secretariat which were given by Commonwealth jurisdictions for the 1977 Survey and the 1982 Report addressed

this aspect of the law, beyond giving references to statutory provisions. This may appear perfectly appropriate, since while abortion may be a crime of distinctive components, the crimes related to it, either before it is or may be committed, or after it has been committed designed to prevent detection, trial or conviction, are not distinctive. They form part of a general pattern of preparatory and inchoate offences like aiding and abetting which surround every substantive offence such as theft and assault.

Conspiracy

Conspiracy to commit a crime is an important crime in itself, which the law punishes in order that the unlawful object should not be attained. Even if those who menace society by their agreement to do wrong actually take no action in furtherance of their common design, they remain punishable for their act of agreement to pursue an unlawful obejctive. Jurisdictional systems of criminal law differ on details of what constitutes and evidences agreement, and on what objectives of agreement, whether to commit a criminal or non-criminal act, render the agreement an unlawful conspiracy. The modern law of unlawful conspiracy was conditioned by its relation to labour and industrial relations, affecting trade unions and conspiracies in restraint of trade, and its earlier history intersects with the oppression practised in the Court of Star Chamber, confirming both the sensitivity of the crime of conspiracy, and its liability to be used in a setting which is political, or which can be politicised.

The aspect of conspiracy which raises problems peculiar to abortion arises from the fact that, under basic abortion law expressed in section 58 of the 1861 Act, a woman acting alone is guilty of committing a crime of abortion upon herself only if she is "with child." The question must therefore be asked whether a woman who is not in fact pregnant can be convicted of conspiring with another that the other should perpetrate an abortion upon her. Reasoning proceeding from first principles that, whether she is pregnant or not, her agreement is in itself harmful to society at large and should be deterred and punished, is confirmed in the historic English case of R. v. Whitchurch (1890). The inference that she could also be convicted of being an accessory to another's attempt to abort her is further confirmed in R. v. Sockett (1908). Questions remain, however, of whether a non-pregnant woman can be convicted for conspiring or being an accessory with another to her own commission of abortion upon herself. This may be where section 59 of the 1861 Act is applicable. Answers to such questions in the context of any particular jurisdiction will be governed, of course, by its peculiar statutory law and case-law, although the latter is likely to be influenced by the historic English cases. For instance, the New Zealand Crimes (Amendment) Act 1977 section 4(2) states that "the woman or girl shall not be charged as a party to an offence" of abortion. Section 5 of that same Act repeals an earlier provision making a woman liable for procuring her own abortion "whether she is wih child or not."

Incitement

A related problem arises regarding the preparatory crime of incitement. Incitement or solicitation at common law is committed when one person counsels, procures or commands another to commit a crime, whether or not the the other actually commits it, or is influenced in any way by the solicitation. If the incitment causes the proposed crime to result, the inciter becomes an accessory to that crime and may be charged as such. Incitement

requires a recipient to the counselling, and what is counselled must be an offence. It is possible in principle for a person to counsel another to do an act the counsellor thinks is not an offence but which actually is, since the counsellor's ignorance of the law in theory affords no defence; although in cases where expressly malicious intent is required, that ignorance may operate to prevent that intent from having been formed, so as to be exonerating. If a person incites another to do an act which that person thinks is an offence, conviction for incitement may be possible even though the act counselled or incited is not actually an offence, since the cousellor or incited is not actually an offence, since the counsellor may be judged as if what was believed was in fact true. Incitement may similarly be found and convicted, even though the act counselled is in fact impossible to commit.

These governing principles reduce the significance of statutory language where a woman, falsely believing herself pregnant, incites another to terminate her pregnancy, since that other is guilty of the crime of abortion by acting upon her whether she is pregnant or not. The woman would accordingly be convictable for incitement. Similarly where a person incites a woman believed to be pregnant to terminate her own pregnancy, the fact that she could not be convicted of abortion when she is not actually with child affords the person who counselled her so to act no defence, since the person counselled what was believed and intended to be a crime. This touches upon a rather complex and uncertain matter, however, namely incitement to commit an attempt. This issue is better considered in the context of the law of attempt, and requires a reiteration of basic Common law principles of criminal liability.

Attempt

A traditional crime, such as unlawful abortion (meaning abortion performed other than for the purpose determined in good faith to preserve a pregnant woman's life or her physical or mental health) has two elements, namely the wrongful act (actus reus) and the wrongful mind (mens rea) causing and evidenced by the wrongful act. A person is not punishable merely for possessing a malicious, vicious or otherwise culpable intention. It is a Common law offence in itself to attempt to commit an indictable offence. The mens rea of the attempt is the mens rea of the offence attempted, and the actus reus of the attempt is an act going beyond mere preparation which falls short of the full offence but which is proximate to the offence attempted. The line between criminal attempt and mere preparation cannot be stated in the abstract, but is a matter for determination on the facts of each case, influenced by advocacy and perceptions of different decision-makers of fact, namely jury members and judges.

A long-standing and unevenly resolved issue concerns an attempt to perform a criminal act which is impossible of completion. The classical example of this is an attempt to steal from an empty pocket, which translates into the abortion context as an attempt to procure the miscarriage of a woman who is not pregnant. Section 58 of the basic English law resolves this problem regarding a person dealing with a woman supposed to be pregnant, since it defines the offence as undertaking certain actions with the unlawful intent "whether she be or be not with child." The problem remains, however, regarding a woman who acts upon herself, since to commit the full offence she must be "with child." More significantly for Commonwealth jurisprudence, however, jurisdictions whose abortion law follows the Indian Penal Code of 1860 face a pervasive problem, since the Code defines abortion, whether by a

woman upon herself or by another person upon her, as committed only when she is "with child." If it cannot be proven that she is, the issue becomes critical of whether a person acting to achieve her abortion is convictable for the crime of attempted abortion.

Proof of pregnancy may become available after menstrual evacuation from analysis of the uterine contents. If a fertilized ovum is disclosed it may become necessary to determine whether or not it had achieved implantation, since modern practice is to regard a criminally terminable pregnancy to have commenced only at the point of implantation (see IV A below, the contraception-abortion distinction). Application of this analysis to Penal Code jurisdictions is not possible in the absence of relevant precedent. The presence of such an ovum whether fertilized or implanted is of no consequence when evacuation was undertaken for a legitimate purpose of contraception or menstrual therapy (see IV B below, Menstrual Therapies). In such a situation there is no intent to abort but only an intent to provide a therapy for a gynaecological problem. If after such a therapy it can be proven that there was a fertilized ovum, this can not alter the intent of the doctor to provide a therapy, and as a result he could not be criminally liable for an attempted illegal abortion. If it was undertaken expressly for the purpose of abortion, the procedure should have conformed to the local abortion law. If it did not and the uterine contents have been preserved and subjected to forensic or other examination disclosing a fertilized (and perhaps implanted) ovum, this may show that the wrongful act of the intended crime of abortion was present, since the woman was "with child." There then may be conviction not just for attempted abortion, but for the full offence, since it is shown that the intent for abortion coincided with the prohibited act. In terms of the classical analogy, it becomes clear that the pocket was not empty. The dilemma remains where such proof is not available.

Regarding analogous "empty pocket" cases, an English decision in R. v. Collins (1864), held that placing one's hand in another's pocket intending to steal its contents but failing because the pocket is empty clearly cannot be criminal larceny or theft, but also that it cannot be criminal attempt either. The reasoning is that there cannot be any more than a preparatory step or a proximate step towards an end which cannot be achieved; that is, towards an act which cannot be done. Reinforcing reasoning may distinguish between using impossible means towards achieving a possible end, which is convictable as criminal attempt, and using any means directed towards an end which cannot be achieved, which can be neither preparatory nor proximate, and so is not convictable. In the later case of R. v. Ring (1892), the court stated that R. v. Collins had been wrongly decided and that attempting to pick an empty pocket is convictable, although the court gave no reasons for considering the 1864 case incorrect.

The Ring case was nevertheless taken to represent the law, and was followed in Malaysia in Munah bt. Ali v. Public Prosecutor, (1958) where the Court of Appeal, Thomson C.J. dissenting, held that under an Indian Penal Code model law, a person could be convicted of attempted abortion even where it was not proven that the woman was "with child." This may accord to the good sense of the community at large, since it was clear that the defendant was in fact attempting abortion. The issue, however, is whether the defendent was guilty of an attempt in law. The defendant appeared without counsel as a litigant in person, and may not have prepared argument that she should not be convicted of criminal intent alone, and that she did not commit the actus reus of the offence under the Penal Code. Section 511 renders it

criminal to attempt "to commit an offence punishable by this Code," but Section 312 dealing with abortion punishes only causing "a woman with child" to miscarry.

English law was clarified on this issue when the House of Lords unanimously decided the case of Haughton v. Smith, (1975) which considered the pre-existing cases and favoured the approach of R. v. Collins, expressly rejecting the conclusion of R. v. Ring. The High Court of Malaysia applied the House of Lords' principles stated in Haughton v. Smith in 1979 in Public Prosecutor v. Kee Ah Bah. The Indian Penal Code 1860 contains an illustration, perhaps itself questionable in light of the 1864 decision in the Collins case, that placing one's hand inside an empty pocket is convictable as attempted larceny or theft. This is not necessarily incompatible with Collins and Haughton v. Smith, however, in that the precondition of placing a hand in a pocket is that the intended victim must have a pocket, and there can by inference be no such intended theft if he had not. By analogy, the preconditon of committing abortion under the Penal Code is that the woman be "with child", and if she is not proven so to be, acting upon her is not a criminal attempt. The equation of a pocket which is empty with a woman's uterus which is not pregnant is appealing, but also deceptive. The true equation may be that for attempted theft the intended victim must have a pocket, and for attempted abortion under the Indian Penal Code the woman must be "with child". In the absence of the proven presence of a pocket or a child, there can be no conviction for unlawful attempt in interfering with the person or woman, since intent alone is not convictable, and the action taken cannot be a proximate step towards commission of the offence. Similarly, in the context of the English 1861 Act, a woman acting to procure her own miscarriage when she is not pregnant can be convicted neither of abortion nor of attempted abortion.

The decision in Haughton v. Smith is difficult to analyse in view of different although concurring judgments handed down by their Lordships, and its interpretation in later cases has proven difficult. Its outcome, furthermore, has been a source of some dissatisfaction, related perhaps to the difficulty of understanding the decision's reasons. In England, the Criminal Attempts Act 1981 came into force late in August of the year, with the intended effect of reversing Haughton v. Smith in "empty pocket" cases. The Act leaves open, however, the position as it exists under Indian Penal Code model laws, since its approach concerns mens rea of defendants. Section 511 of the Penal Code, having no equivalent under non-codified laws and the Criminal Attempts Act 1981, may continue to accommodate an exonerating argument based upon absence of the specified actus reus of criminal attempt, since no attempt is made to commit "an offence punishable by this Code." The Code prohibits abortion only where the woman is "with child". Indeed, commentators have questioned whether the intention of the 1981 Act to reverse the effect of Haughton v. Smith may be frustrated by the Act's judicial interpretation, in view of the interpretation the New Zealand Court of Appeal has given to a comparable provision in New Zealand's Crimes Act 1961, section 72(1). It is interesting to consider whether Malaysian jurisdictions will continue to follow the case of Munah bt. Ali v. Public Prosecutor, since its basis in English precedents was rejected in Haughton v. Smith, and no local legislation appears which as reversed the effect of that decision. (But see Public Prosecutor v. Kee Ah Bah below, IV. B).

v. Supplying or Procuring Means of Abortion

While historic English Common law has constituted such preparatory offences as conspiracy, incitement and attempt, which apply to the crime of abortion no less than to other crimes, statute law since 1861 has created a specific offence of unlawfully supplying or procuring the means of performing abortion. Section 59 of the offences against the Person Act 1861 provides that ...

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

This provision or a variant of it has tended to accompany the basic law expressed in section 58 of Commonwealth jurisdiction. The Code of Queensland and Western Australia, for instance, refer to use of force in the same knowledge. A body of case law on these provisions has arisen in a number of jurisdiction, often close to but not necessarily the same as that in England. The law is generally derived from and co-terminious with interpretations of the section 58 provision, and respond to the Bourne decision and the traditional techniques of statutory construction. Reciprocally, interpretations of such words as "poison", "noxious thing" and "instrument" in section 59 may be applied to the offence of the basic section 58. The resulting legal effect of the section 59 provision clearly relates to abortion. It is not central or sensitive, however, to the wider issue associated with abortion law as such. It is composed of "lawyers' law" which may be regarded as of some what secondary significance to the issues which in recent years have emerged as important to the future of abortion law.

The case of law of England, New Zealand and, for instance, the Australian jurisdictions has been interactive but not necessarily congruent upon such issues as whether a substance not noxious in its nature can be a "noxious thing" within the meaning of section 59. An historic English case has held that a substance not noxious in its nature can not be unlawfully supplied or procured against section 59 even if the woman taking it subsequently miscarries. In New South Wales it has been held, however, that an instrument can be supplied or procured unlawfully whether or not it is incapable of achieving a miscarriage. In R. v. Lindner, (1938) the South Australian court of criminal appeal reflected the view that prayer or witchcraft could be the equivalent of a "thing" under such a provision, and limited the section to "something that is, in the common experience of mankind and in some reasonable degree, capable of producing the result". (See p.415).

The 1939 Report of the (Birkett) Interdepartmental Committee on Abortion in England divided abortifacient drugs into two groups. The first group is composed of the many drugs which, in addition of such legitimate purposes as they may serve, have acquired a reputation of being capable of terminating pregnancy. Such drugs can usually be obtained without evidence of the purpose for which they are acquired. Even though the seller may suspect the purpose, for instance, from the quantity purchased or personal knowledge of the purchaser it can't be said that an ordinary open sale, and even less that a supply on regular prescription, will be an offence. The second group is composed, however, of special substances occasionally called such as "female

pills" or "female mixtures", which include among their ingredients drugs widely considered to have effective abortifacient properties which have few if any therapeutic qualities but which are ostensibly offered and advertised as remedies for "female irregularities", "women's ailments" or as "corrective medicines". The supply or procurement of such substances may violate the section 59 provision and perhaps other enactments on drugs or poisons.

The 1939 Report found that many drugs and preparations widely taken and perhaps sold in the beleif that they may terminate pregnancy are in common use for legitimate purposes. The Report observed that "it is clearly out of the question to attempt to impose a general restriction on the sale of all of these substances" (para 152). The Report made a number of restrective proposals but added that "it is clear ... that there will still be a great variety of abortifacient drugs and preparations untouched by any legislation, and we doubt whether any restrictive measures can be devised which would cope with the problem satisfactorily or adequately" (para 161). These words may remain particularly significant in jurisdictions where herbal or folk remedies may exist which are employed for the purpose of termination of pregnancy. Further, an analogy exists between substances and instruments, since many instruments in common use may be employed for unlawful abortifacient purposes. However strongly it may be wished to discourage their use upon moral, hygienic or therapeutic grounds, it is clear that the sale of such items as knitting needles, crochet hooks and hair pins cannot be restricted even when their intended use is strongly suspected to be unlawful.

Instances of "lawyers' law" arising under section 59 include the proposition that to be convictable for having acted to "procure" a poison, noxious thing or instrument, a defendent must have acquired it a proximate time before the unlawful attempt to use or empty it or achieve abortion. R. v. Mills (1963) a regular abortionist obtained instruments of abortion some time before the act charged and stored them in a cupboard. In quashing his conviction under section 59, the court held that to "procure" meant to obtain from another and one could not so procure against the section what was already a theft. Further, Australian jurisprudence holds that a defendant must be charged with supplying a prohibited means of abortion to a particular person or with procuring such means for use upon a particular women.

Thus, Commonwealth statutes based upon section 59 of the 1861 Act have produced an interesting but relatively minor jurisprudence of their own. The major interpretations of such provisions depend, however, upon matters more relevant to basic abortion law contained in section 58 and its equivalents. Acccordingly, acting with the legitimate intention of achieving contraception or menstrual therapy will create no offence against a provision modelled on section 59. A woman intentionally procuring means to achieve her own miscarriage may in principle be liable under section 59 "whether she be or be not with child", whereas she can be convicted under section 58 of using such means upon herself only when she is "with child". She may be convictable under section 58, however, for an attempt, in jurisdictions where attempting an end impossible to achieve is convictable. In jurisdictions where that is not a convictable attempt against section 58 it may be that procuring means is not unlawful against section 59. It remains possible in theory, of course, that a woman obtaining and using means upon herself when she is not pregnant who is convictable of neither a full offence nor an attempt based on a section 58 provision may be convictable of unlawfully procuring of means against a section 59 provision. However the latter provision's requirement for conviction of "unlawfully" procuring a means to be "unlawfully" used may make that an unlikely interpretation.

IV. The Legal Foreground: Emerging Issues

A. The Contraception-Abortion Distinction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Menstrual Therapies

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

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

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

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

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

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

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

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

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

The 1860 Penal Code provides in Section 312 that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Health and Allied Health Personnel

1. Generally

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

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

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

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

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

* Native custom recognition acts;

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

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

* Judicial interpretation of statutes or subordinate regulations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

iii. Trained Health and Allied Health Personnel

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

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

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

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

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

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

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

iv. The Role of Nurses and Comparable Professionals

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

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

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

> "... whosoever, with intent to procure the miscarriage of any woman ... shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony ..."

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Constitutional and International Human Rights Principles

1. Generally

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

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

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

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

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

ii. Guarantees of Health and Health Care

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

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

Other constitutions enunciate policies toward ensuring access:

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

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

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

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

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

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

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

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

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

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

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

iii. Provisions on Elimination of Discrimination

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

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

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

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

Discrimination against Women

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

Discrimination against the Poor

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

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

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

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

Discriminatory Effect

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

Negative and Positive Rights

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

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

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

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

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

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

iv. Privacy Provisions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

its due process clause:

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

its equal protection clause:

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

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

v. Remedies

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

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

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

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

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

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

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

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

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

V. Conclusion

'Past', we are told, 'is prologue' and this is no where more evident than in Commonwealth abortion law. This analysis suggests that the background to Commonwealth abortion law may provide more opportunities for the lawful introduction of medical tehnologies emerging in the foreground than may presently be realized. Commonwealth legal reforms may have tended to overlook these antecedents, possibly because it was thought that they could provide little perspective to the application of modern bio-technologies. Lord Macaulay, first and foremost a historian, in 1837 applied criminal sanctions only when a woman could be proven "with child". He explained to his Governor-General that pregnancy was family matter needing sensitive family support to determine its outcome, not the crude sanctions of criminal law. As a result, he urged that criminal law be applied, but only sparingly, when a woman was certain to have been "with child". A century-and-a-half later, Lord Macaulay's view of abortion as a private family matter is coming to be reincarnated in and possibly protected under some Commonwealth constitutions and human rights instruments with provisions on individual privacy and private family life.

Of those countries that have inherited the Indian Penal Code, Bangladesh is one of the few that has capitalised on its legal heritage to promote the health of women and their families. That heritage enables the provision of procedures up until the point when a woman can be proven, by reasonably available methods, to be "with child", i.e. about six to eight weeks since her last menstrual period. It would seem that other countries which have acquired the Indian Penal Code or variations on it might also consider providing such health benefitting services. Still others, in the process of changing their laws, might benefit from the Bangladeshi experience.

It is suggested that no one can seriously advocate the curative methods of abortion as being desirable methods. Most would probably agree that preventive methods of contraception are far preferable and should be more widely accessible to reduce the present high incidence and severe health effects of abortion. The point at which contraception becomes abortion is not clearly delineated in Commonweatlh abortion laws, and the point varies according to jurisdiction. Further, while some might consider a particular procedure to amount to abortion in fact, it may not necessarily be so in law. Before criminal liability can exist for abortion in some Commonwealth jurisdictions, certain stages such as implantation, proof of pregnancy or quickening have to have been established beyond reasonable doubt to have occurred. These stages of gestation can vary according to Commonwealth jurisdiction, and to whether a person is acting on a woman or a woman is acting on herself. A woman acting on herself does not appear to be criminally liable under the abortion provision in the majority of Commonwealth jurisdictions unless and until she can be proven to be "with child". This legal position holds the potential for being of major significance to women's health, particularly as self-administered methods (such as those discussed by M.P. Embrey in Appendix C) become available. Although it may not be widely appreciated, some legal provisions are thus capable of accommodating recent advances in medical technology as was urged by the Fourth Commonwealth Medical Conference, without the need for legislative intervention.

TABLE I

GESTATIONAL STAGES

(as of 1 November 1982)

Commonwealth country by region	Gestational Stages
	Quickening Stage Acting before a woman can be proven beyond a reasonable doubt to be quick with child, about 12-14 weeks, irrespective of indications for legal abortion under developed or advanced laws and irrespective of whether someone is acting on a woman or a woman is acting on herself.
Africa	
Lesotho	Might be subject to Roman Dutch law.
Sierra Leone	Might be influenced by the application of the 1861 Act.
Swaziland	Might be subject to Roman Dutch law.
Asia and Oceania	
Maldives	Subject to Islamic Shari-a law

With Child Stage

Acting before a woman can be proven beyond a reasonable doubt to be with child, about 6-8 weeks, irrespective of indications for legal abortion under developed or advanced laws.

	Those acting on a woman		A woman acting on herself	
	Legal	Illegal	Legal	Illegal
Africa				
Botswana		x	x	
Gambia		x	x	
Ghana		x		x
Kenya		x	x	
Lesotho	see above		see above	
Malawi		x	x	
Mauritius	x		x	
Nigeria				
Southern		x		x
Northern	x		x	
Seychelles		x	x	
Sierra Leone	see above		see above	

Table I (continued)

Commonwealth country by region	Gestational Stages			
	With Child Stage			
	Those acting on a woman		A woman acting on herself	
	Legal	Illegal	Legal	Illegal
Swaziland	see above		see above	
Tanzania		x	x	
Uganda		x	x	
Zambia		x	x	
Zimbabwe		x	x	
Asia & Oceania				
Australia				
Capital Terr.		x	x	
N.S.W.		x	x	
N.T.		x	x	
Queensland		x		x
S. Australia		x	x	
Tasmania		x	x	
Victoria		x	x	
W. Australia		x		x
Bangladesh	x		x	
Brunei	x		x	
Fiji		x	x	
Hong Kong		x	x	
India	x		x	
Jammu & Kashmir	x		x	
Kiribati	x		x	
Malaysia	x		x	
Maldives	subject to Islamic Shari-a law			
Nauru		x		x
New Zealand		x	x	
Papua New Guinea		x		x
Singapore	x		x	
Solomon Islands		x	x	
Sri Lanka	x		x	
Tonga		x		x
Vanuatu	depends on whether Customary, English or French law is applied			
Western Samoa		x		x
Europe				
Cyprus		x		x
Gibraltar		x	x	
Malta	x		x	
U.K.				
England/Wales		x	x	
N. Ireland		x	x	
Scotland	x		x	

Table I (continued)

Commonwealth country by region	Gestational Stages			
	With Child Stage			
	Those acting on a woman		A woman acting on herself	
	Legal	Illegal	Legal	Illegal
Western Hemisphere				
Antigua		x	x	
Bahamas		x		x
Barbados		x	x	
Belize		x		x
Bermuda		x		x
B.V.I.		x	x	
Canada		x	x	
Caymans		x	x	
Dominica		x	x	
Falkland Islands and Dependencies		x	x	
Grenada		x		x
Guyana		x		x
Jamaica		x	x	
Montserrat		x	x	
St. Kitts & Nevis		x	x	
St. Lucia		x		x
St. Vincent & the Grenadines		x		x
Trinidad & Tobago		x		x
Turks & Caicos		x	x	

TABLE II

LEGAL INDICATIONS

Commonwealth countries by region	Legal indications for granting an abortion							Statutes and cases in force as of 1 November 1982
	Risk to life	Physical health	Mental health	Fetal indications	Juridical (rape, incest, etc.)	Socio-economic	On request	
AFRICA								
Botswana	x							Penal Code(Cap.8:01), Secs. 160-162.
Gambia	x	x	x					Criminal Code(Cap.37), Secs. 15, 140-142. R. v. Bourne applied.
Ghana	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							Penal Code(Cap.7:01), Secs. 149-151.
Mauritius	x							Penal Code Ordinance(Cap.195), Sec. 235. Anath v. The Queen Supreme Court, 17 May 1977 Record No. 3103.

TABLE II (continued)

Commonwealth countries by region	Legal indications for granting an abortion							Statutes and cases in force as of 1 November 1982
	Risk to life	Physical health	Mental health	Fetal indications	Juridical (rape, incest, etc.)	Socio-economic	On request	
AFRICA (continued)								
Nigeria								
Northern States	x							Laws of Northern Nigeria, Laws R.E. 1963, Penal Code (Cap.89), Secs.232-234.
Sourthern 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.

TABLE II (continued)

Commonwealth countries by region	Legal indications for granting an abortion							Statutes and cases in force as of 1 November 1982
	Risk to life	Physical health	Mental health	Fetal indications	Juridical (rape, incest, etc.)	Socio-economic	On request	
AFRICA (continued) Uganda	x	x	x					Penal Code (Cap.106), Secs.136-138, 217, R. v. Bourne applied.
Zimbabwe	x	x		x	x			Termination of Pregnancy Act, 1977 S. v. Collop [1979 (4)] SA 381
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.
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.

TABLE II (continued)

Commonwealth countries region	Legal indications for granting an abortion							Statues and cases in force as of 1 November 1982
	Risk to life	Physical health	Mental health	Fetal indications	Juridical (rape, incent, etc.)	Social economic	On request	
Queensland	x	x	x					Criminal Code, Secs. 224-226, 282; R. v. Ross and McCarthy (1955) Q.S.R. 48.
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							Criminal Code Act 1924, Secs.51(1) 134-135, 165.
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							Criminal Code Act 1913, Secs. 199-201, 259
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
Brunei	x							Penal Code (Cap.22) Secs.312-316

TABLE II (continued)

Commonwealth countries by region	Legal indications for granting an abortion							Statutes and cases in force as of 1 November 1982
	Risk to life	Physical health	Mental health	Fetal indications	Juridical (rape, incest, etc.)	Socio-economic	On request	
ASIA AND OCENIA (continued)								
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. 46-47, 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 (formerly Gilbert Islands)	x							Penal Code (Cap. 8), Secs.150-152.

TABLE II (continued)

Commonwealth countries by region	Legal indications for granting an abortion							Statutes and cases in force as of 1 November 1982
	Risk to life	Physical health	Mental health	Fetal indications	Juridical (rape, incest, etc.)	Socio-economic	On request	
ASIA AND OCEANIA (continued)								
Malaysia	x	x	x	x	x			Penal Code (Cap.75), Secs. 312-316, The Penal Code (Amendment and Ex-Extension) Act 1976 extended the Penal Code (FMS Cap.45) thorughout 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, Sterlisation, and Abortion Act 1977 as amended 1978, Abortion Regulations 1978 and Amendment No.1

TABLE II (continued)

Commonwealth countries by region	Legal indications for granting an abortion							Statutes and cases in force as of 1 November 1982
	Risk to life	Physical health	Mental health	Fetal indications	Juridical (rape, incest, etc.)	Socio-economic	On request	
ASIA AND OCEANIA (continued) Papua New Guinea	x	x	x					Criminal Code (Cap.XXII), Secs.228-230; (Cap.XXVI), Sec.285, 319 Law Department/Legal Opinion, 13 August 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							Penal Code (Cap.19), Secs.303-305.
Tuvalu	x							Penal Code (Cap.8) Secs.150-152.
Tonga	x							Criminal Offences Act (Cap.15), Secs.94-96.
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.

TABLE II (continued)

Commonwealth countries by region	Legal indications for granting an abortion							Statutes and cases in force as of 1 November 1982
	Risk to life	Physical health	Mental health	Fetal indications	Juridical (rape, incest, etc.)	Socio-economic	On request	
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							Criminal Offences (Cap.37), Secs. Secs.52-53.
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.

TABLE II (continued)

Commonwealth countries by region	Legal indications for granting an abortion							Statutes and cases in force as of 1 November 1982
	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 Bowrne applied
Antigua and Barbuda	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					Offences against the Person Act, 1868 (Cap.141), Secs.61-62. R. v. Bourne applied.
Belize	x	x	x	x		x		Criminal Code Ordinance 33/1980, Title IX Secs.108-110, 125.
Bermuda	x	x	x					Criminal Code, Title 8: Item 31, Secs.194-196. R. v. Bourne applied.
British Virgin Islands	x	x	x					Offences against the Person Act (Cap.54), Secs.53-54, R. v. Bourne applied.

TABLE II (continued)

Commonwealth countries by region	Legal indications for granting an abortion							Statutes and cases in force as of 1 November 1982
	Risk to life	Physical health	Mental health	Fetal indications	Juridical (rape, incest, etc.)	Socio-economic	On request	
WESTERN HEMISPHERE (continued)								
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							General (Part V) Secs. 129-131
Dominica	x							Offences against the Person Ordinance (Cap.44), Secs.56-57.
Falkland Islands and Dependencies	x	x	x					Offences against the Person Act (Cap 56) Secs,53-54. R v Bourne applied.
Grenada	x							Criminal Code 1958 (Cap.76), Secs. 238, 250-251, 263
Guyana	x	x	x					Criminal law (Offences) Act (Cap. 8:01), Secs.78-80. R. v. Bourne and R. v. Newton and Stungo applied.

TABLE II (continued)

Commonwealth countries by region	Legal indications for granting an abortion							Statutes and cases in force as of 1 November 1982
	Risk to life	Physical health	Mental health	Fetal indications	Juridical (rape, incest, etc.)	Socio-economic	On request	
WESTERN HEMISPHERE (continued) 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							Offences against the Person Act (Cap.56), Secs.53-54.
St. Christopher and Nevis	x	x	x					Offences against the Person Act (Cap. 56), Secs.53-54. R. v. Bourne applied.
St. Vincent and the Grenadines	x	x	x					Indictable Offences Ordinance (Cap. 6), Secs.98-100. R. v. Bourne applied.
Trinidad & Tobago	x	x	x					Offences against the Person Ordinance (Cap.4), No.9, Secs.57-58. R. v. Bourne applied.
Turks & Caicos	x							Offences Against the Person (Cap.21) Secs.38-39.

TABLE III

PROVISIONS FOR PERFORMANCE OF ABORTION (IN LAW AND PRACTICE)

(as of 1 November 1982)

Commonwealth countries by region	Specified professionals	Specified institutions	Stage of pregnancy	Approval procedures
AFRICA Ghana	Practice suggests registered medical practitioner	Practice suggests Government hospital or other approved institution	Practice suggests up to 16 weeks	
Kenya	Practice suggests registered medical practitioner	No firm instructions but hospitals advised		Practice suggests 2nd medical opinion but not mandatory
Nigeria				Practice suggests 2nd medical opninion
Seychelles	Consultant gynaecologist	Victoria Hospital, Mahe	16 weeks and for "exceptional circumstances" thereafter as determined by the Director of Health Services	3 medical practitioners "(a) medical practitioner who is attending the pregnant woman and who proposes the termination of pregnancy; (b) the consultant gynaecologist who is to terminate the pregnancy; (c) the Director of Health Services".

TABLE III (continued)

Commonwealth countries by region	Specified professionals	Specified institutions	Stage of pregnancy	Approval procedures
Swaziland	Practice suggests registered medical practitioner	Practice suggests Government hospital, private clinic, and/or approved institution	Practice suggests up to 20 weeks	Practice suggests Chief Medical Officer
Uganda	Practice suggests registered medical practitioner			Practice suggests 2nd medical opinion
Zambia	Registered medical practitioner	Government hospital or other approved institution		3 registered medical practitioners "one of whom is specialized in the branch of medicine in which the patient is specifically required to be examined" except if it is "immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the woman"
Zimbabwe	Medical practitioner	Hospital, clinic or other institution so desinated		For physical health and fetal indications, the superintendent of the designated institutions in which the procedure is performed shall give approval for the procedure provided that the doctor performing the procedure and one

TABLE III (continued)

Commonwealth countries by region	Specified professionals	Specified institutions	Stage of pregnancy	Approval procedures
Zimbabwe (continued)				other doctor not in the same partnership as the performing doctor give their approval or 2 other doctors who are not members of the same partnership give their approval. For approval under fetal indications all approving doctors have to ensure that "prescribed investigation, scientific or otherwise, has been carried out." For the indication of unlawful intercourse the superintendant of the designated institution in which the procedure is performed shall give approval for the procedure provided that a Magistrate of a court in the jurisdiction in which the pregnancy is terminated has issued a certificate to the effect that he has satisfied himself that (i) a complaint about the unlawful intercourse has been lodged with the appropriate authorities,

TABLE III (continued)

Commonwealth countries by region	Specified professionals	Specified institutions	Stage of pregnancy	Approval procedures
Zimbabwe (continued)				(ii) on the balance of probabilities that the pregnancy in question is a result of that unlawful intercourse, (iii) in the case of alleged incest, the woman concerned is related within a prohibited degree to the person with whom she is alleged to have had incest, (iv) the woman concerned has alleged in an affidavit or in a statement under oath to the Magistrate that the pregnancy in question could be the result of that alleged rape or incest
ASIA AND OCEANIA Australia New South Wales	Medical practitioner			
Northern Territory	Gynaecologist obstetrician	Hospital	14 weeks for broad indications, 23 weeks for physical and mental indications	

TABLE III (continued)

Commonwealth countries by region	Specified professionals	Specified institutions	Stage of pregnancy	Approval procedures
Queensland	Medical practitioner			
South Australia	Legally qualified medical practitioner	Prescribed hospital	28 weeks	Law requires 2nd medical opinion except in emergency cases
Tasmania			Viability	
Victoria	Doctor		28 weeks	
Western Australia			Viability	
Bangladesh	Practice suggests 1. Registered medical practitioner 2. Appropriately trained health personnel including trained family welfare visitors	Practice suggests 1. Hospital 2. Outpatient procedures done during first eight weeks		

TABLE III (continued)

Commonwealth countries by region	Specified professionals	Specified institutions	Stage of pregnancy	Approval procedures
Hong Kong	Registered medical practitioner	Government hospital or a hospital or clinic approved by notice in Gazette by the Director of Medical and Health Services	24 weeks "unless such termination is in the opinion of 2 registered medical practitioners formed in good faith, necessary to save the life of the pregnant woman."	Law requires 2nd medical opinion except in emergency cases
India	Registered medical practitioner with prescribed training or experience in obstetrics and gynaecology as provided in 1975 Rules	Government hospital or Government approved institution as provided in 1975 Rules	20 weeks unless "immediately necessary to save the pregnant woman"	Law requires 2nd medical opinion between 12 and 20 weeks except in emergency cases
Malaysia	Practice suggests registered medical practitioner	Practice suggests Government, university and other hospitals		Practice suggests 2nd medical opinion
New Zealand	Registered medical practitioner	Licensed institution Full license - authorizes performance of abortions regardless of length of pregnancy Limited license - authorizes performance of abortion during the first 12 weeks of pregnancy	20 weeks unless"necesary to save the life of the woman or girl or to prevent serious permanent injury to her physical or mental health"	Two certifying consultants of whom atleast 1 shall be a practising obstetrician or gynaecologist

TABLE III (continued)

Commonwealth countries by region	Specified professionals	Specified institutions	Stage of pregnancy	Approval procedures
Papua New Guinea	Practice suggests registered medical practitioner	Practice suggests Government health institution	Practice suggests up to 12 weeks	
Singapore	Authorised medical practitioners with specified qualifications in obstetrics and gynaecology up to 16th week and further specified qualifications between 16 and 24 weeks	The abortion may be done in any clinic or doctor's office where drugs are used but it has to be done in a "government hospital" or a Government "approved institution" where surgical procedures are used	24 weeks	
EUROPE Cyprus	Registered medical practitioner	Hospital or approved clinic		Law requires 2nd medical opinion and competent police authority where the pregnancy is the result of rape
United Kingdom except Northern Ireland	Registered medical practitioner and Nurses under the delegation of a doctor	Government hospital or institution approved by the Secretary of State	1. Up to 20 weeks in an approved institution 2. Up to 28 weeks or viability if earlier in a Government hospital or approved institution specially authorized to do so	Law requires 2nd medical opinion except in emergency cases

TABLE III (continued)

Commonwealth countries by region	Specified professionals	Specified institutions	Stage of pregnancy	Approval procedures
United Kingdom except Northern Ireland			Government hospital or approved institution specially authorized to do so	
WESTERN HEMISPHERE Bahamas	Practice suggests registered medical practitioner	Practice suggests Hospital, not necessarily Government	Practice suggests 20 weeks (majority under 12 weeks)	
Belize	Registered medical practitioner		28 weeks unless necessary to save the woman's life or if the unborn child is incapable of being born alive	Law requires 2nd medical opinion
Canada	Registered medical practitioner	Accredited or approved hospital	Practice varies according to province	Hospital therapeutic abortion committee (not less than 3 physicians)
St. Christopher and Nevis			Viability	

TABLE IV

DIVISION OF JURISDICTIONS WITH COMMON CUSTOMARY LAW, BASIC, DEVELOPED AND ADVANCED LAWS

COMMON/CUSTOMARY	BASIC	DEVELOPED	ADVANCED
Africa	Africa	Africa	Africa
Lesotho	Botswana	Ghana	Seychelles
Sierra leone	Gambia	Kenya	Zambia
Swaziland	Malawi	Nigeria (Southern States)	Zimbabwe
	Mauritius	Sierra Leone	
	Nigeria (Northern States)	Uganda	
Asia and Oceania	Asia and Oceania	Asia and Oceania	Asia and Oceania
Maldives	Australia (Queensland)	Australia (Capital Territory)	Australia (Northern Territory)
	Australia (Western Australia)	Australia (New South Wales)	Australia (South Australia)
	Brunei	Australia (Victoria)	Hong Kong
	Kiribati	Bangladesh	India
	Nauru	Fiji	India (Kashmir)
	Solomon Islands	Malaysia	New Zealand
	Sri Lanka	Papua New Guinea	Singapore
	Tonga	Western Samoa	Vanuatu
Europe	Europe	Europe	Europe
	Gibraltar	Northern Ireland	Cyprus
	Malta		Great Britain
Western Hemisphere	Western Hemisphere	Western Hemisphere	Western Hemisphere
	Antigua & Bermuda	Bahamas	Belize
	Cayman Islands	Barabdos	Canada
	Dominica	Bermuda	
	Falkland Islands & Dependencies	British Virgin Is.	
		Guyana	
	Grenada	Jamaica	
	Monserrat	St. Christopher, Nevis & Anguilla	
	Turks & Caicos	St. Lucia	
		St. Vincent and the Grenadines	
		Trinidad and Tobago	

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Appendix A. Commonwealth Secretariat, Report of a Combined Medical-Legal Workshop, Barbados 18-22 June, 1979

ITEM III : THE LAW ON MEDICAL TERMINATION OF PREGNANCY AND RELATED ISSUES: CARIBBEAN AND PACIFIC ISLANDS AND CYPRUS: CONCLUSIONS

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61. This item was dealt with in three stages, introduced respectively by Professor Michael Beaubrun, head of the Department of Psychiatry at the University of the West Indies (Trinidad campus), and by Professor Bernard Dickens and Miss Rebecca Cook, joint authors of the discussion paper Law on medical termination of pregnancy (see p.64) and of A survey of abortion laws in Commonwealth countries, contained in the Commonwealth Secretariat publication Abortion Laws in the Commonwealth (published separately and available from the Secretariat - also to be republished shortly by the World Health Organisation, Geneva, in the International Digest of Health Legislation, Vol. 30, no. 3 or 4, 1979.

General Survey

Introduction

62. Professor Beaubrun noted a world-wide trend towards more liberal abortion laws, the main reasons for which he saw as being:

(a) the recognition of a woman's right to determine her child-bearing career and how her body was used, as a matter of health and welfare;

(b) the high incidence of unwanted pregnancies and illegal abortions, with resultant high maternal mortality;

(c) improved medical technology which had made termination in the early months safer than pregnancy itself; and

(d) the world population explosion.

63. Modern technologies had blurred the distinction between contraception and abortion, and had made the old abortion laws obsolete. The "morning after" pill, the intra-uterine device (IUD), prostaglandins and menstrual regulation by vacuum aspiration before the first period was missed were instances of methods which might be technically considered abortion but which were virtually impossible to detect or control. The test-tube baby also provided an example of a situation with which the laws of most Commonwealth countries could not deal. The old laws, he observed, had become unenforceable; an unenforceable law was a bad law, leading only to disrespect and disregard, and, if only for this reason, ought to be changed.

64. Professor Beaubrun noted that there had always been a gap between law and practice. The practice of abortion was

world-wide. When laws were restrictive, the poor were pushed into the hands of back-room abortionists. Obstetrical services were overloaded with the incomplete and septic abortions which resulted. Statistics from The human problem abortion - the report of the International Planned Parenthood Federation expert panel on abortion, Bellagio, Italy, February 1978 - indicated that more permissive laws were often followed by a decrease in maternal mortality.

65. The basic law from which most Commonwealth countries derived their abortion laws was the United Kingdom Offences against the Person Act of 1861. This stemmed from an Act of 1803, passed at a time when all surgery was dangerous and intended to preserve life. Because of surgical advances, the Act was no longer relevant.

66. Even where developed laws now existed which could be interpreted by government officials, there might be uncertainty about how such interpretation would stand up in a court of law. This could lead to ambivalence on the part of doctors and reluctance to perform abortions, or even to refer cases to other doctors who were willing to do so. Such ambivalence produced delays which could be dangerous, especially in adolescence when the recognition of pregnancy was often delayed anyway.

67. Other delays were occasioned by bureaucratic referral procedures required by some categories of advanced laws. Professor Beaubrun suggested that there was no need for committees or second referral procedures for the first trimester, but that doctors should be able to perform early abortions simply on request. Excessively detailed legal restrictions as to who should perform medical termination of pregnancy, and where it could be performed, could also cause undesirable delays.

68. In any culture, the person who actually delivered health care should be licensed to terminate pregnancy in accordance with the law. Where medically-qualified personnel were in short supply, appropriately-trained health and auxiliary personnel could safely perform simple procedures, thus releasing scarce obstetric and gynaecological specialists for more complicated cases. Nor where hospital facilities essential for the termination of early pregnancies, provided this was done by skilled, licensed, supervised paramedicals.

69. In Professor Beaubrun's view, the real issue was not just the right to life, but the right to an adequate quality of life, and the right to be a wanted child. The cycle of unwanted human reproduction increasingly polluted the human resource pool. Unwanted children grew up unable to give love or to trust, and were less able than others to succeed in life. This was particularly important in developing countries, where the quality of the human resource was a critical factor in development.

70. He took the view that the old basic law was now unworkable and counter-productive and should be repealed. If, instead of repeal, it was decided to develop new advanced laws, then the mistakes made in some countries should be borne in mind. Consent procedures should be simple or should not be included in laws at all. Ideally, only the consent of the woman herself should be needed. Existing laws which were first enacted to promote health now endangered it, Professor Beaubrun considered. He invited participants in the workshop to share with each other their problems of practice under the existing laws.

Discussion

71. In the discussion, it was generally acknowledged that a woman with an unwanted pregnancy was likely to turn to any means available to abort, if no legal and acceptable procedure were available. The frequent outcome was that she needed to be treated later in hosptial for complications resulting from the unhygienic and unskilled surgery.

72. Poorer women suffered most, since they could not afford to travel to other countries where advanced laws were in operation, nor could they afford to buy a safe abortion from a medical practitioner. They were thus obliged to resort to illegal abortionists or to dangerous, self-induced miscarriage.

73. Religious opposition to abortion was seen by some participants as a signficant obstacle to reform in certain countries, but existing cultural and social attitudes also presented obstacles.

74. Concern was expressed about abortion performed outside hosptials and approved clinics, as standards in doctors' surgeries in some areas would be difficult to control.

75. Problems of adolescent pregnancy were recognised as common to many countries. Participants in the workshop were unanimous in expressing their grave concern at the increasing incidence of teenage conception. Discontinuation of education, resulting in future unemployment and consequent lack of economic independence, was referred to. It was noted that adolescents tended to delay seeking help, both because they failed to recognise that they had conceived and because they feared to admit to sexual activity. The question of parental consent to abortion on a minor extended the problem of termination still further.

76. It was suggested that consideration should be given to de-criminalising abortion, and to the repeal of prohibitive language in laws, so leaving abortion to the medical and legal controls governing all other forms of surgery. In this event, there would be no need for new abortion legislation.

The Law on Abortion

Introduction

77. Professor Dickens, introducing the paper of which he and Miss Cook were the joint authors (see p.64), identified three types of Commonwealth law on abortion:

(a) basic law, which absolutely prohibited abortion in all circumstances - this might conform to the preference of some jurisdictions, although such a law cost lives which might be saved;

(b) developed law, which was based on the English 1938 Bourne decision permitting abortion to preserve life or physical or mental health - although such law was implicit in basic law, it often required to be made explicit by declaration of the courts or of a senior law officer, or possibly a health minister.

(c) advanced law, which set out in detail the conditions under which abortion was lawful.

78. Professor Dickens outlined the characteristics of an advanced law, beginning with the indications upon which such a law permitted abortion. These included strict necessity (to save life), the therapeutic indication (regarding serious danger to life or to physical or mental health), the fetal or eugenic indication (concerning serious handicap to the prospective child) and the juridical indication (rape and incest). Some of these were alternatives for others; for instance, the mental health indication might be applied to a rape victim where no rape indication was adopted.

79. Control of delivery of abortion services might be by various and alternative means. Practitioners with specified qualifications might be given authority to perform abortions, perhaps with a requirement of higher qualifications for later, more complex procedures, and permission of less specialisation for earlier procedures, which might be undertaken by paramedicals. A condition of authorisation might be service in public sector facilities, to aid equitable social distribution of services and to prevent concentration in the fee-paying sector.

80. Alternatively, control might be through facilities such as hospitals and approved clinics, which might be relied upon to employ personnel with appropriate qualifications. Again, facilities might be authorised for performance of procedures within specified gestational limits.

81. Professor Dickens emphasised that approval procedures, such as second or further medical opinions, could be a source of health-threatening delay and could be difficult to implement in practice where resources and personnel were limited. Similarly, consent of third parties, such as spouses or parents, might cause delay and loss of confidentiality for the patient. Nevertheless, some cultures might require an approach through the family structure rather than through an individual patient in isolation.

82. Conscientious objection to abortion should be accommodated, where compatible with preservation of the patient's life and health. In particular, the convictions of nursing personnel should be taken into consideration, although equally

they should not be permitted to place abortion patients at a disadvantage.

Discussion

83. A number of participants stressed difficulties due to the consent requirement, particularly regarding minors. It was also noted that women needed protection from third-party pressure to have abortions they did not want. This could be a source of subsequent maladjustment to having been aborted. Parental pressure on a minor might be particularly dangerous.

84. It was recognised that liberalisation of abortion law involved the issues both of the legal status of adolescents and of their capacity to give independent consent to contraceptive assistance. Legal doctrine on the mature and the emancipated minor might make legitimate treatment of minors more available than might at first appear, but clarification was needed for the satisfaction and protection of physicians and appropriate paramedical personnel.

85. Some participants considered that the linking of abortion services to general family planning counselling and service delivery was essential. They thought that abortion should be brought within government health services, and that where necessary the law should be changed to make this possible. It was considered that family planning guidance should involve males as well as females.

86. It was noted that abortion services might be more easily rendered under a developed law than under an advanced law, but that this might expose the practitioner to greater insecurity, risk and anxiety. An advanced law, specifying qualifications, facilities, approval procedures and possibly residence tests, might be more restrictive than a simple developed law.

87. The workshop noted that prohibitive abortion laws remained unenforced by prosecution even in the face of clear evidence of repeated violation. The value of such laws was thus open to question, especially when they prevented access to safe medical therapy. The effect was to send women to unskilled practitioners and to deny them continuing care and introduction to contraceptive information. Also, restrictive laws tended to affect only the poor, as women of financial means could easily evade them.

88. It was pointed out that the rape indication for abortion could raise difficulty, since rape was a juridical conclusion rather than a medical diagnosis. Evidence of rape had both legal and social aspects; physicians tended to respond to the latter rather than the former. However, the mental health therapeutic indication could be used to justify abortion in cases of rape.

89. The indication for abortion of failure of a conscientiously-used means of reasonably reliable contraception was seen as regarding abortion as a back-up or fail-safe service for contraception, not as an alternative, and as offering an incentive to use contraceptive means.

90. The need for simple procedures to obtain medical approval for abortion was stressed by a number of participants. Legally-compelled procedures which caused delay and anxiety were regarded as counter-therapeutic.

91. Some participants favoured toleration of conscientious objection to the peformance of abortion, but considered that the onus should be on the objector to show good faith and not to prejudice care of the patient. The possibility of a conflict arising between the objector's right to non-discriminatory advancement and the government's duty to make services available was noted. Applicants for appointments might be required to be prepared to carry out the full range of services offered.

Strategies for Interpretation or Reform

Introduction

92. Miss Cook outlined principles of law which might be applied in countries where legal reform was not yet possible, and suggested strategies which doctors might adopt to engage lawyers in a combined effort to interpret the law more broadly.

93. Doctors might attempt to get Attorneys-General or Directors of Public Prosecution to make statements clarifying how they would interpret existing laws. Although not an ideal solution, this might be the best that could be achieved in some countries. Doctors had an interest in persuading lawyers to clarify the law and to find creative ways of interpreting it, so that medical duties could be properly undertaken.

94. Efforts should be made to find common ground for discussion of fundamental principles with religious groups which were opposed to abortion, with the aim of developing a dialogue and mutual respect. Church groups, Miss Cook suggested, might respond to arguments based on the United National Declaration of Human Rights, and to the recent statement in Poland by Pope John Paul II on freedom of conscience.

95. The decriminalisation of abortion law might be sought through the repeal of specific provisions concerning early termination of pregnancy, and the control of illegal abortion might be effected through statutes governing the unqualified practice of medicine. Doctors should seek to be consulted by lawyers when medical statutes were re-drafted.

96. Miss Cook also suggested various methods of protecting and reassuring providers of abortion care. Physicians could be made aware that they could not withhold appropriate care from their women patients lawfully entitled to termination of pregnancy. Furthermore, treatment of incomplete abortion did not usually fall under abortion statutes but rather under the provisions of medical statutes and general law, and was usually considered a legitimate medical procedure. Consequently, failure to give treatment for incomplete abortion could constitute negligence.

97. Physicians should also be made aware that it had to be shown that there was a wrongful intention as well as a wrongful act for a conviction of a crime to be secured. If a doctor could show that an abortion had been performed in good faith, with proper regard and care, to preserve the woman's life or health, it would be very difficult to prove wrongful intent.

98. Good faith could be shown through openness as to the fact that such care was being provided for the community, directed to meeting the health needs of women, through consultation with colleagues; through maintaining proper medical records, evidence of which could be shown by the completion of a medical check list; and through charging reasonable fees, consistent with patients' financial means.

99. Physicians faced two questions regarding abortion, arising from its criminal and its welfare aspects respectively. The first was whether they could legally perform an abortion; the second, which there had been a tendency to ignore, was whether they could refuse to perform an abortion to which a patient was entitled. As the welfare aspect of abortion counselling and care developed, this second question might become the more important in guiding medical practice.

Discussion

100. The workshop noted that some existing advanced laws might be more inhibiting than developed law. Reference was made to bureaucratic delays resulting from the law in force in Canada and in Britain. It was agreed that there were lessons to be learned from the British and Canadian experience, and that these should be borne in mind when new legislation was being drafted.

101. There was some agreement that the options for decriminalisation should be considered, and also that statutes regulating the functions of health and auxiliary personnel needed some re-definition.

102. A number of participants expressed the view that medical termination of pregnancy during the first twelve weeks of gestation should be available on request.

103. In relation to parental consent to medical termination of pregnancy, lawyer-participants referred to the legal duty of parents to provide health services for their children, and saw this as constituting an overriding legal obligation which could be used in the particular case of pregnant adolescents. Participants were agreed on the principle that a minor had a right to privacy and confidentiality.

Conclusions

104. The following were the general conclusions reached.

National

(a) The material before the workshop, and the experience of participants, suggested that existing laws in many countries may be out-dated and in some instances may even create health

risks. Where this situation exists, legislative reform is the only remedy. The options which emerged are simple repeal, which may be unacceptable, or the introduction of an advanced law. Those concerned with the drafting of advanced laws could learn much from the experience of countries which already had advanced laws, and in this way avoid repeating some of their faults.

(b) It was desirable for the legal formalities in advanced laws to be kept to a minimum, to allow procedures for termination at the earliest possible stage of pregnancy.

(c) Notwithstanding the desirability that termination should be at an early stage, care should be taken to ensure that it is the woman's real and considered wish that her pregnancy should be terminated, and also to ensure her protection from undue pressure.

(d) Consideration might be given to decriminalising abortion during the first twelve weeks of pregnancy.

(e) It was considered important that abortion services should be rendered by adequately-qualified, but not over-qualified, personnel. In principle, it seemed that the person providing general health care for the community should be responsible for providing abortion services. If this person were a registered medical practitioner, there did not appear to be any reason why other qualifications should be sought unless they were required for specialised procedures.

(f) Consideration should be given to authorising suitably-trained paramedical personnel to provide early abortion services under appropriate supervision.

(g) It was considered appropriate for abortion for adolescents to be regulated under comprehensive provisions for fertility control and education. Ideally, parental concurrence should be sought, but when this is not available or is refused and the minor seeking abortion is left in jeopardy to life or health then naturally the patient's interest should prevail. In such cases there might be an alternative source of permission: perhaps the minor and her physician might have immediate access to an independent public officer, such as an Official Guardian or Children's Ombudsman, to present evidence and apply for legal authorisation by this officer in loco parentis.

(h) In the case of adult patients - and also minors, subject to (g) above - it was seen as desirable to minimise the need for third-party consents in legislation. Most participants felt that only the informed voluntary consent of the patient, competent to give consent, on whom the procedure is to be performed should have to be obtained.

(i) Pending possible implementation of an advanced law, measures should be considered which would ease physicians' fears of acting under existing laws. These could include the

development of a check-list of items which physicians could show they had taken into account in their decisions, in order to demonstrate their good faith. Emphasis on physicians' good faith directed to the welfare of patients might do much to remove the criminal taint from abortion procedures.

(j) It was desirable that providers of health who claim conscientious objection to being involved in abortion should be required to refer patients to personnel or agencies known not to be averse to the procedure. However, the workshop saw no room for conscientious objection in cases of emergency or post-abortion care.

(k) Ideally, abortion services should be rendered in facilities offering general female health services, including contraception counselling and services, sterilisation and breast self-examination.

(l) Consideration should be given to accommodating abortion primarily in laws focussing not upon crime and punishment but upon health and welfare.

(m) A continuing dialogue should be maintained between doctors and lawyers on the impact of legislation upon medical practice, and the impact of medical technology upon the relevance and application of laws.

(n) National documentation of proposals for legislative reform and copies of legislation enacted should be sent to the Commonwealth Secretariat, in order to ensure that other jurisdictions might benefit from collective experience in this difficult field.

Regional

(o) Regional groups of countries should explore the possibility of regional collaboration to improve the legal availability of abortion services, to make means of fertility control more freely available, to determine the appropriate qualifications of paramedical personnel involved, and to clarify and, where necessary, reform relevant legislative provisions, including those concerning adolescents. The provision of a consultant, on request, to assist governments of the region in this connection, and to advise on how recommendations of the workshop might be implemented, should be considered.

(p) Regional groups should also promote the training and monitoring of appropriate health care providers, on a regional basis, in the light of the workshop's recommendations.

Commonwealth Secretariat

(q) The Secretariat should, where requested, assist in whatever way it can governments and regional groups seeking to implement recommendations of the workshop.

(r) The Secretariat should from time to time circulate to member governments documentation on proposals for legislative reform and copies of relevant national legislation. A periodic list of relevant health legislation in the Commonwealth should also be made available, possibly by

extracting references and citations from the Commonwealth Law Bulletin.

(s) The Secretariat should seek to arrange further workshops and continue to promote discussion to improve understanding between doctors and lawyers on abortion, contraception, adolescent health care and associated matters.

Appendix B Commonwealth Secretariat, Report of a combined Medical-Legal Workshop, Malawi, October 1979

ITEM III : THE LAW ON MEDICAL TERMINATION OF PREGNANCY AND RELATED ISSUES: AFRICAN AND ASIAN COUNTRIES: CONCLUSIONS

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63. This item was introduced by three speakers. Dr. Nimrod Mandara, formerly head of the Muhimbili UMATI clinic in Dar es Salaam and medical director of the Tanzania Family Planning Association, and now working as a gynaecologist in Swaziland, dealt with medical issues relating to the medical termination of pregnancy. Professor Bernard Dickens, Director of the Law and Health Care Programme of the Faculty of Law, University of Toronto, Canada, and also Associate Professor in the Faculty of Medicine of that university, analysed the main features of various types of law governing abortion. Miss Rebecca Cook, formerly head of the Law Programme, International Planned Parenthood Federation, outlined options for doctors. Miss Cook and Professor Dickens are the joint authors of the discussion paper Law on medical termination of pregnancy (see p.69) and of A survey of abortion laws in Commonwealth countries, contained in the Commonwealth Secretariat publication Abortion laws in the Commonwealth (published separately and available from the Secretariat - also to be re-published by the World Health Organisation, Geneva).

Medical Issues

64. Dr. Mandara said that, in general, about ten per cent of all pregnancies aborted before the twenty-fourth week. A large proportion of these sponteneous abortions (about 80 per cent) were incomplete and required medical attention. Complications such as bleeding and sepsis were the common reasons for seeking medical treatment, and even with good medical attention some abortion cases died, usually because of delay in seeking treatment.

65. In many African countries numerous hospital beds were taken up by abortion cases. In the main medical centre in Dar es Salaam, for instance, over 4000 (two-thirds) of the total of 6000 gynaecological admissions in 1978 were diagnosed as abortion cases. Of these, it was estimated that 85 per cent were spontaneous abortions and 5 per cent had been interfered with before admission; as for the remaining 10 per cent, it was difficult to ascertain whether there had been any interference or not. Complications, usually bleeding and sepsis, were common and had resulted in nine deaths (a mortality rate of over 2 per 1000). A study in Khartoum, Sudan, in 1975 had shown that the ratio of admissions of incomplete abortions to other admissions of maternity cases was 1:1. The pattern in other centres in Africa was similar.

66. Dr. Mandara pointed out that induced abortions had been carried out for a variety of reasons in almost every culture before proper medical services had been established. In parts of Africa, such procedures had been carried out before the Western medical and legal systems had been established, and even to this day cases of abortion complications frequently arose, caused by the use of herbs or crude instrumentation, often with grave results.

Indications for pregnancy termination

67. Indications for the medical termination of pregnancy varied, depending on the law governing abortion in particular countries. On the whole, however, the law was imperfectly understood by those carrying out terminations. Common indications included:

(a) risk to the life of the woman;

(b) risk to the physical or mental health of the woman if the pregnancy were allowed to continue;

(c) some degree of likely physical or mental impairment of the child;

(d) pregnancy resulting from rape or incest, or some other unaccpetable sexual union;

(e) socio-economic reasons, where the pregnancy would affect the welfare of existing members of the family;

(f) failure of routine contraceptive use.

68. In most African countries, Dr. Mandara explained, legal justifications for abortion were restrictive, and allowed only for the first two of these indications, risk to life and risk to health. A woman seeking abortion for any other reason was consequently obliged to consult a back-street abortionist. The expertise of such abortionists was questionable and they often employed unsafe procedures which put women in grave danger of serious complications and even death. This was one important reason why abortion was becoming a serious problem in so many countries.

69. The deaths of all the nine abortion cases who had died in the Dar es Salaam medical centre in 1978 had resulted from illegally induced abortions. Of the surviving cases, a high proportion of those who had developed sepsis would not be capable of bearing children in the future because of obstructed fallopian tubes. Infertility was a common problem in Africa; infertility management was not only time-consuming and expensive, but gave disappointing results even when surgery had been attempted. And few infertile women were fortunate enough to be able to consult a physician, let alone undergo surgery.

Current medical practice

70. Medical developments in recent years had changed this gloomy picture to the extent that the risks of legally performed abortion, especially in early pregnancy, were less than

those of allowing the pregnancy to continue to its full term. During the first few weeks of a missed period, termination of pregnancy could be easily and safely carried out by vacuum aspiration - either as a simple menstrual extraction or regulation without an anaesthetic or with only a local anaesthetic and as an outpatient procedure (a "lunchtime" abortion); or by means of vacuum aspiration apparatus in the operating theatre under local or general anaesthetic during the first twelve weeks of pregnancy. Routine dilation and curettage (D and C) could also be employed during this early period. Complications arising from apsiration termination were few, and without any deaths in many centres.

71. More recently, vaginal prostaglandin tablets had been tried and "morning after" pills were also under trial, in some countries with promising results.

72. Surgical evacuation of the uterus became increasingly dangerous during the second trimester of pregnancy because of the risk of injury to the uterus and excessive bleeding. Intra-amniotic or extra-amniotic prostaglandins were safer and more effective than first trimester abortions. The aim should therefore be to carry out the medical termination of pregnancy before the twelfth week of pregnancy, or, better still, as a simple menstrual extraction as soon as the woman missed a period. Where second trimester terminations were unavoidable, prostaglandins were much safer than hysterotomy, which was not only costly in terms of personnel and hopsital beds but also involved risks associated with scarred uterus.

The need to review abortion law

73. Despite the fact that medical developments had made pregnancy termination such a safe procedure, Dr. Mandrara observed, legal developments had lagged behind. The consequence was that induced abortion, which was known to occur frequently, was still being performed by persons not trained to carry out the procedure - secretly, in places with very poor facilities, and often with serious complications resulting.

74. Besides pointing to the need for a complete reappraisal of the laws governing abortion, Dr. Mandara suggested that attention should also be focused on the moral, cultural and legal aspects of contraception, with the aim of making contraceptives available to all who needed them. If existing laws could be modified to allow easier access to legal abortion, the use of contraceptives might even be made mandatory after every pregnancy termination.

75. Dr. Mandara ended his presentation with the warning that the present system for the delivery of medical care in many countries, particularly in Africa, would be hard pressed to meet the demand that could be expected to follow the introduction of liberal abortion laws. It was therefore necessary to move carefully, and to try to balance the law against the medical availability of abortion services.

The Law on Abortion

Types of abortion law

76. Professor Dickens opened his presentation by distinguishing three types of law governing abortion in the jurisdictions represented at the workshop, namely:

(a) basic law,

(b) developed law,

(c) advanced law.

77. Basic law had emerged from section 58 of the English Offences against the Person Act, 1861, and was expressed in simply prohibitive language. Professor Dickens read the section verbatiam, and emphasised that it used the word "unlawfully" on four occasions to define the prohibition; at no point, however, did the section say when abortion might be undertaken "lawfully".

78. Developed law demonstrated that, as an exception to the criminal prohibition, abortion might be lawfully performed where necessary to preserve a woman's life or health. The development of the law had been established by the judgement in the celebrated 1938 English case, R. v. Bourne. In that case, the pregnancy of a young girl made pregnant by rape had been terminated lest she might become a "mental wreck". In instructing the jury that abortion performed in good faith on this ground justified acquittal, the judge had recognised the legality of both physical and mental health indications for abortion.

80. While every basic law was inherently developed when construed, cases leading to clarification were few. Professor Dickens observed that development could be achieved not only by legislatures and by judicial rulings, but also by senior members of the executive, such as attorneys-general and ministers of health, presenting their understanding of the law. This would not be legislative, nor would it bind the judiciary; it would in fact be nothing more than a clarifying statement of what the law already was.

81. Advanced law specified indications upon which abortion was lawful, and provided machinery for the prior establishment of legality. Specific indications included the indication of strict necessity, concerning risk to life and grave risk to permanent health, and the therapeutic indication incorporating the Bourne test of serious danger to physical or mental health. Other indications included the fetal or eugenic indication, relating to the fetus and its prospect of serious handicap; the juridical indication, where rape or incest had caused the pregnancy; and the social, socio-medical or socio-economic indication.

82. A number of advanced laws included such indications, but the therapeutic indication could be quite comprehensive, so that an advanced law excluding a rape indication as such

might permit termination of a victim's pregnancy resulting from rape on the ground of danger of mental health, compatibly with the Bourne cases.

Considerations for legal reform

83. Professor Dickens noted the evolution from crime-control laws (basic), through laws recognising medical exceptions (developed), to laws focusing upon health and welfare (advanced). He stressed the desirability, for purposes of public comprehension and health providers' protection, of the law being at least developed, and expressed in language clearly stating what was lawful. Where legislators did not address the issue, attorneys-general and ministers of health might be requested or encouraged to offer clarification.

84. He observed that a gap existed between the restrictiveness of the written law and its very rare enforcement, although breach was obviously frequent. He further observed that women with means could meet or evade the law with skilled, safe medical attention; the poor, the young and the uneducated bore the health hazards of unskilled, unqualified interference. This was the more tragic when grounds existed for lawful treatment.

85. Laws governing abortion were silent as to the point in time when pregnancy might be said to commence, but evolving methods of contraception - particularly by "hindsight" methods such as "morning after" pills - might blur the distinction between contraception, which was lawful, and abortion. Accordingly, however abortion was defined, the law should not be applicable in such a way as to obstruct means of legitimate contraception. Indeed, the case was worthy of consideration to revert to the position of the historic Common Law, where pregnancy was first evidenced by "quickening", which was taken to occur at the end of the first trimester.

86. In conclusion, Professor Dickens noted the obstacles that might exist to enacting an advanced law. He also pointed out that certain forms of advanced law could in fact be restrictive, by introducing mechanisms for approval which depended on the use of personnel who might not be available. A clear statement that national law was in developed form might well be adequate to serve the health needs of the majority of women.

The Position of Doctors

Options

87. Miss Cook began her presentation by dealing with options for doctors where laws were not developed. Abortion laws expressed both in basic and in developed forms permitted doctors to perform abortions when medical indications were indentified in good faith, she observed. Doctors who could provide suitable evidence of their good faith were thus in a secure position. To assist them to demonstrate good faith they could use a check-list of considerations which a doctor acting in the interest of a patient's health would apply. An adequate medical history, with diagnosis and prognosis properly recorded, as for any other conscientiously-proposed medical

procedure, would furnish convicing evidence. Furthermore, such evidence would be re-inforced if the fee charged for an abortion were moderate and in accordance with the reasonable means of the patient to pay, since if the procedure were medically necessary to preserve the patient's health, it could not conscientiously be priced beyond the patient's means.

88. A patient presenting an incomplete or a threatened abortion, impossible to identify as either spontaneous or induced in origin, exposed doctors to suspicions and risks against which legal protection was required. The conceptual transition of abortion law from criminal law to law focusing on health and welfare should permit immediate treatment to be given without regard to the production or preservation of forensic evidence.

Obligation and objection

89. Miss Cook pointed out that under both developed and basic law a doctor might have an obligation to peform an abortion. Where a woman's health was endangered in such a way that it was desirable to terminate her pregnancy, the practitioner's duty to the patient would necessitate the offer to her of the option to have an abortion. The doctor could not abandon the patient, but might have to refer her to someone else for the option to be taken up. Failure to offer the option, leading to the woman's death, might possibly incur prosecution for manslaughter by criminal negligence. If death, or injury to physical or mental health, resulted, a civil claim for malpractice might arise. Only a law expressly affording doctors, nurses and other personnel the right of conscientious objection to abortion would relieve them of their legal duty to a patient. A condition of such a law would be that it should state that performance of abortion was lawful upon specified indications.

Regulations

90. Where the drafting of an advanced law was proposed, legal regulation of abortion might be by means of the medical and other indications already outlined by Professor Dickens, Miss Cook continued. Alternative means existed, however, such as permitting persons of specified qualifications to make the decision that an abortion might be performed and to act accordingly. Some existing advanced laws specified that late-term procedures could be performed, except in emergency, only by doctors holding specialist qualifications. Conversely, it might follow that under a prospective advanced law paramedicals might be authorised to perform very early procedures.

91. An alternative to regulation by specifying professional qualifications was regulation by specifying the types of facilities required for the performance of abortions. Some advanced laws now in force specified the use of government or other specially-approved clinics or hospitals, where personnel could be expected to possess the requisite skills and conscientious judgement. The standard of facilities and the level of qualifications required could be related to the stages of the pregnancies to be terminated - early stages needing simpler facilities and lower qualifications, later stages needing more sophisticated facilities and higher qualifications.

92. Miss Cook suggested that this gestational criterion might also be applied to indications for the medical termination of pregnancy. Early abortion might be allowed on a broader range of indications than later abortion, which might be permitted, consistently with common child destruction laws, only to save life or prevent permanent serious injury to health.

93. She also stressed that, especially where abortion was permitted only on the grounds of preserving life or health, approval procedures required by advanced laws should not be such as to jeopardise the very services the laws were designed to make available. These procedures should not involve delay, or degrading difficulties for the pregnant woman, through the introduction of persons who were, in practice, unlikely to be accessible. Similarly, the introduction of a third party in the decision on treatment might give that party a right of veto over a medical initiative taken in good faith to preserve a woman's life or health.

94. Some advanced laws contained distinction and sometimes complex reporting requirements, presumably to prevent abuse of legal provisions. Evidence suggested, however, that in practise such reporting requirements served little purpose, except to differentiate the medical termination of pregnancy from other medical procedures. It was questionable whether requirements for abortion needed to be different from those relating to other comparable procedures.

95. In conclusion, Miss Cook suggested that governments which were unable to back up an advanced law with the resources needed to make it operate properly might better serve the interests of their people by having a developed law. Furthermore, where available resources were limited these might be used more beneficially by being concentrated on preventive care, through programmes providing contraceptives and information about contraception.

Discussion

The cost of illegal abortion

96. The workshop recognised that costs associated with illegal abortion were a sizeable charge upon the limited resources of personnel and facilities in all countries. Individual and family costs were expressed in women's deaths and morbidity, in infertility caused by unskilled interference, and also, for instance, in premature school-leaving. It was not possible in many cases to identify whether the abortions were spontaneous or induced. Frequent cases occurred, however, where abortion induced by such means as the use of herbs or crude instruments had grave results. Virtually all abortion-related deaths in major hospitals were known to have followed illegal interference. For survivors of such interference there was a high risk of secondary infertility, which could have unfortunate personal consequences, particularly in African cultures.

97. It was noted that medical developments in recent years had greatly reduced the risks relating to medically-performed

terminations of pregnancy. Such risks were now less than those connected with childbirth. In the first few weeks of a missed menstrual period vacuum aspiration techniques could be employed, and safe operating-room techniques were available for the termination of pregnancies of up to 12 weeks. Such means as vaginal prostaglandin tablets offered promise for the future. Later terminations carried greater risks; in the interests of health care it was best to perform terminations at the earliest possible stage, preferably in the first trimester - i.e. within the first 12 weeks after conception.

98. It was also noted that modern thinking on abortion, as reflected in recent legal developments in many parts of the world, had turned from concentration on criminality to consider actions of health and welfare. New laws enacted in recent years thus tended to focus on the health and well-being of women and children as indications for the lawful termination of pregnancy.

99. Participants pointed out, however, that to liberalise the law on abortion might place existing health services under even greater pressure than that at present caused by the need to treat complications arising from illegal abortions. It was thought desirable, therefore, also to give attention to preventive medical intervention, notably through making the means of contraception more easily available and encouraging their use.

100. The lack of sufficient data, systematically gathered, on the consequences of illegal abortion, was thought to conceal the extent of the problem, particularly from government agencies. Information could be obtained from hospitals, schools and other sources on the social cost of maintaining legal prohibition in appearance, if not in practice - of the medical termination of pregnancy.

The law and its shortcomings

101. The workshop noted that abortion laws tended to be expressed in three different ways. Basic law prohibited abortion when done "unlawfully", but was silent on the circumstances in which abortion might be performed lawfully. Developed law recognised the legality of abortion carried out in order to save a woman's life, or to preserve her physical or mental health. Advanced law prescribed a range of medical, and sometimes non-medical, indications for lawful abortion and procedures for establishing legality before the event. Developed law interpreted basic law in accordance with the Bourne case of 1938, so that developed law could be seen as implicit in basic law, as understood by lawyers and as interpreted by Commonwealth judges after the event. It was considered, however, that the law was better understood by doctors and the public at large when its meaning was explicit.

102. The disadvantages fo the law appearing to doctors and the public to be prohibitive were seen to include the following:

(a) Women turned to illegal means of procuring abortion, even when legally entitled to the procedure, and might delay going to hospital when illegal interference had resulted in injury or infection.

(b) Pre-abortion and post-abortion counselling (for instance, the provision of advice on methods of contraception) was inhibited by the potentially criminal setting of abortion.

(c) The unreliability of available services might deny a woman the opportunity calmly to consider and discuss whether to end a legally termirable pregnancy.

(d) Lack of time might deny a person authorised to perform a termination the opportunity to decide whether the applicant for abortion was genuinely seeking it or was acting under pressure from someone else, such as her partner or her family.

103. The workshop recognised that, while there were instances of manslaughter charges against illegal practitioners being laid, prosecutions for unlawful abortion as such were rare. In a number of jurisdictions they were unknown. It thus appeared that a law with identified harmful effects was being neither enforced nor amended. In such circumstnaces, particularly where change to an advanced law was found impracticable, it was thought that the law might at least be clarified, for the guidance of doctors and women, by an authoritative statement of the life and health indications on which abortion was permissible.

104. It was also recognised that some societies were unable to accept, or even to consider, an advanced law, which might include such indications for legal abortion as threatened damage to fetus, social or socio-medical grounds, and the juridical grounds of rape or incest. Further, participants considered that it would be unwise for a government to contemplate the introduction of such a law unless it was able to provide the personnel and facilities which the operation of an advanced law might require. It might be more beneficial to devote scarce resources to family planning programmes.

Protection and liability

105. The workshop accepted that doctors acting under a developed law could be protected by a clear statement of its provisions, by providing evidence that they were acting in good faith, and by charging moderate fees. They should be able to treat cases of incomplete or threatened abortion without fear of criminal involvement. At the same time, they should be made aware that wrongful refusal to treat a patient, who would suffer injury if her pregnancy continued, might expose them to civil legal liability, or even to criminal liability should the patient die.

Special requirements

106. It was noted that under advanced law the availability of abortion services was regulated not only by indications concerning the patient but also by specifying the qualifications

of practitioners authorised to terminate pregnancies, the types of equipment and facilities required for the procedure, and the gestational limits. Such requirements could be framed so as to make abortion more accessible in the early stages of pregnancy, but harder to obtain in the later stages. Participants considered that approval procedures should be governed by medical need and should not involve undue delay; nor should they be subject to veto by a third party, although discussion with parents might be desirable because of cultural sensitivities. An advanced law allowing non-medical indications might accommodate the views or interests of third parties.

Conscientious objection

107. The workshop agreed that the right of an authorised person conscientiously to object to abortion per se should be properly recognised, but it was considered that this should apply only when the patient's health needs would be properly met if the authorised person were to withdraw from the case. A law stating that abortion was lawful in given circumstances should include provision for conscientious objection. The suggestion that a conscientious objector should be placed under the obligation to secure the services to another authorised person who was willing to perform the procedure did not meet with agreement.

Acceptability

108. On the question of the general acceptability of abortion, the workshop recognised that it was for each country to decide how the difference between preserving a prohibitive law for public purposes, at a cost of health care, and using the law pragmatically to reduce harmful acts and their consequences (and perhaps leaving the protection of moral values to non-legal institutions) should be resolved. Disapproval of abortion might remain, but it might be made legally acceptable as the best of several sad options available.

109. There was some discussion of the rape indication for abortion, which was found to raise issues of a technical legal nature, and in particular the issue of whether it was open to unacceptable abuse. It was noted that a woman's sincere claim that she had been raped and a doctor's acceptance that her mental health was consequently threatened might justify abortion under the mental health indication contained in a developed law. Evidence of the doctor's good faith should protect from criminal liability the doctor deciding to terminate a pregnancy. It was also noted, however, that there was in some countries wide public acceptance of the rape indication for abortion.

110. Participants observed that the approval procedures for abortion should be realistic and appropriate to local circumstances, and should not make excessive demands on medical personnel or on women who applied. It was suggested that, in principle, as for any other legitimate procedure, only a single doctor's clinical judgement should be required for abortion on medical grounds. For non-medical indications, however, other special opinions might be required.

111. It was noted that the abortion indication of contraceptive failure presented problems of evidence. It was suggested that this indication might be considered acceptable if narrowly construed as a fail-safe or safety-net means to encourage the practice of contraception. Again, evidence of the doctor's good faith in deciding to terminate a pregnancy on these grounds would be required. It was also suggested that an indication allowing termination of a pregnancy occurring soon after childbirth might be justified, as constructively assisting the spacing of childbirth where this was culturally acceptable.

Paramedicals

112. While it was recognised that in some circumstances it might be permissible, as was the case of other comparable medical procedures, for paramedicals to perform terminations of pregnancy under a doctor's supervision, there was disagreement about the desirability of paramedicals doing this independently, on their own decision. The distinction was also drawn between the position of a paramedical acting where a doctor was available, and that of a paramedical acting where the only alternative might be non-treatment. Some participants thought that it might be appropriate for paramedicals to perform terminations during the earlier stages of pregnancy, but others insisted that the person carrying out terminations should possess the skill required to deal with possible complications.

Resources

113. On the subject of resources, it was pointed out that an applicant refused an abortion by a hospital on the ground of inadequate resources might seek illegal means and then return to the hospital shortly afterwards as an emergency case. The initial refusal would thus have saved nothing in hospital services. Alternatively, the unwanted child, when born, might be abandoned and might then have to be maintained at public expense. On the other hand, it was also pointed out that patients needing other than abortion procedures whose treatment was delayed by the admission of abortion patients might themselves become emergency cases. Competition for scarce hospital resources was unavoidable and could not invariably be resolved in favour of abortion patients.

Legal provisions

114. The suggestion was made that laws prohibiting abortion might possibly be so construed as to restrict evolving methods of contraception. It was considered that legal provisions dealing with contraceptive methods (e.g. in drug laws) should be kept separate from abortion law.

115. Although sympathy was expressed, there was not complete agreement on the principle of decriminalising termination of pregnancy during the first trimester on the grounds that this would permit prompt treatment when it was safest and when there was least psychological trauma.

116. The question was raised of why legislation on abortion needed to be different from that on other medical procedures, in being governed by criminal law whereas the other procedures were not. It was felt that justification of the distinction

Appendix C

Regular Review

Prostaglandins in human reproduction

M P EMBREY

Prostaglandins undoubtedly play a major part in reproduction, including the control of parturition, and are now believed also to be concerned in many other vital processes, but their precise functions are not fully understood. Nevertheless, much is known; and the prostaglandins are now widely used. Current clinical applications include prelabour cervical priming as well as induction of labour, termination of first and second trimester pregnancy, and management of abnormal pregnancy.

The prostaglandins are hormone-like compounds. They differ from classical hormones in being synthesised and released locally on demand from precursor fatty acids and are rapidly inactivated and metabolised in the blood stream. Within cells they are thought to exert their effects by changes in cyclic AMP; release of calcium ions may be important in some target tissues, including the myometrium.

The naturally occurring prostaglandins are a group of at least 14 related compounds, each a 20-carbon hydroxyfatty acid possessing a five-carbon ring and two side chains. Prostaglandin chemistry and nomenclature are complex, but of the naturally occurring prostaglandins only two, prostaglandin E_2 (PGE_2) and prostaglandin $F_{2\alpha}$ ($PGF_{2\alpha}$), are clinically important in reproduction. Biosynthetic and metabolic pathways need not be considered here except to observe that some of the endoperoxide precursors are physiologically active and that two recently discovered related compounds, prostacyclin (PGI_2) and thromboxane A_2, are powerful regulators of blood clotting. The activity of prostaglandins may be modified by substitution of artificial groups in the molecule (for example 15-methyl- or 16:16-dimethyl-groups), resulting in analogues resistant to degradation or more specific in action; some already show promise in clinical use.

The therapeutic uses of the prostaglandins in labour and abortion depend on three properties. Firstly, they are strikingly uterotonic, stimulating or augmenting uterine contractions. Despite contradictions in very early work, both PGE_2 and $PGF_{2\alpha}$ stimulate contractions, PGE_2 being some five times more potent than $PGF_{2\alpha}$. Secondly, the prostaglandins are responsible for the structural alterations in its connective tissue which soften and "ripen" the uterine cervix. A third possible role as a luteolytic agent, inhibiting the corpus luteum and preventing production of progesterone, has been substantiated in animals but remains unproved in man.

The prostaglandins are also concerned in other reproductive functions including ovulation and the control of menstruation, so that their clinical uses seem likely to be extended. In other instances (for example, dysmenorrhoea, thought to be due to accumulation of endometrial prostaglandins) there is a place for non-steroidal, anti-inflammatory drugs which are "prostaglandin synthesis inhibitors." The use of prostaglandin inhibitors in premature labour is more controversial; there is a potential risk that the fetus could be compromised since patency of the ductus arteriosus is believed to be maintained by endogenous prostaglandins.

The prostaglandins were first used clinically by intravenous infusion to induce labour in 1968[1 2] and to induce abortion in 1970.[3 4] As it became apparent that intravenous administration, especially in the high concentration needed for abortion, caused unpleasant side effects (notably vomiting and diarrhoea), this route has since been largely superseded, with varying degrees of success, by alternatives including oral, intramuscular, intrauterine (extra-amniotic or intra-amniotic), and vaginal administration.

Induction of labour and cervical ripening

The early studies of induction of labour using intravenous prostaglandins showed the effectiveness of the method and established dose ranges. Initial comparisons with orthodox oxytocin infusion produced conflicting views,[5] but continuing experience showed that generally prostaglandins were no more effective than oxytocin—except in patients in whom the cervix was unripe[6] (see later). Early fears that prostaglandins would produce hypertonus and fetal distress more often than oxytocin have not been clearly substantiated.[7] The chief disadvantage of the method is the frequency of gastrointestinal side effects, and as a result oral, vaginal, and intrauterine (extra-amniotic) routes of administration have been explored in recent research studies.

The convenience of oral treatment makes it attractive, but it is generally less effective than other routes of administration. The necessary systemic absorption produces troublesome side effects, which with $PGF_{2\alpha}$ are severe. Oral tablets of PGE_2 are available and are usually prescribed at a dose of 0·5 mg hourly (increasing step-wise to 2 mg) and combined with amniotomy. Gastrointestinal side effects occur in about one-fifth of patients, and vomiting reduces the likelihood of successful induction (especially in primigravidae, who require higher doses). The usefulness of the method is chiefly in multiparae with favourable induction prospects.[8]

The most recently identified obstetric use of the prostaglandins is that of "priming" or "ripening" (that is, softening and effacing) the cervix—in practical terms an important development. Though the ripening effect was commented on in some early clinical studies,[2] many assumed that it was the indirect result of induced uterine contractions. Now there is increasing evidence that prostaglandins, especially PGE_2, bring about the structural alterations in the connective tissue of the cervix accompanying ripening which are a necessary prelude to progressive labour and delivery.[9 10]

The prognosis in induced labour is governed primarily by the degree of ripeness of the cervix, best expressed in a Bishop score or "inducibility" score.[11] When the cervix is unripe (long, tightly shut, and rigid) labour is difficult to establish and it may "fail to progress" or be prolonged, often resulting in a high caesarean section rate and a poor outcome for mother and fetus.[12]

Prospects can be much improved by ripening of the cervix with prostaglandins before induction. Latent-phase cervical effacement and dilatation are achieved with little or no distress to the patient, with intact fetal membranes, and without jeopardy to the fetus. Local administration is best; the technique first used (in 1976) was extra-amniotic administration through a transcervical catheter of PGE_2 in a methyl cellulose gel the night before planned induction.[12] Assessment of this method in 121 primigravidae with unripe cervices (inducibility score 0-3) showed that one-fifth laboured without further intervention, while in the remainder labour was shorter, the caesarean section rate was halved, and fetal well-being improved compared with a control group.

Soon, however, essentially similar benefits were being obtained by the simpler non-invasive technique of vaginal administration of PGE_2 gel.[13] In a group of 168 primigravidae the instillation of PGE_2 gel resulted within half to 2 hours in backache and uterine contractions of mild intensity (recurring at one to three minute intervals and not exceeding 40 mm Hg pressure), persisting for four to five hours and then waning or else progressing to established labour. With PGE_2 5 mg the cervical score improved in 88% while 49% began labour before planned induction. There were no maternal or fetal side effects.[13]

As the method was extended to primigravidae and multigravidae with Bishop's scores in all ranges the results showed that as the pretreatment cervical score increased so did the proportion of patients labouring during priming, while the average duration of labour decreased, the frequency of spontaneous vaginal delivery increased, analgesic requirements diminished, and caesarean section was less often required. These benefits were greatest when labour followed priming without the need for formal induction—which occurred in about 40% of primigravidae with an unripe cervix rising to 90% in multigravidae with a favourable cervix.[14]

The value of preinduction ripening of the cervix with vaginal PGE_2 has since been confirmed in a much wider experience; an alternative to the gel is the use of glyceride-based or other simple pessaries prepared in hospital pharmacies.[15 16]

Differences in patient selection, treatment protocols, and criteria for success make comparisons of induction studies difficult. Nevertheless, in one representative study using 3 mg pessaries of PGE_2 43% of the 110 primigravidae with Bishop scores of 0-4 laboured after a single priming pessary without formal induction while the remainder received a second pessary. There were six failed inductions. In multigravidae when the cervix was ripe (Bishop score ≥ 4) 90% laboured without additional measures.[16] In another trial, when inducibility scores were favourable, pretreatment with PGE_2 pessaries (5 mg in primigravidae, 2·5 mg in multigravidae) was followed by amniotomy in three hours. Successful labour and delivery ensued in about 80% of multigravidae and 60% of primigravidae without the need for oxytocin infusion; further, there was a reduced requirement of epidural analgesia and the incidence of postpartum haemorrhage was lowered.[16]

While there have been no control studies, the cervical ripening method has been used successfully in many patients previously delivered by caesarean section and in those with breech presentation, in whom the promotion of the effacement and dilatation of the latent phase of labour with intact membranes may have merit.[15] Most authors have not considered it necessary to monitor "low risk" and uncomplicated cases, but continuous monitoring (at least for the first four to five hours) would seem prudent for patients in whom insufficiency is suspected.[14 15]

The evidence from all these published data points to the relative safety of the method and its freedom from adverse effects. Because priming doses are low, gastrointestinal symptoms are very uncommon (less than 1%), as is any thermogenic effect. Uterine hypertonus is likewise rare, while if it occurs fetal distress is not always evident.

Nevertheless, while the value of vaginal prostaglandins in ripening the unfavourable cervix when labour needs to be induced may be considered well established, their use for routine induction of labour is perhaps more controversial. The method is gaining in popularity, for it offers important benefits in patient acceptability and ease of management for medical personnel. Labour tends to be more natural than after formal induction, analgesic requirements are reduced, and both women in labour and nursing staff appreciate the likely avoidance of intravenous oxytocin infusion and the immobility it entails, while permitting patients to walk about during early labour may actually hasten delivery.

The prostaglandin cervical priming method would be still more widely used were a conveniently packaged product available. Unfortunately, in the current simple formulations PGE_2 does not possess adequate long-term stability and this has prevented development of a commercial product. This lack has prompted the use in some units of oral tablets of PGE_2 by the intravaginal route.[17] An additional practical problem is that dissolution and absorption of the available products are rapid (within two to four hours), with the possible risk in some multiparae of unduly rapid labour. A recent report of induction of labour using a novel polymer vaginal device suggests that these drawbacks can be resolved to provide a stable delivery vehicle giving controlled sustained release of PGE_2.[18] Such a development would be welcome, for on grounds of efficacy, safety, and acceptability vaginal PGE_2 seems likely to be used increasingly for cervical ripening as a prelude to formal induction or as an alternative procedure which may make induction unnecessary.

Other obstetric uses

The management of fetal death in utero has been much simplified by the prostaglandins, which now provide safe and effective means of emptying the uterus in missed abortion or intrauterine death near term and also in cases of hydatidiform mole and anencephaly. Intravenous infusion or extra-amniotic injection may be used, but equally good results follow simple vaginal administration of PGE_2 in gels or pessaries.[19] High dosage, as in one series,[20] provokes gastrointestinal irritation, but if dosage is related to gestation and the size of the uterus, side effects are not troublesome.

Termination of pregnancy

Despite their potential as fertility-regulating agents, the prostaglandins have not yet fulfilled all their promise. Experience has so far fallen well short of expectations in relation to termination of early pregnancy. Prostaglandins have,

however, established a place in the termination of second trimester pregnancy, and in many units they are used to the exclusion of alternative methods.

Second trimester terminations—The shortcomings of the natural prostaglandins (PGE_2 and $PGF_{2\alpha}$) as abortifacients are related to their rapid inactivation and the degree of gastrointestinal irritation caused by systemic absorption. Early studies showed that intravenous treatment for abortion requires high dosage (five times that required for induction of labour) and causes unacceptably severe vomiting and diarrhoea, while oral treatment is ineffective. Vaginal administration also results in prominent side effects and is not consistently successful.

Fortunately, however, the prostaglandins act locally and are effective when given by the intrauterine route. This was first achieved by the simple technique of extra-amniotic instillation using a catheter introduced just through the cervix, and later by intra-amniotic injection through the abdominal wall. The latter was promoted as a "one shot" method, but a large experience of treatment with intra-amniotic $PGF_{2\alpha}$ has shown that, for an acceptable level of efficacy (90% or more abortions within 48 hours; mean abortion time less than 24 hours), an injection of 25 mg frequently needs to be repeated, while if the initial dose is increased to 40-50 mg gastrointestinal side effects are severe.[5 21] Because of its limited availability intra-amniotic PGE_2 has been used less widely, but several studies have shown its effectiveness, the administration of 20 mg, or 10 mg repeated in six hours, giving a high success rate with relatively few side effects.[5 21]

The extra-amniotic method is comparable in efficacy with the intra-amniotic route. Two hourly instillations of PGE_2 200 μg (or $PGF_{2\alpha}$ 750 μg) or equivalent amounts by continuous infusion results in abortion within 48 hours in some 90% of patients.[22 23] In 1975 it was shown that the extra-amniotic administration of PGE_2 1·5-3 mg in a viscous methyl cellulose gel provides a more prolonged effect, limiting or eliminating the need for frequent or continuous injection and gives equivalent results.[24] Nowadays this is the method commonly used. Because the dosage is low the incidence of gastrointestinal effects is lower with extra-amniotic than with other routes of administration, while the theoretical risk of infection has in practice not proved a hazard.

To shorten abortion times prostaglandins may be used in conjunction with other methods such as the intra-amniotic injection of hyperosmolar saline or urea solutions,[25] or laminaria tents (advocated particularly in the United States). Alternatively, abortion can be accelerated by using the enhancement effect of intravenous oxytocin (100 mU/min).[26] Intra-amniotic hypertonic solutions carry a risk of serious adverse effects—for example, hypernatraemia or consumptive coagulopathy—and are probably best reserved for ensuring lack of fetal viability in gestations of 20 weeks or over.

Though prostaglandin analogues are not available in Britain except for investigations, several have been evaluated clinically and the $PGF_{2\alpha}$ analogue 15-methyl $PGF_{2\alpha}$ has been widely tested in other countries. Longer acting than the parent compound (because the 15-methyl-group inactivates the dehydrogenase enzyme responsible for the first and most rapid step in prostaglandin metabolism), it has the merit that a single intra-amniotic injection of 2·5 mg[27 28] or a single extra-amniotic administration of 1 mg[28 29] usually suffices, but side effects are unfortunately troublesome. While repeated intramuscular injection is effective, the accompanying severe gastrointestinal side effects are generally unacceptable.[30] The analogue has also been administered per vaginam (1-1·5 mg three hourly) in glyceride-based pessaries.[31] Its high efficacy (resulting in about 90% abortions in 30 hours) is again marred by the high level of gastrointestinal symptoms. Moreover, these success rates were not substantiated when a single "longer acting" Witepsol pessary was used,[32] while incorporation of the agent in a silastic vaginal device did not provide the expected controlled, sustained release and gave disappointing results.[33 34] Equally or more effective, yet causing many fewer side effects, the 16:16-dimethyl-PGE_2 analogue and its semicarbazone ester would have great potential were it not for their lack of stability.[35] Improved products may be forthcoming. Meantime, the vaginal route remains an attractive goal because of its non-invasive nature, though in mid-pregnancy a considerable proportion of incomplete abortions occur (40-70%) requiring evacuation.

First-trimester termination—Most first trimester abortions are dealt with surgically by vacuum aspiration and generally complications are few, but potential risks from injury and haemorrhage are associated with rapid mechanical dilatation of the cervix. With the aim of reducing these problems and—possibly—the risk of premature delivery from cervical incompetence in a subsequent pregnancy, prostaglandins may be administered not to induce abortion but for their cervical "priming" effect before surgery. Endocervical administration of PGE_2 gel and intravaginal PGE_2 in a pessary[36] have both been used, but the most promising results have come from one of the newer PGE analogues either in a vaginal suppository[37] or intramuscularly.[38] Such methods are likely to be used more frequently as these newer preparations become available.

Early investigators prophesied an important place in fertility regulation for the prostaglandins when used to induce menstruation or prevent or interrupt early pregnancy through luteolysis or interference with implantation by effects on uterotubal contractility. At this early stage of pregnancy abortion may be almost indistinguishable from normal menstruation, and, provided bleeding is not unduly prolonged and pain and side effects are kept to a minimum, the method has great potential.

To date, however, the luteolytic effect in women has not been substantiated and the attainment of the expected objectives has proved elusive. Yet the prospect of a simple, safe, non-invasive, chemical method for early abortion remains a major goal, and recent research has concentrated on the development of vaginal pessaries containing newer prostaglandin analogues.

Though the natural prostaglandins are effective by transcervical intrauterine injection the results have been disappointing when they are given vaginally. Nevertheless, vaginal treatment became practicable with the synthesis of prostaglandin analogues which, by resisting metabolic degradation, have enhanced potency and longer action or show greater specificity of action, so causing fewer side effects. The new compounds have been administered in cellulose derived gels or simple lipid-based pessaries (usually three to four hourly) with a degree of success, though clinical trials have shown that not all the problems have been resolved. For example, while the uterotonic potency of the $PGF_{2\alpha}$ analogue 15-methyl-$PGF_{2\alpha}$ (the most widely tested analogue) is high, the severity of gastrointestinal side effects limits its clinical applicability.[39 40]

More selective in action, the 16-16-di-methyl-PGE_2 analogue and its semicarbazone ester are, at least, equally effective and cause fewer adverse effects when given in repeated vaginal pessaries[35 40] and would have considerable clinical impact were it not that problems of chemical instability have hampered commercial development. The same lack

of stability affects other recent PGE derivatives which have shown clinical promise. One of these, 16-phenoxy-ω-tetranor-PGE_2, has given encouraging results by the intramuscular route,[41] the other 16:16-di-methyl-trans-Δ_2-PGE_1 when administered vaginally.[42]

Current research is seeking to overcome the disadvantages of the products available. The instability of PGE_2 and PGE analogues may be resolved by the employment of improved gels[43] or by new sustained-release vaginal delivery systems.[18] The development of such devices would undoubtedly promote the use of vaginal PGE_2 in the induction of labour on a much wider scale and might be expected to result in better prostaglandin products for use in the termination of early pregnancy and menstrual induction. A prostaglandin analogue with an appreciable luteolytic effect in women remains an actively pursued research goal, while other derivatives exhibiting greater specificity of action and therefore fewer side effects are being sought in pharmaceutical laboratories. These and other related research developments may be expected to extend to the range of the clinical uses of these remarkable compounds in obstetrics and gynaecology.

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