As I began to write this chapter, Canadian MP Stephen Woodworth’s Motion 312 (henceforth M-312) had just been defeated in a 203-91 parliamentary vote. M-312 proposed “that a special committee of the House be appointed and directed to review the declaration in Subsection 223(1) of the Criminal Code of Canada which states that a child becomes a human being only at the moment of complete birth.” Since that vote, Canada has undergone a change in government that will likely keep the abortion debate off the legislative radar for the foreseeable future. However, the M-312 debate did not occur in a vacuum: it was part of a systematic effort by North American pro-life advocates to extend to fetuses the legislated rights and privileges accorded to persons. While Woodworth’s motion failed, pro-life forces have had too much success with this method in other jurisdictions to abandon the approach any time soon. Thus, it is worth examining the positions at play in the M-312 debate, and considering their merits.
In what follows, I begin with a brief sketch of the rights-based dialectic that emerged over the course of the M-312 debates. I then contend that the arguments that were advanced on both sides were precisely the wrong ones to have. In any competition between fetal rights and women’s autonomy, a loser is inevitable. It is a zero-sum game. I argue that shifting the discussion to a focus on harms is less polarizing and hence more conducive to compromise and agreement, and that such a shift could actually accomplish the most important goals for both sides. Indeed, characterizing the abortion issue as one with two opposing sides may be counterproductive for all concerned.

Whose Rights?

The Rights of the Child

Subsection 223(1) of the Criminal Code of Canada, to which M-312 refers, is situated in a portion of the code concerned with homicide. Subsection 223(1) stipulates at what stage a child legally becomes a human being and hence the kind of legal entity who could be a victim of homicide:

A child becomes a human being within the meaning of this Act when it has completely proceeded, in a living state, from the body of its mother, whether or not

- (a) it has breathed;
- (b) it has an independent circulation; or
- (c) the navel string is severed.

Subsection 223(2) goes on to say that “a person commits homicide when he causes injury to a child before or during its birth as a result of which the child dies after becoming a human being.”

In a December 2011 press release about M-312, Woodworth described subsection 223(1) as “an unusual Canadian statute which defines a human being as a child who has completely proceeded in a living state from the mother’s body, whether or not the child has breathed.” It follows from this, argued Woodworth, that in Canada, “a child is legally considered to be sub-human while his or her little toe remains in the birth canal, even if he or she is breathing.”

According to Woodworth, subsection 223(1) is outdated, in that it does not reflect contemporary scientific evidence about when someone becomes
a human being. In his view, if science shows that a baby is actually a human being at some point before birth, then the law ought to extend human rights to the baby after that point. In various interviews, Woodworth mocked the idea that the event of birth could magically confer humanity upon a baby. It is, after all, counterintuitive to suppose that a baby delivered at thirty-nine gestational weeks is a human being while an overdue baby, still unborn at forty-one weeks, is not. When we examine our ideas of what makes an entity a human being, we tend to think in terms of such things as cognitive development and ability to survive outside of the womb. The forty-one-week undelivered baby surely satisfies these criteria just as well as—or better than—the thirty-nine-week delivered baby. So why should the law treat the former differently than the latter?

Woodworth insisted that subsection 223(1), which has its origins in seventeenth-century English common law, wrongly fails to attribute humanity to the forty-one-week undelivered baby because of the now outdated science of the period. This is mistaken on two counts. First, seventeenth-century science was more advanced than Woodworth implies. The period saw enormous progress in all areas of science, not least medicine, in which sophisticated anatomical and physiological research swiftly eclipsed the Aristotelian and Galenic medicine of the Middle Ages. Woodworth’s suggestion that seventeenth-century scientists were ignorant of the character of fetal development is simply mistaken. Second, and just as crucially, no science is necessary to underwrite our strongly held intuitions that the forty-one-week undelivered baby is worthy of moral consideration. Most of us, regardless of our views on the abortion debate, regard such a child as a human being worthy of protection and sympathy. This was as much the case in seventeenth-century England as it is in twenty-first-century Canada. In other words, even if seventeenth-century scientists were ignorant of the stages of fetal development that might be relevant to the question of a child’s humanity, it wouldn’t matter. Our sympathy with the third-trimester fetus is rooted in human nature and common sense. And this sympathy is powerfully motivating.

So why does subsection 223(1) (and the older law from which it descends) fail to accord humanity to such children? In brief, section 223 is intended neither to deny human fetuses membership in the human species nor to make any claim about when life begins or at what developmental stage a fetus is the appropriate object of sympathy and moral concern. The question
addressed in subsection 223(1) is a purely legal one: At what point does one become a legal agent, the kind of entity who can \textit{(inter alia)} be the victim of a crime? Subsection 223(1) answers this question by stipulating the condition that legal human beings must have been born.\footnote{7}

Ought we to value, respect, and seek to protect third-trimester fetuses? I think that we should. It seems clear to me that at this developmental stage, babies have the kind of cognitive complexity and capacity for independent existence that makes them worthy of moral consideration.\footnote{8} So why not extend legal consideration to them as well? Why not amend the Criminal Code to recognize third-trimester fetuses as legal human beings?

One obvious answer (but not the one that I will ultimately endorse) is that such an amendment would create the legally untenable position of recognizing the existence of legal, rights-bearing human beings who reside inside of other legal rights-bearing human beings. Such an amendment would thus potentially conflict with the rights of pregnant women.

\textit{The Rights of the Mother}

In 1988, in \textit{R. v. Morgentaler}, the Supreme Court of Canada struck down Canada’s abortion law on the grounds that it violated women’s rights to “life, liberty and security of the person,” rights encoded in section 7 of the Canadian Charter of Rights and Freedoms. The Court ruled that the law, in limiting access to abortion, put both women’s health and safety and women’s aspirations at risk. It is worth noting that the Court did not rule that \textit{any} abortion law would necessarily conflict with women’s section 7 Charter rights, only that the particular abortion law then on the books did so. (In fact, that law is still on the books, even though it has been unenforceable since the 1988 decision.) In principle, any new abortion law that did not threaten women’s life, liberty, or security of the person would be unaffected by the 1988 decision. However, it is difficult to conceive of a law limiting access to abortion that would not, in so doing, compromise one or more of these rights.

However important section 7 rights are in the history of abortion in Canada, even Canadian pro-choice proponents do not discuss women’s rights to life, liberty, and security of the person as frequently or as centrally as they do the alleged “right to choose” whether or not to have an abortion. Since \textit{Roe v. Wade}, pro-choice advocates in the United States have sometimes located the right to choose in the Ninth Amendment of the US Constitution,
but it is arguably more plausible to regard the phrase “right to choose” as a corollary of the “pro-choice” appellation, itself a rhetorical move to avoid the label “pro-abortion.” Unlike “pro-abortion,” the “pro-choice” label and the corresponding assertion of women’s right to choose emphasize that abortion rights supporters are motivated by a desire to support women’s autonomy, not by a desire to promote abortion for its own sake. While the right to choose may have had rhetorical rather than constitutional origins, it is sometimes invoked as a basic human right. Debating M-312 in Parliament on 26 April 2012, MP Niki Ashton, of the New Democratic Party, averred: “A woman’s right to reproductive choice is a human right. In Canada, in 2012, a woman’s right to choose is not up for negotiation.”

Toward a Harm-Reduction Approach to Abortion

The Harm-Reduction Landscape

Ultimately, the debate about whose rights matter most—those of the fetus or those of the pregnant woman—is probably intractable. Moreover, pursuing this polarizing debate has gotten in the way of addressing the abortion issue in a sensible way that addresses the chief concerns of both sides. Indeed, I suggest that the very notion that the issue has two sides is a mistake. The pro-life/pro-choice distinction is, quite simply, a false dichotomy. If we bracket pro-life and pro-choice dogmas, we can see that most interlocutors in the abortion debate are primarily concerned not with rights but with abortion-related harms and how best to avoid them. While both sides deploy the language of rights for rhetorical reasons, most individuals actively involved in the abortion debate are motivated less by in-principle support of particular rights than by the very practical desire to reduce harms—with pro-life advocates focusing on harms to fetuses and pro-choice proponents focusing on harms to pregnant women. When we consider the abortion debate through the lens of harm, we can see that there are actually three, not two, broad positions in the abortion debate. These three positions are distinguished by their views on whether abortion causes harms and on whether and how to reduce those harms. I will argue that logic dictates that proponents of two of the three positions ought to agree on abortion law, policy, and practice, since they ought to agree to support those approaches that reduce abortion-related harms. Adherents to the third position ought
to disagree, but their views should be of no concern to jurists, legislators, voters, or policy makers.

At the heart of this way of thinking about abortion is the concept of “harm reduction,” a notion that is perhaps most familiar in such contexts as sex work and drug addiction. Here is the definition of *harm reduction* used by the Centre for Addiction and Mental Health (CAMH) in the context of substance abuse: “Harm reduction is any program or policy designed to reduce drug-related harm without requiring the cessation of drug use. Interventions may be targeted at the individual, the family, community or society.”

Needle exchanges and safe injection sites are familiar examples of the harm-reduction approach to substance abuse. Neither is designed to cure addiction; instead, both services seek to mitigate the risks to addicts. Crucially, both types of service are premised on the belief that substance abuse causes direct or indirect harm.

Adapting the CAMH definition, I consider a harm-reduction approach to abortion as *any program or policy designed to reduce abortion-related harm without requiring the prohibition of abortions*. Interventions may be targeted at the individual, the family, community, or society. Any policy, program, or set of programs that seeks to reduce harms directly or indirectly caused by abortion would count as abortion-related harm reduction. Of course, this conception is premised on the belief that abortions cause harm.

What might count as an abortion-related harm? The most obvious candidate is death to embryos and fetuses in general. Additionally, many people regard death to gestationally older fetuses—in particular, those potentially capable of experiencing pain—as a more serious harm than death to embryos. Injury or death to women who undergo abortions is also an abortion-related harm. Likewise, being left motherless, with all that entails emotionally and financially, is a harm for the surviving children of women who die because of abortions. Other alleged harms resulting from abortion include depression, increased risk of breast cancer, and difficulty conceiving or bearing children in the future.

Two things are noteworthy about the above list of potential abortion-related harms. First, it is manifestly a matter of opinion whether or not any of the potential harms listed above actually constitutes a harm. Many pro-choice advocates, for instance, do not consider embryonic death in itself a harm. By contrast, pro-life supporters typically do consider it a harm. On this matter, it is unlikely that either side could adduce evidence that might change the
other side’s mind. However, the second noteworthy feature of the above list of potential harms is that while the question of what counts as a harm may be a matter of opinion, the question of which of the potential harms actually results from abortion is an empirical question that must be decided by evidence. If I say that abortion causes injury to women, I must provide evidence to support this claim. It is not enough to insist that it is my opinion. While the likelihood that we will all agree on which potential abortion-related harms actually count as harms is slim, there is good reason to hope that we can agree on the incidence of the alleged harms. All that is required for such agreement is evidence—and sensitivity to evidence.

So do abortions cause the death of fetuses? Manifestly. Do they cause the death of gestationally older fetuses? While such deaths are considerably less common than those of embryos, yes, abortions cause such deaths. Is injury or death to women undergoing an abortion sometimes the result of the procedure? Again, yes. Do children whose mother dies as a result of an abortion suffer harm? Yes. On all of these questions, pro-choice and pro-life proponents can agree. And evidence is plainly available to support all of the foregoing claims, although it is unlikely to be required to persuade anyone since all of the alleged harms just discussed are uncontroversially the direct results of abortions.

What about the last three possible abortion-related harms—depression, breast cancer, and infertility? Are they caused by abortions, as is alleged by some pro-life supporters? Since, in all three cases, the causation (if such there is) is indirect, independent evidence is needed to establish that abortions actually produce such effects. At present, there is no good evidence connecting abortion with either depression or breast cancer. And most researchers agree that abortions—whether surgical or medical—do not affect future reproductive outcomes so long as they are performed using modern techniques and infection does not occur. It seems that, for now, these particular harms do not number among those that should concern supporters of a harm-reduction approach to abortion. However, it bears repeating that in an evidence-based approach, if new evidence emerged that abortion causes any of these harms, we would have to expand any harm-reduction approach to address them.
Three Positions

We have seen that a variety of effects clearly follow from abortions and that some of these effects, to some people, constitute harms. Moreover, on some accounts, abortion in itself constitutes a harm. How do we get from these observations to my claim that there are three, not two, positions in the abortion debate? We need only ask two questions: Are there abortion-related harms? If so, ought we to try to reduce them? At first, this seems to produce four positions based on the four possible pairs of responses to the foregoing questions: yes/yes; no/no; yes/no; no/yes. However, we can remove the final pair, since it is unintelligible to hold at once that abortions do not cause harms and that we ought to try to reduce these harms. This leaves us with three positions. The first affirms that there are abortion-related harms and that we should seek to reduce them. The second position denies that there are abortion-related harms and affirms that nonexistent harms need not be reduced. According to the third position, abortions cause harms but there is no need to reduce those harms.

I propose that most self-described pro-lifers fall into the first category, which I refer to as the harm-reduction position. They regard abortion as constituting a harm and/or as causing harms, and they wish to see such harms reduced. That this is so is apparent in this group’s frequent opposition to abortion on the grounds that it causes fetal suffering and subsequent remorse and health problems for the woman undergoing the procedure—hence, the pro-life chant “One dead, one wounded.” What is striking is that most pro-choice advocates also fall into this category, typically arguing in favour of access to safe abortions precisely because they regard such a policy as reducing harms such as maternal morbidity and death.

Notice that even though both pro-life advocates and pro-choice supporters populate this category, they can (and do) disagree on which aspects of abortion or its effects constitute or cause harms and on how to reduce the harms associated with abortion. However, this is true within both camps as well. That is, there is room within each of the pro-life and pro-choice camps to disagree on which aspects of abortion are harmful and on how best to reduce harm.

The harm-reduction position with respect to abortion is also attractive to many people who do not identify as either pro-life or pro-choice. Many people, for instance, claim that they are not opposed to first-trimester abortions but that they believe in prohibiting abortions of gestationally older
fetuses who could potentially feel pain. For these individuals, legal prohibitions are seen as a mechanism to reduce harms to third-trimester fetuses. Again, people who take this, shall we say, neutral harm-reduction position (neutral in the sense that it is neither pro-life or pro-choice) may disagree both among themselves and with pro-life or pro-choice advocates about what aspects of abortion actually constitute or cause harms and how best to reduce those harms. However, they agree with the basic position that there are harms associated with abortion and that we ought to reduce those harms.

Some pro-choice supporters fall outside the broad harm-reduction category I have just described because they claim that abortion does no harm and that hence there are no harms associated with abortion to be reduced. Against the long list of purported abortion-related harms that are adduced in pro-life materials, these pro-choicers respond by denying that abortion causes or constitutes harm. Thus, for instance, Richard Carrier explicitly maintains that “abortion does no harm” and hence ought to be legal. One line of argument in this vein became particularly pronounced in response to former US president Bill Clinton’s famous dictum that abortions should be “safe, legal, and rare.” This prescription, argue some pro-choice advocates, wrongly casts abortion, unlike other medical procedures, as generally undesirable and hence gives too much away to the pro-life side. Some critics of Clinton’s coinage maintain that it is unrealistic to suppose that abortion ever could be rare. Thus, for instance, in an October 2007 letter to The Lancet, Marge Berer wrote: “Abortion could only become rare in a world in which contraceptives never failed, women and men having sex together never failed to use them, and sex between them was only ever preplanned and consensual. None of that is realistic, and there seems little point in calling for something that is totally unfeasible.”

There is thus good reason to suppose that pro-choicers who deny the harmfulness of abortion do so for rhetorical reasons, in order to avoid contributing to the vilification of abortion. While they deny that abortion constitutes a harm, or remain silent on the question of harm, we shall see below that they nonetheless support those programs and policies that are most effective in reducing those effects of abortion that are often regarded as harms by others. While their refusal to treat abortion as harmful separates them, in principle, from harm-reduction pro-choicers, in practice they support the same or similar programs.
Adherents of the final conceptual position we identified above regard abortion as either constituting a harm or as directly or indirectly causing harms, and yet they do not wish to support mechanisms that reduce the harms associated with abortion. Someone falls into this category if she opposes the mechanisms that reduce the incidence of abortion-related harms even if she knows that these mechanisms effect such reductions. Could anyone really hold such an irresponsible position? We will return to this question below.

Reducing Abortion-Related Harms

We have seen that there are three broad positions in the abortion-related harm-reduction landscape—(1) abortion constitutes or causes harms that should be reduced; (2) abortion does not constitute or cause harms, but mechanisms that reduce alleged abortion-related harms should be supported; and (3) abortion constitutes or causes harms, but mechanisms that reduce those harms should be opposed. So those adhering to either of the first two positions wish to reduce the harms associated with abortion. Which harms are on the table, and how best do we reduce them?

Above, we identified as the main alleged harms associated with abortion: fetal death, including the death of gestationally older fetuses, morbidity and death among women who undergo abortions, and the trauma experienced by children of women who die from unsafe abortions. In order to reduce all of these harms, it is necessary both to reduce the incidence of abortion and to improve the safety of abortions that are performed.

The data shows that, internationally, the lowest abortion rates generally correlate with the most liberal abortion laws. A 2012 study concluded that, worldwide, “the proportion of women living under liberal abortion laws is inversely associated with the abortion rate.” The same study found sharp drops in abortion-related mortality and morbidity in South Africa and Nepal after the procedure was legalized in those countries. However, the authors argue that legalization alone cannot explain either lower abortion incidence or lower rates of morbidity associated with abortion. Just as crucial is access to quality abortion aftercare and availability of contraception and adequate sexual health education: “Other necessary steps include the dissemination of knowledge about the law to providers and women, the development of health service guidelines for abortion provision, the willingness of providers to obtain training and provide abortion services, and government commitment to provide the resources needed to ensure access to abortion services,
including in remote areas.” In short, the best approach to reducing harm is a systemic one that combines safe, legal, accessible abortion services with a wider array of sexual health and education services. Moreover, access to abortion earlier in the pregnancy prevents both the abortion of gestationally older fetuses and the increased risk of injury or death to the mother associated with late-term abortions. While there is a paucity of research on gestational age at the time of abortion, Sedgh et al. suggest that “women might delay seeking an abortion where abortion laws are restrictive or abortion is widely stigmatised.”

The authors conclude that several measures in addition to providing access to safe abortions are needed to ensure a decrease in unwanted pregnancies and unsafe abortions:

Abortions continue to occur in measurable numbers in all regions of the world, regardless of the status of abortion laws. Unintended pregnancies occur in all societies, and some women who are determined to avoid an unplanned birth will resort to unsafe abortions if safe abortion is not readily available, some will suffer complications as a result, and some will die.

What is striking is that a unified approach—one that involves good-quality, comprehensive sexual health services, both clinical and educational; good social services; and legal access to abortions—reduces all of the harms we have been considering. It is, I suppose, obvious that such an approach reduces abortion-related harms to women and, consequently, to their existing children. What is less obvious is that such an approach strongly correlates to a reduction in the incidence of abortion itself. That is, for those who regard abortion as itself constituting a harm and who therefore wish to reduce the incidence of abortion, the most effective mechanism combines liberal abortion laws, access to safe abortions, and a broad suite of sexual health and social services.

For this reason, I think we can characterize those pro-choicers who deny the harmfulness of abortion as de facto supporters of a harm-reduction approach to abortion. Despite their refusal to link abortions with harm, these individuals overwhelmingly support the very mechanisms that correlate with the reduction of abortions, and hence those effects of abortion that are deemed to be harmful by others. Clearly, as well, harm-reduction proponents—those individuals who, whether they identify as pro-life, pro-choice
or neither, think that abortions cause harm and who seek to reduce those harms—ought to favour the approach that is shown to correlate most highly to reductions in abortion-related harms. Logic dictates, then, that all those who seriously seek to reduce the harms associated with abortions, whatever their affiliation in the abortion debate, should agree to support legal, accessible abortions within a broader system of sexual health and social services.

This will be a difficult pill for pro-lifers to swallow, if only because it is counterintuitive to say that the best way to reduce the incidence of abortion is to make abortion legal and accessible. However, any pro-life advocate who is genuinely motivated by a wish to reduce the incidence of abortion and abortion-related harms must, to be effective, approach the reduction of those harms using the best evidence available, even if that evidence turns out to be counterintuitive.

But what should we make of those pro-life advocates who decry the harmfulness of abortions but oppose the very mechanism associated with a reduction in the incidence of abortion? Perhaps they just do not understand the evidence yet, in which case we should seek to persuade with the best evidence, and they should, in principle, be open to such suasion. Other pro-lifers, however, not only reject abortion-reducing mechanisms but champion practices associated with higher abortion rates—for example, abstinence-only sex education and reduced access to contraceptives. Moreover, as we have seen in much of the United States in recent years, they actively promote legislative and clinical delays to abortion seekers, thereby increasing the incidence of harms related to late-term abortion. Why might a pro-life advocate who understands the evidence oppose mechanisms that reduce abortion-related harms and support those that increase them? Most plausibly, this is because they are not primarily concerned with the harms associated with abortion. Rather, they are motivated by their deeply held moral or religious conviction that abortion is always wrong, regardless of its consequences.

Given this landscape, who should opt for a harm-reduction approach to abortion? The answer is everyone—pro-life, pro-choice, and neither—who genuinely wishes to reduce the incidence of abortion and the harms that result from abortion, as well as those pro-choicers who deny the harmfulness of abortion but nonetheless champion the mechanisms shown to reduce abortion-related harms. The only people who should oppose a harm-reduction approach are those who privilege adherence to personal
ethics and/or religious convictions over the reduction of abortion-related harms. However, since law and public policy should be based on the public good rather than on people’s individual moral or religious commitments, the views of such individuals should be of no concern to courts or governments.

Notes


2 Not all persons with uteruses identify as women. Increasingly, for instance, trans men are choosing to give birth. I use “woman” and “women” throughout as a term of convenience. Clearly, however, our approach to abortion affects anyone who might become pregnant, whether or not that person is a woman.

3 The question of what terminology to use for the unborn child is perhaps even more fraught than that of what terminology to apply to the competing camps in the abortion debate. Unlike terms like pro-choice and pro-life, which make very explicit one’s philosophical and political commitments, terms like child, fetus, embryo, and baby can influence readers and interlocutors in subtle, implicit ways. Pro-choice proponents tend to favour embryo and fetus in order to sound clinical and avoid arousing the reader’s or listener’s sympathy for the child. Pro-life supporters prefer baby and child for converse reasons. Throughout, I alternate among these terms, but in general, I use baby or child for the third trimester and embryo or fetus for the first or second trimester.


5 See, for example, “Stephen Woodworth on Talk Local Kitchener/Waterloo,” Talk Local, hosted by Hayley Zimak, Rogers Cable Kitchener, 11 January 2012, https://www.youtube.com/watch?v=bW-QRzIp7v8.

6 “When Are We Human?” and “Stephen Woodworth on Talk Local.”

7 Having said this, it bears note that the next subsection, 223(2), is explicit that if a (fully born) human being dies because of an act performed upon it in utero, that death constitutes a homicide. This is to say that section
223 actually does provide some legal protection to unborn children, even though \textit{qua} unborn they do not yet count as legal human beings.

8 I will not defend that view here, but see Laurie Schrage, \textit{Abortion and Social Responsibility}, 72, for a discussion of the moral status of late-term fetuses.

9 Niki Ashton, “Private Members’ Business: Special Committee on Subsection 223(1) of the Criminal Code.” Ashton has represented the riding of Churchill, Manitoba, since 2008.


11 Such abortions are extremely rare. Of the 27,576 abortions reported by Canadian hospital (excluding Québec) in 2010, only 537, or 1.9 percent, were performed on fetuses at twenty-one gestational weeks or later. Canadian Institute for Health Information, \textit{Therapeutic Abortion: Data Tables, 2010}, Table 4: Number and Percentage Distribution of Induced Abortions Reported by Canadian Hospitals (Excluding Quebec) in 2010, by Gestational Age. This proportion is skewed, however, by the fact that in Canada, late-term abortions are performed only at hospitals, not in clinics. If we include in our total 2010 abortion count the 37,065 abortions performed at clinics (excluding Québec), the total number swells to 64,641, meaning that late-term abortions constitute a mere 0.83 percent of all abortions performed in Canada outside of Québec. Ibid., Table 1: Number Induced Abortions Reported in Canada in 2010, by Province/Territory of Hospital or Clinic.


13 Royal College of Obstetricians and Gynaecologists, “Induced Termination of Pregnancy and Future Reproductive Outcomes—Current Evidence.” A report on complications associated with Canadian abortions performed in 2010 found that, of the 27,576 abortions for which detailed reports were available, infections occurred in only 107 cases, or 0.38 percent. Canadian Institute for Health Information, \textit{Therapeutic Abortion Data Tables, 2010}, Table 8: Number and Percentage Distribution of Induced
Abortions Reported by Canadian Hospitals (Excluding Quebec) in 2010, by Complication Within 28 Days of Initial Induced Abortion.


See, for instance, Joyce Arthur, “Yes, Legalizing Abortion Does Save Women’s Lives.”


Sedgh et al., “Induced Abortion,” 631.

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