Abortion Rights Coalition of Canada

Your Voice for Choice

Canada's only national political pro-choice advocacy group

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Position Paper #29

This position paper is not intended as a 'how-to' guide on self-managed abortion, nor is it intended to constitute health, medical, or legal advice.

Self-Managed Abortion in Canada

Self-managed abortion (SMA) is part of a broader spectrum of abortion care, defined by the World Health Organization (WHO) as abortion care that is carried out "without the direct supervision of a health worker."[1] SMA enables abortion seekers to end their pregnancy outside of clinical settings and only interact with healthcare professionals if and when they choose to do so.[2] WHO recommends that abortion care can be safely self-managed up to 12 weeks of pregnancy as long as the abortion seeker has access to accurate information, quality medicines, and access to healthcare professionals (if desired or needed).[3]

SMA most commonly uses mifepristone and misoprostol tablets to end the pregnancy;[4] however, there are circumstances of SMA where individuals use traditional medicines, herbal supplements, or methods of self-harm to induce a pregnancy. When discussing SMA in Canada, this position paper will primarily refer to the obtaining and administering of abortion pills outside of the medical system.

Why Self-Managed Abortion?

SMA may be sought after because it offers greater autonomy, privacy, and accessibility. Individuals may choose SMA because they face a variety of barriers to accessing abortion care within the current medical system. For some, geographic inaccessibility to clinics or abortion providers, especially for those living in rural and remote areas in Canada, makes travelling for in-clinic care extremely difficult. Travelling to the nearest abortion clinic may be costly, and filled with logistical barriers such as work, school, and childcare considerations.[5]

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1 World Health Organization (2022). *WHO recommendations on self-care interventions. Self-management of medical abortion*. https://iris.who.int/bitstream/handle/10665/362984/WHO-SRH-22.1-eng.pdf?sequence=1

2 Stevenson, J. & Taylor, J. (2022). *Self-Managed Abortion in Canada: A Status Report*. LEAF. https://www.leaf.ca/wp-content/uploads/2022/04/SMA-Report-April-2022.pdf

3 World Health Organization (2022).

4 Stevenson & Taylor (2022).

5 Stevenson & Taylor (2022).

Additionally, abortion seekers may face stigma or judgement from family, community, or healthcare providers, which drive them to seek abortion care in ways that feel more private,[6] such as doing so outside the medical system. Others may attempt to avoid the healthcare system altogether due to previous negative experiences, lack of trust, or concerns about treatment and confidentiality. In particular, Indigenous, trans, non-binary, and racialized individuals have historically experienced discrimination and harm from interacting with the healthcare system, and therefore are more likely to avoid the healthcare system altogether.[7][8] This is even the case in abortion care settings, where a US study found that trans, nonbinary, and gender-expansive individuals are more likely to attempt SMA than their cisgender counterparts, likely due to wanting to avoid reproductive health clinics that are often highly gendered.[9]

Incidences of Self-Managed Abortion

A 2017 study conducted in the US[10] found that the most commonly reported methods of SMA included the use of herbs, supplements, or vitamins (52%); emergency contraception or multiple contraceptive pills (19%); mifepristone and/or misoprostol (18%); and abdominal or other physical trauma (18%).

While data on the prevalence of SMA in Canada is lacking, there have been reports of abortion seekers in Canada who have used unsafe methods of SMA, such as self-harm. In a Manitoba study, an international student without access to public healthcare reported that the cost of abortion care was too high, so they took various medications and self-harmed to induce an abortion.[11] In an anonymous Google Form response, ARCC asked for Canadian stories of SMA, and one individual reported that they drank alcohol until they induced an abortion due to having to keep their abortion a secret from others. Another respondent reported ordering Mifegymiso from the Internet because they didn't want to interact with the medical system. These examples make it clear that self-managed abortion is already happening in Canada, even if national data is limited. Given that the 2017 study (mentioned above) estimated 7% of people in the US attempt SMA at some point in their lives,[12] it is possible that similar rates exist in Canada.

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6 Pleasants, E. A., Cartwright, A. F., & Upadhyay, U. D. (2022). Association Between Distance to an Abortion Facility and Abortion or Pregnancy Outcome Among a Prospective Cohort of People Seeking Abortion Online. *JAMA Network Open*, *5*(5), e2212065–e2212065. https://doi.org/10.1001/jamanetworkopen.2022.12065

7 Nguyen, Nam Hoang, et al. Barriers and Mitigating Strategies to Healthcare Access in Indigenous Communities of Canada: A Narrative Review. *Healthcare (Basel)*, vol. 8, no. 2, 2020, p. 112, https://doi.org/10.3390/healthcare8020112.

8 Tami, Abigail, et al. Avoidance of Primary Healthcare among Transgender and Non-Binary People in Canada during the COVID-19 Pandemic. *Preventive Medicine Reports*, vol. 27, 101789, 2022, https://doi.org/10.1016/j.pmedr.2022.101789.

9 Verma, N., & Grossman, D. (2023). Self-Managed Abortion in the United States. *Current Obstetrics and Gynecology Reports*, *12*(2), 70–75. https://doi.org/10.1007/s13669-023-00354-x

10 Verma & Grossman (2023).

11 Cowman, E., Larios, L., Thomas, O., & Paterson, M. (2025, *pending publication*). *Abortion in Manitoba: An intersectional analysis of care. Summary Final Report*.

12 Verma & Grossman (2023).

Women on Web SMA Consultations

Women on Web (WoW) is a Canadian non-profit organization that facilitates online access to medical abortion internationally. Although WoW does not directly provide abortion pills for SMA in Canada, they still offer consultations with those seeking SMA in Canada to collect demographic data, as well as why people may be seeking SMA.

WoW's 2021 consultation[13] collected data from 216 Canadians looking to self-manage their abortions. The data showed that most people seeking SMA in Canada were in their twenties and early thirties, though the full age range was 15-43, and over 10% were minors. Nearly all participants (93.5%) confirmed their pregnancy with a test and reported being under seven weeks' gestation at the time of seeking services. Those seeking SMA experienced various barriers to accessing abortion care through the healthcare system, including needing to keep their abortion a secret (55.7%), facing COVID-19 disruptions (50.6%), work or school obligations (32.9%), distance (32.9%), and stigma (31.6%). Despite these challenges, SMA was also reported to be a preferred model of care for many, with 72% identifying reasons they actively preferred SMA, such as privacy (53.7%), comfort at home (52.8%), and autonomy in managing their own abortion (49.1%). More recent data (2022-2024) from WoW is currently undergoing analysis,[14] but is consistent with their previous findings.

From this data, secrecy and distance emerged as central to shaping both the barriers' people faced and the reasons they found SMA desirable. The data also suggests that those who encounter more barriers to abortion care also report stronger preferences for SMA, which highlights how structural obstacles and experiences of marginalization shape not only access to care, but also people's visions for how they want to experience healthcare.

Practical Realities & Legality of Self-Managed Abortion in Canada

In Canada, abortion pills, namely misoprostol and mifepristone, are sold together under the name Mifegymiso. This combination pack is generally covered under provincial and territorial health insurance, and can be prescribed by doctors, nurse practitioners, and some midwives, up to 9 weeks of pregnancy.[15] Health Canada has approved the prescription of Mifegymiso without a physical exam or ultrasound by using the pregnant person's own report of their late menstrual period.[16] Unless there is reason to suspect an ectopic pregnancy or there is uncertainty about gestational age, Mifegymiso can be prescribed without an ultrasound. Despite this, physical exams and ultrasounds continue being a regular part of providing medical

[13] WoW shared data with ARCC. Some preliminary data is discussed here by Women on Web: *More telemedicine services are needed in Canada, Women on Web data shows*. Sept 28, 2021. www.womenonweb.org/en/news/more-telemedicine-services-are-needed-in-canada-women-on-web-data-shows/

[14] Pending publication. WoW shared preliminary data with ARCC.

[15] Stevenson & Taylor (2022).

[16] Government of Canada (2019). *Health Canada approves updates to Mifegymiso prescribing information: Ultrasound no longer mandatory*. https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/fact-sheets/mifegymiso.html

abortion care,[17] with ultrasounds particularly required if there are concerns of an ectopic pregnancy or uncertainty of gestational age.[18]

While Mifegymiso has been proven to be an extremely safe and effective way of ending a pregnancy,[19] Canada was decades behind European countries in approving and implementing its use. Although approved by Health Canada in 2015, access was initially restricted by unnecessary regulations, including requirements for mandatory ultrasounds, physician-only dispensing, and direct in-person supervision. These barriers were gradually removed following significant advocacy work led by physician groups and non-profit organizations. By 2019, Mifegymiso was publicly funded in all provinces and territories, and since then, access has improved. While geographic and systemic barriers remain for some populations, Canada's rollout of Mifegymiso ultimately represents a success in expanding abortion access in the country.

A status report from LEAF[20] analyzes the legality of SMA in Canada. The report finds that while ending one's own pregnancy is not itself illegal, there are several criminal laws and regulatory restrictions that apply to specific activities involved in the process that may create legal risks for those who self-manage or assist others in doing so. Under Health Canada's *Food and Drugs Act,* Mifegymiso is classified as a Schedule I drug, meaning that it can only be sold or dispensed legally in Canada with a prescription from a licensed healthcare provider. While this regulation is intended to ensure the safe use of medications, it creates a major barrier to acquire Mifegymiso for those who do not have access to a prescriber.

Another significant legal complication is the prohibition on importing prescription drugs from other countries into Canada. Obtaining abortion pills online to import into Canada is a desirable option for some abortion seekers who prefer to access care outside of the medical system. While Women on Web does not offer this service in Canada, they do provide this service for other countries where importing prescription drugs is not a legal violation. In Canada, importing abortion pills for personal use is a violation of the law. According to the *Food and Drug* regulations, only specified professionals can legally import prescription medications. Any packages ordered that contain prescription medications are often intercepted by border agents, and the individuals who ordered the medication may face legal penalties, including fines or prosecution. People who help others obtain imported abortion pills also may be held legally responsible for doing so.

Other legal considerations mentioned in the LEAF report include Sections 238(1), 242, and 243 of the Canadian Criminal Code, which focus on the legality of disposing of the products of conception, and birthing considerations. Despite these Criminal Code offences, the most

[17] University of British Columbia (2023). *Medical Abortion Prescriber Checklist Resource Guide.* https://caps-cpca.ubc.ca/index.php/File:Medical_Abortion_Prescriber_Checklist_Resource_Guide.pdf

[18] Government of Canada (2019).

[19] World Health Organization (2022).

[20] Stevenson & Taylor (2022).

significant legal considerations for SMA in Canada are the requirement for a prescription and the ban on importing abortion pills.[21]

Toward a Canadian Model of Self-Managed Abortion

An alternative understanding of SMA is that the process may also encompass situations where someone undertakes some of the steps to have an abortion without a healthcare provider, but still engages with the system for other steps in the process.[22] As Canada has a universal healthcare system, it is crucial that SMA, and thereby Mifegymiso, remains fully covered under the current system. Implementing a SMA model within the Canadian universal healthcare system requires some contact with the health system to remain covered by public health insurance, but this contact can be significantly reduced while still following Health Canada's guidelines. Two key ways of implementing a SMA model in Canada include enabling more healthcare practitioners to dispense or prescribe Mifegymiso, including pharmacists and midwives, and expanding telehealth services.

Enabling pharmacists and midwives to be able to dispense and prescribe Mifegymiso as an over-the-counter medication would remove the significant barrier of finding a doctor or NP who is able and willing to prescribe, while ensuring that the pills remain free under universal healthcare. Currently, midwives in Quebec and Saskatchewan can already prescribe Mifegymiso, and midwives in four other provinces and territories can do so under a physician's directive.[23] Similarly, telehealth may be another solution to implement a SMA model in the Canadian context, as it is proven to reduce abortion-related travel barriers.[24] Some telehealth services in Canada already provide virtual and telephone medical abortion services, such as QDoc in Manitoba,[25] but this availability is inconsistent across Canada. Just as with pharmacies, telehealth allows abortion seekers to obtain abortion pills through limited contact with the healthcare system, while reducing barriers associated with abortion care, such as travel, stigma, and logistical barriers.

The Abortion Rights Coalition of Canada calls for a shift toward a self-managed abortion model in Canada that expands access to care through an expansion of telehealth service and pharmacist dispensing, and more provinces allowing midwives to prescribe Mifegymiso. These measures would empower individuals to manage their abortion care with greater ease and fewer barriers, while still maintaining safety and coverage under Canada's universal healthcare system. Implementing SMA in the Canadian context should involve minimal contact with the healthcare system so that abortion seekers can manage their care with less barriers, and in the ways they desire.

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21 Stevenson & Taylor (2022).

22 Stevenson & Taylor (2022).

23 Canadian Association of Midwives. (2025). *Midwife-Led Abortion Care*. https://canadianmidwives.org/midwife-led-abortion-care/

24 Koenig, L. R., Becker, A., Ko, J., & Upadhyay, U. D. (2023). The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis. *JMIR Public Health and Surveillance*, *9*, e45671-. https://doi.org/10.2196/45671

25 Cowman et al., (2025, *pending publication*).