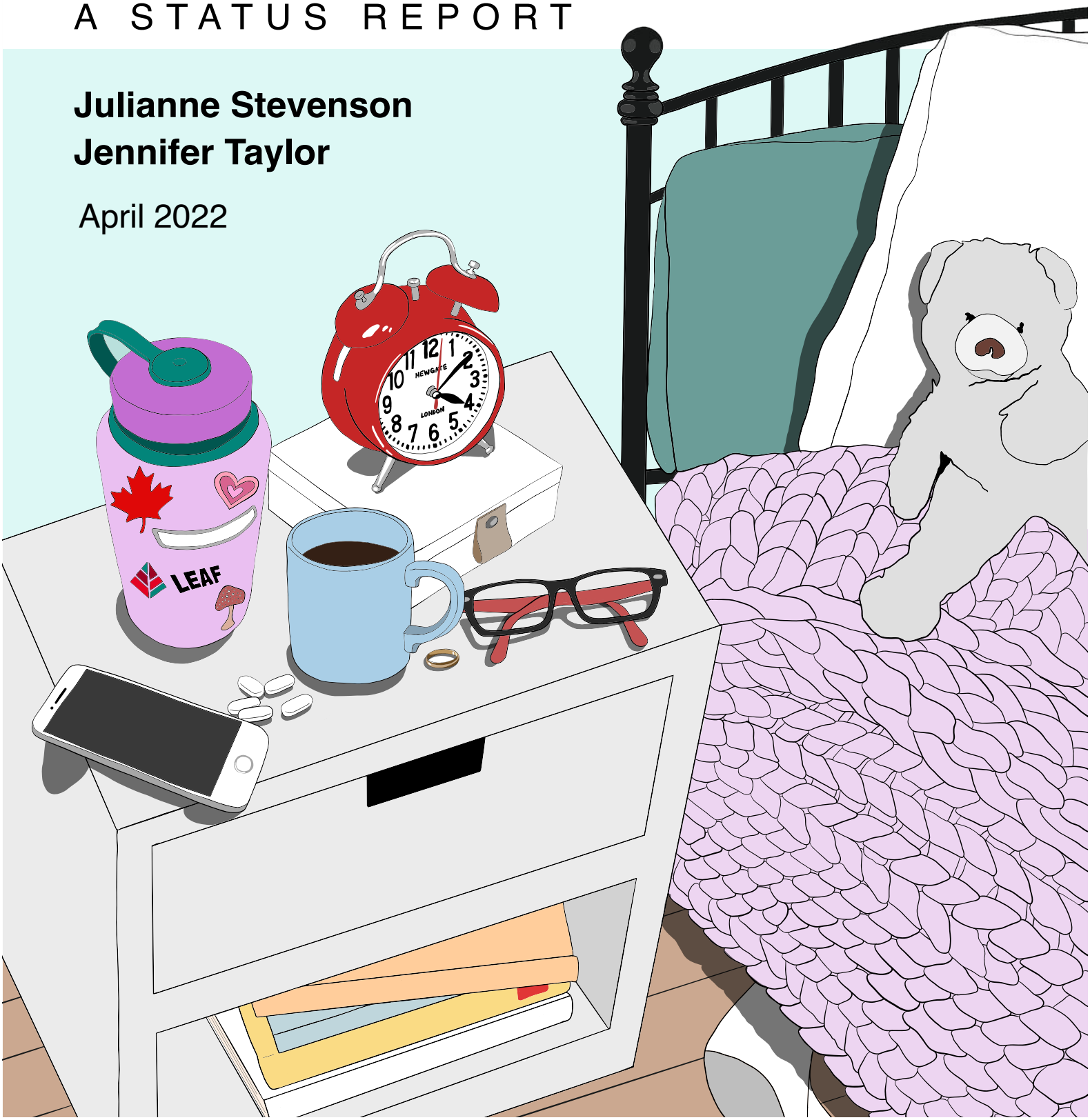
Self-Managed Abortion in Canada

A STATUS REPORT

Julianne Stevenson
Jennifer Taylor

April 2022



DISCLAIMER: The information contained in this report is current to March 29, 2022. This report does not constitute legal or medical advice.

Published in partnership with
Women's Legal Education and Action Fund (LEAF)
180 Dundas Street West, Suite 1420
Toronto, Ontario, Canada M5G 1C7
www.leaf.ca

This report was written in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq people, which is governed by the Peace and Friendship Treaties.

Contents

Statement of Intent

This report is intended to contribute to the body of legal research on self-managed abortion, from a Canadian perspective. The authors hope the report is nevertheless accessible to a wider audience, beyond the legal community.

The medical and other scientific research discussed in this report is a backdrop for the legal analysis and provides context for the discussion. **The report is not intended as a 'how-to' guide on self-managed abortion, nor is it intended to constitute health or medical advice.**

Authors

Julianne Stevenson (she / her) is a lawyer in Halifax. She was called to the Nova Scotia Bar in 2019 and recently finished a two-year clerkship at the Nova Scotia Court of Appeal in Halifax. She received her Bachelor of Arts from the University of King's College, and her Juris Doctor from Dalhousie University's Schulich School of Law.

Jennifer Taylor (she / her) is a lawyer in Halifax who was called to the Ontario Bar in 2010 and the Nova Scotia Bar in 2013. She received her law degrees from Dalhousie University and the University of Cambridge. A former law clerk with the Nova Scotia Court of Appeal, Jenn is currently involved with the Canadian Bar Association, the Dalhousie Feminist Legal Association, and the East Coast Prison Justice Society. She can be found on Twitter @jennlmtaylor.

This report was illustrated by **Olivia Piccolo**. Her artwork can be found on Instagram at @livpicspics.

The authors prepared this report in their personal capacities.

Acknowledgements

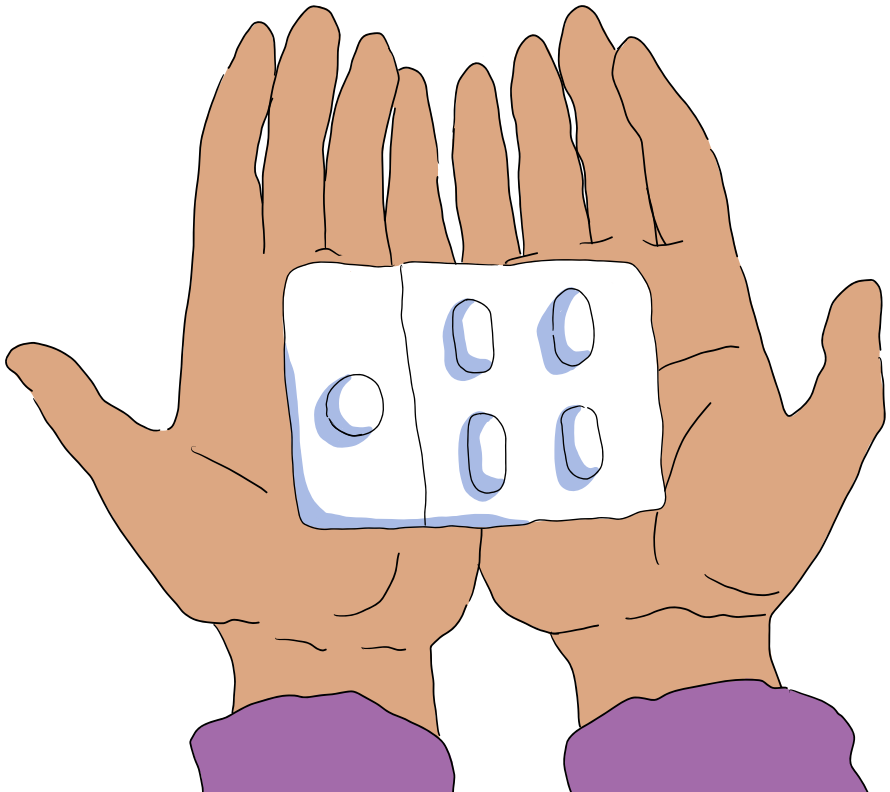
The authors would like to sincerely thank **Dr. Alicia Malone**, a resident physician in Family Medicine at the University of Ottawa, for providing research assistance.

The authors are incredibly grateful to **Prof. Joanna Erdman** of the Schulich School of Law for inspiring this project and reviewing an earlier draft.

Self-managed abortion, as envisioned in this report, is part of a larger spectrum of abortion care. The authors wish to acknowledge and thank abortion providers and prescribers working within the Canadian health care system. Clinical providers and prescribers are essential to abortion care in Canada, and part of the robust legal protection for abortion access that currently exists in Canadian law.

As recent international legislative changes have brought the limits of law into stark focus, this report seeks to advance knowledge about the status of self-managed abortion in Canada as a means of protecting and preserving essential access, without taking away from the incredible and compassionate work that abortion providers perform every day.

Last but not least, current scholarship on SMA is indebted to the work of feminist activists and collectives around the world, particularly in the Global South.[1] This work may offer models for the continued transformation of abortion care in Canada.[2]



Executive Summary

This report is intended to contribute to the body of legal research on self-managed abortion (SMA), from a Canadian perspective.

There is currently robust legal protection for abortion access in Canadian law. However, recent international legislative changes have demonstrated the limits of law as the main way to protect abortion access. This report on SMA will hopefully encourage readers to think of abortion not just in relation to the law, but as something that can happen safely at home in appropriate circumstances, without direct medical supervision or state involvement.

The report has four main parts.

Part I looks at the basics of SMA. In this report, "self-managed abortion" refers to situations where someone takes steps to end their pregnancy outside of clinical settings. One common method of SMA, and the focus of the report, is using abortion pills to end a pregnancy. The process is described as "self-managed" because people obtain and administer abortion pills themselves, and only interact with health care professionals if and when they choose or need to do so.

While acknowledging the imperfections and limitations of this model, Part I concludes by listing several reasons why someone might choose SMA. These reasons include the need to travel long distances to obtain surgical or medication abortion; financial barriers; personal autonomy; and prior negative experiences with the health care system.

Part II reviews the efficacy and safety of abortion pills. The drugs used to induce a medication abortion are mifepristone and misoprostol, and various regimens and combinations exist. Studies have shown these drugs to be effective and safe when used properly.

Whether abortion pills are a safe option involves two key considerations: (1) being able to accurately determine gestational age (how many weeks' pregnant the person is) and (2) being able to assess the risk of an ectopic pregnancy. These considerations are explained in Part II. Part II also discusses the potential dangers of using herbal products instead of abortion pills.

In Canada, the drugs mifepristone and misoprostol are sold together under the trade name Mifegymiso, which is generally covered under provincial and territorial health insurance schemes when obtained with a prescription.

Part III outlines the legal considerations and risks involved with SMA in Canada. The ability to access abortion through the publicly funded health care system is a

constitutional right in Canada, as the authors have written elsewhere. However, there are legal risks related to SMA as it is defined in this report.

These risks primarily arise under the *Food and Drugs Act* and *Regulations*. There is currently no legal way to obtain abortion pills within Canada without a prescription. The designation of Mifegymiso as a prescription drug in Canada is a barrier to self-procurement for people seeking SMA, because they must interact with the health care system in order to obtain a prescription.

It is also an offence under the food and drugs regime to import prescription drugs for personal use. No Canada-based websites seem to allow for the purchase of abortion pills, meaning that current online ordering options would all involve importing the drugs. This would be illegal under the current *Food and Drugs Act* regime.

Designating Mifegymiso as an over-the-counter medication (similar to Plan B) would address some of these legal risks, as explored in Part III.

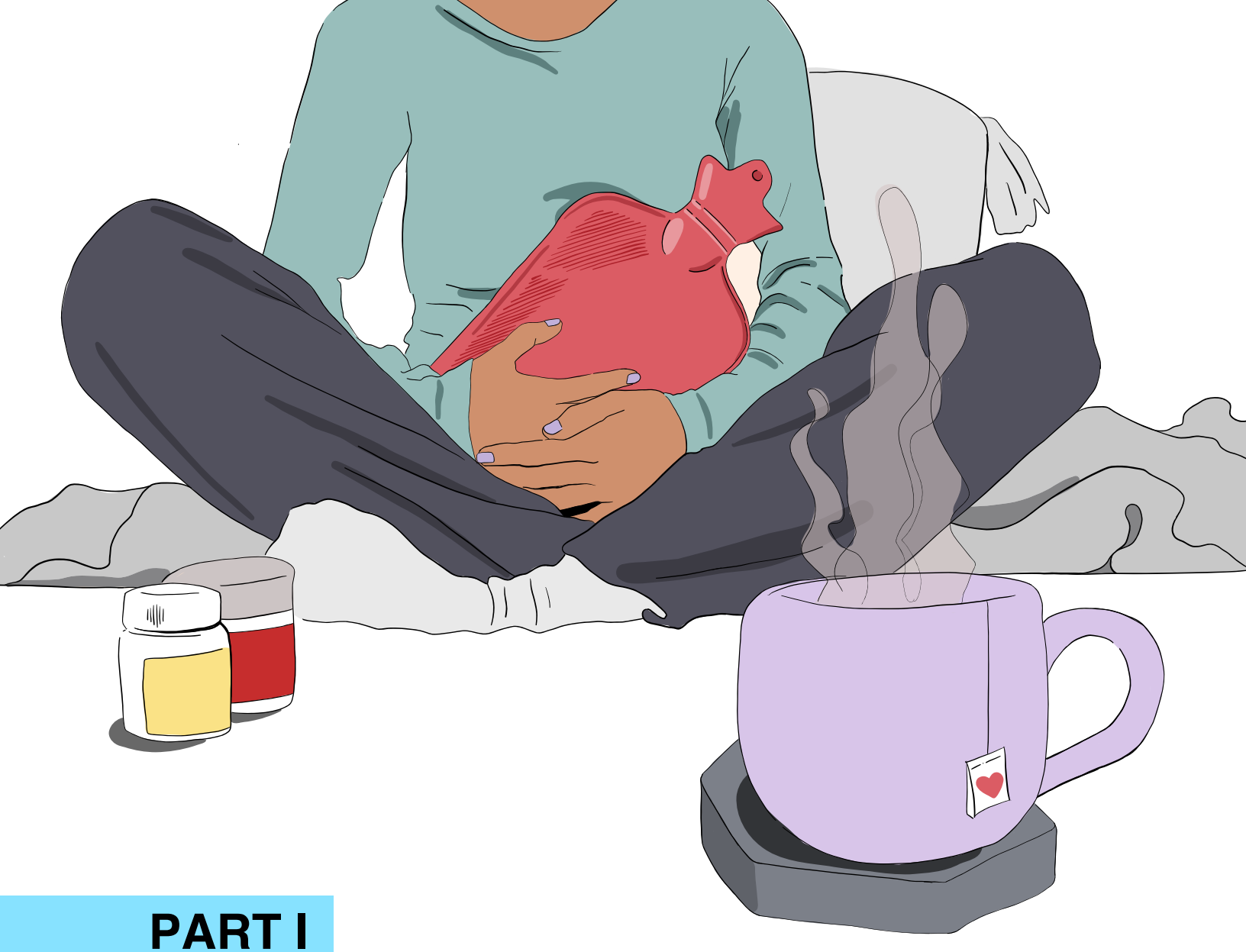
Part IV considers other facets of abortion care that share some of the features of SMA and are available within the current legal framework.

Telemedicine, when a healthcare provider prescribes abortion pills over the phone or internet, can enhance access for those living in rural areas, seeking to limit their in-person contact with the health care system, or otherwise wanting to have more control over the process. The advance provision of abortion pills to people who are not, but may become, pregnant could also serve to increase abortion access.

Abortion doula services, abortion hotlines, and abortion funds all exist in Canada already. These community-based supports connect people to abortion care and also help meet related needs, like travel costs.

Part IV then discusses the role that abortion apps, social media, and other online spaces can play in providing information about SMA and other ways to access abortion, noting that users must guard against misinformation from ‘crisis pregnancy centres’ and other anti-abortion organizations.

Finally, Part IV calls for more public health education on self-managed abortion in Canada. While the Canadian health care system may be years away from de-regulating abortion pills to the point that true SMA is an accessible option, public health education on SMA would be an important intervention to help people realize their reproductive decisions and rights.



PART I

The Basics of Self-Managed Abortion

1. What is self-managed abortion?

Defined broadly, “self-managed abortion” (or “SMA”) refers to the “actions or activities by a pregnant individual to end a pregnancy outside of clinical settings.”[3] One common method of SMA, and the focus of this report, is using medication abortion drugs (“abortion pills”) to end a pregnancy.[4] The process is described as “self-managed” because people obtain and administer abortion pills themselves, and only interact with health care professionals if and when they choose or need to do so.[5]

The term “SMA” can also encompass situations where someone undertakes some of the steps to have an abortion without a health care provider, but still engages with the system for other steps in the process.[6]

In a typical self-managed abortion, the pregnant person will take the drug mifepristone and then, 24-48 hours later, may take the drug misoprostol.[7] The process is very similar to what happens when a health care provider prescribes abortion pills. The difference is that self-managed abortion involves both *self-procurement* and *self-administration* of the medication (getting and taking the pills on one’s own).[8]

The World Health Organization (WHO) states that self-assessment and self-management of abortion “without direct supervision of a health-care provider […] can be empowering for individuals and help to triage care, leading to a more optimal use of health-care resources.”[9]

With accompaniment support in the form of abortion counsellors (with or without clinical training), self-managed medication abortion can be as effective as clinician-managed medication abortion.[10]

2. What are the limitations of this model?

In addition to the legal risks discussed below, the model of SMA discussed in this report includes its own practical barriers to accessibility. For incarcerated people, migrant workers, unhoused people, those experiencing domestic violence, and others with more precarious living situations, the option of managing an abortion at home is either unavailable or unrealistic, and potentially dangerous for reasons unrelated to the effectiveness of the pills. Navigating SMA also requires a level of literacy and internet access that is not available to everyone,[11,12] in addition to the financial resources to purchase abortion pills outside of the public health care system.

Furthermore, the term “self-managed abortion” itself may be something of a misnomer, as community support is often a fundamental part of the model. Incorporating concepts of accompaniment support[13] within general understandings of SMA (“supported SMA”) may help minimize some of the barriers of this model.[14]

Finally, although SMA is framed in this report as an example of self- and community care outside the health care system, this framing does not sufficiently confront the ways the Canadian health care system has been wielded against Indigenous people through settler colonialism.

Reproductive coercion is an acute example of the harms of settler colonialism.[15] In Canada, this reproductive coercion has included "forced sterilization, abusive abortions, and the promotion of birth control for population control ends."[16] To paraphrase Prof. Karen Stote, settler feminists must work to decolonize feminism, particularly in the reproductive justice context.[17]

Prof. Stote's call to decolonize feminism involves challenging the default role of the state in reproductive health care. As Prof. Stote puts it, "State-provided reproductive rights are not enough to achieve justice."[18] SMA is one way that people can assume more control over their own reproductive health, which also helps advance reproductive justice.

While framed as *limitations*, it is hoped that these ideas and topics may inspire future conversations and research, particularly in the Canadian context.

3. Why choose a self-managed abortion?

While people are generally more likely to opt for self-managed abortion in countries where legal access to abortion is restricted,[19] there are many reasons why people may seek out self-managed abortions,[20] including in Canada.

These reasons may include:

- the need to travel long distances to obtain surgical or medication abortion;[21]
- financial barriers associated with travel (taking time off work, organizing childcare, having enough money for gas and accommodations);[22]
- difficulty accessing the health care system if primary health care providers in their area are unwilling to prescribe the medication — either because of a so-called conscientious objection to abortion, or due to a misperception that it is difficult to prescribe or outside of their scope of practice;[23]

- personal autonomy (taking health care into one's own hands), empowerment, and self-care;[24]
- simply wanting to manage an abortion on one's own;[25]
- privacy interests;
- the need for a less invasive process to end a pregnancy;
- fear of stigma;
- cultural barriers that make it difficult to interact with the health care system; and/or
- prior negative experiences with the health care system.

Many Indigenous people have experienced discrimination in the health care system, including when it comes to sexual and reproductive health care.[26] It is also not uncommon for trans and non-binary people to experience discrimination within the health care system, and therefore opt for abortion outside the formal system.[27]

The ability to self-assess and self-manage abortion at home, or in another safe, non-clinical space, may lessen many of these burdens.[28]

PART II

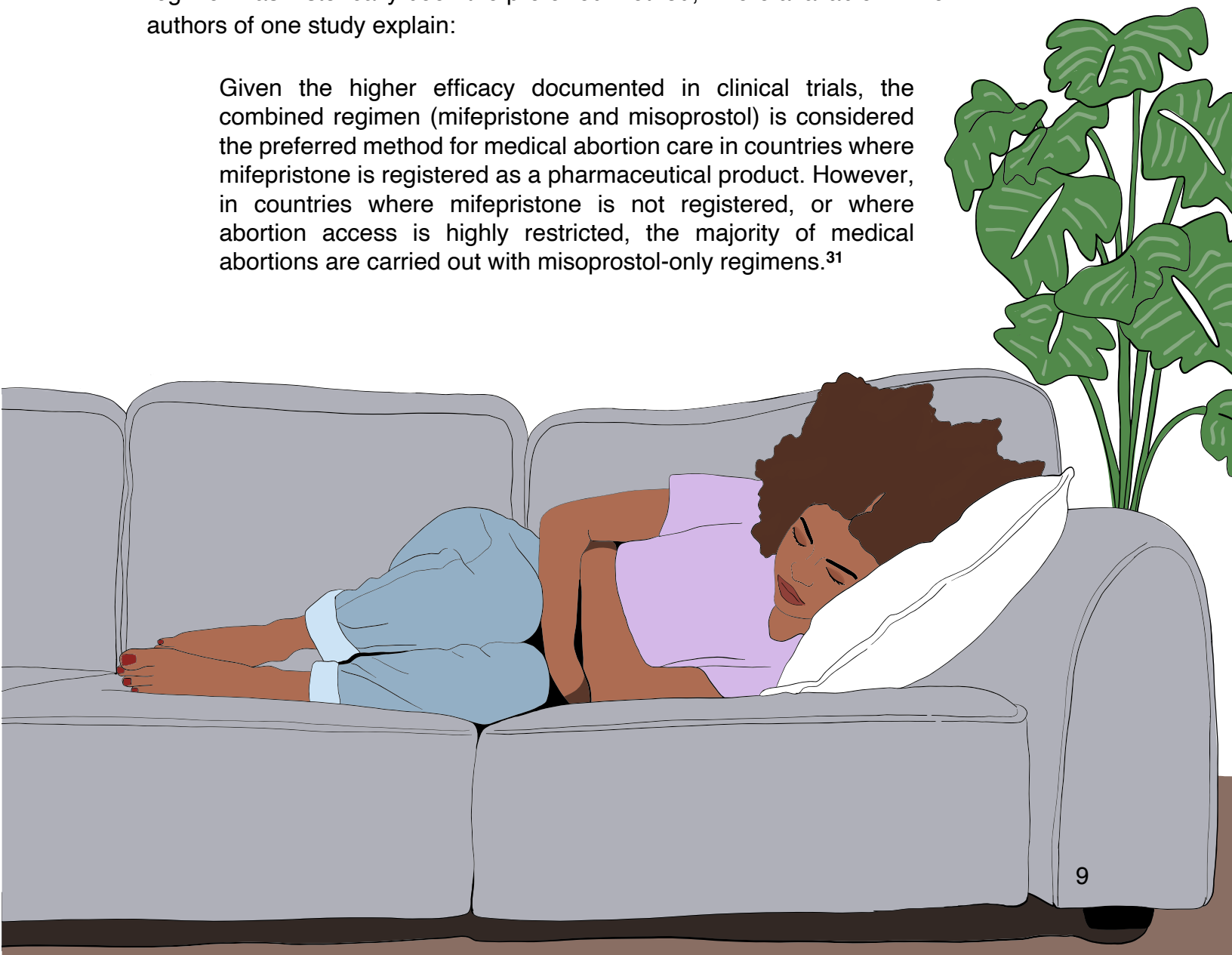
The Efficacy and Safety of Abortion Pills

1. Using abortion pills

The drugs used to induce a medication abortion are mifepristone and misoprostol. The safety of both mifepristone and misoprostol is well-established.[29]

An abortion is likely to be successful if misoprostol is used alone, but the combined regimen has historically been the preferred method, where available.[30] The authors of one study explain:

> Given the higher efficacy documented in clinical trials, the combined regimen (mifepristone and misoprostol) is considered the preferred method for medical abortion care in countries where mifepristone is registered as a pharmaceutical product. However, in countries where mifepristone is not registered, or where abortion access is highly restricted, the majority of medical abortions are carried out with misoprostol-only regimens.[31]



However, a recent study showed that, with appropriate support,[32] 99% of people who self-managed abortion using misoprostol alone had a complete abortion.[33] This is an important development, because misoprostol alone is more widely obtainable outside clinical settings than the combination regimen of misoprostol and mifepristone.[34]

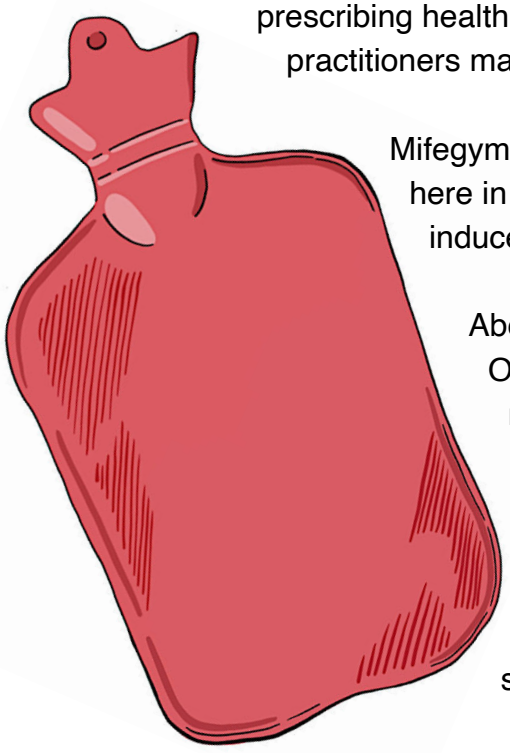
In Canada, the drugs are sold together under the trade name Mifegymiso.[35] Mifegymiso, as a prescription drug, is generally covered under provincial or territorial health insurance schemes.[36]

The standard medication abortion regimen in Canada, using Mifegymiso, contains two medications: **mifepristone** (1 tablet) which is taken first, followed 24-48 hours later by **misoprostol** (4 tablets).[37,38]

Mifepristone destabilizes the lining of the uterus and ends the pregnancy; misoprostol causes cervical ripening and uterine contractions.

The process is irreversible once the first pill (mifepristone) is taken.[39] After taking the first pill, it is necessary to continue with the other pills, or obtain surgical intervention, to end the pregnancy.[40]

Health Canada does not require that an ultrasound be performed before Mifegymiso is prescribed.[41] Health Canada's Guideline on prescribing and dispensing Mifegymiso states that Mifegymiso may be dispensed directly to patients "by a pharmacist or a prescribing health professional."[42] In many Canadian jurisdictions, nurse practitioners may prescribe Mifegymiso.[43]



Mifegymiso was approved in Canada in 2015 and first marketed here in January 2017,[44] but the drugs have been safely used to induce abortion in other parts of the world for decades.[45]

Abortion pills, when used according to the World Health Organization ("WHO") guidelines, are very safe and the results are often indistinguishable from a miscarriage.[46] It has been reported that a medically-induced abortion is typically safer than childbirth.[47]

In a recent Canadian study of medication abortion, the authors found that: "Abortion safety outcomes remained stable during the period before mifepristone had become

available and during the period after its availability with a normal [Mifegymiso] prescription."[48] This study also indicated "that patients who received mifepristone most often correctly used the medication without supervision"[49]–a finding that supports the safety of SMA.

The main concerns that clinical providers report concerning self-managed abortion are related to the medical risks that may arise if a person does not have a source of accurate information on what to expect, and/or does not have access to medical care (including emergency care) when desired or needed.[50]

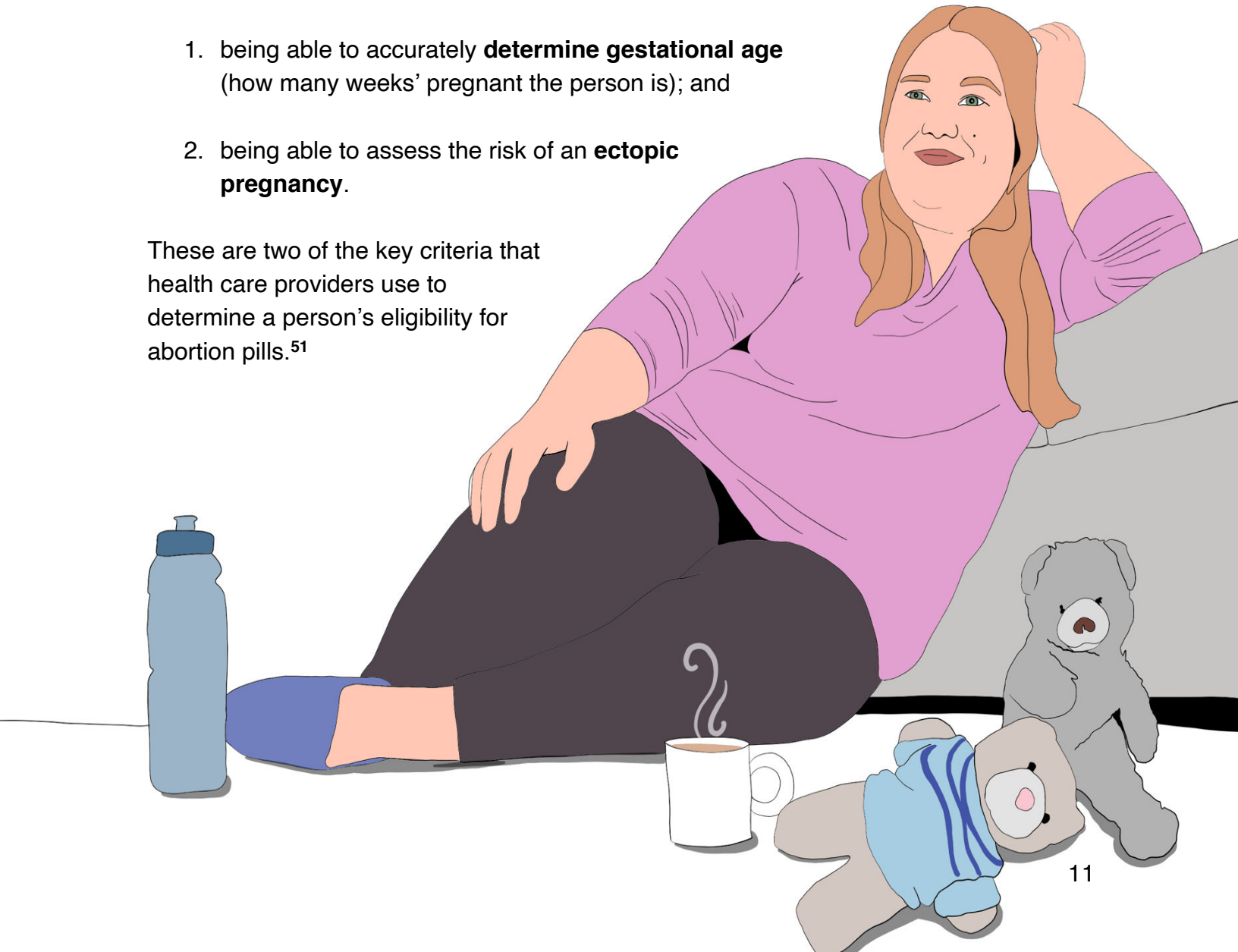
The safety of self-managed abortion depends in large part on whether a pregnant person will be able, on their own, to figure out whether abortion pills are right for them (and, if so, to determine if they need to access emergency medical care after taking the pills).

Whether abortion pills are a safe option involves two main considerations:

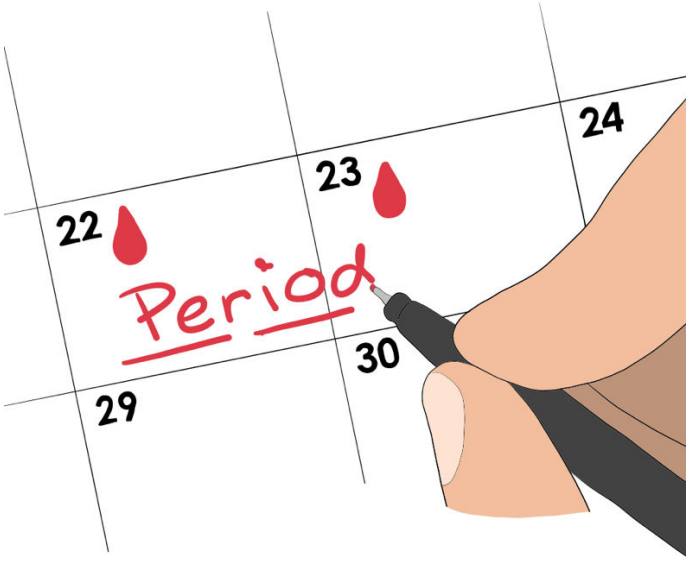
1. being able to accurately **determine gestational age** (how many weeks' pregnant the person is); and

2. being able to assess the risk of an **ectopic pregnancy**.

These are two of the key criteria that health care providers use to determine a person's eligibility for abortion pills.[51]



2. Determining gestational age



Health professionals in Canada figure out how far along someone is in their pregnancy by measuring from the date of the first day of their last menstrual period (LMP). The clock "starts" from the date of the person's LMP rather than the date of conception.[52]

Published evidence demonstrates that abortion pills can be safely used without the need for a physical exam or ultrasound performed by a care provider by using the pregnant person's own report of their LMP.[53]

The WHO says abortion pills can be used safely up to 12 weeks' gestation, with less evidence available regarding use after that point.[54] In Canada, Health Canada has approved the use of Mifegymiso for up to **9 weeks'** gestation.[55]

If someone is not pregnant and takes the pills it is not usually harmful. They may experience nausea and vomiting or cramps.[56]

3. Assessing the risk of an ectopic pregnancy

Ectopic pregnancies are not common, but they can be very dangerous and potentially fatal. An ectopic pregnancy occurs when the fertilized egg implants somewhere other than the uterus—usually in one of the fallopian tubes. The fallopian tubes are the tubes that connect the ovaries to the uterus. If a fertilized egg gets stuck in a fallopian tube, the pregnancy will not develop properly, and the pregnant person's health may be at serious risk.[57]

HealthLinkBC identifies the key signs of an ectopic pregnancy as:

- Pelvic or belly pain. It may be sharp on one side at first and then spread through the belly. It may be worse when you move or strain.
- Vaginal bleeding.[58]

Ectopic pregnancies are treated with a specific medication to stop the pregnancy from growing, and/or surgery to remove the fertilized egg.[59] It is important to seek medical assistance if someone has, or believes they have, an ectopic pregnancy, because there is a serious risk that the ectopic pregnancy will cause the fallopian tube to split open (rupture).[60] A rupture is a medical emergency that can result in the death of the pregnant person.

If someone has an ectopic pregnancy and they take abortion pills, the pills will not cause a rupture—but they also will not end the ectopic pregnancy.[61]

The main risk is that someone might take abortion pills and believe they have ended their pregnancy, but it is actually an ectopic pregnancy and the pregnant person goes on to experience a rupture later.[62]

A recent Canadian study found "that after mifepristone had become available with a normal prescription dispensed by pharmacists and taken at user discretion, […] abortion-related adverse events and ectopic pregnancy remained rare, as compared with before mifepristone had been available."[63,64]

4. Using herbal products

People who need an abortion and do not want to involve medical providers may be tempted to search the internet for information about inducing abortion naturally, using herbs or other at-home methods. There are serious, and potentially fatal, risks in taking herbal or other at-home remedies to induce abortion.

It is acknowledged that "land-based and traditional medicines were commonly used to prevent or end pregnancies" in many Indigenous communities before colonization, and that these practices were interrupted by colonization.[65] This section refers to self-managed abortions that people *without* the benefit of this kind of cultural and traditional knowledge or support may be tempted to undertake.

In a recent study using data from the Google Ads Abortion Access Study, researchers found that 28% of the relevant participants "reported attempting self-managed abortion." Of those, 52% had tried using herbs, supplements, or vitamins. The study found that "…interest in self-managed abortion may be higher in places with more barriers to abortion access"—particularly structural barriers like travel time and expenses. The authors explained:

> The most commonly reported method was taking herbs, vitamins, and supplements, most of which appear benign. Substantial information is available on the internet about herbs and other methods to "induce a miscarriage." Many vitamins and herbs, including vitamin C and dong quai, are traditional and indigenous approaches that people have used for hundreds of years to end pregnancy. While scientific evidence for their efficacy is limited, some may have abortifacient properties. However, these approaches are undoubtedly less effective than mifepristone/ misoprostol and in-clinic procedural abortion and may delay individuals from obtaining needed care. Indeed, 1 qualitative study reported some individuals who attempted self-managed abortion did not realize they were unsuccessful for several weeks.[66]

The study did not actually determine whether those who used herbs, vitamins, or supplements were able to successfully end their pregnancies.

Recipes for "herbal abortions" may include herbs known or believed to be abortifacients or "emmenagogic," meaning they are used to induce uterine contractions and/or menstrual bleeding. While a large number of plants are classified as being emmenagogic in nature, the ways they work in the body are not well understood[67] and can result in dangerous outcomes for the pregnant person, including death:[68] "ingesting enough of a particular herb or vitamin to actually cause an abortion could be toxic."[69]

Even if the pregnant person is not otherwise harmed, these methods may not end the pregnancy.

Unlike herbal products, abortion pills such as Mifegymiso (or misoprisotol taken alone) are proven to be safe and effective at terminating pregnancies, including when self-administered at home (subject to the risk factors discussed above).[70]

PART III

Legal Considerations & Risks

The ability to access abortion through the publicly funded health care system is a constitutional right in Canada, as part of the right to autonomy in medical decision-making.[71,72]

While the actual act of self-administering abortion pills is legal, there are criminal and regulatory prohibitions on some activities (especially those related to self-procuring abortion pills) that could expose people who self-manage abortion, or assist with another person's self-managed abortion, to legal risk.[73]

The following sections discuss potential legal risks related to SMA in Canada.

1. *Criminal Code* offences

If a person chooses to have an abortion on their own (whether by taking abortion pills prescribed by health care providers or through a completely self-managed abortion) instead of in a clinical facility, they will have to dispose of the products of the pregnancy. Depending on how far the pregnancy has progressed, this may mean disposing of blood (similar to a very heavy period) or it may mean disposing of fetal remains.[74]

Section 243 of the *Criminal Code* makes it a crime to "conceal the body of a child." The section reads:

> **243** Every person who in any manner disposes of the dead body of a child, with intent to conceal the fact that its mother has been delivered of it, whether the child died before, during or after birth, is guilty of
>
> **(a)** an indictable offence and liable to imprisonment for a term of not more than two years; or
>
> **(b)** an offence punishable on summary conviction.

In *R v Levkovic*,[75] the Supreme Court of Canada heard the appeal of a woman who was charged under section 243 of the *Criminal Code*. The woman gave a statement to police

explaining that she gave birth after falling while alone in her apartment. She then put the remains of the fetus in a bag on the balcony and left the apartment. Nothing in her statement to police suggested the child had been born alive.

The Supreme Court of Canada considered whether section 243 of the *Criminal Code* was unconstitutional because it is too vague, specifically because it referred to concealing the body of a child that died "before birth." It upheld the law, meaning it decided it was not too vague and was, therefore, constitutional.

However, as legal commentator Stephanie Voudouris explains:

> To be clear, the trial judge stated that this provision would not apply to abortions or to miscarriages. As such, the provision is activated when something other than an abortion or miscarriage causes the death of a "child" prior to birth [emphasis added].[76]

The Supreme Court of Canada did not disagree with the trial judge on this point. In other words, section 243 does not apply to situations where the pregnancy was ended by abortion or miscarriage. The Supreme Court explained that, instead, section 243 of the *Criminal Code* is "focused on the event of birth"[77] rather than prior action taken by the pregnant person or anyone assisting them.

Following the decision of the Supreme Court of Canada, the woman received a new trial in which she was found not guilty of the offence of concealing the body of a child. The trial judge explained that the evidence in the case left "open the reasonable possibility that the" woman self-induced an abortion.[78] She explained that the decision of the Supreme Court of Canada "make[s] it clear that there can be no conviction pursuant to s. 243 in these circumstances."[79]

In summary, *R v Levkovic*[80] affirms that a pregnant person who self-induces an abortion at any point in pregnancy and disposes of the products of the pregnancy is not violating section 243 through those actions.[81]

On this basis, an individual who assists a pregnant person with disposing of the products of a pregnancy following miscarriage or abortion would also not be violating section 243.

In addition, those seeking to self-manage an abortion or assist in the self-management of abortion in Canada should be aware of the following:

- Section 238(1) of the *Criminal Code* prohibits the killing of an unborn child during the process of birth.[82]
- Section 242 of the *Criminal Code* makes it a crime for a person giving birth to fail to obtain assistance in childbirth, when that failure results in a permanent injury or death of the child.[83]

Like section 243, these sections of the *Criminal Code* are aimed at protecting "children",[84] meaning they are designed to protect those who are born alive or very likely would have been born alive but for a failure to do something during the process of birth or some external event. A fetus is not a legal person until it is born alive.[85]

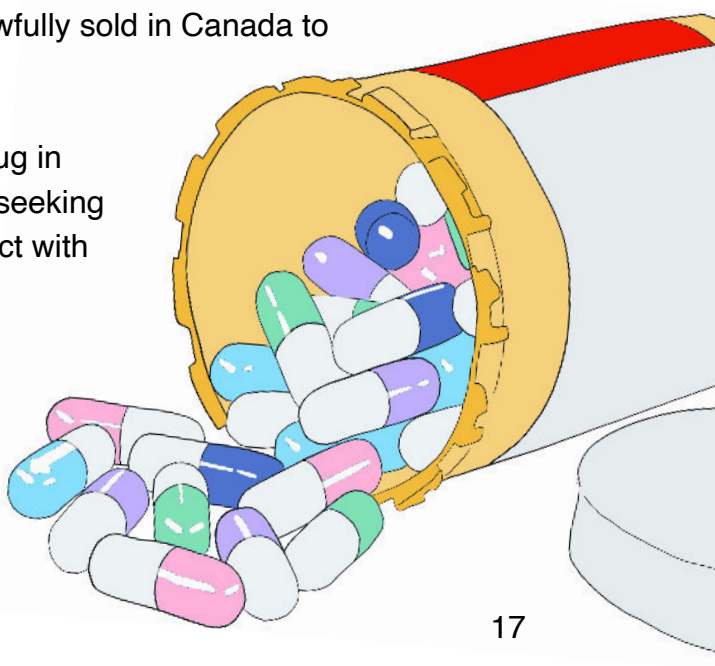
These provisions of the *Criminal Code* would be unlikely to apply to most situations involving a termination of pregnancy.[86] Nonetheless, it is important to be aware of the possible criminalization of activities related to self-managed abortion care.[87]

2. Regulation of prescription drugs

It is not illegal in Canada to self-administer an abortion, but there is currently no legal way to obtain abortion pills within Canada without a prescription.

The *Food and Drugs Act*[88] and *Food and Drug Regulations*[89] govern the sale of prescription and non-prescription drugs in Canada.[90] Health Canada determines which drugs require a prescription for purchase and sale, and which do not.[91]

Mifepristone is designated a Schedule I drug in Canada, meaning that neither mifepristone nor Mifegymiso (the Canadian trade name for the combination product containing mifepristone and misoprostol) can be lawfully sold in Canada to any person without a prescription.[92]



The designation of Mifegymiso as a prescription drug in Canada is a barrier to self-procurement for people seeking self-managed abortion because people must interact with the health care system in some form to obtain a prescription.[93]

Furthermore, it is an offence to import prescription drugs for personal use. The *Food and Drug Regulations* state that "importation of prescription

drugs is restricted to practitioners, drug manufacturers, wholesale druggists or registered pharmacists, or a resident of a foreign country while a visitor in Canada."[94]

Section 31.2 of the *Food and Drugs Act* sets out the penalties for importing prescription medications.[95] Section 31.5 of the *Food and Drugs Act* directs judges sentencing individuals for unlawful importation of prescription drugs to consider "the harm or risk of harm" caused by the offence and "the vulnerability of consumers of the therapeutic product."[96]

In addition, section 31.6 of the *Food and Drugs Act* states that any people involved in the procurement of imported prescriptions may also be convicted of the offence — meaning someone could be charged if they attempted to order pills for another person, with no intent to use the pills themselves.[97]

3. Online access to abortion pills

Online access to abortion pills is an important part of the SMA conversation.[98]

Currently in Canada, self-managed abortion, including self-procurement of pills, is hindered by barriers to legally obtaining abortion pills without a prescription. As outlined above, it is illegal to import or possess Mifegymiso in Canada without proper authorization (such as a prescription). No Canada-based websites seem to allow for the purchase of abortion pills,[99] meaning that current online ordering options all involve importing the drugs, which would be illegal as the *Food and Drugs Act* regime currently stands.[100]

Health Canada and the National Association of Pharmacy Regulatory Authorities do not recommend ordering from online pharmacies that are not licensed by the appropriate provincial college of pharmacists, due to concerns regarding the legitimacy of the medications, possible contamination, and online scams to obtain personal and financial information.[101] Shipping times and potential shipping delays are also factors to consider with online ordering, along with the risk that the pills could be seized at the border.[102] However, reporting and studies have demonstrated that, in most cases, people who order medication abortion pills online from reputable websites will receive drugs containing the required active ingredients (although sometimes less than labelled).[103]

Websites connecting people to telemedicine services — as distinct from websites that allow pills to be purchased directly — offer another avenue for online access to abortion pills.

The organizations Aid Access (for US clients)[104] and Women on Web (for international clients),[105] both founded by Dr. Rebecca Gomperts, are fully remote services that facilitate access to medication abortion through an online consultation with a licensed physician. The doctor can provide a prescription and send it to a third-party pharmacy, which will then ship it to the patient.[106]

Women on Web (WoW) is based in Toronto and offers online consultations to people located in Canada. However, WoW does not actually send abortion pills to Canadian addresses. There are several reasons for this. WoW recognizes that abortion pills are already legal and usually free in Canada, and that there are legal barriers to mailing prescription drugs to Canadian addresses. Instead, WoW focuses its Canadian efforts on advocacy to increase the availability of medication abortion, to build the pool of telemedical providers across Canada, and to demonstrate the growing demand and preference for at-home medication abortion care.[107]

4. Potential designation of Mifegymiso as an over-the-counter medication

The term “over the counter” (“OTC”) means medications that are sold lawfully without a prescription, such as everyday pain relievers like acetaminophen. OTC may also be used as a broader term that includes “behind the counter medicines,” referring to drugs dispensed by a pharmacist without needing a prescription (such as Plan B).[108]

At this time, abortion pills are prescription-only medications in Canada. However, both Mifegymiso and misoprostol alone are currently available OTC from pharmacies in many countries around the world.[109]

Several studies have raised concerns about making mifepristone and misoprostol available OTC, citing risk of complications especially when used at increased gestational age, and concern that taking the pills without proper medical guidance could be risky.[110] However, a “growing body of evidence has found that [abortion pill] users can have safe, complete abortions with medications provided by pharmacy staff.”[111]

At this point, more research is likely required on the appropriate framework for abortion pills to be sold OTC in Canada in a safe and reliable way. However, that is not to say that abortion pills will not become OTC medications over time.

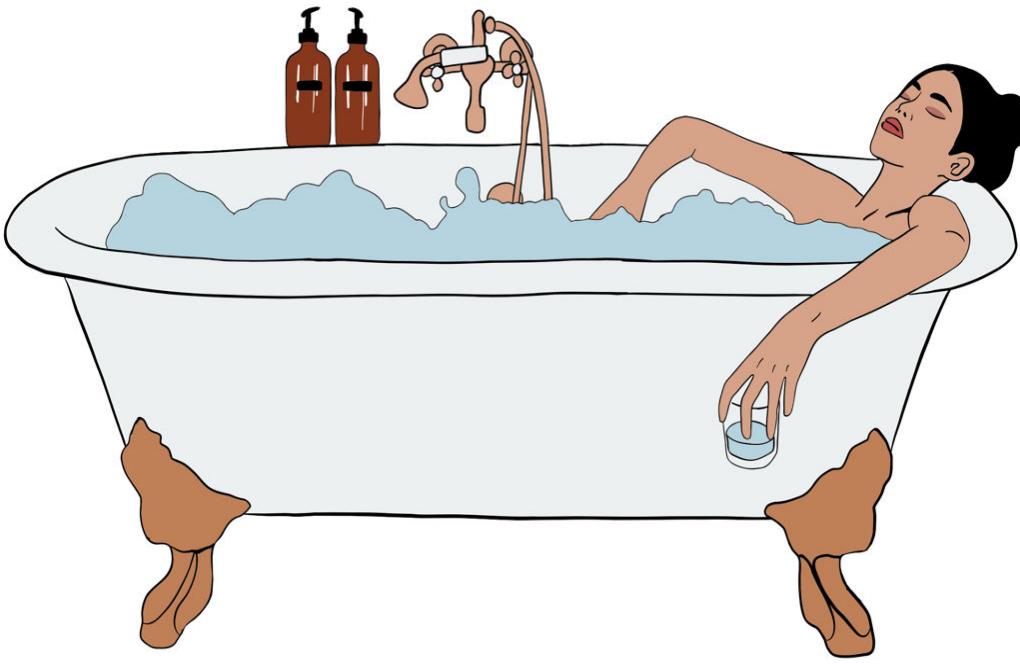
Take, for example, the drug levonorgestrel (Plan B),[112] which was once a prescription-only medication. In 2005, Canada became the fifth country in the world to approve access to levonorgestrel as emergency contraception without a prescription. The approval of the drug's non-prescription status by Health Canada came after significant effort and years of lobbying by the manufacturer Paladin, the Society of Obstetricians and Gynaecologists of Canada, the Canadian Pharmacists Association, the Women's Health Network, and the Royal College of Physicians and Surgeons of Canada.[113]

Health Canada explains the process by which a drug may be removed from the prescription drug list as follows:

> Switches from prescription to non-prescription status can be initiated by a request from a company in the form of a drug submission. Drug submissions/product licence applications contain information and data regarding the drug's safety, quality and efficacy. After reviewing this data, Health Canada may determine that the ingredient should be available by prescription only, or that non-prescription sale is appropriate.[114]

While the process of transitioning a drug from prescription to OTC may be long, there are many factors to suggest mifepristone and misoprostol may be good candidates for OTC sales: "[t]hey are safe, have no risk of overdose, are not addictive, and people are already using them safely on their own in many parts of the world."[115]

As academic research[116] and dialogue[117] about the possibility of OTC medication abortion become more widespread, there may be increased interest within Canada about the possibility of this approach to abortion care.[118]



PART IV

Other Aspects of Abortion Care

This section discusses other aspects of holistic abortion care that offer some of the benefits of SMA within the current legal framework.

1. Telemedicine

Telemedicine may refer to telephone or videoconference appointments with health care practitioners, or even care provided over email or text message in some provinces.[119] Depending on the province, the health care provider may be required to arrange follow-up care for a telemedicine appointment.[120]

Studies have demonstrated the success of telemedicine in increasing abortion access.[121] In particular, several studies conducted during the COVID-19 pandemic have shown that in-person dispensing of abortion pills by a clinician "is not necessary to ensure medication abortion effectiveness or safety." According to these studies, "the effectiveness of medication abortion ranged from 93% to 97%."[122]

Within Canada, there are currently logistical and regulatory barriers to cross-border prescribing of abortion pills through telemedicine.[123] However, the increase in—and more widespread acceptance of—telemedicine during the pandemic presents an opportunity to explore this option further. According to a recent report for Women on Web International Foundation, "The most likely solution is to leverage existing reciprocal billing arrangements between provinces for patients seeking care outside of their jurisdiction, so that claims are billed to the regulatory licensing jurisdiction and billing authority of the prescriber."[124]

More widespread and centralized use of telemedicine in delivery of abortion services may also help to create a more anonymous and comfortable environment for people seeking abortions who have to, or wish to, limit their interactions with the formal medical system.[125]

2. Advance provision & menstrual regulation

Advance provision "means people have abortion pills on hand in case they need them."[126] This would require a prescriber being willing to prescribe medication abortion for someone who is not pregnant. The prescriber would likely have to conduct advance screening to ensure the prescription is appropriate.[127] Alternatively, advance provision could involve the person obtaining the pills online (which is subject to the logistical and legal risks discussed earlier), at a time when they are not pregnant.[128]

The term "menstrual regulation" (or "MR") refers to people taking mifepristone and misoprostol after a missed period, without knowing whether or not they might be pregnant.[129] The term "missed-period pills" (or "MPP") may also be used in this scenario.[130]

A 2020 study reported that over 40% of 678 people surveyed would be interested in missed-period pills. The study concluded that "some people with missed periods do not desire pregnancy confirmation before taking medications that might disrupt a pregnancy. As a result, provision of missed period pills in the United States would expand reproductive service options and could improve the delivery of patient-centered care."[131] The same would likely hold true in Canada.

A more flexible understanding of when abortion pills may be obtained or taken could help increase abortion access and decrease abortion stigma.

3. Abortion doulas

Abortion doulas are community members working outside the formal medical system who provide multiple types of support for people having abortions,[132] which may be offered for free to those who need it. This support may include "providing transportation for appointments, helping people find lodging, raising funds for travel and offering emotional support."[133]

Some of the Canadian organizations offering these types of services include Abortion Support Services Atlantic (ASSA);[134] the Montreal Abortion Access Project (MAAP);[135] the SHORE Centre in Ontario;[136] the Alberta Abortion Access Network;[137] the Saskatoon Abortion Support Network;[138] and the Vancouver Full Spectrum Doula Collective.[139,140]

4. Abortion hotlines & abortion funds

Abortion hotlines are a “common global strategy for facilitating access to SMA” and owe their origins to feminist activists in Ecuador.[141]

There are two main abortion access hotlines in Canada:

- The **Access Line** run by **Action Canada for Sexual Health & Rights** (1-888-642-2725), which answers questions about abortion and other sexual and reproductive issues. There is also a text option (1-613-800-6757).[142]

- The **NAF Hotline Fund** run by the **National Abortion Federation** (1-800-772-9100), which gives callers “accurate information, confidential consultation, and referrals to providers of quality abortion care” as well as “case management services and limited financial assistance” to help with costs of care “and travel-related expenses.”[143]

As indicated, hotlines are also connected with abortion funds, which offer financial and other supports to people facing barriers to abortion access.[144] Abortion funds are well-established across the United States,[145] particularly in places where there are more restrictive laws on abortion access, but there are funds in Canada as well.

Action Canada’s Norma Scarborough Emergency Fund assists with “travel, medication, and related expenses.”[146] NAF Canada has the Dr. Henry Morgentaler Patient Assistance Fund, among other options.[147] Abortion Support Services Atlantic also provides financial support.[148,149]

The Abortion Rights Coalition of Canada maintains an up-to-date list of Abortion Clinics and Services in Canada, including hotlines and abortion funds.[150]

5. Abortion apps, social media & other online spaces

There are several abortion apps available for mobile devices.[151] The apps “Safe Abortion” and “Euki” provide general information that may be useful in the Canadian context.[152]

Within Canada, the web app Choice Connect helps users find their nearest abortion provider.[153] Choice Connect is operated by the SHORE Centre in the Kitchener-Waterloo region of Ontario. Helpfully, the Choice Connect website includes a prominent “leave” button for users to click to quickly exit the website. Choice Connect also links to information on how to clear browser history. The Online Abortion Resource Squad (OARS) is another example of the creativity of online abortion support.[154] This is a “peer-based online counseling model” where trained volunteers respond to questions about abortion that come up on Reddit subreddits.

Social media is, of course, a key online source of general information about abortion, including abortion pills and self-managed abortion: “Most or all organizations, whether autonomous collectives or NGOs, have a social media presence, at least in the dominant media outlets of Facebook, Twitter, and Instagram” (and now TikTok).[155]

These are just a few of the online spaces used by feminist activists across the globe to share information about abortion.[156]

In addition to users taking steps to protect their online privacy, it is important to double-check the origins of any online space that deals with abortion, as some anti-abortion organizations (like so-called ‘crisis pregnancy centres’) have created apps, accounts, and websites that may provide misleading and harmful information.[157]

6. Public health education on self-managed abortion

While Canada may be years away from de-regulating abortion pills to the point that self-managed abortion is an accessible option, people in Canada are already self-inducing abortions—to varying degrees of success and safety.[158]

Because many people who self-induce abortions do so covertly or secretly, it is difficult to understand the scope of the potential harm caused by the vacuum of public health education on self-managed abortion. One source explains:

> It is unlikely that there are any statistics regarding the number of women who die from self-induced abortions in Canada. In reports, 'abortion related deaths' tend to refer to those that occurred in medical facilities, and do not account for suicide or self-induction.[159]

Public education programming and initiatives related to self-managed abortion, in multiple accessible formats, would be important interventions to help people realize their reproductive decisions and rights,[160] and to overcome the stigma that continues to exist regarding these topics.

In the meantime, the following resources provide helpful information to assist in self-managing an abortion:

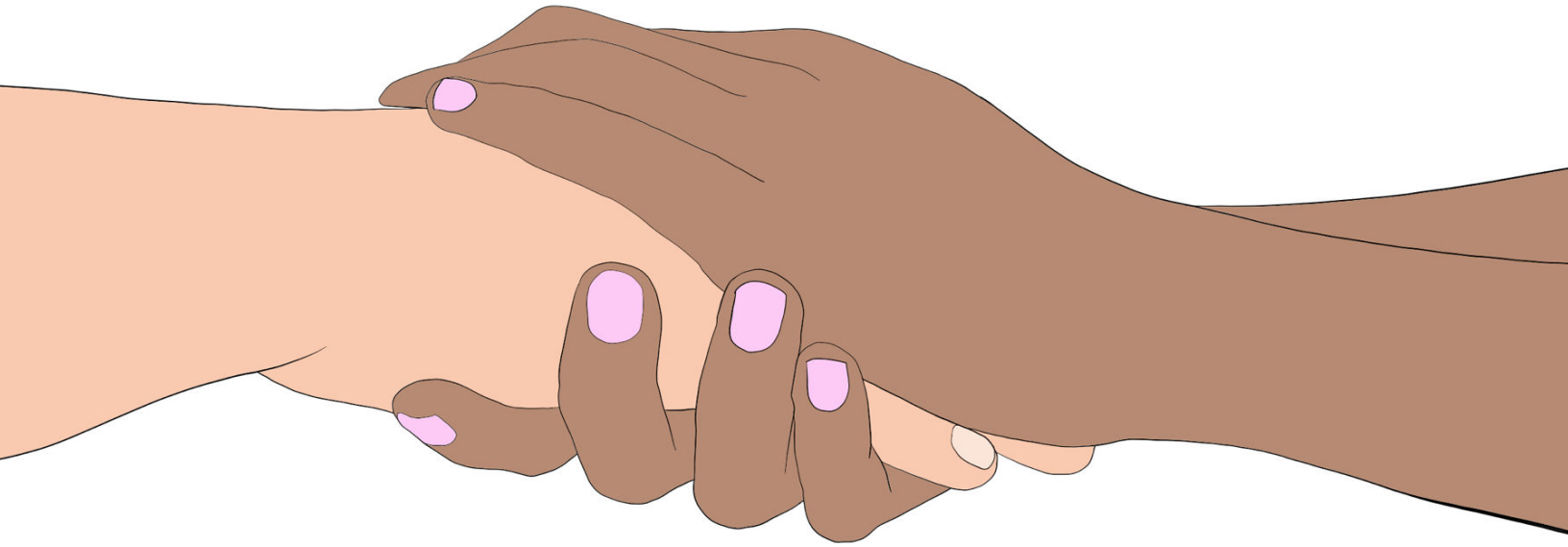
- The website https://www.howtouseabortionpill.org/ provides a detailed instruction manual on how to use abortion pills, including information on steps to be taken depending on individual health needs (e.g. if the person taking the pills is breastfeeding, has an IUD, has anemia, etc.)

- This "Medical Abortion 101" infographic from the School of Pharmacy at the University of Waterloo includes advice on how to take abortion pills and manage side effects, facts about medical abortion, and information on when to seek emergency care: https://static1.squarespace.com/static/52dc09bee4b00bd4279bf2de/t/5b9e9edf4d7a9c70bd718d62/1537122040570/MA+Infographic+%283%29+%281%29.pdf[161]

- The podcast "Access: a Podcast About Abortion" has a dedicated episode about self-managed abortion called "The At-Home Abortion Revolution," available to listen online and transcribed: https://www.apodcastaboutabortion.com/episodes/episode-3-what-is-self-managed-abortion

- International Planned Parenthood Federation (IPPF) has a helpful 5-minute video about how abortion pills work: https://www.youtube.com/watch?v=91gxrgm57HY&feature=youtu.be

- The Reproductive Health Access Project (RHAP) has created an illustrated, first-person narrative of self-managing an abortion: https://www.reproductiveaccess.org/wp-content/uploads/2019/04/2019-04-Sams-Med-Ab_color.pdf



References & Notes

[1] See e.g. Joanna N Erdman, Kinga Jelinska & Susan Yanow, "Understandings of self-managed abortion as health inequity, harm reduction and social change" (2018) 24:54 Reproductive Health Matters 13-19, online: https://www.tandfonline.com/doi/full/10.1080/09688080.2018.1511769; Lucía Berro Pizzarossa & Rishita Nandagiri, "Self-managed abortion: a constellation of actors, a cacophony of laws?" (2021) 29:1 Sexual and Reproductive Health Matters at 3, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1899764; Mariana Prandini Assis & Sara Larrea, "Why self-managed abortion is so much more than a provisional solution for times of pandemic" (2020) 28:1 Sexual and Reproductive Health Matters, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1779633; Naomi Braine & Marissa Velarde, "Self-Managed Abortion: Strategies for Support by a Global Feminist Movement" (2022) Women's Reproductive Health at 1 and 17, online: https://www.tandfonline.com/doi/full/10.1080/23293691.2022.2016142.

[2] Email from Prof. Joanna Erdman to the authors, May 19, 2021.

[3] Lucía Berro Pizzarossa & Rishita Nandagiri, "Self-managed abortion: a constellation of actors, a cacophony of laws?" (2021) 29:1 Sexual and Reproductive Health Matters at 1, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1899764. Footnotes have been removed from Pizzarossa & Nandagiri excerpts so the full article should be consulted for further references.

[4] Lucía Berro Pizzarossa & Rishita Nandagiri, "Self-managed abortion: a constellation of actors, a cacophony of laws?" (2021) 29:1 Sexual and Reproductive Health Matters at 1, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1899764.

Pizzarossa and Nanagiri explain that SMA may refer to a broad range of "actions or activities undertaken by a pregnant individual to end a pregnancy outside of clinical settings," encompassing an array of actions by the pregnant individual, as well as a "collective dimension" of people who assist the pregnant individual in accessing SMA, by, for example, providing information, sourcing pills, and providing accompaniment or childcare (p. 2).

[5] For a helpful collection of recent articles on SMA, see "Special Edition: The Future of Abortion Access" from Rewire News Group (February 2021-on), online: https://rewirenewsgroup.com/abortionfuture/.

[6] Sometimes when people refer to self-managed abortion, they mean that a health care provider is still involved, but no in-person appointment is required. This format often includes telemedicine. The term "self-managed abortion" in this guide does not always or necessarily refer to a model involving health care providers. Because different sources use this term in different ways, it is important to confirm the definition used in studies assessing the prevalence and safety of self-managed abortion when interpreting the results of those studies.

[7] Typical medication abortion in clinical settings involves the combination drug Mifegymiso, which includes both mifepristone and misoprostol. However, due in part to the difficulty of procuring mifepristone outside clinical settings, self-managed abortions are also often performed using misoprostol alone.

The SAFE study, published in November 2021, demonstrated that 99% of people who self-managed abortion with accompaniment support using misoprostol alone had a complete abortion. This research indicates that provided an individual has appropriate support (in the form of trained abortion counsellors with or without clinical training), misoprostol alone is very nearly as effective as the combination mifepristone and misoprostol. See: Heidi Moseson, Ruvani Jayaweera, Ijeoma Egwuatu et al, "Effectiveness of self-managed medication abortion with accompaniment support in Argentina and Nigeria (SAFE): a prospective, observational cohort study and non-inferiority analysis with historical controls"

(2021) The Lancet Global Health, online: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00461-7/fulltext.

[8] Joanna N Erdman, Kinga Jelinska & Susan Yanow, "Understandings of self-managed abortion as health inequity, harm reduction and social change" (2018) 24:54 Reproductive Health Matters 13-19, online: https://www.tandfonline.com/doi/full/10.1080/09688080.2018.1511769.

[9] World Health Organization, "Medical management of abortion" (2018) at 2, online: https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1.

[10] Heidi Moseson et al, "Effectiveness of self-managed medication abortion with accompaniment support in Argentina and Nigeria (SAFE): a prospective, observational cohort study and non-inferiority analysis with historical controls" (2021) The Lancet Global Health, online: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00461-7/fulltext. See also Naomi Braine & Marissa Velarde, "Self-Managed Abortion: Strategies for Support by a Global Feminist Movement" (2022) Women's Reproductive Health 11-12, online: https://www.tandfonline.com/doi/full/10.1080/23293691.2022.2016142.

[11] There are also emerging threats of state surveillance in online spaces, particularly in jurisdictions where abortion access is limited by law, as detailed in Cynthia Conti-Cook & Kate Bertash, "Digital surveillance presents new threats to reproductive freedoms" *The Washington Post* (December 15, 2021), online: https://www.washingtonpost.com/outlook/2021/12/15/digital-surveillance-reproductive-freedom/.

[12] Using the Internet to search for abortion information or pills online involves additional practical barriers due to Google algorithms, which "[filter] people's access to information" in a manner that gives preference to official government websites, effectively "gatekeeping" safe abortion services online: Jill Filipovic, "Choice by Mail" *The New York Review of Books* (January 11, 2021), online: https://www.nybooks.com/daily/2022/01/11/choice-by-mail/.

[13] Heidi Moseson et al, "Effectiveness of self-managed medication abortion with accompaniment support in Argentina and Nigeria (SAFE): a prospective, observational cohort study and non-inferiority analysis with historical controls" (2021) The Lancet Global Health, online: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00461-7/fulltext.

[14] See e.g. recent reporting on the work of Mexican organization Las Libres in Amy Littlefield & Laura Gottesdiener, "The Radical Future of Self-Managed Abortion Is Already Here" *The New Republic* (March 4, 2020), online: https://newrepublic.com/article/156667/radical-future-self-managed-abortion-already; David Remnick & Jia Tolentino, "Mexican Abortion Activists Mobilize to Aid Texans", *The New Yorker Radio Hour* (November 23, 2021), online: https://www.wnycstudios.org/podcasts/tnyradiohour/articles/mexican-abortion-activists-mobilize-aid-texans-pod.

[15] Native Women's Association of Canada, *Women's and girls' sexual and reproductive health and rights in situations of crisis*, Submission to the UN Working Group on Discrimination against Women and Girls (August 27, 2020), online: https://www.ohchr.org/Documents/Issues/Women/WG/ReproductiveHealthRights/CSOs/nativewomensassociationofcanada/submission.pdf.

[16] Karen Stote, "Decolonizing Feminism: From Reproductive Abuse to Reproductive Justice" (2017) 38:1 Atlantis 110 at 111, online: https://journals.msvu.ca/index.php/atlantis/article/view/4767/110-124%20PDF. See also Native Women's Association of Canada, *Women's and girls' sexual and reproductive health and rights in situations of crisis*, Submission to the UN Working Group on Discrimination against Women and Girls (August 27,

2020), online: https://www.ohchr.org/Documents/Issues/Women/WG/ReproductiveHealthRights/CSOs/nativewomensassociationofcanada/submission.pdf.

[17] Karen Stote, "Decolonizing Feminism: From Reproductive Abuse to Reproductive Justice" (2017) 38:1 Atlantis 110, online: https://journals.msvu.ca/index.php/atlantis/article/view/4767/110-124%20PDF.

[18] Karen Stote, "Decolonizing Feminism: From Reproductive Abuse to Reproductive Justice" (2017) 38:1 Atlantis 110 at 116, online: https://journals.msvu.ca/index.php/atlantis/article/view/4767/110-124%20PDF.

[19] Lauren Ralph et al, "Prevalence of Self-Managed Abortion Among Women of Reproductive Age in the United States" (2020) 3:12 Journal of the American Medical Association, online: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774320.

[20] See e.g. URGE x Liberal Jane, "SMAshing Stigma" (January 2022), online: https://urge.org/SMAzine/.

[21] Abortion Rights Coalition of Canada, *Position Paper #7 – Access to Abortion in Rural/Remote Areas* (July 2020), online: https://www.arcc-cdac.ca/wp-content/uploads/2020/06/07-Access-Rural-Remote-Areas.pdf.

[22] Abortion Rights Coalition of Canada, *Position Paper #8 – Problems with Hospital Access to Abortion* (April 2017), online: https://www.arcc-cdac.ca/wp-content/uploads/2020/06/08-Hospital-Access-Problems.pdf.

[23] Michelle Cohen, "Why the abortion pill is more important than ever during the coronavirus" *Maclean's* (April 29, 2020) online: https://www.macleans.ca/opinion/why-the-abortion-pill-is-more-important-than-ever-during-the-coronavirus/.

[24] Lucía Berro Pizzarossa & Rishita Nandagiri, "Self-managed abortion: a constellation of actors, a cacophony of laws?" (2021) 29:1 Sexual and Reproductive Health Matters at 1, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1899764.

[25] Heidi Moseson et al, "Self-managed abortion: A systematic scoping review," Best Practice & Research: Clinical Obstetrics & Gynaecology (2020) 87-110, online: https://www.sciencedirect.com/science/article/pii/S1521693419301191.

[26] Native Women's Association of Canada, *Women's and girls' sexual and reproductive health and rights in situations of crisis*, Submission to the UN Working Group on Discrimination against Women and Girls (August 27, 2020), online: https://www.ohchr.org/Documents/Issues/Women/WG/ReproductiveHealthRights/CSOs/nativewomensassociationofcanada/submission.pdf.

See also the Calls for Justice in *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*, online: https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Calls_for_Justice.pdf. Calls for Justice 7.1 – 7.9 are directed to health and wellness service providers. Call 7.1 urges "*all governments and health service providers to recognize that Indigenous Peoples – First Nations, Inuit, and Métis, including 2SLGBTQQIA people – are the experts in caring for and healing themselves, and that health and wellness services are most effective when they are designed and delivered by the Indigenous Peoples they are supposed to serve, in a manner consistent with and grounded in the practices, world views, cultures, languages, and values of the diverse Inuit, Métis, and First Nations communities they serve*."

[27] Heidi Moseson et al, “Abortion experiences and preferences of transgender, nonbinary, and gender-expansive people in the United States” (2020) American Journal of Obstetrics and Gynecology, online: https://doi.org/10.1016/j.ajog.2020.09.035; Heidi Moseson et al, “Experiences of self-managed abortion among transgender, nonbinary, and gender expansive people in the US” (2020) 102:4 Contraception, online: https://doi.org/10.1016/j.contraception.2020.07.032.

See also A.J. Lowik, *Trans-Inclusive Abortion Services: A manual for providers on operationalizing trans-inclusive policies and practices in an abortion setting*, adapted from the original version produced for the Fédération du Québec pour le planning des naissances (FQPN), with input from the National Abortion Federation, online: https://static1.squarespace.com/static/5cef632e66e9b80001f24e05/t/5d4104ad89ce3b0001de98ef/1564542127747/FQPN18-Manual-EN-NTL-web.pdf; Mariana Prandini Assis & Sara Larrea, “Why self-managed abortion is so much more than a provisional solution for times of pandemic” (2020) 28:1 Sexual and Reproductive Health Matters, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1779633.

[28] World Health Organization, “Medical management of abortion” (2018) at 2, online: https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1. See also Lucía Berro Pizzarossa & Rishita Nandagiri, “Self-managed abortion: a constellation of actors, a cacophony of laws?” (2021) 29:1 Sexual and Reproductive Health Matters at 1-2, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1899764.

[29] World Health Organization, “Medical management of abortion” (2018), online: https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1. See also Laura Schummers et al, “Abortion Safety and Use with Normally Prescribed Mifepristone in Canada” (2021) New England Journal of Medicine, online: https://www.nejm.org/doi/full/10.1056/NEJMsa2109779; University of Washington and Plan C, “Access, Delivered: A Toolkit for Providers Offering Medication Abortion,” 2nd ed (May 1, 2021) at 7, online: https://familymedicine.uw.edu/accessdelivered/.

For information regarding side effects, possible adverse reactions, and special considerations (e.g., age, lactation) see: Linepharma International Limited, “Product Monograph: Mifegymiso” (2019), online: https://pdf.hres.ca/dpd_pm/00050659.PDF.

[30] Ruvani T. Jayaweera, Heidi Moseson & Caitlin Gerdts, “Misoprostol in the era of COVID-19: a love letter to the original medical abortion pill” (2020) 28:1 Reproductive Health Matters, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1829406.

[31] Ruvani T. Jayaweera, Heidi Moseson & Caitlin Gerdts, “Misoprostol in the era of COVID-19: a love letter to the original medical abortion pill” (2020) 28:1 Reproductive Health Matters, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1829406.

[32] In this study, the term “accompaniment support” was used to refer to trained abortion counsellors (most of whom did not have formal clinical training) who provided evidence-based counselling and support, either over the phone or in person, to people self-managing their abortions.

[33] Heidi Moseson et al, “Effectiveness of self-managed medication abortion with accompaniment support in Argentina and Nigeria (SAFE): a prospective, observational cohort study and non-inferiority analysis with historical controls” (2021) The Lancet Global Health, online: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00461-7/fulltext.

[34] Steph Herold on Twitter (October 19, 2021), online: https://twitter.com/StephHerold/status/1461708161547743235.

[35] Government of Canada, "Health Canada approves updates to Mifegymiso prescribing information: Ultrasound no longer mandatory" (April 16, 2019), online: https://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2019/69620a-eng.php.

[36] Canadian Pharmacists Association, *Mifegymiso: Access and Coverage in Canada* (June 11, 2019), online: https://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/Mifegymiso_Access_Scan.pdf; Rhian Lewis for Women on Web International Foundation, *Policy Considerations for Expanding Access to Telemedicine Abortion in Canada* (May 2021) [copy on file with the authors]. Nunavut appears to be the only Canadian jurisdiction that does not directly cover Mifegymiso (Lewis at 6). "However, an estimated 86% of Nunavut residents are eligible for the federal Non-Insured Health Benefits program, which does cover Mifegymiso" (Lewis at 42).

[37] Linepharma International Limited, "Product Monograph: Mifegymiso" (2019), online: https://pdf.hres.ca/dpd_pm/00050659.PDF.

[38] The five-pill regimen described is the typical regimen in Canada, but others exist as well, including a 12-pill protocol for misoprostol: "Understanding and Advocating for Self-Managed Abortion," Reproaction (2022), online: https://reproaction.org/campaign/self-managed-abortion/; World Health Organization, "Abortion care guideline" (2022), online: https://apps.who.int/iris/bitstream/handle/10665/349316/9789240039483-eng.pdf?sequence=1&isAllowed=y at 68, 71 & 98.

[39] Society of Obstetricians and Gynecologists of Canada, "SOGC Statement on Abortion Medication 'Reversal'" (March 19, 2021), online: https://sogc.org/en/content/featured-news/SOGC_Statement_on_Abortion_Medication_Reversal.aspx (PDF: https://sogc.org/common/Uploaded%20files/Latest%20News/SOGCStatement_AbortionMedicationReversal.pdf).

The text of the statement is reproduced as follows:

> The SOGC does not support prescribing progesterone to stop a medical abortion. The claims regarding so-called abortion "reversal" treatments are not based on scientific evidence.
>
> Not only are the treatments unproven, they can also result in serious complications for the patient.
>
> The Canadian protocol for medical abortion includes counselling to identify those who may be ambivalent about the decision, and to ensure that their decision is made freely, informed and with no coercion.
>
> If a patient changes their mind after taking the first tablet, they should contact their care provider. The SOGC fully respects the reproductive and sexual health rights of women, and that every individual is entitled to evidence based treatment, free of coercion by any external body.

[40] Province of Nova Scotia, "Medical Abortion," online: https://811.novascotia.ca/health_topics/medical-abortion/.

[41] Government of Canada, "Health Canada approves updates to Mifegymiso prescribing information: Ultrasound no longer mandatory" (16 April 2019), online: https://healthycanadians.gc.ca/recall-alert-rappelavis/hc-sc/2019/69620a-eng.php. See also Julianne Stevenson & Jennifer Taylor, *Access to Choice: The Legal Framework for Abortion Access in Nova Scotia* (originally prepared in April 2019 for

LEAF Halifax; updated May 2020) at 10, online: LEAF https://www.leaf.ca/wp-content/uploads/2020/05/Abortion-Access-Framework-May-2020.pdf.

The requirements for prescribing Mifegymiso appear to be more stringent in Quebec. Only physicians can prescribe, and the Collège des Médecins insisted on an ultrasound before medical abortion, at least until the COVID-19 pandemic: "In early 2021, the College issued a statement on the provision of medical abortion during the pandemic that conceded that in some circumstances it was permissible to provide Mifegymiso without an ultrasound, provided the reasons for forgoing ultrasound were justified and discussed with the patient, and the physician dated and located the pregnancy by other means." See Rhian Lewis for Women on Web International Foundation, *Policy Considerations for Expanding Access to Telemedicine Abortion in Canada* (May 2021) at 53 [copy on file with the authors], citing Collège des Médecins, "L'interruption volontaire de grossesse en temps de pandémie: Rappel des responsabilités du médecin (February 24, 2021), online: http://www.cmq.org/page/fr/pratique-interruption-volontaire-de-grossesse-pandemie.aspx#:~:text=Malgr%C3%A9%20la%20pand%C3%A9mie%2C%20le%20m%C3%A9decin,%2DIVG%2C%20etc.

[42] Government of Canada, "Health Canada updates prescribing and dispensing information for Mifegymiso," online: http://www.healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2017/65034a-eng.php. See also Julianne Stevenson & Jennifer Taylor, *Access to Choice: The Legal Framework for Abortion Access in Nova Scotia* (originally prepared in April 2019 for LEAF Halifax; updated May 2020) at 10, online: LEAF https://www.leaf.ca/wp-content/uploads/2020/05/Abortion-Access-Framework-May-2020.pdf.

[43] See generally Rhian Lewis for Women on Web International Foundation, *Policy Considerations for Expanding Access to Telemedicine Abortion in Canada* (May 2021). See also Julianne Stevenson & Jennifer Taylor, *Access to Choice: The Legal Framework for Abortion Access in Nova Scotia* (originally prepared in April 2019 for LEAF Halifax; updated May 2020) at 11, online: LEAF https://www.leaf.ca/wp-content/uploads/2020/05/Abortion-Access-Framework-May-2020.pdf.

[44] Laura Schummers et al, "Abortion Safety and Use with Normally Prescribed Mifepristone in Canada" (2021) New England Journal of Medicine at 2, online: http://www.nejm.org/doi/full/10.1056/NEJMsa21097779.

[45] Maija Kappler, "Mifegymiso Can Be Prescribed Without an Ultrasound: Health Canada" *Huffington Post* (April 17, 2019), online: https://www.huffingtonpost.ca/2019/04/16/mifegymiso-health-canada_a_23712955/; Anne Kingston, "How the arrival of the abortion pill reveals a double standard" *Maclean's* (February 5, 2017), online: https://www.macleans.ca/society/new-pill-old-headaches/.

[46] World Health Organization "WHO recommendations on self-care interventions: self-management of medical abortion" (2020) online: https://apps.who.int/iris/bitstream/handle/10665/332334/WHO-SRH-20.11-eng.pdf?ua=1; Beth Kruse et al, "Management of side effects and complications in medical abortion" (2000) 183:2 American Journal of Obstetrics and Gynecology S65–S75, online: https://pubmed.ncbi.nlm.nih.gov/10944371/; Lisa H Harris & Daniel Grossman, "Complications of Unsafe and Self-Managed Abortion" (2020) 382:11 New England Journal of Medicine 1029-1040, online: https://www-nejm-org.ezproxy.library.dal.ca/doi/10.1056/NEJMra1908412.

[47] Suzanne Zane et al, "Abortion-Related Mortality in the United States: 1998-2010" (2015) 126:2 Obstetrics & Gynecology 258–265, online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4554338/; Women on Web, "Is an abortion with pills safe?" (2021), online: https://www.womenonweb.org/en/page/561/is-an-abortion-with-pills-safe.

[48] Laura Schummers et al, "Abortion Safety and Use with Normally Prescribed Mifepristone in Canada" (2021) New England Journal of Medicine at 4, online: https://www.nejm.org/doi/full/10.1056/NEJMsa2109779.

[49] Laura Schummers et al, "Abortion Safety and Use with Normally Prescribed Mifepristone in Canada" (2021) New England Journal of Medicine at 4, online: https://www.nejm.org/doi/full/10.1056/NEJMsa2109779.

[50] Courtney A Kerestes et al, "Abortion providers' experiences and views on self-managed medication abortion: an exploratory study" (2019) 100:2 Contraception 160-164, online: https://pubmed.ncbi.nlm.nih.gov/31002777/#:~:text=Half%20of%20providers%2C%20171%20of,to%20self%2Dmanaged%20medication%20abortion; World Health Organization, "Health worker roles in providing safe abortion care and post-abortion contraception" (2015) at 40, online: https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf?sequence=1.

[51] Jennifer Conti & Erica P Cahill, "Self-managed abortion" (2019) 31:6 Current Opinion in Obstetrics and Gynecology 435-440, online: http://journals.lww.com/00001703-201912000-00011.

[52] There are calculators available online for figuring out gestational age, including this one from the Society of Obstetricians and Gynaecologists of Canada: https://www.pregnancyinfo.ca/your-pregnancy/healthy-pregnancy/due-date-calculator/.

[53] University of Washington and Plan C, "Access, Delivered: A Toolkit for Providers Offering Medication Abortion," 2nd ed (May 1, 2021) at 9, online: https://familymedicine.uw.edu/accessdelivered/; Ushma Upadhyay et al, "Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study" (2022) JAMA Internal Medicine, online: https://pubmed.ncbi.nlm.nih.gov/35311911/.

[54] World Health Organization "Medical management of abortion" (2018), online: (PDF) https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1.

[55] Sheryl Ubelacker, "Health Canada to allow abortion pill Mifegymiso up to 9 weeks into pregnancy" *Canadian Press* (November 7, 2017), online: https://globalnews.ca/news/3848477/health-canada-abortion-pill-mifegymiso-later/.

[56] Women Help Women, "What happens if you take abortion pills and you're not pregnant?", online: https://womenhelp.org/en/page/1201/what-happens-if-you-take-abortion-pills-and-you-re-not-pregnant; Women on Web, "What if you are not pregnant but take the medicines anyway?" (2021), online: https://www.womenonweb.org/en/page/568/what-if-you-are-not-pregnant-but-take-the-medicines-anyway.

[57] NHS, "Overview: Ectopic pregnancy", online: https://www.nhs.uk/conditions/ectopic-pregnancy/; HealthLinkBC, "Ectopic Pregnancy", online: https://www.healthlinkbc.ca/health-topics/hw144921#:~:text=An%20ectopic%20pregnancy.

[58] HealthLinkBC, "Ectopic Pregnancy", online: https://www.healthlinkbc.ca/health-topics/hw144921#:~:text=An%20ectopic%20pregnancy.

[59] NHS, "Ectopic pregnancy: How an ectopic pregnancy is treated", online: https://www.nhs.uk/conditions/ectopic-pregnancy/.

[60] NHS, "Ectopic pregnancy: When to get emergency help", online: https://www.nhs.uk/conditions/ectopic-pregnancy/.

[61] Maija Kappler, "Mifegymiso Can Be Prescribed Without an Ultrasound: Health Canada" *Huffington Post* (April 17, 2019), online: https://www.huffingtonpost.ca/2019/04/16/mifegymiso-health-canada_a_23712955/. Dr. Wendy Norman explains that: "the pill acts on the place where the pregnancy joins with the uterus." This means that if the egg is outside the uterus, abortion pills will not terminate the pregnancy.

[62] E Raymond et al, "Commentary: No-test medication abortion: A sample protocol for increasing access during a pandemic and beyond" (2020) Contraception 101(6): 361-366, online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7161512/. See also this "Medical Abortion 101" infographic by Kelly Grindrod et al and designed by Adrian Poon (University of Waterloo Faculty of Science School of Pharmacy, Pharmacy5in5.com, 2018), online: https://static1.squarespace.com/static/52dc09bee4b00bd4279bf2de/t/5b9e9edf4d7a9c70bd718d62/1537122040570/MA+Infographic+%283%29+%281%29.pdf. The infographic is also available at slide 46 of *Mifegymiso – 2020 Pharmacist Counselling for Medical Abortion: Using the Pharmacist Checklist and Resource Guide* (Canadian Pharmacists Association, 2020), online: Canadian Pharmacists Association: https://www.pharmacists.ca/cpha-ca/assets/File/education-practice-resources/WebinarSlideDeck/2020/2020%20Mifegymiso_Slide%20Deck_Final.pdf.

[63] Laura Schummers et al, "Abortion Safety and Use with Normally Prescribed Mifepristone in Canada" (2021) New England Journal of Medicine at 7, online: https://www.nejm.org/doi/full/10.1056/NEJMsa2109779.

[64] Further research is needed in Canada regarding the lived experiences of people who have chosen SMA, particularly with respect to dating their pregnancies and managing the risks of ectopic pregnancy: Email from Prof. Joanna Erdman to the authors, May 19, 2021.

[65] Dr. Renée Monchalin and Willow Paul, "Abortion Access and Indigenous Peoples in Canada" (21 May 2021), Infographic for Action Canada for Sexual Health & Rights, online: https://www.actioncanadashr.org/resources/factsheets-guidelines/2021-05-21-abortion-access-and-indigenous-peoples-canada. For a discussion of the reproductive practices (including abortion) of the Niitsítapi or Blackfoot Nation within a reproductive justice framework, see Kristin Burnett, "Different Histories: Reproduction, Colonialism, and Treaty 7 Communities in Southern Alberta, 1880-1940" in Shannon Stettner, Kristin Burnett & Travis Hay, eds, *Abortion: History, Politics, and Reproductive Justice after Morgentaler* (Vancouver and Toronto: UBC Press, 2017).

[66] Ushma D Upadhyay, Alice F Cartwright & Daniel Grossman, "Barriers to abortion care and incidence of attempted self-managed abortion among individuals searching Google for abortion care: A national prospective study" (2021) Contraception, online: https://www.sciencedirect.com/science/article/pii/S0010782421003851. Footnotes omitted.

[67] Aviva Romm, Mary L. Hardy & Simon Mills, *Botanical Medicine for Women's Health* (2010: Churchill Livingstone) at pp. 324-325.

[68] Carmen Ciganda, Amalia Laborde "Herbal infusions used for induced abortion" (2003) 41(3) Journal of Toxicology 235-9, online: https://pubmed.ncbi.nlm.nih.gov/12807304/.

[69] Access: A Podcast About Abortion, "Episode 3: The At-Home Abortion Revolution" (2020), online: https://www.apodcastaboutabortion.com/episodes/episode-3-what-is-self-managed-abortion.

[70] Access: A Podcast About Abortion, "Episode 3: The At-Home Abortion Revolution" (2020), online: https://www.apodcastaboutabortion.com/episodes/episode-3-what-is-self-managed-abortion; Heidi Moseson et al, "Effectiveness of self-managed medication abortion with accompaniment support in Argentina and Nigeria (SAFE): a prospective, observational cohort study and non-inferiority analysis with

historical controls" (2021) The Lancet Global Health, online: https://www.thelancet.com/action/showPdf?pii=S2214-109X%2821%2900461-7.

[71] *R v Morgentaler*, [1988] 1 SCR 30; *Carter v Canada*, 2015 SCC 5 at para 68.

[72] Arguably, the *Charter* right to abortion access should not be interpreted as limited to abortion in a hospital or other health care setting, but this interpretation has not yet been confirmed in the case law.

[73] Lucía Berro Pizzarossa & Rishita Nandagiri, "Self-managed abortion: a constellation of actors, a cacophony of laws?" (2021) 29:1 Sexual and Reproductive Health Matters at 2; 4-5, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1899764.

[74] A fetus will not be visible if the pregnancy is "less than 8 weeks gestation": "Medical Abortion 101" infographic by Kelly Grindrod et al and designed by Adrian Poon (University of Waterloo Faculty of Science School of Pharmacy, Pharmacy5in5.com, 2018), online: https://static1.squarespace.com/static/52dc09bee4b00bd4279bf2de/t/5b9e9edf4d7a9c70bd718d62/1537122040570/MA+Infographic+%283%29+%281%29.pdf.

[75] *R v Levkovic,* 2013 SCC 25.

[76] Stephanie Voudouris, "If it's about pregnancy, it's about women: Ivana Levkovic v. Her Majesty the Queen," *The Court.ca* (October 18, 2012), online: http://www.thecourt.ca/if-its-about-pregnancy-its-about-women-ivana-levkovic-v-her-majesty-the-queen/; see also *R v Levkovic,* 2008 CanLII 48647 at para 85.

[77] *R v Levkovic,* 2013 SCC 25 at para 44.

[78] *R v Levkovic,* 2014 ONSC 5544 at para 16.

[79] *R v Levkovic,* 2014 ONSC 5544 at para 17.

[80] *R v Levkovic,* 2014 ONSC 5544.

[81] *R v Levkovic,* 2014 ONSC 5544 at para 18.
[82] *Criminal Code,* RSC 1985, c C-46, s 238(1).

[83] *Criminal Code,* RSC 1985, c C-46, s 242.

[84] *R v Levkovic*, 2013 SCC 25 at para 68.

[85] *Winnipeg Child and Family Services (Northwest Area) v G (DF),* [1997] 3 SCR 925; *Dobson (Litigation Guardian of) v Dobson,* [1999] 2 SCR 753.

[86] In the United States, the criminalization of practices comprising SMA has had a disproportionate impact on BIPOC people. While abortion itself has long been decriminalized in Canada, to the extent Canadian criminal or regulatory law is used to target any of the activities of SMA, similar outcomes would be expected and must be guarded against as practices and policies develop. See generally Imani Gandy, "Purvi Patel and the Case of the Self-Managed Abortion" *Rewire News Group* (February 8, 2021), online: https://rewirenewsgroup.com/ablc/2021/02/08/purvi-patel-and-the-case-of-the-self-managed-abortion/. See also URGE x Liberal Jane, "SMAshing Stigma" (January 2022), online: https://urge.org/SMAzine/.

[87] The idea of mitigating these legal risks by creating new laws to govern SMA should be considered with caution, as Pizzarossa and Nandagiri explain:

> We need to be very vigilant with regard to laws that attempt to regulate SMA, that medicalise it by incorporating a series of unnecessarily burdensome steps or that create vulnerability for the actors involved in safe self-management.

Lucía Berro Pizzarossa & Rishita Nandagiri, "Self-managed abortion: a constellation of actors, a cacophony of laws?" (2021) 29:1 Sexual and Reproductive Health Matters at 5, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1899764.

[88] *Food and Drugs Act,* RSC 1985, c F-27.

[89] *Food and Drug Regulations,* CRC, c 870.

[90] See "Prescription Drugs" in the *Regulations*, found in Part C and beginning at section C.01.040.3. And see generally Matthew Herder, "General Pharmaceutical Production Requirements and Prescription-Only versus Over-the-Counter Drugs" in Joanna Erdman, Vanessa Gruben & Erin Nelson, *Canadian Health Law and Policy*, 5th ed (Toronto: LexisNexis Canada, 2017).

[91] National Association of Pharmacy Regulatory Authorities, "Drug Scheduling in Canada - General Overview", online: https://napra.ca/drug-scheduling-canada-general-overview.

[92] National Association of Pharmacy Regulatory Authorities, "Mifepristone or its derivatives", online: https://napra.ca/nds/mifepristone-or-its-derivatives; National Association of Pharmacy Regulatory Authorities, "Drug Scheduling in Canada - General Overview", online: https://napra.ca/drug-scheduling-canada-general-overview.

[93] The role of pharmaceutical companies in the manufacturing and provision of abortion pills in Canada is a potential avenue of future academic research on making SMA more accessible. See: Mariana Prandini Assis & Sara Larrea, "Why self-managed abortion is so much more than a provisional solution for times of pandemic" (2020) 28:1 Sexual and Reproductive Health Matters, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1779633.

[94] *Food and Drug Regulations,* CRC, c 870, C.01.045.

[95] *Food and Drugs Act,* RSC 1985, c F-27, s 31.2.

[96] *Food and Drugs Act,* RSC 1985, c F-27, s 31.5.

[97] *Food and Drugs Act,* RSC 1985, c F-27, s 31.6.

[98] See e.g. Plan C at https://www.plancpills.org/guide-how-to-get-abortion-pills and Plan C, "Legal Support," online: https://www.plancpills.org/guide-how-to-get-abortion-pills#support-legal; Aid Access at https://aidaccess.org/; and Women on Web at https://womenonweb.org/. See also: Naomi Braine & Marissa Velarde, "Self-Managed Abortion: Strategies for Support by a Global Feminist Movement" (2022) Women's Reproductive Health at 2-13, online: https://www.tandfonline.com/doi/full/10.1080/23293691.2022.2016142.

[99] There are online prescription platforms, such as https://felixforyou.ca, where individuals can obtain prescriptions through licensed Canadian physicians, without a referral from their family physician, for a variety of health needs, including contraception. Abortion pills are not included. Virtual visits using Felix are not covered by provincial health insurance, so patients would have to pay an out-of-pocket fee of $40. However, the prescriptions themselves may be covered by a person's private or provincial insurance plan.

[100] Regarding legal 'grey areas' in the context of online abortion access, see e.g. Moira Donegan, "'Women are capable of doing this': the doctor defying local laws to provide safe abortions by sea or mail" *The Guardian* (December 12, 2021), online: https://www.theguardian.com/world/2021/dec/12/rebecca-gomperts-doctor-defying-laws-abortions; Jill Filipovic, "Choice by Mail" *The New York Review of Books* (January 11, 2021), online: https://www.nybooks.com/daily/2022/01/11/choice-by-mail/.

[101] Government of Canada, "Buying drugs over the internet – Canada.ca", online: https://www.canada.ca/en/health-canada/services/buying-drugs-over-internet.html; National Association of Pharmacy Regulatory Authorities, "Online Pharmacies," online: https://napra.ca/online-pharmacies.

[102] *Food and Drugs Act,* RSC 1985, c F-27, s 27(1).

[103] Farhad Manjoo, "Opinion: Abortion Pills Should Be Everywhere" *The New York Times* (August 2, 2019), online: https://www.nytimes.com/2019/08/03/opinion/abortion-pill.html; Chloe Murtagh et al, "Exploring the feasibility of obtaining mifepristone and misoprostol from the internet" (2018) 97:4 Contraception 287–291, online: https://dx.doi.org/10.1016/j.contraception.2017.09.016.

[104] See https://aidaccess.org/.

[105] See https://www.womenonweb.org/en/.

[106] In December 2021, the US movement Shout Your Abortion organized an action called "Abortion Pills Forever" to promote order-by-mail abortion pills, in response to the Supreme Court of the United States hearing in *Dobbs v Jackson Women's Health Organization*. Online: https://shoutyourabortion.com/take-action/#abortion-pills-forever.

[107] Interview with Venny Ala-Siurua, Executive Director of Women on Web (January 18, 2022) and follow-up email correspondence. See also Rhian Lewis for Women on Web International Foundation, *Policy Considerations for Expanding Access to Telemedicine Abortion in Canada* (May 2021) at 5.

[108] Plan B, sometimes called the "morning-after pill", is a form of emergency contraceptive that can stop a pregnancy if taken within three days of having unprotected sex (though it is more likely to be effective the earlier it is taken). See e.g. Action Canada for Sexual Health & Rights, "Emergency Contraception", online: https://www.actioncanadashr.org/resources/sexual-health-info/hub/emergency-contraception. "Plan B" is made of the drug levonorgestrel. It works by stopping ovulation temporarily, preventing fertilization, and preventing implantation (https://planb.ca/en). Levonorgestrel is also sold under other trade names in Canada, including "Contingency One" and "Option 2" (https://www.rexall.ca/articles/drugs/?q=levonorgestrel).

[109] Marie Stopes International (now MSI Reproductive Choices), Evidence Brief, "Supporting self-management of medication abortion from pharmacies: Evidence update and recommendations for practice" (September 28, 2020), online: https://www.safeaccesshub.org/media/1169/ma-information-evidence-brief.pdf?mode=pad&rnd=132455284460000000.

[110] N Kapp et al, "A research agenda for moving early medical pregnancy termination over the counter" (2017) International Journal of Gynecology & Obstetrics 1646-1652, online: https://pubmed.ncbi.nlm.nih.gov/28317327/; Jennifer Conti & Erica P Cahill, "Self-managed abortion" (2019) 31:6 Current Opinion in Obstetrics and Gynecology 435-440, online: http://journals.lww.com/00001703-201912000-00011; Megan Wainwright et al, "Self-management of medical abortion: a qualitative evidence synthesis" (2016) 24:47 Reproductive Health Matters 155-167, online: https://www.tandfonline.com/doi/full/10.1016/j.rhm.2016.06.008.

[111] Marie Stopes International (now MSI Reproductive Choices), Evidence Brief, "Supporting self-management of medication abortion from pharmacies: Evidence update and recommendations for practice" (28 September 2020), online: https://www.safeaccesshub.org/media/1169/ma-information-evidence-brief.pdf?mode=pad&rnd=132455284460000000.

[112] Not all forms of emergency contraceptive pills are available without a prescription in Canada. For pregnant people who weigh more than 165 pounds or have a BMI over 25, Health Canada recommends a newer emergency contraceptive drug, ulipristal acetate, sold under the brand name "Ella." Ella currently requires a prescription. See Lauren Vogel, "Rethink weight limits on morning-after pill" Canadian Medical Association Journal (2014) 187(10): 719-720, online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4500687/).

[113] Barbara Sibbald, "Nonprescription status for emergency contraception" (2005) 172:7 Canadian Medical Association Journal 861-862, online: https://www.cmaj.ca/content/172/7/861.

[114] Government of Canada, "Questions and Answers - Prescription Drug List: What does Health Canada consider when adding or removing a medicinal ingredient from the Prescription Drug List?", online: https://hpr-rps.hres.ca/static/content/qanda-pdl.php?wbdisable=true - :~:text=Switches from prescription to nonprescription,form of a drug submission.&text=After reviewing this data, Health,that nonprescription sale is appropriate.

[115] University of California San Francisco, Advancing New Standards in Reproductive Health, "Research on abortion: Over-the-Counter Medication Abortion", online: https://www.ansirh.org/research/over-counter-medication-abortion. See also Mariana Prandini Assis & Sara Larrea, "Why self-managed abortion is so much more than a provisional solution for times of pandemic" (2020) 28:1 Sexual and Reproductive Health Matters, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1779633.

[116] University of California San Francisco, Advancing New Standards in Reproductive Health, "Research on abortion: Over-the-Counter Medication Abortion", online: https://www.ansirh.org/research/over-counter-medication-abortion; MA Biggs et al, "P8 'Abortion patients' interest in obtaining medication abortion over-the-counter (OTC)" (Abstract only) Contraception (October, 2020), online: https://www.contraceptionjournal.org/article/S0010-7824(20)30234-1/fulltext; Kate Grindlay, Diana Greene Foster & Daniel Grossman, "Attitudes toward over-the-counter access to oral contraceptives among a sample of abortion clients in the United States" (2014) 46(2):83-9 Perspectives on Sexual and Reproductive Health, online: https://pubmed.ncbi.nlm.nih.gov/24602230/; N Kapp et al, "A research agenda for moving early medical pregnancy termination over the counter" (2017) BJOG: An International Journal of Obstetrics & Gynaecology, online: https://doi.org/10.1111/1471-0528.14646.

[117] Adrianna Rodriguez, "Hormonal birth control should be sold over the counter with no age restrictions, doctors say" *USA Today* (September, 2019), online: https://www.usatoday.com/story/news/health/2019/09/26/birth-control-should-sold-over-counter-gynecologists-without-prescription-acog/2439101001/; Daniel Grossman, "Why 2020 presidential candidates should support over-the-counter access to abortion pills" *USA Today* (December 18, 2019), online: https://www.usatoday.com/story/opinion/2019/12/18/abortion-pills-safe-could-ease-access-crisis-women-column/2665854001/; Daniel Grossman, "Should over-the-counter medical abortion be available?" *The Guardian* (April 28, 2017), online: https://www.theguardian.com/commentisfree/2017/apr/28/should-over-counter-medical-abortion-be-available.

[118] See also Marie Stopes International (now MSI Reproductive Choices), Evidence Brief, "Supporting self-management of medication abortion from pharmacies: Evidence update and recommendations for

practice" (September 28, 2020), online: https://www.safeaccesshub.org/media/1169/ma-information-evidence-brief.pdf?mode=pad&rnd=132455284460000000.

[119] Canadian Institute for Health Information, "Physician billing codes in response to COVID-19", online: https://www.cihi.ca/en/physician-billing-codes-in-response-to-covid-19.

[120] See e.g. College of Physicians & Surgeons of Nova Scotia, *Professional Standards and Guidelines Regarding Prescribing* (March 26, 2021), online: https://cpsns.ns.ca/resource/prescribing/. See also Lucía Berro Pizzarossa & Rishita Nandagiri, "Self-managed abortion: a constellation of actors, a cacophony of laws?" (2021) 29:1 Sexual and Reproductive Health Matters at 1, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1899764.

[121] Wing Kay Fok & Alice Mark, "Abortion through telemedicine" (2018) 30:6 Current Opinion in Obstetrics and Gynecology 394–399, online: http://journals.lww.com/00001703-201812000-00010; Ellen R Wiebe et al, "Comparing telemedicine to in-clinic medication abortions induced with mifepristone and misoprostol" (2020) 2:100023 Contraception: X, online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7286176/; Abigail RA Aiken et al, "Self reported outcomes and adverse events after medical abortion through online telemedicine: Population based study in the Republic of Ireland and Northern Ireland" (2017) 357 The BMJ 2011, online: http://dx.doi.org/10.1136/bmj.j2011.

Based on a systematic review of several studies examining telemedicine abortion care, the WHO has recommended "the option of telemedicine as an alternative to in-person interactions with the health care worker to deliver medical abortion services in whole or in part." See "SERVICE DELIVERY Recommendation 48" in World Health Organization, "Abortion care guideline" (2022), online: https://apps.who.int/iris/bitstream/handle/10665/349316/9789240039483-eng.pdf?sequence=1&isAllowed=y at 95.

[122] Advancing New Standards in Reproductive Health (ANSIRH), Issue Brief, October 2021, "U.S. studies on medication abortion without in-person clinician dispensing of mifepristone", online: https://www.ansirh.org/sites/default/files/2021-10/Issue%20Brief_Summary%20of%20U.S.%20studies_MA%20w-o%20in-person%20clinician%20dispensing%20of%20mife_0.pdf; E Guilbert et al, "Canadian protocol for the provision of medical abortion via telemedicine", Society of Obstetricians and Gynaecologists (April 1, 2020), online: https://www.sogc.org/common/Uploaded%20files/CANADIAN%20PROTOCOL%20FOR%20THE%20PROVISION%20OF%20MA%20VIA%20TELEMEDICINE.pdf; Mariana Prandini Assis & Sara Larrea, "Why self-managed abortion is so much more than a provisional solution for times of pandemic" (2020) 28:1 Sexual and Reproductive Health Matters, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1779633.

[123] Rhian Lewis for Women on Web International Foundation, *Policy Considerations for Expanding Access to Telemedicine Abortion in Canada* (May 2021) at 3.

[124] Rhian Lewis for Women on Web International Foundation, *Policy Considerations for Expanding Access to Telemedicine Abortion in Canada* (May 2021) at 7.

[125] Consider, for example, the prescription telemedicine programs that have been in place for medical cannabis in Canada for several years. Websites such as https://medicalmarijuanaservices.ca provide physician prescriptions specifically for medical cannabis.

[126] Dr. Daniel Grossman on Twitter (October 14, 2021), online: https://twitter.com/DrDGrossman/status/1448661025918623759?s=20.

[127] Daniel Grossman, "American women should have access to abortion pills before they need them," *Los Angeles Times* (November 21, 2018), online: https://www.latimes.com/opinion/op-ed/la-oe-grossman-abortion-pills-20181121-story.html. See also ANSIRH, "Providing abortion pills before patients need them could enable earlier care" (December 6, 2021), online: https://www.ansirh.org/research/research/providing-abortion-pills-patients-need-them-could-enable-earlier-care.

[128] Daniel Grossman, "American women should have access to abortion pills before they need them," *Los Angeles Times* (November 21, 2018), online: https://www.latimes.com/opinion/op-ed/la-oe-grossman-abortion-pills-20181121-story.html.

[129] Patrick Adams, "Why Some Women Might Want 'Missed-Period Pills'" *New York Times* (December 3, 2020), online: https://www.nytimes.com/2020/12/03/opinion/pregnancy-missed-period-pills.html.

[130] Patrick Adams, "Why Some Women Might Want 'Missed-Period Pills'" *New York Times* (December 3, 2020), online: https://www.nytimes.com/2020/12/03/opinion/pregnancy-missed-period-pills.html.

[131] Wendy R Sheldon et al, "Exploring potential interest in missed period pills in two US states" (2020) 102:6 Contraception at 414, online: https://www.contraceptionjournal.org/article/S0010-7824(20)30337-1/pdf.

[132] Hannah Matthews, "Abortion Doulas Are More Important Than Ever" *Elle* (September 2, 2021), online: https://www.elle.com/life-love/a37456775/abortion-doulas-texas-sb8-scotus/. See also URGE x Liberal Jane, "SMAshing Stigma" (January 2022), online: https://urge.org/SMAzine/.

[133] CBC Radio, "'We aren't going to hide the fact that this is what we do': How abortion doulas are breaking down stigma" *White Coat, Black Art* (January 31, 2020), online: https://www.cbc.ca/radio/whitecoat/we-aren-t-going-to-hide-the-fact-that-this-is-what-we-do-how-abortion-doulas-are-breaking-down-stigma-1.5442283. See also Sarah Ratchford, "An Abortion Doula on Canada's Problematic Lack of Access" *Refinery29* (July 28, 2020), online: https://www.refinery29.com/en-ca/abortion-doula-canada-access.

[134] Abortion Support Services Atlantic, Facebook, online: https://www.facebook.com/abortionsupportatlantic/.

[135] Montreal Abortion Access Project (MAAP), online: https://sexted.org/service/montreal-abortion-access-project-maap/.

[136] The Shore Centre, online: https://www.shorecentre.ca/.

[137] Alberta Abortion Access Network, online: https://www.albertaabortionaccess.com/i-need-help.

[138] Saskatoon Abortion Support Network, online: https://sasn.ca/.

[139] Vancouver Full Spectrum Doula Collective, online: https://fsdvancouver.wixsite.com/fsdvan.

[140] For a detailed list of doula and abortion support services in Canada, see: Abortion Rights Coalition of Canada, "Abortion Clinics and Services in Canada" (updated December 8, 2021), online: https://www.arcc-cdac.ca/wp-content/uploads/2020/08/list-abortion-clinics-canada.pdf.

[141] Naomi Braine & Marissa Velarde, "Self-Managed Abortion: Strategies for Support by a Global Feminist Movement" (2022) Women's Reproductive Health at 9, online: https://www.tandfonline.com/doi/full/10.1080/23293691.2022.2016142.

[142] Online: Action Canada for Sexual Health & Rights https://www.actioncanadashr.org/call-access-line-1-888-642-2725.

[143] Online: NAF Hotline https://prochoice.org/patients/naf-hotline/.

[144] National Network of Abortion Funds, "Abortion Funds 101", online: https://abortionfunds.org/about/abortion-funds-101/.

[145] National Network of Abortion Funds, "Need an Abortion?", online: https://abortionfunds.org/need-abortion/.

[146] Action Canada for Sexual Health & Rights, "Donate to the Norma Scarborough Fund", online: https://www.actioncanadashr.org/take-action/donate-norma-scarborough-fund.

[147] NAF Canada, "Make a Donation to Increase Access to Abortion Care", online: https://nafcanada.org/donate/.

[148] Abortion Support Services Atlantic, Facebook, online: https://www.facebook.com/abortionsupportatlantic/.

[149] People who incur travel-related expenses to obtain abortion services may also be eligible for provincial or territorial medical travel subsidy programs. See, for example: Ontario Northern Health Travel Grants (https://www.health.gov.on.ca/en/public/publications/ohip/northern.aspx); Newfoundland and Labrador Medical Transportation Assistance Program (https://www.gov.nl.ca/hcs/mcp/travelassistance/); Yukon (https://yukon.ca/en/medical-treatment-travel). Yukon additionally has a specific subsidy policy for people who travel to obtain Mifegymiso: https://open.yukon.ca/sites/default/files/mt006-mlfe.pdf.

See also, generally: Maria Mathews and Dana Ryan, "Publicly Funded Medical Travel Subsidy Programs in Canada" (2017) 34:1 Canadian Social Work Review, online: https://www.erudit.org/en/journals/cswr/2017-v34-n1-cswr03182/1040998ar.pdf.

[150] Abortion Rights Coalition of Canada, "Abortion Clinics and Services in Canada" (updated December 8, 2021), online: https://www.arcc-cdac.ca/wp-content/uploads/2020/08/list-abortion-clinics-canada.pdf.

[151] See e.g. Lucía Berro Pizzarossa & Rishita Nandagiri, "Self-managed abortion: a constellation of actors, a cacophony of laws?" (2021) 29:1 Sexual and Reproductive Health Matters at 3, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1899764; Naomi Braine & Marissa Velarde, "Self-Managed Abortion: Strategies for Support by a Global Feminist Movement" (2022) Women's Reproductive Health at 13, online: https://www.tandfonline.com/doi/full/10.1080/23293691.2022.2016142.

[152] Ipas, "Hesperian Health Guides launches multilingual 'Safe Abortion' app" (March 5, 2019), online: https://www.ipas.org/news/hesperian-health-guides-launches-multilingual-safe-abortion-app/.

[153] Online: Choice Connect https://choiceconnect.ca/.

[154] Online: Online Abortion Resource Squad (OARS) https://www.onlineabortionresources.org/.

[155] Naomi Braine & Marissa Velarde, "Self-Managed Abortion: Strategies for Support by a Global Feminist Movement" (2022) Women's Reproductive Health at 14, online: https://www.tandfonline.com/doi/full/10.1080/23293691.2022.2016142.

[156] Naomi Braine & Marissa Velarde, "Self-Managed Abortion: Strategies for Support by a Global Feminist Movement" (2022) Women's Reproductive Health at 13-14, online: https://www.tandfonline.com/doi/full/10.1080/23293691.2022.2016142.

[157] Steph Herold, "Need an Abortion? There's an App for That", *Bitch Media* (January 22, 2020), online: https://www.bitchmedia.org/article/abortion-apps-spreading-misinformation. See also Joyce Arthur et al, "Review of "Crisis Pregnancy Centre" Websites in Canada" *Abortion Rights Coalition of Canada* (May 2016), online: https://www.arcc-cdac.ca/wp-content/uploads/2020/06/CPC-Website-Study-ARCC-2016.pdf. See also Lucía Berro Pizzarossa & Rishita Nandagiri, "Self-managed abortion: a constellation of actors, a cacophony of laws?" (2021) 29:1 Sexual and Reproductive Health Matters at 3, online: https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1899764.

[158] Jessica Shaw, "Abortion as a Social Justice Issue in Contemporary Canada" (2013) 14:2 Critical Social Work at 10, online: https://ojs.uwindsor.ca/index.php/csw/article/view/5878/4865; Teresa Wright, "Women turning to desperate measures due to lack of abortion services" *The Guardian* (November 10, 2011), online: https://www.theguardian.pe.ca/news/local/women-turning-to-desperate-measures-due-to-lack-of-abortion-services-95013/.

[159] Jessica Shaw, "Abortion as a Social Justice Issue in Contemporary Canada" (2013) 14:2 Critical Social Work at 10, online: https://ojs.uwindsor.ca/index.php/csw/article/view/5878/4865.

[160] Marie Stopes International (now MSI Reproductive Choices), Evidence Brief, "Supporting self-management of medication abortion from pharmacies: Evidence update and recommendations for practice" (September 28, 2020), online: https://www.safeaccesshub.org/media/1169/ma-information-evidence-brief.pdf?mode=pad&rnd=132455284460000000.

[161] The infographic is also available at slide 46 of this 2020 presentation from the Canadian Pharmacists Association: https://www.pharmacists.ca/cpha-ca/assets/File/education-practice-resources/WebinarSlideDeck/2020/2020 Mifegymiso_Slide Deck_Final.pdf.