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“You can do this at home and people won’t find out”: a qualitative exploration of women’s experiences with the use of medication abortion drugs received directly from pharmacies in Nepal

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Abstract

Background In Nepal, over two-thirds of abortion seekers use medication abortion drugs to terminate their pregnancies. However, fewer than half of all abortions occur in government-approved facilities. Although the government of Nepal discourages pharmacy sale of medication abortion drugs without a prescription, pharmacies account for one-fifth of all abortion services in the country. We conducted a qualitative study to gain insight into why women obtain medication abortion care through pharmacies and document their experiences.

Methods Using a multi-modal recruitment strategy, we interviewed 25 women from three populous districts of Nepal’s Koshi Province who had used medication abortion drugs purchased from pharmacies within the previous two years. We used ATLAS.ti 24 to manage our data and analyzed interviews for content and themes using inductive and deductive techniques.

Results We found that confidentiality, convenience, cost, and connection led women to obtain medication abortion care from pharmacies. Many of our participants were unaware of the free services offered by government health centers or reported that they avoided these facilities due to privacy concerns and/or the perceived need for accompaniment. Most of our participants received the mifepristone/misoprostol regimen from pharmacies without a prescription but were charged more than the mandated maximum retail price. Although pharmacy workers informed women on how to administer the medications, they provided little or no counselling on side effects, complications, post-abortion contraception, or additional medications such as those for pain management. Despite confidence in their decision to terminate their pregnancies and their ability to self-diagnose the pregnancy, take the pills, and confirm completion of the abortion, some of our participants found the abortion process challenging due to insufficient counselling, variable costs, and the lack of pain medications.

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Conclusion Women seek pharmacy-based medication abortion services for various reasons, including barriers within the health system that limit access to public sector abortion sites. Strengthening the role of pharmacies as medication abortion providers is crucial as they are in a position to enhance women's agency by providing accurate information, medically sound services, and appropriate referrals. Establishing policies and guidelines to formally integrate pharmacies as safe medication abortion sites in Nepal appears warranted.

Keywords Abortion, Mifepristone, Misoprostol, Nepal, Pharmacy, Qualitative research

Background

The constitution of Nepal guarantees abortion as a fundamental right. Abortion is permitted up to 12 weeks of gestational age without restriction as to the reason, up to 18 weeks for pregnancies due to rape or incest, and at any stage if the woman's life or health is at risk or if the fetus is malformed. At the same time, there is a high (21%) unmet need for contraception [1] and unintended pregnancies are common. A recent study suggested that more than half (53.3%) of pregnancies in Nepal are unintended [2]. In 2021, approximately 333,343 abortions took place in Nepal resulting in abortion rate of 41 abortions per 1,000 women aged 15–49 [2]. Medication abortion with mifepristone and misoprostol was introduced in 2009 and trained health practitioners in registered health facilities are able to provide free abortion services up to 9 weeks of pregnancy using a combination package.

Since its introduction, the mifepristone/misoprostol regimen has been the most popular method of pregnancy termination and is now used by over two-thirds of women in Nepal [3]. However, fewer than half of all abortions (about 42%) occur in government-approved facilities [4]. The majority take place clandestinely, performed by an untrained provider and/or in a non-approved facility or induced by the woman herself [4]. This can result in negative health outcomes; one study found that 68% of women seeking post-abortion care in tertiary-level hospitals had used medications as the primary method of induction and 89% of these women took unsafe, ineffective, or unknown-quality drugs [5].

The World Health Organization's (WHO's) 2022 abortion care guidelines state that abortion service delivery in the first trimester with minimal medical supervision is safe, effective, and can substantially increase access. The guidelines further recommend task-sharing to pharmacy workers, noting that they have the competencies to dispense medication abortion drugs for use through 12 weeks, and supports self-management of medication abortion provided that individuals have access to quality medications, accurate information, and health system referrals if needed [6]. Although mifepristone and misoprostol are registered in Nepal and available for early abortion care, the regulatory framework in Nepal restricts pharmacy dispensing of medication abortion drugs. The government of Nepal discourages pharmacy sale of medication abortion drugs without a prescription.

Nonetheless, pharmacies often serve as the first contact point for those seeking abortion information and services due to their privacy, proximity, and value for price, especially when compared to private clinics and government health facilities in rural areas [5, 7, 8]. Indeed, official statistics indicate that pharmacies account for 19% of all abortion services in Nepal [3] in part because registered and/or unregistered medication abortion drugs are widely available in pharmacies and drug shops [9]. A recent mystery client survey conducted across six out of seven provinces in Nepal found that one in three pharmacies dispensed medication abortion pills, highlighting their widespread availability [10]. Additionally, Nepal shares about 1,750 km of open borders with India. India is the third largest producer of medicines globally and there is considerable speculation that unregulated medication abortion drugs make their way into Nepal through this border [9, 11].

Despite this widespread pharmacy use, the reasons why such a large proportion of Nepalese women seek abortion services through extra-legal channels have not been fully explored. However, multiple factors likely influence decision-making, including lack of awareness, patriarchy, socio-cultural and religious dynamics, geographic location, and cost [5, 7, 12]. About three in five women of reproductive age do not know that first-trimester abortion care is legal in Nepal and a little more than half (52%) are unable to cite a place where a safe abortion can be obtained [3]. Research indicates that women lacking knowledge of the legal status of abortion, belonging to ethnic minority groups, residing in the Terai region, having lower education and having less familiarity with the public health system are more likely to seek services from pharmacists and extralegal channels [5, 13, 14]. Access is further constrained by provider bias, misinformation, and system failures; one in four women is denied legal abortion services in Nepal because of reasons like gestational age, lack of available medications, or non-evidence-based contraindications [15]. At the same time, abortion stigma in Nepal remains pervasive. Nepalese women face dual stigma from both the community and the healthcare system, manifested as verbal harassment, social exclusion, disapproval of those seeking abortions, and refusal of services [16]. The impact of abortion stigma is made more complex by its intersections with

other marginalized and stigmatized characteristics and identities, like being young and unmarried [17, 18].

Scholarship exploring women’s experiences obtaining medication abortion care in Nepal is limited. While some studies have examined women’s experiences with abortion services from non-governmental organization (NGO) clinics and pharmacies, they have not detailed the specific types of medications used [19]. No studies to date have explicitly documented the experiences of Nepalese women obtaining extralegal abortions through pharmacies or the types of medications they used. We conducted this qualitative study to gain insight into why women seek medication abortion services from pharmacies and document their experiences with this type of abortion care.

Methods

Study setting

We conducted this study in southeast Nepal, in the Jhapa, Morang, and Sunsari districts of Nepal’s Koshi Province

(see Fig. 1). These are the three largest districts in the province in terms of population: Morang (1,157,186), Jhapa (994,090), and Sunsari (934,461) [20]. They are ethnically and linguistically diverse with large numbers of internal migrants and all are near the Indian border. Between November 2023 and January 2024, we conducted in-depth interviews with 25 women¹ who obtained medication abortion services from pharmacies on/after January 1, 2022 (within two years of the interview) in the aforementioned districts. We specifically targeted women living in municipalities or metropolitan cities of these districts.

Data collection

We used a multi-modal recruitment strategy to identify participants residing in one of the three study districts. We recruited participants through community organizations, personal networks, local pharmacies, and word of mouth. We also asked early participants to share information about the study with friends and family (if they were comfortable doing so). In addition, we contacted



Fig. 1 Map of Nepal with study sites in Koshi Province indicated

¹ Throughout this paper, we use the term women as this is consistent with the existing literature and culturally resonant. However, we acknowledge that not all abortion seekers identify as women or girls.

local female community health volunteers (FCHVs) who are the community-based health educators, and auxiliary nursing midwives to spread awareness of the study and shared recruitment flyers to them.

We recruited two women research assistants (SSR and HS) from the study area. The research assistants were affiliated with a women's welfare NGO and a government health insurance enrollment program, respectively, and thus had extensive networks within the study communities and facilitated participant recruitment. AMF, a medical doctor and medical anthropologist with expertise in qualitative medication abortion studies, trained NR, a PhD student and a native Nepali, who then trained the research assistants and supervised overall study implementation. NR debriefed with SSR and HS immediately after each interview and debriefed with AMF regularly. The research team's backgrounds and positionalities shaped the study in important ways. As women from the study area, the research assistants shared cultural and linguistic familiarity with participants, which helped establish trust and rapport during interviews. NR's prior experience in implementing sexual and reproductive health and rights programs, including safe abortion in Nepal, supported fieldwork implementation and enabled the team to secure necessary approvals from local governments. AMF's extensive expertise in qualitative abortion studies informed the study design, refinement of research tools, and provided an outsider perspective in the interpretation of findings.

Women who were interested in participating contacted the research assistants. The research assistants then shared further information about the study, screened for eligibility, and arranged a suitable date, time, and location for the interview. The interview location was selected by the participant, most often her home or workplace. One interview was conducted in a pharmacy consultation room, where the participant had been contacted by the pharmacy worker. All interviews were conducted in private, ensuring confidentiality, except in a few cases where a respondent's young child was present. We did not specify the type of medication abortion drugs as an eligibility requirement but explored the specific medications used during the interview. After obtaining informed consent, research assistants conducted in-person interviews using a guide designed specifically for this study but informed by similar projects [21–23].

We began the interview by soliciting demographic information and the participant's reproductive health history. Next, we gathered information about the index pregnancy, starting with a discussion of the circumstances surrounding the pregnancy, the decision to have an abortion, and the decision to seek an abortion through a pharmacy. We then turned to the participant's abortion experience, including the process of obtaining the medications, the abortion process itself, and the outcome. We

asked the participant to reflect on her overall experience and identify ways that services from the pharmacy, or for abortion care more generally, could be improved. With permission, we audio-recorded all interviews. On average, each interview lasted 40 min. We provided participants with 500 Nepali Rupees (NRS) (USD3.75) as a thank you for participating and provided NRS 500 (USD3.75) as incentives to recruiters, including FCHVs and pharmacy workers, who helped identify potential study participants. SSR and HS took notes during the interview and created a memo immediately after the interview. NR transcribed and translated all interviews, notes, and memos into English for analysis.

Data analysis

We analyzed data for content and themes [24, 25] and used ATLAS.ti 24 to manage the data. NR developed the initial codebook based on a priori codes determined by the study objectives. AMF reviewed the codebook and a selection of coded transcripts. Our iterative approach involved simultaneous data collection and analysis, allowing us to identify thematic saturation, the point at which additional interviews did not result in new themes. We suspected thematic saturation after 21 interviews and conducted four additional interviews for confirmation, as guided by the literature [26].

We created additional codes over the course of analysis to accommodate emergent ideas and thus used both inductive and deductive techniques [24, 25]. NR and AMF met regularly to guide interpretation of findings. In the final analytic phase, we identified key themes to give meaning and significance to the results.

In the results section we begin by providing information about the demographic characteristics of our participants and their health histories and then organize our findings by broad themes. We present narrative vignettes to showcase participant experiences and provide a thick description [24] and use quotes to illustrate themes and subthemes. Furthermore, we generated a word cloud in ATLAS.ti from participants' responses about their reasons for seeking medication abortion care from pharmacies. The visualization displays the most frequently occurring words in proportion to their frequency, after filtering out common stop words, thereby providing a visual summary of the dominant terms used by participants. To protect participants' identities, we have masked all personally identifiable information and used pseudonyms throughout the manuscript.

Results

Participant characteristics

Our participants were between 20 and 40 years of age, with an average of 29.3 years. Most of the participants were between the ages of 30–34, followed by 25–29.

The majority lived in Sunsari district ($n=18$), followed by Morang ($n=4$), and Jhapa ($n=3$). The majority of our participants ($n=12$) were of Janjati ethnicity. Most ($n=15$) had completed some lower secondary education. A significant majority of participants were married ($n=20$), while three were separated and two were never-married. Most participants ($n=17$) did not work outside of the home and cared for their families and household, while seven had part-time or full-time jobs and one ran a small business. One participant had obtained two abortions, while the remaining 24 had experienced one abortion during the eligibility period for this study. Of the 25

participants, five had sought medication abortion care from pharmacies within six months of the interview, one within 7–12 months, five within 13–18 months, and 14 within 19–24 months. The majority ($n=14$) had two children, seven had one child, three had no children and one had three children. Out of our 25 participants, three reported a previous miscarriage.

Pharmacies were the first and preferred choice for participants to terminate their pregnancies

As showcased in Gita's experience (see Fig. 2), our participants reported that pharmacies served as their primary

Gita is a 39-year-old woman living in Sunsari district with her husband and two children. She lost her job during the COVID-19 lockdown and now works part-time as a daily laborer in other people's homes. Her marriage was inter-caste and because of this she said she "faced discrimination from both my in-laws and my own parents". Gita primarily relies on the pharmacy for sexual and reproductive health services, finding it quick and convenient. She explained, "I have to work at other people's houses, so I go to the pharmacy quickly if I need anything...The government health centers are very time-consuming and you have to stand in a queue. Sometimes you have to wait 2-3 days. It is difficult to get good treatment."

In the summer of 2022, Gita's period was 10-12 days late and she noticed her body started acting "differently", leading her to suspect she was pregnant. The couple had not been using contraception and the pregnancy was unintended. Gita had no intention of keeping the pregnancy and did not disclose it to anyone, not even her husband. "I already have two children. If I have more, how will I raise them? It's difficult. Things are costly these days."

She went to the pharmacy to get a urine pregnancy test kit and discuss the possibility of an abortion if the test was positive. Gita recalled, "When I first went to buy the kit, the pharmacy worker told me to see the test result and if there were two lines I could come back for [abortion] medicine after consulting [with family]. However, I didn't seek advice from friends or family". After testing positive at home, Gita gathered money for the medication abortion and returned to the same pharmacy. The pharmacy worker only asked about her gestational age and did not request a prescription or an ultrasound report. She was given five white pills and instructions on how to take them, but received no information about possible complications, conditions warranting follow-up, or post-abortion contraception. Gita paid NRS3000 (USD22.5) for the medicine, took the first pill the same day, and 24 hours later, as instructed, administered the remaining four pills.

After completing the regimen Gita experienced severe abdominal pain, heavy bleeding, and frequent urination. She explained, "It was very difficult for me to bear the pain. I couldn't even drink water; it was that bad. I couldn't do anything. In fact, I couldn't do anything for three days. The pain was as intense as labor pain. My child boiled water for me. Other than that, I didn't eat anything. I was frequently going to the toilet and back."

A few days before her period returned, Gita bought another urine pregnancy test kit, which confirmed that she was no longer pregnant. Reflecting on her experience, she said, "As the pregnancy progressed, I was afraid that my friends and acquaintances would find out. Day by day, [my] pregnancy was advancing. However, I could do it [the abortion] quickly. I liked how I was able to manage things quickly."

Fig. 2 Gita's story

contact point for sexual and reproductive health services, including medication abortion care. While a significant majority of participants were aware that a medication existed to terminate pregnancy prior to having the abortion, they lacked detailed information such as where to obtain these medications, the name of the medicine(s), the number of pills required, the mode of administration, or the cost involved. When faced with unintended pregnancy and deciding to obtain an abortion, participants sought more information and learned that pharmacies provided medication abortion services.

Few participants were aware of other sites, such as government health centers or NGO clinics, that offer abortion services either for free or at a highly subsidized rate in Nepal. Those who knew of such locations had concerns about the confidentiality of the clinical interaction, being required to be accompanied by a husband or partner to obtain the services, other people in the community knowing the specific reasons for their visit, and the quality of abortion procedures performed at these centers, views that were typically based on misinformation. Namrata, a 26-year-old woman from Sunsari district explained why she opted for pharmacy-based medication abortion services over government centers:

Whatever was nearby. My house is in [the village of] Khairani, right? I used to live there at that time. So, Deurali [village] was near that place and there was a pharmacy run by a brother who I knew. I also buy other medicines [from the same pharmacy]. Many people raised the fear that [if I went] to the hospital, they will remove it by inserting a hand. And so, I preferred to use medicine for [the abortion]. There is also a chance of death of a mother due to [use of a] curette.

Only a handful of participants were connected to their local FCHVs, the primary agents for disseminating SRH information in the community. Participants cited several reasons for not reaching out to their local FCHV, including a lack of connection with the FCHV in their area, fear of a breach of confidentiality regarding issues like abortion, lack of trust, prior negative experiences, and the inability of the FCHVs to provide abortion medications.

Participants cited a number of reasons that influenced their decision to seek medication abortion care at pharmacies; we depict key words and phrases on the word cloud in Fig. 3. The most dominant reason was the desire for confidentiality, as participants preferred to keep their abortion process covert. Other common reasons included the geographic proximity of the pharmacies and the ability to get timely access to affordable care. Participants reported that they regularly visited the same

pharmacy for other health needs thus, they were familiar and comfortable with the pharmacy worker. Additionally, participants felt that pharmacies were well-suited to respond to the time sensitive issue of unintended pregnancy because of their non-judgmental approach. Rupa, a 36-year-old housewife from Sunsari explained:

In the pharmacies, there is confidentiality. They already know you. I feel this [abortion] is best not to be known by other people. If the community finds out, they will start talking about this. I have heard gossip about other people having abortions. I can share my private matters with them [pharmacy workers] and that's the reason.

Participants adopted self-care practices when managing their unintended and unwanted pregnancies

Self-screening of pregnancy, self-administration of medication abortion pills at home, and subsequent confirmation of non-pregnancy status were some of the self-care practices commonly adopted by our participants. As highlighted in Elina's experience [see Fig. 4], the majority of our participants inquired and received information on pharmacy provision of medication abortion from members of their social circles, including friends, family members, and neighbors. A few participants sought information from the Internet or directly from pharmacy workers. Many were familiar with stories of other women who obtained abortion medications from pharmacies, which made them more comfortable approaching pharmacy workers. About half of the participants confirmed their pregnancies through an at-home urine pregnancy test (UPT). Samjhana, a 21-year-old woman from Jhapa, shared her experience, "My menses stopped and I went to the [pharmacy] and got the thing [UPT kit] to test. When I checked, it tested positive and that's how I came to know."

Reflecting a preference for self-administering the medication abortion pills, all but one participant took the pills at home; the outlier took the pills at a friend's house. Participants generally confirmed that the abortion was complete by using an at home UPT kit without consulting a pharmacy worker. Rupa, a 36-year-old woman from Sunsari, explained, "I didn't do anything until I was bleeding [after taking medication abortion medicines]. And then when the bleeding stopped. Well, it took me around one week, almost nine days to completely heal. After that, I bought the [UPT] kit. Once I tested, [I learned the pregnancy] was not there and I felt relieved."

Only a few participants relied on advice from pharmacy workers, who informed them that the presence of

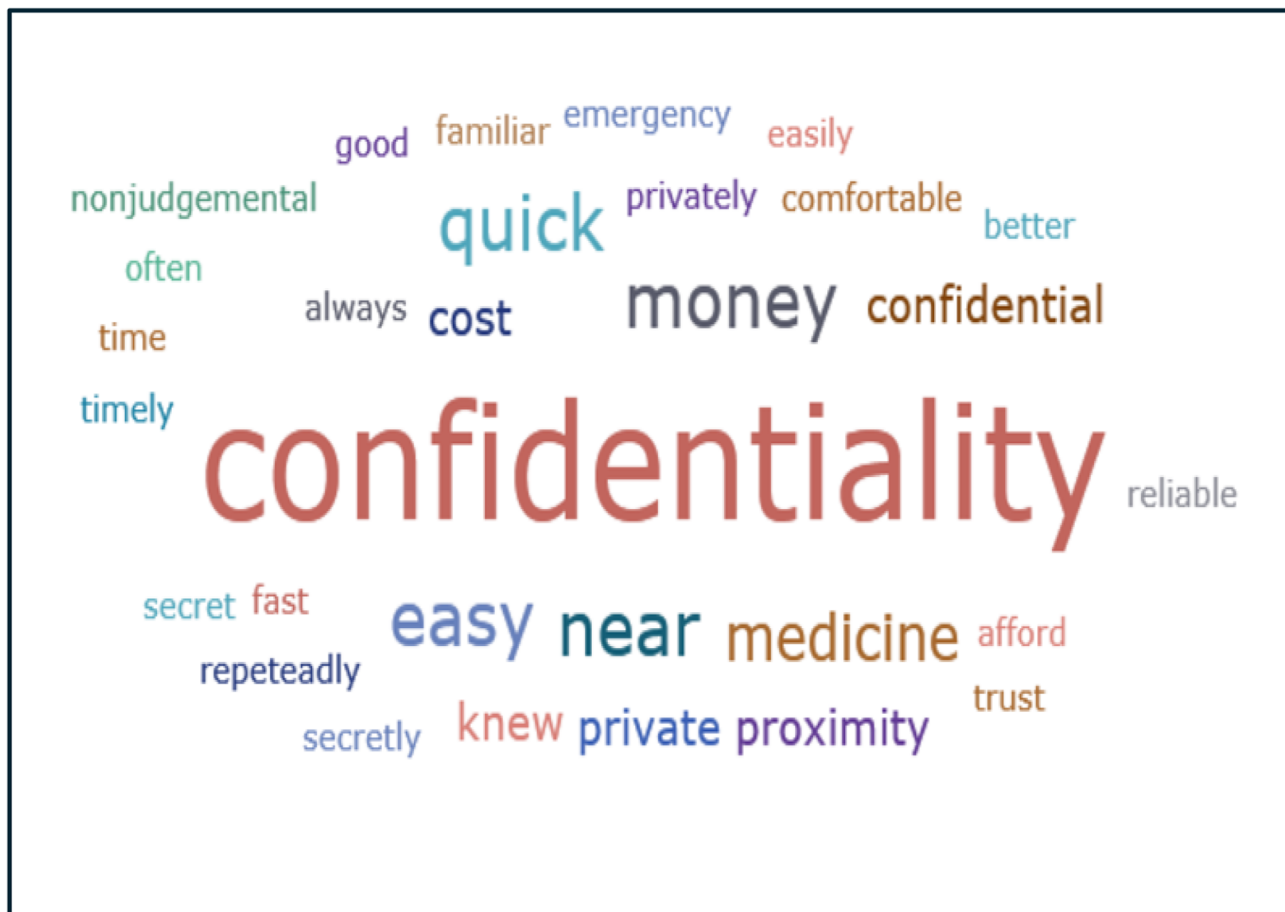


Fig. 3 Reported reasons that our participants' sought medication abortion care through pharmacies

small tissue-like discharge along with the blood would be indicative of a successful abortion. As Seema, a 35-year-old housewife from Sunsari explained, "He [the pharmacy worker] had told me. Well, my pregnancy was not of that long duration. I was asked to observe the whitish tissue-like expulsion and so it was expelled. Things gradually became normal after that...I did not have any issues related to bleeding. And so, I didn't go [for follow-up]...I did not do any tests."

Participants were offered mifepristone-misoprostol combination packs without a prescription but often at a high price and without counseling

None of our participants could provide the brand or trade name of the medication abortion pills offered. However, based on the descriptions of the number, size, and color of the pills, the packaging, and mode of administration it appears that the majority were offered a mifepristone/misoprostol combination package. Most participants confirmed they were offered a total of five pills, one large and four small, and told to take all of the white, round, pills that came in a blister pack within

24 hours of taking the larger pill. A small number of our participants reported receiving either three or four pills and a few were unable to recall details due to the stress of the situation or the passage of time.

None of our participants were asked for a prescription or an ultrasound report to obtain the medication abortion pills. The cost of medication abortion pills varied from NRS 500 (USD3.75) to NRS 6500 (USD48.5); the majority of our participants paid more than NRS 1000 (USD7.5). Most of our participants described the amount that they paid as "substantial". As Manisha, a 30-year-old woman from Morang, stated, "Considering my financial situation, I felt it [the medication abortion regimen] was expensive. I wish they were cheaper." Participants also described incurring other expenses. For example, employed participants mentioned they had to take unpaid leave from work and those taking care of their households reported having to leave their children with someone else and being unable to do household or farm work for several days. Some participants also mentioned local travel costs. Rupa, a 36-year-old housewife from Sunsari, explained:

Elina is a 20-year-old unmarried woman who originally hails from Taplejung district. After her mother's death, she had to discontinue her education at Grade 9. About a year before our interview, Elina moved to Sunsari district, where she lives with her sister and works at a retail store. Elina has a boyfriend but is often busy with work and doesn't get much free time. Although she doesn't engage in sexual activity frequently, she and her boyfriend did not use contraception when they did. After feeling nauseous and missing her period, Elina took a urine pregnancy test, which came back positive. She explained her initial reaction, "I am not married. How would I keep (the pregnancy)? It was very difficult. My friend gave me this suggestion [medication abortion] and so I opted for it. My friend already had experienced it. She also has a son. And from her, I came to know about".

Elina and her friend walked half an hour to a pharmacy. Without asking for a prescription or an ultrasound report, the pharmacy worker gave her five pills, one of which was larger than the others. She did not receive any additional medications or post-abortion contraception counseling and paid NRS1,500 (USD11) for the medicines. Elina recalled, "And we came back home and had dinner. Dinner was around 9:05 PM. I had four pills that evening and one pill the day after". When asked to clarify if she took four pills in the beginning, she confirmed, "No, first I had four pills and one pill later. That's what I was told." After taking the medication, Elina experienced abdominal pain and bleeding, which lasted for about a month before subsiding. She did not seek any follow-up care but was relieved that she was able to terminate the unwanted pregnancy.

Fig. 4 Elina's story

Sure, there will be other expenses. You simply cannot come back [from the pharmacy] only with the medicine. Once you go to the market [where the pharmacy is located] there are travel expenses involved. I have to go and return [using local transportation]. There are small children at home. I promised them that I would bring things for them [from the market]. I have to get them those things. Suppose it took 900 [NRS, USD7] for the medicines, then my total expenses are likely to be 1800 [NRS, USD14].

As reflected in Anjali's story (see Fig. 5), a significant majority of the participants we interviewed reported having received instructions on how to use the abortion pills from the pharmacy worker. However, only a few were asked to come for follow-up or were counseled on how to manage pain, bleeding or emergencies or about post-abortion contraception. Our participants repeatedly described being unprepared for the pain and bleeding that they experienced. Rekha, a 28-year-old housewife from Sunsari, explained:

I had severe lower abdominal pain and I also had bleeding. I also had heavy back pain at that time. It was quite difficult. I had to put on a patuka [a tight cloth around the abdomen] and do household work. Even when I was bleeding, I wrapped the patuka and had to do household work. I was also feeling afraid

at the same time...I was very afraid of the heavy blood loss. The pain was severe as well. Many things were playing in my mind looking at the blood that was lost.

Poonam, a 20-year-old unmarried woman from Jhapa who was living with her parents at the time of her medication abortion echoed these sentiments:

The day after I took the [abortion] medicine, I had a feeling of weakness. The bleeding was also heavy and there were a lot of tissue-like discharges. I was feeling weak and didn't feel like eating. My mouth was very dry. I constantly had vertigo. For all these reasons, I could not even help my mother with household chores...My lower abdomen was cramping. My back was also intensely hurting so much that I felt that I had a fever...At some point, I thought of going to a doctor. It was quite difficult and also in my home, no one knew about [the abortion]. I told my parents that I had a fever".

Two of our participants had someone else (one a husband, one a sister) purchase the medication abortion pills for them and therefore could not confirm the information provided by the pharmacy worker. Both described abortion pills that were likely not from a mifepristone/misoprostol combination package and faced significant

Anjali, a 30-year-old housewife from the Sunsari district, resides with her husband and their 12-year-old daughter. Originally from Khotang district, she completed her education up to the School Leaving Certificate level before getting married. Anjali had her regular period in June 2023, but when she missed her period in July, she became worried. She explained, "I wasn't planning on having another child. I used to take daily oral contraceptive pills, but I didn't have them at that time, and that's how this pregnancy occurred."

Anjali visited a nearby pharmacy, where she often seeks care for general health issues. The pharmacy worker suggested she take a urine pregnancy test, which confirmed she was pregnant. After discussing the situation with her husband, they decided not to have another child and agreed to terminate the pregnancy. Choosing the option was quite easy for her. Anjali had prior knowledge of medication abortion as she had "heard from friends and other women who terminated their pregnancies using medication. For me, I come to this [pharmacy] for most of my health issues. So, I went to her [the pharmacy worker] and asked [about medication abortion.]" Anjali was not asked for a prescription. The pharmacy worker provided Anjali with a medication pack containing five pills, which cost her around NRS680 (USD5). She also received instructions on how to administer the medications and what to expect during the process. However, she did not receive any additional instructions about pain management or post-abortion counseling. Anjali recalls, "The pharmacy worker gave me... She explained what might happen after taking the medicine. She also mentioned that after the last pill, there might be abdominal pain."

After returning home from the pharmacy, Anjali took the first pill and 24 hours later she took the remaining four pills at once. She further described her experience, "The abdominal pain was intense, as strong as labor pain. There were small, ball-like objects in the bleeding. The pain was more intense when those came out. In the following days, the pain was less, not as severe." The pharmacy worker called Anjali on the day she started the regimen to check on her, but Anjali did not immediately return for a follow-up. However, 15 days later, when she visited the pharmacy for another reason, she shared her experience with the pharmacy worker.

Fortunately for Anjali, her cousin was staying with her at the time and took care of the household chores, allowing her to rest. However, except for the husband, Anjali did not tell anyone else, including her cousin, about the abortion. When asked how she feels about her abortion decision, Anjali expressed no regrets, stating that it was a better choice than giving birth and being unable to properly raise and educate another child. When asked how she felt about the pharmacy provision of medication abortion care, she stated, "Because for us women, there might be unintended pregnancy, this service [pharmacy-based medication abortion care] is working very well for us. Some say this should not be disclosed as this is illegal. Overall, it's good. This is a needed service for women."

Fig. 5 Anjali's story

difficulties during the abortion process. Megha, a 20-year-old woman from Sunsari explained, "[My] sister brought that for me...She doesn't know how to read. She gave me the medicines and I took them with water... I don't know (the name of the medicine). How would I know? I never went there...I took two and two. First, I had two. And again, at the same time the day after, I took the other two...The abdomen hurt a lot. The blood was all over the bed."

Participants expressed considerable decisional certainty

As illustrated in the stories of Gita (Fig. 2), Elina (Fig. 4), and Anjali (Fig. 5), our participants were confident in their decision to have an abortion. Most women explained that their desire to have an abortion was related to already having enough children, poverty, unemployment, and inflation. Our two unmarried participants explained the decision was straightforward: they were not married and therefore could not continue the

pregnancy. Several participants also explained that they lacked support from their husband or in-laws, had plans to travel abroad for work, and had an existing condition that increased the health risks associated with continuing the pregnancy. Manju, a 26-year-old from Sunsari, explained her situation:

I had a miscarriage [in the past]. It was a six-month-old pregnancy. It was in the camp [Bisheshwor Prasad Koirala Institute of Health Science] where I did all my treatment. The child died inside the womb. Then I became pregnant for the second time. However, the doctor had told me not to have a pregnancy for at least 2–3 years after the miscarriage. The doctor also told me if I decided to get pregnant, I needed to come to the hospital and discuss it with him...I feared that this pregnancy might end up in miscarriage. I would be happy with the pregnancy... Because of this reason, I took the [abortion] medicine.

Our participants were firm in their decisions to terminate their pregnancies, but some had concerns about whether they could afford an abortion. They were also uncertain about where to obtain medication abortion services, whom to consult, what to expect during the abortion process, and whether their health might be at risk. Shanta, a 25-year-old woman from Morang was apprehensive about the medication abortion process and explained, “Sure, I had [doubts]. Many people have died due to [abortion]. Sure, I was afraid deep inside.”

Most participants reported feeling a sense of relief after successfully terminating their unwanted pregnancy. They expressed no regret or remorse and have since “moved on” from the abortion experience. However, a few of our participants expressed having a range or mix of emotions, feeling both relief and satisfaction and either wistfulness about what could have been or guilt or shame for having needed an abortion. Uma, a 39-year-old woman with two adult sons from Sunsari, explained her complex feelings:

[When I became pregnant] I was worried about how I was going to deal with my two [grown-up] children and how I was going to live the rest of my life. If this [birth] happened, it would be a matter of shame. How I am going to survive and how are my grown-up children going to react? I [had an abortion] because of all these fears I had. I did this [the abortion] for me, for my children...And so, I don't regret it. Inside my heart, I feel I did the right thing...I didn't regret a bit. However, sometimes later, as I reflect, as I think about children [in general], I feel how that child would look like if it had been born. Whether it was

a boy or a girl? Maybe I should have given birth. I already had two sons and how would it be if I had one daughter. Being a woman and being a mother, I regretted and felt I committed a sin. You have these regrets inside your heart.

Most participants would recommend medication abortion from pharmacy workers to others

Most of our participants said they would recommend pharmacy provision of medication abortion pills to others needing care. They highly valued the convenience of being able to take the pills at home in the comfort of their own space. Although a few said they would only cautiously recommend pharmacy provision of medication abortion, a number went on to say they would share their own experience with others and would be willing to show others the specific pharmacy where they could obtain medication abortion pills. Rekha, a 28-year-old woman from Sunsari, stated, “Yes, I would recommend [medication abortion]. You can do this at home and people won't find out. And that's why I feel doing [medication abortion] at home is better. If there are difficulties, they need to go to the hospital, however, if [complications] don't arise, this is possible at home. No one will find out.”

Discussion

To our knowledge, this is the first study in Nepal to document the experiences of women who sought medication abortion care exclusively from pharmacies. Our findings show that women are obtaining abortion care from pharmacies because they trust pharmacy workers and because these service delivery points are convenient and confidential. Pharmacies have become the preferred service providers not only for women unaware of other abortion facilities but also for those who were aware of them, underscoring the role of pharmacies as a key component in Nepal's abortion care landscape. Our findings are consistent with existing literature in Nepal, which indicates that pharmacies often serve as the first point of contact and play a crucial role as a source of information for women seeking abortion care [7]. Evidence from Nepal further suggests that both pharmacy workers and mid-level health workers can effectively dispense medication abortion pills when adequately trained [27, 28]. The World Health Organization's updated abortion care guidelines also acknowledge that pharmacy workers possess the necessary competencies to provide medication abortion services [6].

Despite this evidence, Nepal's regulatory framework currently discourages pharmacy provision of medication abortion. The interim COVID-19 guidance allowed home-based medication abortion services only under direct health worker supervision [29]. This cautious stance contrasts with WHO's endorsement

of self-managed abortion as safe and effective for first trimester pregnancies [6]. It also stands in contrast to women's lived practices in Nepal, where self-care and pharmacy access are already widespread, as evidenced by our findings. This divergence between national policy, global guidance, and women's realities creates a gap that risks undermining both safe abortion access and women's reproductive autonomy.

Given their extensive reach and ability to offer convenient and confidential care, pharmacies have the potential to bridge the gap in abortion service provision in underserved areas. Therefore, there is an opportunity to improve access to medication abortion in Nepal by training and orienting pharmacy workers. Local governments can support this by offering training, supportive supervision, and clinical mentoring to help increase the competency of pharmacy workers in delivering high-quality medication abortion care. For instance, using a call center to provide pharmacy workers with timely and accurate information on medication abortion has been shown to improve knowledge [30]. Furthermore, recognizing that instructions provided by pharmacy workers were often incomplete or lacking, the Government of Nepal should also consider integrating medication abortion management into the pre-service curricula of all professionals recognized by the Drug Advisory Committee [31] who are authorized to sell or distribute prescription drugs.

However, our findings also show that women seeking abortion care lack knowledge about the availability of free and subsidized clinic-based care and that many hold misinformation about the safety and efficacy of in-person care and instrumentation abortion care. Our findings are consistent with recent reviews of the literature on abortion in Nepal, which highlight persistent gaps in women's understanding of abortion laws and service availability that continue to create major barriers to care, including uncertainty, fear of legal repercussions, stigma, and misconceptions [16]. Despite over two decades of abortion legalization, it is important for the government of Nepal to recognize that there is work to be done to increase awareness about the legality, availability, and quality of these services and provide more information to women on what to expect during the abortion process. FCHVs can play a vital role in this effort. However, our findings also suggest urban women lack trust in FCHVs. With Nepal's recent federalization, the responsibility of managing FCHVs has shifted to local governments. Thus, it is crucial that the local authorities effectively mobilize and motivate these groups of outreach workers to effectively disseminate sexual and reproductive health information and build trust with their communities.

Our study also suggests an increasing preference among women for greater autonomy and control over their abortion process. Self-care practices such as

self-assessment of pregnancy, self-administration of medication abortion pills, and self-evaluation of the abortion outcome were commonly practiced by our participants. These findings align with emerging evidence suggesting that Nepalese women frequently practice self-care when seeking abortion services, including through telemedicine/telehealth abortion services [32, 33]. While the government's interim COVID-19 guidance marked a positive step by permitting home-based medication abortion services supported by telecommunications [29], its caution against unsupervised use contradicts the principle of self-care. Expanding the definition of self-care to align more closely with WHO abortion care guidance [6] would better reflect women's current practices and improve access. Furthermore, global evidence shows that medication abortion through telemedicine is safe, effective, and well-accepted by both women and healthcare providers [34–36]. The government of Nepal could consider adopting this service delivery model, especially in areas where access to abortion services is limited.

It is also clear from our interviews that abortion stigma in Nepal is considerable. That so many of our participants did not feel comfortable telling others in their lives about the abortion and preferred pharmacy-based care because of concerns that others in the community would learn about their abortion, reflects externalized stigma. Women seeking abortion care may be shunned by their communities or referred to as *sinners*, *murderers*, and *fetus killers*, thus driving abortion care out of the formal health system [37]. A recent study in Nepal found that over two-thirds of women believe that terminating a pregnancy is sinful and that abortion negatively affects women's health [38]. To address this, community-level interventions are essential, not only to raise awareness about abortion but also to destigmatize abortion. Interventions such as values clarification and attitude transformation exercises, abortion education integrated into sexual health curricula, and counseling for women and girls during family planning services may help enhance reproductive health autonomy and reduce stigma and negative stereotypes within the community. Additionally, integrating pharmacy-based medication abortion services into the formal health system could contribute to normalizing abortion by enhancing both the availability of and awareness about medication abortion care.

Limitations

Our study's findings may not be generalizable or representative due to their qualitative nature and sampling being limited to a single province of Nepal. However, the results are likely relevant to other urban municipalities of Nepal with similar social, economic, and cultural contexts. Future research would benefit from taking place in rural areas and with rural communities, as well

as capturing voices of women from multiple provinces. We acknowledge that our findings are likely impacted by recall bias, as women may not remember all of the details surrounding an interaction and process that took place up to two years prior to the interviews. Our participants were women who self-selected to disclose their use of medication abortion pills from pharmacies, which may have introduced some degree of selection bias. However, their characteristics were consistent with national patterns of women seeking abortion through pharmacy channels, supporting the credibility of our findings. In addition, about half of our participants were from Janajati communities, which may not fully reflect the perspectives of other ethnic groups in Nepal. Nonetheless, this study provides insights into the beliefs, behaviors, and experiences of women who sought medication abortion from pharmacies in Nepal, filling a previous information gap. Future research could focus more intentionally on the experiences of unmarried women and girls as well as of women who used medication abortion pills bought from the pharmacy by someone else.

Conclusion

Nepalese women seek medication abortion care from pharmacies due to their trust in pharmacy workers and the convenience and confidentiality these service delivery points offer. This trend of women relying on pharmacies for medication abortion is likely to persist. Conversely, abortion seekers often avoid safe abortion facilities in the formal health system due to a lack of awareness and misinformation. Therefore, it is important to recognize and strengthen the role of pharmacies as key providers of these services. At the same time raising awareness and reducing stigma around medication abortion is essential. The Nepal government could explore community-based distribution models, such as pharmacy-based distribution of medication abortion and abortion self-care through telemedicine, to enhance access to medication abortion services.

Abbreviations

FCHV	Female community health volunteer
NGO	Non-governmental organization
NRS	Nepali rupees
SRH	Sexual and reproductive health
UPT	Urine pregnancy test
USD	United States dollar
WHO	World Health Organization

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Authors' contributions

NR and AMF conceptualized and designed the study protocol and data collection instruments. NR conducted the fieldwork with support from SSR and HS and analyzed data with AMF supervision. NR wrote the first draft and AMF revised the manuscript. All authors reviewed and approved the final version for journal submission.

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Data availability

The interview guide and de-identified dataset used and analyzed during the current study are available from the corresponding author on reasonable written request.

Declarations

Ethics approval and consent to participate

We received ethics approval for this study from the Research Ethics Board at the University of Ottawa (S-04-19-3909) and the Nepal Health Research Council (417/2023). All participants provided consent to participate and for the research team to audio-record their interviews. We confirm that we conducted this study in accordance with the Declaration of Helsinki.

Consent for publication

Study participants provided consent for personal quotes to be used in all reports and publications. We removed or redacted all personal identifying information and we used pseudonyms throughout the paper.

Competing interests

The authors declare no competing interests.

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