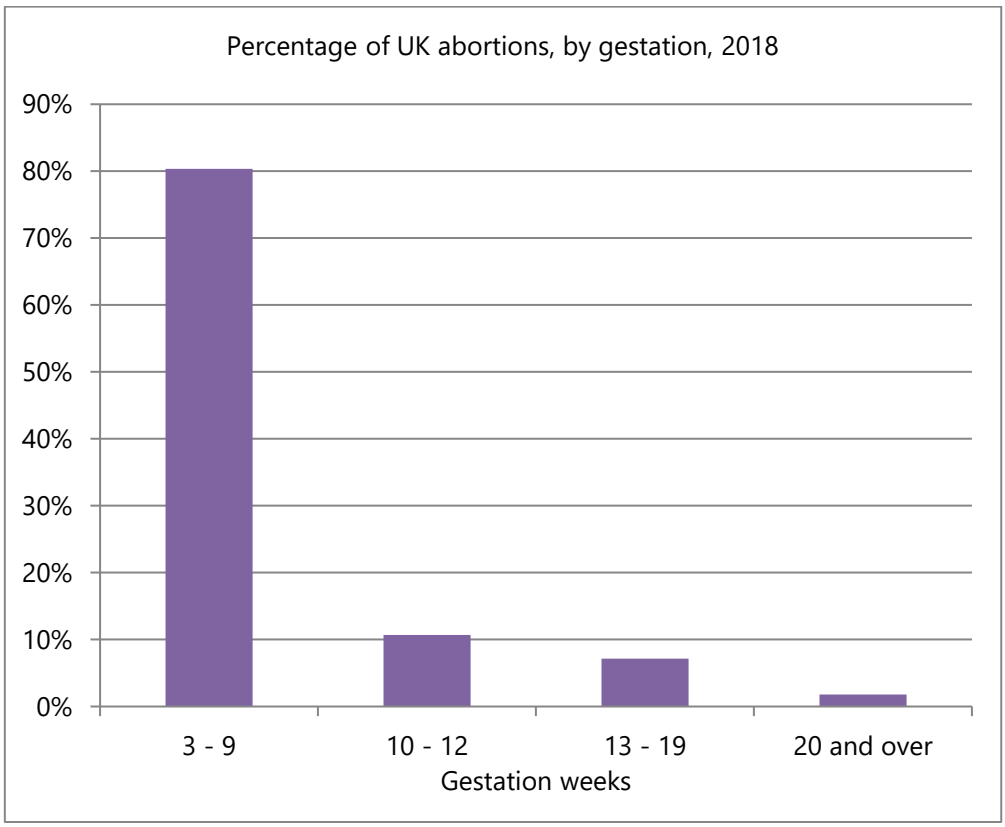
Why do women need abortions after 20 weeks?

bpas
British Pregnancy Advisory Service

Contents

Introduction

In the UK, the vast majority of abortions happen early. In 2018, 91% of all abortions took place in the first trimester. The proportion of later abortions (defined here as abortions taking place at 20 weeks' gestation or later) is consistently extremely small: between 1-2%.[1]



Around 1 in 3 of women seeking an abortion after 20 weeks do so because there is a serious problem with the development of the foetus, often during the course of a much wanted pregnancy. The others are likely to be in different – but equally challenging – circumstances.

BPAS is a reproductive healthcare charity that sees over 80,000 women per year for pregnancy options counselling, abortion care and related services. We provide abortions up to the legal UK limit of 24 weeks, including for foetal anomaly, and as such are uniquely placed to advocate for women and their reproductive needs.

There are many factors that may contribute to a woman presenting later for abortion care. Women who seek later abortions are likely to do so for complex reasons, or because they're experiencing challenging circumstances in the wider context of their lives. This report is not intended to be an exhaustive exploration of women's reasons for needing later abortions, since every individual woman's situation is unique. But it is intended to give a broad overview of some key themes that emerge as women navigate their fertile years.

Why do women present later?

1. Foetal anomaly

Around a third of abortions taking place after 20 weeks' gestation are due to a serious problem with the development of the foetus. The term 'foetal anomaly' refers to a range of conditions that may be detected during a pregnancy, including disorders of the nervous system such as neural tube defects like spina bifida or anencephaly; congenital malformations of other systems or organs, including of the cardiovascular, musculoskeletal or urinary systems; or chromosomal anomalies such as Down's, Edward's and Patau's syndromes.

Terminations for a foetal anomaly are recorded by the Department of Health and Social Care (DHSC) under 'Ground E'. In 2018, of the abortions carried out under Ground E:

21% were for disorders of the nervous system
27% were for congenital malformations of other systems or organs
33% were for chromosomal anomalies
18% were for other conditions.[1]

Often, a diagnosis of one of these conditions cannot be made until well into the second trimester of pregnancy.[2] Chromosomal anomalies are screened for between 10-14 weeks of pregnancy, and subsequently confirmed by further diagnostic testing during the second trimester. Serious congenital malformations such as problems with the nervous system are usually detected by ultrasound scanning, and may not be seen until the mid-pregnancy scan at around 20 weeks' gestation. Women with a foetal anomaly therefore may have missed the opportunity for an earlier abortion by the time they find out something is wrong, or may need extra time to establish the severity of the condition and how they would manage it. BPAS offers women the option of surgical management of abortion at these later gestations, when the hospital providing their maternity care can only provide medical abortion due to lack of training in surgical skills. Surgical abortion in the second trimester is safe and can often be preferable for women than undergoing a medical induction.

Client contacted BPAS after her scan confirmed a foetal anomaly at 22 weeks. Client was devastated to be told the pregnancy would likely not survive after birth. She felt she could not mentally go through the pregnancy following this diagnosis.[*]

Client contacted us after receiving inconclusive results regarding a foetal anomaly. Client and her partner were very emotionally distressed, as this was a wanted pregnancy. At 22 weeks, the spina bifida diagnosis was confirmed; client decided she wished to terminate. BPAS supported client with her wishes regarding a burial, and counselling was provided.

[*] *Unless otherwise stated, all case studies in this report attended BPAS*

The decision of whether to terminate in a situation where the baby is unlikely to survive is always deeply personal. Some women may choose to continue with the pregnancy, while for others the prospect of carrying an unviable pregnancy to term is unfathomable. Some women will not be able to see their way to raising a child with a serious disability, due to worries about the emotional cost; the impact this is likely to have on their existing children and/or their ability to care for them; the financial cost to their family; or fears that the child will need constant medical intervention and may live in pain. Only the pregnant woman, in consultation with her medical team and support network, can know the right path for herself and her family.

2. A change in circumstances

A tragic event or the onset of a crisis may influence a woman's decision not to continue with a pregnancy, even if it had previously been planned and wanted. The death of a family member or partner, or a change in family income through the loss of a job, for example, may cause women to feel unable to cope with the prospect of becoming a mother or expanding her family. These decisions are never easy, but for some women such events may mean she re-evaluates the decision to become pregnant or to continue an unplanned pregnancy, and ending that pregnancy becomes the option she thinks is best in the circumstances.

Client lost her partner to a serious illness just a few weeks ago. Suffers from complex mental health issues, and has a physical health condition which means this pregnancy is high risk.

Client is 22 weeks pregnant. Partner has just left her with significant debts. Feels financially and emotionally unable to have a baby. Ex-partner ignoring all calls and messages.

Client has children and both her parents have recently been diagnosed with serious illnesses. She couldn't cope with another child now.

A woman may also become aware in the course of the pregnancy that she is not entitled to the financial assistance she may have assumed, either with ongoing child support – such as welfare payments for an additional child, or immediate healthcare costs. Women who do not have settled status in the UK for example are not eligible for NHS-funded maternity care, and this may impact upon their decisions regarding the pregnancy.

3. Domestic abuse

Intimate partner violence is associated with non-consensual, unprotected sex and unintended pregnancy. As such, women seeking both maternity care and terminations may have experienced domestic violence or related abuse.[3–6]

Evidence suggests that around a third of domestic violence cases either begin or worsen during pregnancy.[7,8] For women in this situation, the escalation of violence may be a major factor in their decision to terminate, as they worry for their ability to escape an abusive relationship with a child and for the safety of that child.

Client was referred by her GP at 21 weeks, after being a victim of domestic violence. Her circumstances changed as the violence progressed, and she no longer felt mentally or physically able to support a child.

Due to recent domestic abuse client felt unable to cope emotionally or physically with the pregnancy. She has a number of other children and a complex medical history including lasting physical complications from the attacks by her partner.

An abusive or controlling home environment can also make it much more difficult for women to seek help. Some women in a coercive relationship have reported concealing their pregnancy for as long as possible due to fear of their partner's reaction. This desire to keep the pregnancy secret can delay contact with abortion services.

A recent study which investigated why UK women seek illegal abortion pills online found that nearly a fifth of these women were in controlling circumstances, including experiencing partner violence. One woman who was hiding her pregnancy from a violent partner said she could not visit a clinic for fear he would find out and intervene:

"I'm in a controlling relationship, he watches my every move, I'm so scared he will find out, I believe he's trying to trap me and will hurt me. I can't breathe. If he finds out, he wouldn't let me go ahead, then I will be trapped forever. I cannot live my life like this."[9]

Some women may be able to access the Internet in order to request abortion pills from online telemedicine services, although it should be noted they risk prosecution in the process under section 58 of the Offences Against the person Act, which makes it a crime punishable by life in prison for a woman to procure her own abortion. In cases where this is not an option, women have no choice but to seek a termination through the formal healthcare system, which can extremely difficult to navigate in secrecy. Several weeks may go by before they can find a way to engage with service providers in confidence.

4. Health problems

Sometimes poor physical and mental health can prevent a woman from continuing with a pregnancy. This could be the sudden onset of an illness, or a gradual deterioration during the course of the pregnancy. Ending a pregnancy for health reasons can be difficult to come to terms with. But some women, in consultation with their doctor, will decide this is the best path in their situation.

Client with confirmed blood clot on her brain was advised at 21 weeks that there was a serious risk to the health of both mother and baby if the pregnancy continued. Client had to be treated in a hospital setting due to complex health problems.

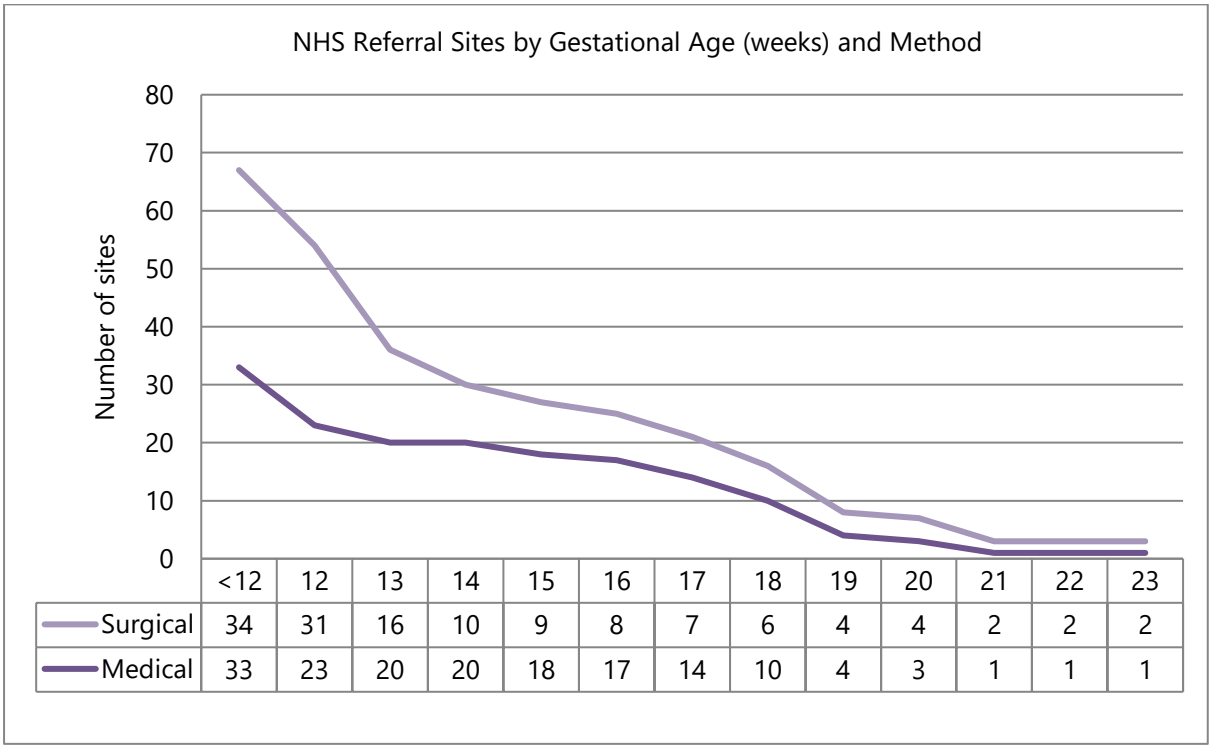
Client had attempted suicide during pregnancy. Suffers severe mental health problems from sexual abuse. Presented at 20 weeks unable to cope.

Unfortunately, women with certain medical conditions are likely to face much longer waiting times before they can access a termination, delaying their access to care.[10] For safety reasons these women must be treated in hospital instead of in standalone clinics, so that there is swift access to specialist medical help should any complications occur. This includes women with a range of health conditions including poorly controlled diabetes, epilepsy and unexplained seizures, asthma, high blood pressure, blood disorders such as deep vein thrombosis, sickle cell disease and haemophilia, stroke, brain tumours, problems with the location of the placenta, and high BMI (morbid obesity). But appointments in hospital settings are scarce, and women may have to wait weeks before an appointment for a procedure can be confirmed.

Client suffers severe epilepsy and seizures which got worse during her pregnancy. She already has children. She required a termination in a hospital setting due to her medical needs and had to wait 4 weeks for the procedure.

Client with children had a serious liver condition and approached us at 19 weeks of pregnancy for a termination. She had to receive treatment in a hospital setting due to her complex medical needs, for which she had to wait 4 weeks for an available appointment.

As gestation advances, the number of hospital sites available to treat women falls dramatically, compounding the problem. The result is long waiting times, which can push women further and further into the second trimester:



	<12	12	13	14	15	16	17	18	19	20	21	22	23
Surgical	34	31	16	10	9	8	7	6	4	4	2	2	2
Medical	33	23	20	20	18	17	14	10	4	3	1	1	1

5. Late detection of pregnancy

One key reason that women present late is they simply had not realised they were pregnant. Pregnancy symptoms can be missed, or disguised by factors such as hormonal contraception, a pre-existing health condition or an irregular menstrual cycle. Breastfeeding, which impacts upon bleeding, can also delay detection. Breastfeeding can work as an effective method of contraception, but only if it is the exclusive method of feeding in the first six months.

Client (39) suffers with Irritable Bowel Syndrome and has irregular periods. She has been using the combined pill without any problems, and was unaware of the pregnancy until two weeks ago. She had no symptoms but felt her stomach was more prominent than usual so decided to do a pregnancy test. Her GP referred her for an emergency scan and the pregnancy was confirmed at 19 weeks gestation.[11]

Hormonal methods of contraception such as the implant or IUS can make it more difficult to detect a pregnancy. Because women know these methods are highly effective, they may not be watching out for possible pregnancy symptoms. This is especially true because these methods suppress menstrual bleeding, and therefore a missed period is not interpreted as a cause for concern. These methods have become much more popular in recent years, but every method of contraception has a failure rate, and some women are therefore presenting to abortion services late because their hormonal contraception had disguised the pregnancy.

Client in her 40s, already has children, with an IUS [Mirena] fitted. Her periods have been erratic since. She is currently in the care of a mental health team. Presented at 23 weeks as did not suspect she was pregnant.

Substance misuse can also supress or alter bleeding, and women with additions to drugs like heroin are also likely to be leading very challenging and chaotic lives.

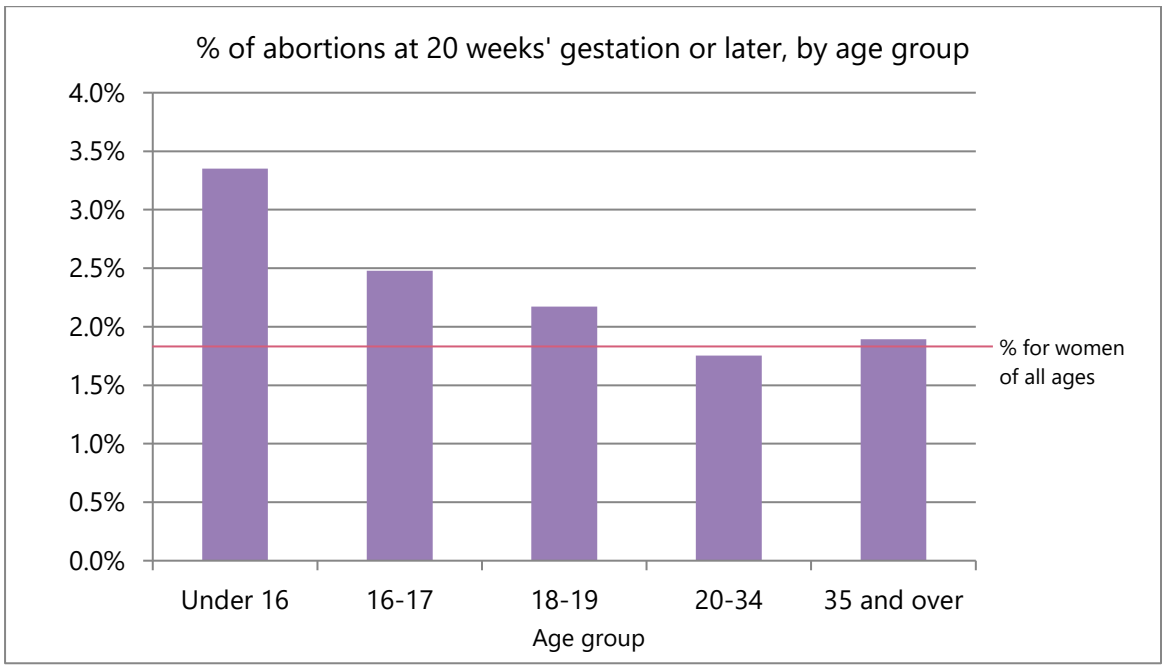
Client called BPAS thinking she was a few weeks pregnant. A heroin addict, her periods were erratic and she already had children who were not in her care. She felt it was wrong to have another baby. Presented at 23 weeks.

In one UK study, women having later abortions had taken significantly longer to suspect that they were pregnant.[12] The three most common reasons given for failing to detect a pregnancy were 'because my periods are irregular' (49%), 'because I continued having periods' (42%) and 'because I was using contraception' (29%).

For these women, the opportunity to have an earlier abortion is missed altogether, because they did not know they had a decision to make.

6. Young women

Of the women who have terminations in the UK, young women are disproportionately likely to present later. Statistics from the DHSC demonstrate that women under 20 who opt for a termination are more likely than those in other age brackets to have their treatment at 20 weeks' gestation or later:[13]



Young women who become pregnant may detect their pregnancy later as their periods are more likely to be irregular, and it may therefore be more difficult to recognise the symptoms.[14]

Client (17) has an irregular cycle and did not initially consider pregnancy. She eventually became suspicious and took test – she was very shocked by result. Client feels too young to have a baby. She has no resources to provide for herself and no partner support.[11]

Client (18) has always had irregular periods so did not worry that she might be pregnant. She was about to go on holiday when she became dehydrated and started vomiting. Client was advised to go to A&E, where they confirmed that she is pregnant. Her mum is with her and is supportive – both are upset and in disbelief.[11]

Young people may also be unsure what to do upon realising they may be pregnant. One UK study found that women under 18 are more likely to cite certain concerns, which cause delays in the earliest stages of their decision making process:[15]

- *a suspicion of pregnancy but not doing anything about it*
- *not being sure what to do if they were pregnant (leading to a delay in taking a pregnancy test)*
- *concern about how their parents would react*
- *concern about what an abortion involved, so waiting a while to ask for one*

Due to concerns such as these, some young people may delay seeking help or even conceal their pregnancy altogether.[16] They may therefore only seek help at a later stage of pregnancy, once it can no longer be easily concealed.

Client (17) presented at 21 weeks. Client felt she had no one to turn to and was not comfortable telling anyone so concealed the pregnancy for as long as possible. Client received counselling and support through BPAS, and travelled over 100 miles for procedure.

The themes of anxiety, concern and worry are particularly prevalent among young people experiencing an unwanted pregnancy. Understandably, these concerns can cause hesitation and anxiety about seeking help, delaying contact with abortion services.

Barriers to access

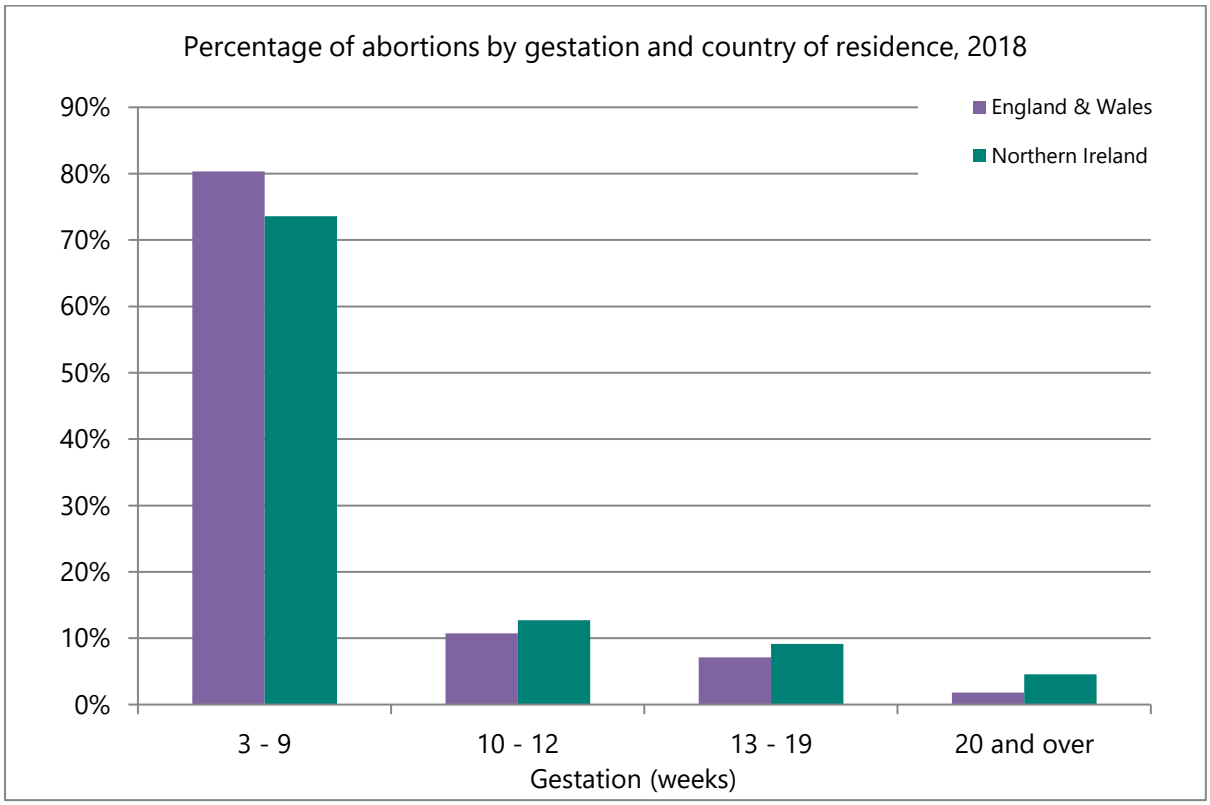
Even if a woman decides to seek an abortion earlier in her pregnancy, she may encounter obstacles that delay her access to treatment. For women who have already decided on a termination, these delays may be particularly stressful, since women usually prefer to proceed as quickly as possible once they are certain of their decision.

Geography

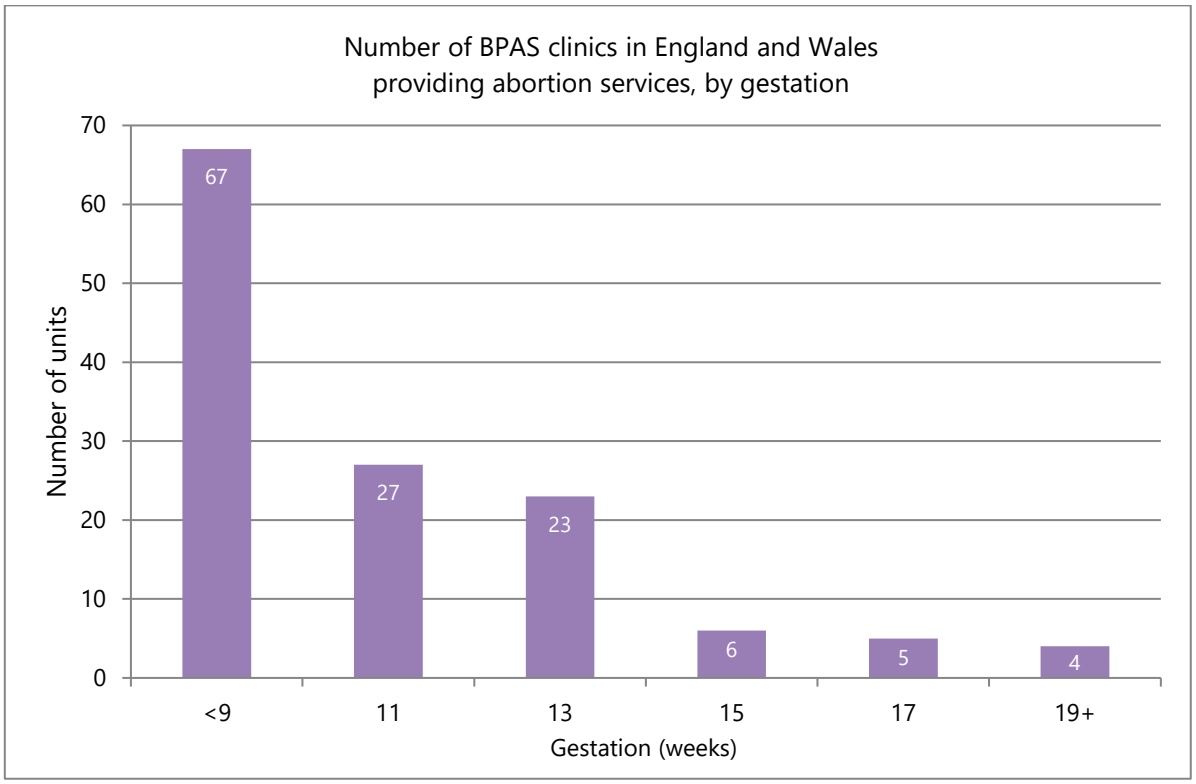
A long distance to travel can be a major logistical barrier for women seeking an abortion. Women in Northern Ireland, for example, must travel to England to attend a clinic, and therefore face the prospect of a long journey and a night away from home, with the accompanying difficulties of taking time off work, arranging childcare, etc.

"The distress and anguish that I experienced was not making the decision to have an abortion, it was travelling, and having to make arrangements for that travel and waiting the weeks until I could have a surgical abortion and borrowing money for the travel and operation that caused me emotional harm. I know that I am not alone in this experience…I know many other people have had to wait like me, from the time of finding out you are pregnant until finally being able to access an abortion."[17]

Inevitably, the additional logistical barriers faced by Northern Irish women delay their access to abortion services. Statistics from the DHSC clearly show that women from Northern Ireland who have an abortion are disproportionately likely to present late: for residents of England and Wales, 1.8% of abortions take place at 20 weeks or later, but for residents of Northern Ireland this proportion is over 2.5 times higher, at 4.56%.[1]



But travelling is not only an issue for women from Northern Ireland. As gestation advances, so do the number of sites able to treat women, as the table below illustrates. Two of these sites providing abortions at 19 weeks and later are in London.



Many women live in parts of the UK where, despite being lawful, a later abortion service is not easily accessible, and arrangements need to be made for travel and overnight accommodation, hundreds of miles from where they live. For women already in challenging circumstances or with existing children to care for, the logistical demands of travel can add to the time between first contact and treatment.

Client had been raped, police describe her as "extremely vulnerable". She is living in an area of the country where later abortions are not available. Logistics and preparation needed for travel across the country for care intensely challenging. Treated on last day of upper time limit.

Client with a young baby had not suspected that she was pregnant and was suffering postnatal depression from her prior birth, and needed to travel a considerable distance for care. Treated on last day of upper time limit.

Referral and waiting times

Regardless of gestation, sometimes women may struggle to get a referral from their GP, which delays their access to treatment. This is particularly problematic if women cannot self-refer to abortion services, and GPs therefore play a key role as 'gatekeepers'.[18] Although everything is done to raise

awareness that women can usually refer themselves directly into services, many women still expect to see their GP in order to access tertiary care.

In small towns or rural areas, many women may feel uncomfortable talking to their GP about an unwanted pregnancy, especially if they know their GP personally.

In other cases, women may have a GP who conscientiously objects to abortion. Currently, GMC guidance does not require GPs to refer patients to abortion services, although the 'best practice' guidance recommends that they ensure the patient has enough information to see another doctor.[19] Despite this, women have reported being obstructed by GPs.

"I approached my GP about my options for termination I was treated appallingly by clearly partisan doctors and, essentially, a refusal was made to give even medical information about my options."

In a Scottish study, one woman described the impact of being asked to send a urine test away to a laboratory to confirm the pregnancy and then return a week later for the result:[20]

"... I'd said stuff like 'did they actually do this so that you don't go ahead with the operation, you know, so you've got time to think about it and stew over it?' It didn't feel like it was, you know, supportive in any way, it felt like it was just kind of like "oh, you shouldn't be doing it so we'll leave you to decide and hopefully you'll change your mind."

Inability to navigate the care pathway can also be an issue for women who do not have a GP, and when or if they do book an appointment directly, are unable to effectively communicate their needs – and the urgency.

Following a referral, waiting times can also slow women down; although once a provider is aware of how advanced her pregnancy is, organisations like BPAS run a Specialist Placement Service to ensure women are seen as quickly as possible. However, as documented above, it can be difficult to find some women appointments within hospitals due to restricted capacity.

Abortion is a very safe procedure, and considerably safer than carrying a pregnancy to term, however the earlier it can be performed the better for a woman's physical and mental health.

The women compelled to continue their pregnancies

Despite presenting before the time limit, on a regular basis women in the UK are compelled to continue pregnancies they do not want and which put their mental and physical health at risk.

As noted already in this report, women with complex health conditions may wait long periods for treatment, as hospital appointments are scarce. The reasons for this are complex, but the fact that abortion remains in the criminal law in the UK can prove a deterrent to doctors training in this area of care; and the fact that so many abortions are provided within the not-for-profit sector means young doctors in training are often not exposed to this vital area of care, and do not therefore consider training in it.

Sadly, some women run out of time altogether. Around twice a month, BPAS is unable to find a hospital placement for a woman with a medical condition, meaning she has no option but to continue an unwanted pregnancy that poses an absolute threat to her health. In 2018, cases included the following:

Underwent major surgery last year and remains under consultant care. Partner is opposed to continuing the pregnancy, and client doesn't feel she can cope physically or mentally. Suffers from anxiety and panic attacks. Was using hormonal contraception when she conceived. Difficulties finding appointment, when client did present at clinic she was at legal limit of 24+0 and the clinic was unable to provide a termination for this client.

Mother in her 30s. Brain tumour removed in previous year. Transient Ischemic Attack (TIA) and seizure 7 months ago, suffers from anxiety and panic attacks. Client discovered pregnancy at 6 weeks and sought "definitive answers from doctors / oncology re: risks of pregnancy causing tumour returning" but has recently been advised that she needs to terminate due to risks to her own health. Presents at BPAS at 18 weeks and attends multiple counselling consultations due to anxiety and distress. No suitable appointment available.

Client in her mid-40s, referred to BPAS due to high BMI at a gestation of 23 weeks. Pregnancy is unplanned, client has an implant is in situ and experienced irregular bleeding which she attributed to the start of the menopause. Client states her family would disown her if they found out she was pregnant and she couldn't cope mentally. Stated that she is feeling suicidal and will "jump in front of a train" if she cannot get an appointment. Client is currently staying with her abusive alcoholic partner (who is unaware of her pregnancy) and does not have a support network around her. Unable to attend standby appointment at 23+6 due to transport issues. When informed that we cannot offer treatment and she will have to continue the pregnancy, client disclosed that she has considered drinking bleach. Client referred to social services.

Late 30s. Multiple children not in her care due to violent relationship. On methadone programme but not controlled. No IV access. First scanned at 18 weeks. Client did not attend first appointment - social worker reports that the "client couldn't get to appointment due to financial issues, issues with her script and just not the support to get her there." Client's midwife contacts BPAS and reports that client "had a table top with her children's clothes and toys, to try raise the money, and couldn't." BPAS had not been informed client couldn't afford transport. No suitable appointment available.

Equally, women without complex care needs may be unable to access treatment, despite contacting services within the time limit.

In July 2018, the Department of Health and Social Care introduced a new restriction on the upper time limit. For many years, the wording within the 1967 Abortion Act, "has not exceeded its 24th week", was interpreted to mean an abortion was lawful provided it was performed by 24 weeks and 0 days. The DHSC declared this interpretation to be wrong and that an abortion must be completed by 23+6 days in order to be lawful. This decision was taken despite the knowledge that the UK's later abortion service is fragile and that appointments are already restricted. Since the decision was implemented, BPAS has been unable to find treatment for at least 12 women who presented in time. They include:

A teenage mother who already had a young child, about to start college as she had just secured a childcare place. No appointment available.

Teenager, victim of domestic abuse – police had been involved although she did not want to press charges.

Heroin addict, presented at 23 plus 5 - the client was a recovering drug addict and was currently on 60mls of methadone. Client has two previous children which she lost to Social Services due to her substance misuse. Client currently recovering and trying to get her children back

Conclusion

There is an assumption that the timing of an abortion is always within a woman's control, and that later abortions could therefore be avoided, if only women would take more care.

However, this characterisation of women as irresponsible is not rooted in the reality of women's lives. Women cannot make a decision about whether or not to continue a pregnancy if they do not know they are pregnant; the complexities of women's lives which mean they need to end a pregnancy do not change whether they discover the pregnancy at 4 weeks, 14 weeks, or 24 weeks. The available evidence suggests women who have later abortions may also be more vulnerable: they are younger; they have travelled further; they may have poorer health; and their circumstances may be more challenging.

The truth is that women cannot always control the timing of their abortion. No woman makes the conscious choice to have a later abortion, but for women in particularly difficult or complex circumstances, a later abortion may be the best option in the wider context of their lives and those of their families. More than half of women seeking abortion already have children, and the welfare of their existing children is often a key factor in the decision to end a pregnancy.

It is for these reasons that women still present later in countries where early abortion is very easily accessible, such as the Netherlands. In a legal landscape where logistical barriers to early abortion have largely been removed – women can access abortion pills conveniently and cheaply – later abortions have not disappeared. A study of women's reasons for needing later abortions in the Netherlands found that their reasons were remarkably similar to those discussed in this report, particularly relationship problems, a young age, or difficulties recognising the pregnancy.[21]

Every individual woman's need for and experience of later abortion is unique, and the circumstances are different in each case. The British Pregnancy Advisory Service is committed to ensuring each and every woman can access abortion services to the full extent of the law: as early as possible, as late as necessary.

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