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Why Women Seek Abortions after 24 Weeks of Pregnancy

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Public opinion consensus is in support of safe and legal abortion in the United States, and that consensus has remained relatively unchanged since *Roe v. Wade* was decided. Support wanes, however, as the gestational age of the pregnancy increases. This likely owes, at least in part, to pervasive myths and misunderstandings about later abortion. The often hostile media and public discourse treatment of people who have obtained abortions later in pregnancy contributes to a dearth of public accounts of women's experiences of later abortion that could otherwise serve to dispel misleading narratives.

Two Common Pathways to Later Abortion

To remedy this gap and to contribute to public, clinical, and research understandings of women's experiences of later abortion, I interviewed 28 women who obtained an abortion after the 24th week of pregnancy. I find two common pathways through which women find themselves seeking a later abortion:

A woman learned a piece of information that made her—always in consultation with her husband/boyfriend and other loved ones—realize this was not, or was no longer, a pregnancy she wanted to carry to term.

The information that catalyzed her decision pertained to the pregnancy itself: typically a serious health problem with the fetus. Crucially, this pivotal information was not available earlier in her pregnancy. Sometimes this was because the problem itself simply was not evident until this later point in pregnancy. This happened with a respondent for whom every test and scan showed that her pregnancy was entirely healthy until a routine ultrasound scan at 28 weeks revealed an emergent—and serious—fetal development problem. Sometimes this information was apparent only later in pregnancy because the severity of the problem was not clear until this later point of development, and there had been a chance that an earlier identified problem would resolve as the pregnancy progressed. This happened with a respondent whose routine ultrasound scan at 20 weeks' gestation identified a fetal development anomaly that her doctor predicted had a 70% chance of fully resolving. Hopeful and reasonably playing her odds, she continued her pregnancy only to learn at her 28-week follow-up ultrasound scan that, not only had the anomaly failed to resolve, it was now identifiable as severe, with a very poor prognosis.

After deciding they did not want to continue the pregnancy, my respondents found themselves entangled in state laws that required unobtainably precise diagnoses in order for them to proceed with their plans. Sometimes, although physicians could identify a clear fetal development problem, they had no explanation for it. In states that only allow later abortions for a narrow category of fetal health problems, the lack of explanation meant these women were ineligible for an abortion in their home state. Other times, certainty of severe anomalies was combined with medical uncertainty as to whether a health issue would result in death before delivery or after. Unable—or sometimes unwilling—to certify the anomaly as lethal, respondents' physicians could not legally perform a later abortion under their state law. The inherent medical uncertainty in prognosis means this in not just a question of getting more or better data.

A woman had already determined she wanted an abortion before her 24th week of pregnancy, but faced significant obstacles to obtaining care and thus was pushed past the gestational limit for her home state.

Women on this second pathway were often low income and faced difficulties paying for abortion because their state-administered public insurance banned coverage of abortion care. Others, including women located in more rural areas, faced difficulty finding and getting to a provider because of state policies that have reduced the number of clinics near them. Some were simultaneously navigating challenges not directly related

to their pregnancy such as homelessness and domestic abuse by a partner or their parents.

For instance, one respondent discovered her pregnancy in the first trimester and knew right away that it was not the right time for her to have a baby. But she couldn't afford the out-of-pocket cost for an abortion nor the time away from her college classes to travel an hour each way, twice (because of her state's two-visit requirement), to get to the nearest provider. She and her boyfriend started saving money and planned for her to seek an abortion in her hometown during the next school break. Once home, however, her emotionally-manipulative mother, angry that her boyfriend was of a different race than she, confined her to the house. By the time she returned to school and secured transportation to an abortion provider, she was over her state's gestational limit.

Each woman I interviewed had a unique story, with a common thread: **all were subject to blunt and unsympathetic laws regulating abortion that forced them to travel out of state for their care**. Although hospitals throughout the country selectively provide later abortions to their patients, there are only three clinics in the U.S. publicly known to provide abortions after the 24th week of pregnancy; travel to these three clinics for women seeking later abortions can be prohibitively expensive and entail further burdens such as securing childcare and time off from work. Many women who decide to have a later abortion navigate these obstacles while undergoing the emotional toll of publicly existing in a visibly pregnant body, prompting co-workers, acquaintances, and even strangers to offer congratulations, ask about their due dates, and touch their bellies.

Restrictive State Policies Affect Women on Both Pathways

Even as these two different paths described the experiences of the women I interviewed, there is no bright line between them. To learn about the health of the fetus, a woman has to have adequate—and sometimes exceptional—prenatal care. She typically has to undergo several ultrasound scans, have blood work and an amniocentesis, and sometimes even have an fMRI. She has to meet with specialists. For people with no health care or inadequate health care, these necessary steps to obtain a fetal health diagnosis are unavailable. Some respondents were told by their ob-gyns that, based on their medical history, there were likely fetal development issues, but declined to pursue additional testing. They explained that to me they already had enough information to know they did not want to continue the pregnancy, could not afford the cost of more testing, and did not want to delay their abortion.

These data demonstrate how laws that allow later abortion only under limited circumstances fail to ensure women's bodily and decisional autonomy. Specifically, they fail to ensure access to abortion for myriad instances where there are severe fetal anomalies. Especially given medical uncertainty and the ever-present possibility of unexplainable fetal health abnormalities, the law is ill-equipped to codify distinctions between valid and invalid justifications for a later abortion.

Additionally, in concert with the ever-growing spate of other restrictions on abortion, laws restricting later abortion disproportionately punish already socially- and economically-vulnerable women who wanted an abortion earlier in pregnancy but could not overcome barriers to care.

These data, drawn from women's real experiences of seeking and obtaining an abortion after 24 weeks, can challenge the prevalent myths and misunderstandings about third trimester abortion patients.