

Access to and Experience of Later Abortion: Accounts from Women in Scotland

CONTEXT: Except in the presence of significant medical indications, the legal limit for abortion in Great Britain is 24 weeks' gestation. Nevertheless, abortion for nonmedical reasons is not usually provided in Scotland after 18–20 weeks, meaning women have to travel to England for the procedure.

METHODS: In-depth interviews were conducted with 23 women presenting for "later" abortions (i.e., at 16 or more weeks' gestation) in Scotland. Participants were women who sought an abortion at a participating National Health Service clinic between January and July 2013. Interviews addressed reasons for and consequences of later presentation, as well as women's experiences of abortion. Thematic analysis attended to emerging issues and employed the conceptual tool of candidacy.

RESULTS: Delayed recognition of pregnancy, changed life circumstances and conflicting candidacies for motherhood and having an abortion were common reasons for women's presentation for later abortion. Women perceived that the resources required to travel to England for a later abortion were potential barriers to access, and felt that such travel was distressing and stigmatizing. Participants who continued their pregnancy did so after learning they were at a later gestational age than expected or after receiving assurances of support from partners, friends or family.

CONCLUSIONS: Reasons for seeking later abortion are complex and varied among women in Scotland, and suggest that reducing barriers to access and improving local provision of such abortions are a necessity. The candidacy framework allows for a fuller understanding of the difficulties involved in obtaining abortions.

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Timely access to safe abortion remains a global health concern, as an estimated 21.6 million unsafe abortions and 47,000 abortion-related deaths occur worldwide each year.¹ The global decline in abortion rates has stalled, and the rate of unsafe abortions is increasing.² In Ireland, although legislation has passed to ensure access to abortion when a woman's life is in danger, most women still have to travel outside the country for the procedure and thus face added physical, financial and emotional burdens.³ In the United States, increasingly restrictive laws are being passed to limit access to abortion.^{4–6} Even where abortion law is relatively liberal, as in Great Britain, significant barriers to access persist.

Women who seek abortions in the second trimester of pregnancy may encounter particular difficulties. Reasons for presenting in the second trimester are manifold, and may be woman-related or service-related,⁷ including delays in recognizing pregnancy, denial, ambivalence, concerns about the procedure, uncertainty regarding service entitlements, changes in life circumstances, limited financial resources, delayed referral for abortion and waiting for appointments.^{7–13} The need to travel to an abortion provider has been identified as a barrier to access and source of additional delay.^{6,14–16} Each year, thousands of women are estimated to travel from Ireland to other European Union countries for abortion;³ in the United States, half of women of reproductive age live in states described as hostile to

abortion rights,⁵ which increases the likelihood that they may have to travel substantial distances to access services.¹⁴

In Scotland, abortion provision after 18 weeks is subject to significant limitations. We conducted a qualitative study to examine women's experiences of seeking later abortion, including their experience of traveling to England.

ABORTION IN GREAT BRITAIN

Abortion is permitted in Great Britain under the Abortion Act 1967, and is legal to term to save a woman's life, when her physical or mental health is in grave danger and in the case of severe fetal anomaly. Ground C of the act—the legal basis for the majority of abortions—allows for an abortion up to 24 weeks' gestation for psychosocial indications (i.e., when two doctors certify that "continuance of the pregnancy would involve [greater risk] of injury to the physical or mental health of the pregnant woman" than would termination of the pregnancy). Abortion is available through the publicly funded National Health Service (NHS). In 2012, the abortion rate was 16.5 procedures per 1,000 resident women aged 15–44 in England and Wales,¹⁷ and 12.0 per 1,000 in Scotland.¹⁸

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While the majority of abortions in Scotland occur before nine weeks' gestation (70% of 12,447 procedures in 2012), a low but consistent number are obtained at 18 or more weeks (160 in 2012, of which 81 were for medical indications).¹⁸ Although legally permissible, abortion is not usually provided under Ground C in Scotland after 18–20 weeks. Gestational limits vary among the 14 geographic NHS boards* responsible for provision, but the reasons for this are unclear. The specialized surgical service of dilation and evacuation for later abortion is not currently provided in Scotland. All maternity units have the expertise to provide medication abortion at this stage. However, later abortions under Ground C are usually provided at hospital gynecology (rather than maternity) departments, and so medication abortion is not currently offered to women having Ground C terminations. Research suggests that medical providers may have some distaste for offering later abortions, and that senior health service management does not support such procedures.¹⁹

Women who request a Ground C termination after 18–20 weeks must travel to England (usually London) to obtain the abortion in a not-for-profit clinic; this can entail a round-trip of 800–1,400 miles. While the procedure itself is usually funded by the woman's local NHS board, individuals may have to pay for their own travel and accommodation. In most circumstances, expenses may be reimbursed, but this additional support is assessed case by case, can be claimed only retrospectively and requires completion of a significant amount of paperwork.

THE CURRENT STUDY

Our analysis offers a novel illustration of a situation in which abortion is legally permitted, but women face substantial barriers to access when seeking a later abortion. To explore these experiences, we use the concept of candidacy, conceptualized as a “dynamic and contingent process”²⁰ through which women's eligibility for abortion services is constructed and negotiated in interactions between women, health care professionals and health service organizations.^{20–22} We also consider women's efforts to assert their candidacy for abortion services. This study builds on existing research to offer a holistic analysis comprising the perspectives of those who have used local services, traveled to obtain services or decided to carry their pregnancy to term.

It is valuable to consider the identification of candidacy for abortion in the context of social norms, particularly regarding the impact of stigma on access. In more general terms, individuals might experience symptoms and immediately

assert their candidacy for a medical condition or treatment with their general practitioner. In some circumstances, however, candidacy is less likely to be asserted because individuals may be less able to identify it, may be less likely to visit a health care provider or may view candidacy as undesirable because of associated stigma.²² These issues are particularly relevant to pregnancy and abortion. Significant effort is required for individuals to assert their candidacy for pregnancy or abortion services, especially in relation to obtaining a later abortion, a service that is subject to social and moral sanctions. In light of such sanctions, it is all the more essential to better understand barriers to abortion access. Moreover, candidacy may be positive, negative or plural: Multiple candidacies²¹—for example, for later abortion and motherhood—may conflict and, crucially, further complicate the route to accessing services.

By adapting the process conceptualized in candidacy research,^{20–22} and mapping this onto the “pathway to abortion,”¹⁸ we identified four key stages in the candidacy for obtaining a later abortion: identifying candidacy for pregnancy; considering options; identifying candidacy for later abortion; and navigating services. The three possible outcomes of this process are having an abortion locally, traveling to England for the procedure and continuing the pregnancy. The use of these stages in thematic data analysis enabled us to address women's experiences of later abortion as primarily an issue of access (whether equitable or inequitable). As a sensitizing concept in our examination of women's presentation for and navigation of abortion services, candidacy has aided our analysis of how cultural and organizational constraints create barriers to access, and helped in the identification of ways to improve abortion care in Scotland.

METHODS

In-depth interviews were conducted with 23 women presenting for later abortion (i.e., at 16 or more weeks of gestational age) in Scotland. Participants constituted a convenience sample, and were recruited between January and July 2013 by specialist nurses from among all women presenting at 16 or more weeks' gestation at clinics of five NHS boards. This gestational length was selected because 16 weeks had been the upper limit for three of the participating boards until 2012. Recruitment criteria excluded females who were younger than 16, who spoke insufficient English to participate in an interview or who were overly distressed when attending services. The five NHS boards—Ayrshire and Arran, Greater Glasgow and Clyde, Grampian, Highland, and Lothian—were selected to give a range of urban and rural experiences, and because they were expected to see approximately two-thirds of women traveling to England for a later abortion (the number of which is unknown, but is estimated at 20 for the recruitment period).†

Recruiting nurses gave potential participants written information and explained the study; written informed consent was obtained, and contact details were passed to

*The term “NHS board” refers to both a geographic area and the medical body responsible for the management and delivery of health care services.

†As a complement to this study, we conducted a prospective audit of all women presenting at 16 or more weeks' gestation at participating NHS boards. Audit findings show that of the 83 women who presented for later abortion in the recruitment period, 25 decided to continue their pregnancies.

the research team. Individual interviews were conducted 3–4 weeks after women's abortions—or following presentation at health services for those continuing their pregnancy—and lasted 35–110 minutes. All interviews were conducted by the first author and were semistructured. Interviews began with the following request: “Tell me about when you first suspected you were pregnant.” The interviewer then followed the lead of the woman and used a topic guide to elicit information on areas of interest.²³ Ethical approval was obtained from the West of Scotland NHS Research Ethics Committee 4.

Of the 23 women interviewed (representing one-quarter of those presenting at 16 or more weeks' gestation at participating sites during the recruitment period), 13 had an abortion locally, five traveled to England for the procedure and five continued the pregnancy. Four abortions (all in England) were surgical, and the others were medication abortions. Participants' ages ranged from 17 to 39; 11 women had at least one child, and two had previously had an abortion. Interviews were audio-recorded, transcribed verbatim and anonymized, and interviewees were assigned pseudonyms. Data were analyzed thematically using NVivo 10. We employed initial coding to explore emerging issues while data collection was ongoing, and focused coding to link initial themes to the process of recognizing candidacy for later abortion.²⁴ The first author performed the coding in consultation with the last author.

RESULTS

Identifying as a Candidate for Pregnancy

To identify as candidates for abortion, women first had to identify as candidates for pregnancy, and this step led to significant delay for many participants. Reasons for identifying candidacy for pregnancy and for abortion (or for not doing so) were complex, manifold and context-specific, echoing findings from England, the United States and elsewhere.^{9,13} Some women who were not expecting a pregnancy did not recognize potential signs that, in hindsight, could have been attributed to being pregnant. For many, however, typical physical signs of pregnancy (e.g., nausea, weight gain) were absent, and some reported monthly bleeding that they attributed to menses, leading them to believe they were not pregnant. Thirty-year-old Chloe, who had an abortion locally at 16 weeks, had not believed that she was pregnant because of the absence of signs: “I've had my periods all the way through, for 16 weeks. I never had morning sickness. I had nothing. Never put on weight.” Furthermore, women who had menstrual problems could not assume that their amenorrhea was a sign of pregnancy. In addition, several participants had recently given birth—seven within the preceding eight months—which contributed to their not expecting to be pregnant and to a disguising of physical signs.

Contraceptive use also contributed to participants' not expecting pregnancy. Fourteen women reported using a contraceptive when they got pregnant, and many were unclear about why it had failed. For example, 19-year-old

Vivienne—who had an abortion in England at 21 weeks—said she “just thought that condoms would be enough”; moreover, she and her boyfriend “hadn't even [had sex] a lot,” and she had not suspected condom failure. Some women who had used hormonal contraceptives acknowledged that they had not been in a “routine” of taking the pill regularly, and others believed that an interaction between antibiotics and the pill left them unprotected. Although evidence has shown little or no such interaction—and clinical guidelines have changed in this respect²⁵—this information does not appear to have filtered down to these women.

While most participants eventually recognized their pregnancy themselves, four had their candidacy identified by parents, partners or friends. The pregnancies of six women were identified only by a health professional, when the women presented with symptoms of “illness,” as was the case for Tia, a 20-year-old who had an abortion locally at 16 weeks:

“It was just so sore.... It was just this tiny wee bit here [tummy], and it was rock solid.... And even when I went to the doctor, she was going to test me for cancerous cells and whatnot 'cause she couldn't feel any form of a baby.”

For women in this position, there was an element of shock that their symptoms could be attributed to pregnancy.

Considering Options

Several interrelated factors created delay at the next stage in the process. Fourteen participants were ambivalent about both the pregnancy and the prospect of having an abortion. They found candidacy for abortion difficult to commit to, in some cases because it conflicted with their candidacy for motherhood, as was the case for 31-year-old Beth, who had an abortion locally at 17 weeks:

“One minute I was keeping it, even if I had to bring it up on my own, and the next minute I wasn't, and I just could not make my mind up. It was really, it was hard.”

The delay in asserting candidacy for services was also linked to fear of others' reactions. This fear was a factor in the delay that 17-year-old Melissa—who had an abortion locally—experienced between discovering her pregnancy at around four weeks and terminating at 18:

“I really didn't know how to handle it, I was just so confused, like, ‘What do I do?’ ... I was just so scared,... I just didn't want [my mother] to be disappointed.”

Three women suggested that denial played a part in the delay in accessing services, although they were in the minority and said this was not the sole factor. Paula—who was 37 and had an abortion locally at 17 weeks—said that she had had a “concealed pregnancy” when she had her first child at age 19, and that it had “messed things up a wee bit in [my] head.” She said she had recognized her second and third pregnancies only in the later stages. This time, she had suspected she was pregnant at around six weeks and quickly identified as a candidate for abortion. Nevertheless, she had difficulty getting to services:

“Different things kept happening.... The kids all had about four flus, one after the other. There was no way I could go anywhere.... And I'm terrible for important

things. Just ‘Oh, forget it, I’ll deal with it later,’ you know? And I think probably using excuses not to deal with it.”

Orla, who was 20 and had an abortion locally at 17 weeks, explained that she had “compartmentalized” her thinking, in part from fear of the procedure, which she had been through before:

“I think that was where the emotional block was, actually going and admitting it, and going through the procedure, because last time was fairly traumatic, and it was uncomfortable and painful, and I was upset and alone.... Having to go and do it again was hard, so putting it off was easier.”

**[Participants’
stories]
illustrate
the complex
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Identifying as a Candidate for Abortion

Some women who had initially decided to carry their pregnancies to term experienced changes in life circumstances that were largely beyond their control, and the subsequent decision to have an abortion led to later presentation for health services. Four participants had initially planned to continue their pregnancies, but changed their minds when the men they had conceived with lost interest. For example, having first planned to continue her pregnancy, 17-year-old Yvonne—who terminated locally at 19 weeks—discovered that her partner had subsequently conceived with two other young women. This development, combined with the fact that she did not want to raise her child as a single mother, led her to reassess her decision: “I thought I can’t have this [child] being brought up with a dad like that.”

In some instances, women who had initially planned to continue a pregnancy had their candidacy for abortion identified by a third party, including partners and, in one case, a health visitor (a community nurse who works primarily with mothers and infants). Leila, who was 33 and terminated in England at 20 weeks, was keen to continue her pregnancy, but felt guided toward having an abortion when her health visitor pointed out that as a result of child protection concerns regarding her two-year-old, government social services would become involved with a new baby. Leila felt that this was more than she and her partner could cope with, and that her only option was an abortion.

In the case of 21-year-old Emma, her partner influenced the decision to obtain an abortion. Although he was initially supportive of having a baby, he eventually decided that he did not want the pregnancy to continue. Emma was past the 12-week gestational limit of the country in which she was living when her pregnancy was confirmed, but her partner pursued abortion options in Scotland and convinced her to return there for the termination. With only a few days in Scotland, Emma had to make the final decision while at the hospital, and underwent the procedure at 17 weeks:

“He was like, ‘If you want, you can have your baby in Scotland, but I can’t. I don’t know if my family will accept it.... I can come and visit you, or maybe I can come back later.’ But that made me feel really scared because I didn’t want to be living on the state’s money, without a boyfriend, completely on my own.”

These examples illustrate the complex situations in which women make reproductive decisions. While the majority of

participants said they experienced relief following the abortion, the decision to terminate a pregnancy weighed heavily upon those whose candidacy for abortion was proposed by others, and conflicted with expectations around their relationships and motherhood.

Changes in women’s life circumstances that occurred shortly before they learned they were pregnant also influenced their decision making. Five women were no longer in a relationship with the prospective father, and three of these women were in new relationships. Being tied to ex-partners was a significant concern. Fiona—who was 28 and had an abortion locally at 19 weeks—noted, “I didn’t want to resent my child, you know? I would love to have a family, but I want to be happy when I find out I’m pregnant.” Her comment reflects a normative expectation shaping her idea of candidacy for motherhood—namely, that a pregnancy should be planned and should occur within an ongoing relationship. Further reasons for identifying candidacy for abortion related primarily to a woman’s not identifying as a candidate for motherhood at that time. Indeed, several women felt that they were “not ready” or “too young,” although none ruled out childbearing altogether.

A key reason for seeking termination among women with children was a concern for the well-being of their family, including the financial impact. Paula had an abortion locally at 17 weeks because, at 37, she felt she was getting too old to “do it again.” She also worried that supporting another baby would conflict with her and her partner’s ability to provide for their three children. Because her eldest was about to leave for college and her middle child was attending daily after-school activities, their finances were stretched. As Paula described her situation, she “just couldn’t [have another]: not mentally or financially or anything.”

Participants’ concerns about family and being “ready” echo findings from other research on reasons for seeking abortion at any gestational age.⁹⁻¹⁵ We also found that these concerns were significant enough to outweigh women’s desire for motherhood, even when health care professionals characterized the abortion as “late,” or when the abortion decision was at odds with women’s sense of themselves (several commented that they had “never thought” they would choose to have an abortion). In general, women described their decision as “doing the right thing” and “taking responsibility.” For younger and older women alike, this characterization reflects normative ideas of appropriate timing for childbearing, and the construction of an “ideal” candidate for motherhood.

Navigating Services

A key component of women’s experience of later abortion is the extent to which they found services to be accessible and “receptive” to their needs. Not all participants knew exactly what services were available to them, and some sought advice or information from friends, from relatives or online before presenting at their general practitioner or community sexual health service. The receptivity of services affected participants’ experiences in two ways.

Some women expected that staff might be unreceptive to their request to have an abortion and therefore delayed their assertion of candidacy. However, only one participant met with any clear objection: A general practitioner advised Yvonne that at 17 weeks, she was “too late” for a termination, as the fetus was “a baby now.” It was more common for general practitioners to appear “confused” or “unclear” regarding the gestational limit of their NHS board, and to initially tell women that the limit was lower than the actual case, before having to seek clarification from their local abortion service. Of participants who knew at the time of the interview that travel to England might be necessary for women after 18 weeks’ gestation (three were not aware), none had known this when initially asserting their candidacy for abortion.

Once women requested an abortion and were referred to specialist services, delays were uncommon, and most participants were satisfied in this respect. Abortion services were largely receptive, and women appreciated staff’s being “comforting,” “reassuring” and “there for” them. Only two women experienced any substantial delay (of a week or more). In one case, a missed appointment because of illness resulted in delay. In the other, Natalie—who was 22 and eventually had an abortion in England at 21 weeks—experienced both personal and service-related problems that caused her to pass the local gestational limit:

“[The general practitioner] booked me in, and I went to a clinic, and then it just took so long. I found out when I was 13 weeks, and it took three weeks for me to get an appointment [for abortion]. So, that was making me 16 weeks, and then I missed the appointment and thought it was the following week.... I had to go back to the doctor [and wait to be referred] again. And now I’m just back from [England].”

While the specific reasons for the delays Natalie faced are unknown, it appears that the referral procedure was unclear, and that delays resulted in her having to travel to England for the abortion.

Outcomes of the Candidacy Process

The majority of participants (13 of 23) had an abortion locally. For some, a consequence of later presentation at health services was an emotionally and physically challenging experience of the procedure, although not all women said their experience was traumatic. For others, a key concern was avoiding having to travel to England, and learning how close they were to local gestational limits added urgency to their decision to have an abortion and to the referral process. Many women perceived that the travel and accommodation costs of going to England would be prohibitive, and for several, such a trip would have necessitated their telling more people than they wanted to. Furthermore, the prospect of traveling to a distant and unfamiliar place was off-putting, and would mean they would be at an even later gestation. Fiona commented:

“If [traveling to England] was gonna be my only option, I think I’d be having a baby just now.... The thought of having to go to a strange place for something like that,... and

those weeks just past [20], it’s really like a proper baby.... I just don’t think I could do it.”

Women who did travel to England had to mobilize a range of resources, including financial, practical and emotional support, and access to these varied. Travel costs—train tickets or flights and 2–3 nights’ accommodation, booked at short notice—were high. The women who traveled were in a range of socioeconomic positions, but none found it easy to obtain such funds, and none was clear on how to claim reimbursement from health services. Una—who was 24 and had an abortion at 21 weeks—had been able to fund a trip to England, but she was informed while en route that because of a health complication, she could not have the procedure at that time. This necessitated her returning home (a 17-hour round-trip) and rebooking travel and accommodation for the following week. Without disclosing what the money was for, Una was forced to ask her father for help:

“The first week was fine ‘cause I had [the money]. But the second week I was like ‘Oh, shit.’ So I ended up just saying ‘I went and bought something for the house, can you help me out?’ I don’t ever ask my dad for money.... He would always say yes, but that’s not the point.... I hate asking people for money.”

For women who were employed, another difficulty was taking time off work. Irregular work patterns and low-autonomy positions left some women unsure of their rights to sick pay, and the need to explain their absence to managers or colleagues was magnified for those who had to travel, since they had to account for a potentially longer absence.

In addition, women who traveled to England for an abortion were aware that services were less available in Scotland, and felt there was judgment implicit in this disparity. Vivienne was aware of and perplexed by the fact that if a fetal anomaly had been detected, she could have been treated within five miles of home, rather than several hundred miles away. Rachel, who was 29 when she obtained an abortion in England at 21 weeks, noted that women having later miscarriages were treated locally:

“Women [who] unfortunately have a miscarriage at that stage, they’re not being sent [to England] to have a baby removed. So it’s not really a huge difference.... Having to travel that far just to have a termination because they don’t do it in Scotland—it’s not fair. And the people [who] make that decision, they’re not really thinking about ... the physical and mental situation that woman’s going through.”

Thus, for the women we interviewed who had traveled to England, obtaining an abortion required significant additional emotional and physical effort. The need to travel exacerbated an already unpleasant and stressful experience, and contributed to a sense of stigmatization and discrimination, because they were aware of being treated differently than others.

Five participants had decided to continue their pregnancy, primarily because of gestational age and the social support available to them. On discovering that their pregnancies were more advanced than expected, most felt that

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abortion was not a viable option. Some had considered termination because they already had a child younger than one and worried about coping with two young children. In contrast, Holly—our eldest participant, who continued her pregnancy—felt that at 39, this might be her “only chance” to have a child, and that while she was not in a relationship with the man with whom she had conceived, she had the support of friends:

“[My friend] said, ‘You can’t terminate. We all have kids, so you better have that kid.’ ... If maybe I was on my own, maybe I could have considered a termination, yeah. If I didn’t have, like, anyone to talk to or maybe I didn’t trust my friends.”

In part because Holly’s peer group strongly favored her continuing the pregnancy, her ambivalence dissipated, and between the medical confirmation of her pregnancy and her clinic appointment, she decided against an abortion. Hence, the combination of later gestational age and reassurances of support from significant others led some women to reject their candidacy for abortion.

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DISCUSSION

This article represents the first exploration of women’s experiences of later abortion in Scotland, and the application of a candidacy framework contributed to our understanding of several key issues. While some of our findings regarding women’s reasons for having or not having an abortion echo those from existing research on later abortion, the present analysis reveals the difficulties associated with asserting candidacy for later abortion, and with having to travel to obtain the procedure. Our findings are original in presenting an account of a context in which abortion is legally permissible but restricted by varying local gestational limits, and in highlighting that conflicts among multiple candidacies may result in delay at different stages of the process. Interpreting these women’s experiences of later abortion from the perspective of candidacy frames the process as an issue of inequitable access to a health care service.

Our data suggest that two key reasons why assertion of candidacy for pregnancy or abortion is delayed are that typical signs of pregnancy are absent and that pregnancy was not expected. That these are common reasons in other contexts^{7–10} suggests that an appropriate approach to reducing the incidence of later abortion may be effective intervention to improve the earlier recognition of pregnancy,¹² including raising awareness that typical pregnancy signs may not always be present. How this might be achieved requires further research, but might involve, for example, improvements in sex education or an appropriate public health social media campaign.

Another significant source of delay was changed life circumstances after the pregnancy was confirmed.^{26,27} For several women who were no longer in the same relationship when the pregnancy was discovered, the absence of the partner or his unsuitability as a parent was a factor in the decision to have an abortion, as was the rejection of ties with him. Together, later recognition of pregnancy and the

need to give women time to consider their options highlight why the provision of accessible later abortion services is an ongoing necessity. Moreover, women’s formulation of candidacy for abortion or motherhood is shaped not just by individual circumstances or in relation to significant others, but also by prevailing social norms. That most of the women we interviewed identified as candidates for later abortion despite the difficulties they faced in obtaining one speaks to the strength of norms relating to “appropriate” childbearing (i.e., who should have a child and when), as much as to the reproductive choices available to them.

The candidacy lens also allowed for detailed examination of women’s experiences of navigating abortion services. Most participants found specialist services to be receptive to their needs, and experiences of referral were largely positive. While the overall picture may compare favorably with that in other countries, women did identify some problems in their interactions with general practitioners. If general practitioners, who are gatekeepers to further NHS services, are unsure or uninformed about local gestational limits, they may misinform women about their eligibility for abortion or the need to travel to England for the procedure; such misinformation could cause some women to proceed with an unwanted pregnancy. Similar issues regarding access to information on abortion have been raised elsewhere.^{3,28} Given that lack of clarity about which services practitioners may lawfully provide or advise on is a known barrier to the provision of safe abortion,³ it is essential that the information made available to and by frontline practitioners be unambiguous, accurate and accessible. Indeed, our study may understate this problem, since participants who were continuing their pregnancy may not be representative of this group in general. Participants who decided against having an abortion upon learning of the later stage of their pregnancies also felt they had sufficient financial and emotional resources to have a child.

Of the women in our study who had later abortions locally, some described the process as very distressing, particularly those whose candidacy for abortion was identified by a third party; this finding suggests that women need to feel in control of their reproductive decisions.²⁶ Others spoke pragmatically about their experience, and the majority of participants felt relief following the abortion.

The key issue that the candidacy framework foregrounds is that it takes a significant amount of effort (and thus agency) for a woman to assert herself as a candidate for later abortion, and to stay committed to that decision. Women are presented with challenges to their candidacy, in some instances by health care professionals, and to a greater extent (in this context) by a health care system that requires them to travel a significant distance to obtain a later abortion. Existing research highlights “frequent ambivalence” among women having later abortions,⁷ and adding a complication at this stage further disadvantages women in this position. The Scottish example differs from the U.S. context in that women do not have to identify a specific provider who will perform a later abortion. Although such procedures may not

be available from a woman's local NHS board, she will be referred to a specialist clinic. However, the situation is similar to that in the United States and elsewhere in that women have to do a considerable amount of additional work, and draw on a substantial range of resources, to achieve the desired outcome. Our findings suggest that this may be more than some women feel able to manage when they are in an already difficult and complex position. Obtaining sufficient financial resources to travel on short notice was an uncomfortable prospect for most, and could be off-putting to other women seeking later abortion services. Moreover, while women traveling from Scotland to England are usually entitled to have their expenses reimbursed, this requires completion of considerable paperwork, and none of our interviewees knew how to make this claim.

Unlike women in other contexts who are forced to travel for an abortion, women from Scotland must do so not because later abortion is prohibited; nor do they generally experience the "cycle of increasing cost and delay" found in the United States.⁴ Rather, the women we interviewed faced travel solely because they presented later (largely, as we have shown, for unavoidable reasons), and because local gestational limits with unclear justifications precluded local treatment. As in other contexts in which such travel is necessary,^{3,4,14,16} these women felt stigmatized and discouraged by this prospect. The significant resources required, and the potential need to make the abortion known to more people than they might want to, made the experience all the more difficult. Women in this position are forced into a catch-22, in that the stigma of abortion not only creates a need for secrecy, but also leads to restrictions on provision that force disclosure, the prospect of which may result in some women's continuing pregnancies with which they cannot cope or that they do not want.

Limitations

This study involved a self-selected sample, as it includes only those who felt able or willing to take part at the time of recruitment. Our ethical approval limited us to three attempts to contact women who had consented to participate, and specified that no messages be left. Despite our informing women of the study's cell phone number, it is possible that some did not answer a call from an unrecognized number, or were unable or unwilling to return the call. Given the study's sensitive subject matter, the use of interpreters would be inappropriate, so we were unable to capture the experience of women with limited or no English, for whom navigating services could be significantly more difficult.

Conclusions

Many reasons for later presentation at health services could not have been foreseen by the women we interviewed. Our findings suggest that women need adequate time to consider the conflicting candidacies of motherhood and having an abortion, and that the additional work required to obtain a later abortion is a source of inequity. Indeed, women who

have to travel for an abortion are aware of the differential service provision between themselves and others being treated locally for later miscarriage or fetal anomaly. The burden of traveling to England presents one of the most significant barriers to later abortion for women in Scotland, exacerbates an already potentially difficult experience, and contributes to abortion stigma and discrimination. This study highlights that it is not only in countries with restrictive abortion laws that women face barriers to service access. Future efforts to improve health care services should include a policy focus on reducing barriers to abortion access and improving provision of later abortion.

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