"If this can help other people in the future then that would make me happy." :

Lived experiences of termination of pregnancy in Jersey.

February 2024

Centre for Reproductive Research & Communication

https://www.bpas.org/our-cause/centre-for-reproductive-research-communication/

BPAS Centre for Reproductive Research & Communication

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List of acronyms

BPAS: British Pregnancy Advisory Service

CRRC: Centre for Reproductive Research & Communication

EMA: Early Medical Abortion

GoJ: Government of Jersey

GP: General practitioner

NICE: National Institute for Health and Care Excellence

ToP: Termination of Pregnancy

TOPFA: Termination of Pregnancy for Fetal Anomaly

UK: United Kingdom

WHO: World Health Organization

Notes on Terminology

Note that although termination of pregnancy (ToP) has been used throughout this report, abortion is a term widely used in ToP research, clinical practice, and policies. Where relevant, we have used 'abortion' instead of ToP when referencing policy briefings, to reflect the terminology used within them.

We have used the term women/woman throughout this report to reflect the self-ascribed gender of the participants, though it should be noted that non-binary, gender non-confirming and transgender people can also have terminations.

Executive summary

In 2023, Deputy Karen Wilson, Minister for Health and Social Services in Jersey announced a review of their 1997 Termination of Pregnancy Law. To assist the review, The Centre for Reproductive Research & Communication, a team of experts and public health researchers based at the British Pregnancy Advisory Service (BPAS), were commissioned by the Government of Jersey (GoJ) to undertake qualitative interviews with Jersey residents to document the lived experiences of those who have sought or accessed a termination of pregnancy whilst living in Jersey.

The GoJ recruited women through ToP clinics and community organisations in Jersey and social media. Women who agreed to participate were approached by BPAS researchers to arrange and conduct semi-structured interviews. Five women took part and discussed accounts of six ToPs. From the interviews we created two composite narratives, which captured the experiences of accessing ToP on and off-island.

Through the interviews, we also identified eight ‘pinch points’, which included (a) challenges posed by Jersey’s current ToP law, (b) confidentiality, (c) cost of ToP, (d) travelling overseas for ToP care, (e) poor provision of information, (f) stigma and judgement, (g) service capacity and waiting times, and (h) care that did not ‘fit’ with expectations. We use illustrative quotations to describe these themes.

We found that:

- Jersey’s current legal framework for termination, which only permits ToP on the basis of gestational age limits and specified grounds, caused distress to most participants and for some, required travel to receive the appropriate care;
- Participants were concerned about confidentiality within the ToP service, as the service runs only one day a week, and Jersey is a small place where ‘everyone knows everyone’;
- Accurate and transparent information about ToP and the associated costs were challenging for participants to access on the GoJ website;
- Costs associated with ToP were a concern for most participants, and presented barriers to those who were experiencing financial difficulties;
- Participants identified perceived barriers to high quality ToP care within the ToP service, such as inconsistent sensitivity around ToP from health care professionals;
- Many participants expressed gratitude for the health care they received within the service, and felt that health care professionals helped to manage expectations around the ToP experience.

The findings from this report are discussed in the context of existing research and recommendations to support the GoJ in considering revisions to the Jersey 1997 Law and current service delivery.

Background to the report

In 2023, Deputy Karen Wilson, Minister for Health and Social Services in Jersey announced a review of their 1997 Termination of Pregnancy Law. The Minister stated her interest in learning whether Jersey's legislation regarding termination of pregnancy (ToP) reflects current social values, meets the needs of women, and takes account of changes in medical practice. The Centre for Reproductive Research & Communication, based at the British Pregnancy Advisory Service (BPAS), was commissioned by the Government of Jersey (GoJ) to undertake qualitative interviews with Jersey residents who have sought a termination whilst living in Jersey in order to understand the "lived experience" of residents. This findings from this report will form part of the consultation that will inform the review of the law.

About the Centre for Reproductive Research & Communication

Established in 2019, the Centre for Reproductive Research & Communication (CRRC) exists to develop and deliver research that furthers access to evidence-based reproductive healthcare and inform policy, practice, and public discourse. We are situated within the British Pregnancy Advisory Service which is a charity in Britain that provides pregnancy counselling, ToP, contraception, miscarriage management, testing and treatment for sexually transmitted infections, and vasectomy. All members of the research team have extensive experience in qualitative and quantitative research on termination of pregnancy and good research practice. The work of the CRRC is overseen by a steering committee, and research carried out at BPAS is reviewed and approved by BPAS' Research & Ethics Committee, and where applicable, by a Health Research Authority Research Ethics Committee.

The law regarding termination of pregnancy in Jersey

The Termination of Pregnancy Law (Jersey), introduced in 1997, permits ToP on the following grounds:

- where immediately necessary to save the woman's life,
- where necessary to save the woman's life or prevent grave permanent injury to her physical or mental health,
- where the child, if born, would suffer from physical or mental abnormalities as to be seriously disabled, and/or
- where the woman's condition causes her distress.

The 1997 Law permits termination in Jersey with the following gestational limits:

- before the end of the 12th week if the pregnancy is causing the women distress,
- before the end of the 24th week on the grounds of fetal abnormality (where the child, if born, would suffer from physical or mental abnormalities as to be seriously disabled), or
- at any point in pregnancy if necessary to save a women's life or prevent grave permanent injury to her physical or mental health.

According to The Termination of Pregnancy Law (Jersey) 1997 law, it is a criminal offence for someone to have a ToP in Jersey later than the stated gestational limits or outside of the grounds listed above. Both the woman and any person carrying out the termination could be liable for criminal prosecution.

The law also stipulates requirements for two consultations with a medical doctor, 'approved places' where the ToP can take place, and makes provision for the conscientious objection of healthcare professionals (1).

How termination of pregnancy care is provided in Jersey

Terminations are provided at the main hospital in an outpatient clinic that runs on the same day once a week. A referral into the service from a doctor is required, and this is commonly provided by a patient's GP. For medical ToP (i.e., through the use of pills) under 10 weeks of gestation, the first medication (mifepristone) is administered at the hospital, whilst the second medication (misoprostol) is collected from the hospital/pharmacy to self-administer at home 48 hours later. Medical terminations are not available on island for women seeking ToP between 10 weeks to 12 weeks + 6 days gestation, rather these women would be offered a surgical termination, via uterine aspiration. Medical terminations from 13 weeks to 21 weeks 6 days gestation are performed as an in-patient procedure in hospital. Medical terminations after 22 weeks for fetal anomaly require a feticidal procedure before medication administration. These injections are carried out in England followed by induction at the hospital in Jersey. Surgical ToP, is available to women on-island between 7 weeks to 12 weeks + 6 days gestation. Surgical ToP for fetal abnormality after 22 weeks is referred for management in the UK.

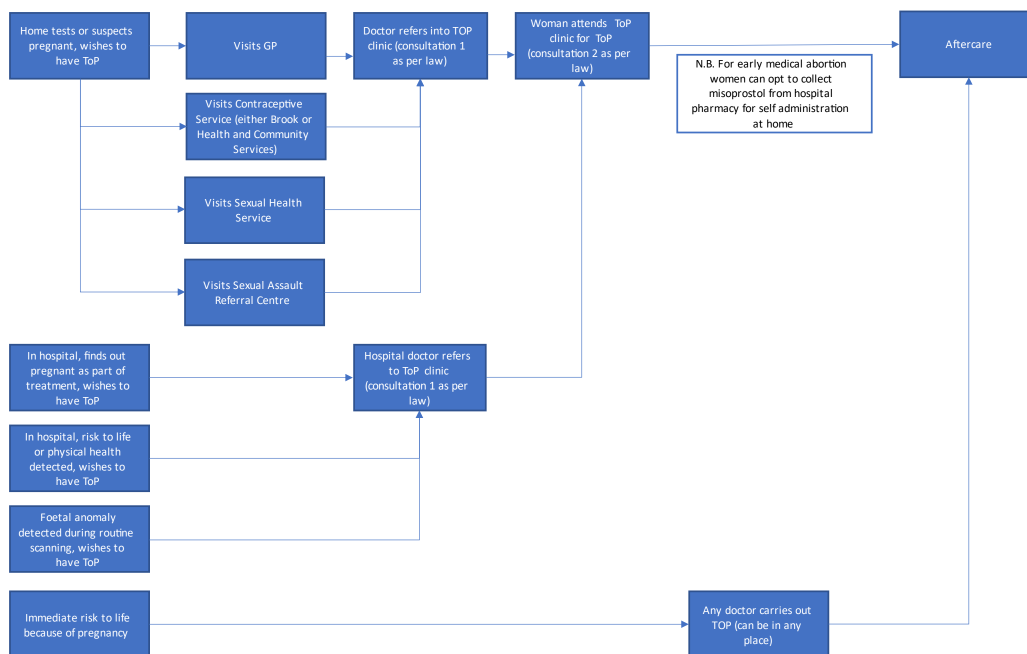

Figure 1. The pathway to accessing ToP care in Jersey. Schematic provided by the Government of Jersey. GP=general practitioner.

Fee Structure

A termination in Jersey costs £185, if the woman is entitled to access Government of Jersey health care or £511 for a woman who is not (e.g., because she has not lived or worked in Jersey for long enough). The charge is the same, regardless of whether the procedure is medical or surgical. The fee can be waived for women under the age of 18 years or in full-time education. It can also be paid by instalments in cases of financial hardship. Terminations provided after 12 weeks' gestation are only legal up to the end of the 24th week in cases of fetal impairment, or at any point if necessary to save the woman's life or prevent grave permanent injury to her physical or mental health. There is generally no charge if terminations are carried out for those indications.

The Jersey General Hospital does not provide all the specialist procedures required for terminations that take place on or after 22 weeks of gestation. In these cases, Jersey General

Hospital will refer the woman to the UK and will fund the procedure and travel. The woman will then return to Jersey General Hospital for aftercare.

A woman seeking a termination on the grounds of distress after the 12-week gestational limit must do so in a jurisdiction with less restrictive limits. This is usually the UK where the gestational limit is up to 23 weeks and 6 days on mental or physical health grounds. Travel to another jurisdiction gives rise to additional costs. A termination in the UK costs approximately £480 - £1,510 depending on the location of care and procedure. The NHS provides free terminations to UK residents, but this does not extend to Jersey residents, so women are required to self-fund procedural costs as well as travel expenses.

Aim

To document the lived experiences of those who have accessed a termination of pregnancy whilst living in Jersey.

Methodology

Study design

We undertook in-depth semi-structured interviews to gather the experiences of those who:

a) Had a ToP in Jersey,
b) Engaged with the formal healthcare system about having a ToP in Jersey,
c) Travelled from Jersey to have a ToP overseas.

We also obtained input from a clinician involved in delivering ToP care in Jersey.

Qualitative research is not intended to generate generalisable findings about a population (2). Instead, it works to understand practices, people, and their perceptions and experiences in more depth than quantitative research allows. It can shed light on 'typical' cases and experiences, but also seeks to understand those at the margins.

Participant selection and recruitment

Eligibility criteria and a recruitment plan were determined with the Government of Jersey. We recruited participants who were 18 years of age or older, residents of Jersey, and who were able to give informed consent. Participants were recruited if they had either (i) a ToP on island, (ii) engaged with the formal healthcare system about having a ToP in Jersey, or (iii) travelled from Jersey to have a ToP overseas. We did not restrict recruitment to a specific gestational age at time of ToP. Initiation of recruitment was led by the Government of Jersey. This consultation work was initially designed to conduct interviews with 20 people across Jersey to capture a wide range of experiences accessing ToP on and off island.

On 20th July 2023, the Government of Jersey posted an initial call for contributions to the consultation on the official Government of Jersey website. To recruit participants, this call was then shared by the Government of Jersey through the following on-island outlets: 1) General media (through a press notice and notes to the media), 2) Social media (Twitter/X, Instagram, Facebook and LinkedIn), 3) advertisements in the local newspaper, 4) posters and leaflets distributed to relevant organisations (for example Health and Community Services clinics that women attend, GP surgeries, counselling and other support services), 5) dissemination of information by various local stakeholder groups, and 6) some Health and Community Services staff actively promoted the consultation during appointments, where relevant and appropriate (for example the termination clinic, the contraceptive service and the women's counselling service).

Potential participants emailed topreview@gov.je to express their interest and provide information to assess against eligibility criteria. A representative of the Government of Jersey then assessed if

the potential participant was eligible. Eligible participants provided consent for their contact details to be shared with the researchers at BPAS/CRRC. A member of the research team then contacted interested participants to arrange an interview. At the time of the interview, the researcher reconfirmed eligibility and obtained informed consent. All subsequent activities and analysis were undertaken by the CRRC at BPAS.

Ethical approval and considerations

As this was considered an evaluation, formal research ethics approval was not sought. A data privacy agreement was established between The Government of Jersey and BPAS prior to the commencement of this work.

Before beginning the interviews, participants were informed of their right to withdraw at any point, and how their data would be used for the purpose of this consultation. Informed consent was sought and obtained verbally from participants after the interviewer provided this information and prior to commencing their interview.

Termination of pregnancy is a common healthcare need. In 2021, Jersey observed a rate of 11.3 terminations per 1000 women aged 15-44 years (3). While the experience can be associated with stigma and the need for support, most women having ToPs are not inherently vulnerably by virtue of seeking this care. Nevertheless, we ensured that participants were not stigmatised through participation in the research itself or made to feel that they should have negative feelings about their ToP. We also ensured that those who wanted emotional support following the interview knew how to access it.

We took extensive steps to protect participant confidentiality. Once transcripts were produced, any possibly identifying information was redacted prior to analysis. Furthermore, participants were given an ID number that was distinct from the Government of Jersey booking ID, so that it would not be possible for the identity nor results from this consultation to be traced back to a single individual. At the beginning of each interview, participants were told that they were entitled to have their consent and data withdrawn from this consultation at any point and were instructed on the process to do so. Finally, for the purposes of the report, participants were allocated a new ID from Participant A to E, known only by the CRRC research team.

Data collection

We conducted semi-structured interviews over the telephone, using a guide developed in collaboration with the Government of Jersey to ensure that the information acquired from the interviews met the aim of this consultation (see **Appendix A**). Interviews were recorded using a dictaphone. During the interviews, we asked participants about where they received their ToP (on or off island), their experience of accessing ToP care services on and off island, and the suitability of the setting and method of ToP.

Data analysis

The audio recordings were transcribed verbatim using a secure, professional transcription service[1]. We then familiarised ourselves with the data by ensuring that both Research and Engagement Lead researchers had read all the transcripts and accompanying field notes.

We used composite narratives to describe the lived experience of women in Jersey accessing ToP care (4). Composite narratives combine several interviews, which are then presented as a story from a single individual. The use of composite narratives protects anonymity whilst also presenting the key issues described by participants. We generated two composite narratives: one

[1] UK Transcription: https://www.uktranscription.com/

of women accessing ToP care on-island and one obtaining ToP off-island. The names used in these composite cases were randomly generated and do not identify any participant in this consultation.

Our analysis of the interview data is informed by previously published work on ToP care trajectories (5), travel for ToP care (6) and patient perceptions of quality in ToP care (7). We drew on this literature to help identify 'pinch points' in the participant testimonies, which we illustrate through supporting participant quotes.

Findings

Between October 2023 and December 2023, 10 participants expressed interest in being involved, 7 responded to an invitation to arrange an interview, and 5 completed interviews, which included accounts of 6 terminations. The participant characteristics are described below. All participants underwent medical terminations of pregnancy, with one also undergoing a surgical ToP, most at 12 weeks of gestation or less. Most participants were recruited through the ToP clinic.

Table 1. Demographic characteristics of interviews participants (N=5).

Participant Characteristic	**Number (%) of participants^**
Age (mean, range)	32 (23-42)
Weeks gestation	
0-10 weeks	4 (67%)
10-12 weeks	0
12-24 weeks	1 (17%)
Unknown*	1 (17%)
Gender	
Female	5 (100%)
Total gross household income** (mean, range)	£85,750 (£28,000-£150,000)
Number of children (mean, range)	0 (0-1)
Number of total pregnancies (mean, range)	2 (1-3)
Number of pregnancy terminations (mean, range)†	1 (1-2)
ToP method	
Medical termination up to 12 weeks' gestation	4 (67%)
Medical termination after 12 weeks' gestation	1 (17%)
Surgical termination	1 (17%)
Birthplace	
Jersey	3 (60%)
Scotland	1 (20%)
England	1 (20%)

*One participant was unable to recall the gestational age at the time of ToP.
**One datapoint missing.
^ Number (%) unless indicated otherwise.
† All terminations took place during the last 5 years, except for one which was approximately 30 years ago.

Composite narratives

The first narrative combines four participants' experiences accessing medical termination at 12 weeks or less on-island, and the second is a composite of two participants' experience of accessing a termination off-island.

Compositive narrative 1- Medical termination of pregnancy on-island

Josephine is a 25-year-old Jersey resident who recently found out she is 7 weeks' pregnant. She just lost her job and does not yet feel mentally or financially ready to be a mother. When she turned to the Government of Jersey website to understand her options for terminating the pregnancy, 'there wasn't any, sort of, like, option to click on, to find out information about termination'. To prepare, Josephine turns to TikTok to get information about what to expect. During her GP appointment, she learns that the ToP will cost £185. Josephine's GP signposts her to social services to receive financial support for her ToP care but she is redirected to many different departments and doesn't feel comfortable telling 'some random person [why she needs the financial assistance] just to help her with £185', especially considering she hadn't told anyone else that she was pregnant.

Logistically, the process of seeking support and referral from her GP is time consuming and stressful. The ToP clinic in Jersey only runs on a Tuesday, and so she must rearrange other commitments to make her appointment. Once at the gynaecology services outpatient department, she experiences a lack of confidentiality, with hospital staff calling out her full name when the doctor is ready to see her. 'Since Jersey is so small, there was a worry that you'd always see someone that you might know.' During her consultation, Josephine doesn't feel well-informed with the full range of ToP options (ie. medical ToP with pills or a surgical). She is offered the first pill to take at the hospital and told to come back two days later to collect the second set of pills.

Josephine experiences heavy bleeding and pain with her termination. She is not adequately consulted on the extent to which she may bleed or experience pain, stating that 'He [her doctor] might have said a bit of cramping pain but he underplayed it'. Whilst she wishes that she was better prepared for this experience, she is satisfied with the aftercare offered. A few weeks after her termination, she receives a call from the clinic to confirm 'she'd done their pregnancy test' and offer 'contraceptive options moving forward'.

Compositive narrative 2 – Termination of pregnancy off-island

Hallie is a 38-year-old lawyer. She is married and has a young child. Hallie and her partner were thrilled to find out that she is pregnant after trying to conceive their second child. However, at the 23-week scan, they are told that their baby has a brain malformation. If she were to continue with the pregnancy, it is likely that the baby would only live until late childhood and would require many healthcare interventions throughout its life.

She and her partner feel confident soon after the diagnosis in their decision to have a termination. Since she is seeking a termination due to fetal impairment, her care is paid for by the hospital, including the termination itself, fetal medicine specialist care in the UK, and transportation to and from the UK. Hallie receives the first part of the termination, feticide, in the UK, before travelling back to Jersey to deliver the fetus. She describes feeling like a 'human coffin' during this time. Though Hallie wants to deliver in Jersey to be around her support system, she finds it difficult delivering on the labour ward. Here, she is ' treated as a woman who was delivering a healthy baby, and so wasn't given all of the pain relief that she could have been given'. This contributes to the emotional distress of the situation.

This experience differed in many ways from her experience of accessing a termination when she was in her late teens. Hallie had just started University and found out that she was pregnant after the gestational limit, at 13 weeks. In addition to the cost of the termination itself, she needed to travel overseas to the UK to access this care. As a student, she couldn't afford the termination herself and so relied on her partner's family to pay for this. Due to fear of stigma and reputation on the small island of Jersey, she didn't tell anyone that she was pregnant and seeking a termination.

Pinch points

We identified the following eight 'pinch points' during participants' termination of pregnancy trajectories. Each of the pinch points is explored in more depth here, supported with quotes from the 5 participants.

1. Challenges posed by Jersey's current termination of pregnancy law
2. Confidentiality
3. Cost of termination
4. Travelling overseas for termination of pregnancy
5. Poor provision of information
6. Stigma and judgement
7. Service capacity and waiting times
8. Care that did not 'fit' with expectations

Challenges posed by Jersey's current termination of pregnancy law.

The constraints of the current legal framework for termination in Jersey caused distress to most [three] participants throughout their pathway, from seeking to obtaining care. The 12-week gestational age limit for termination on the grounds of 'distress' appeared to be well-known by participants and was described as "*one of the very difficult things about living in Jersey*" [Participant A]. She continued, *"sometimes women don't find out until too late to have a termination in Jersey, and that in itself is quite traumatic".* Another participant (D), having been told about the small risk of failure with medical termination, was concerned that she would not have much time to repeat the termination if it was not successful:

"…it was actually a little bit stressful when I got there because they said that sometimes there can be issues with the medical termination and that I was… Because I was almost eight weeks…There's a twelve-week limit…that's why I've got to also do the pregnancy test a month after the termination. So that was my stress because I was just thinking if I turned out to be pregnant now, obviously, I'm past my 12 weeks" [Participant D]

Other aspects of the termination of pregnancy law in Jersey were not as well-known by participants and came as a surprise during the process of seeking care. One participant (E) described how she was "unaware" that termination is not available on request and that she could be refused care:

"I kind of thought it was your- I don't know. From reading the information I saw online, it was sort of like you had to have a reason to have one. Like, you know, you had to have, in my situation, broken up, or something had to have happened. I didn't realise that… the GP could sort of say no, I guess. I had no idea about any of it. Yeah, really unaware." [Participant E]

Confidentiality

All participants we interviewed were concerned about confidentiality. Concerns about Jersey being a *"small place"*, where *"everyone knows everyone"*, and *"if anyone gets a whiff of your business, everybody knows*" foregrounded the experience of seeking and obtaining a termination for all participants. This was compounded by the fact that termination services are delivered in an outpatient unit in the main hospital on the same day each week- *"because it's an outpatient facility, there were quite a few people in there, but I was very aware that, like, Tuesdays are 'the day'."* [Participant E]. One participant described sitting in the waiting room next to a friend of the man with whom she became pregnant:

"Jersey is a very small island. We've got a really small community. So, yes, when I went into the waiting room, I'd already recognised two or three women…I was waiting in the waiting room, again they just… with the whole not being discrete, they literally shout your full name out. At the time, with Jersey being so small, I was sat next to the… well, the guy that I was seeing, obviously it was his baby. But I was sat next to his best friend." [Participant C]

Another participant also saw someone she knew and *"decided to go and sit elsewhere"* [Participant B]. Participants offered several suggestions that they felt would improve their experience and protect their confidentiality. This included shifting termination care from the hospital to primary care, as they felt GPs were more private, and providing care remotely through telemedicine:

"I had to obviously take the first tablet with them, but there was no reason why my GP couldn't have really given me that tablet, and then I just picked up the prescription the next day for the rest, if that makes sense. So, I think a telephone conversation, especially if you're not scanning, would have probably been easier." [Participant E]

Cost of termination of pregnancy

In Jersey, although termination care is provided within a hospital setting, it is not funded in the same way that secondary care is across the island; women are expected to pay for their own ToP out of pocket.

All participants, bar one who had a termination for fetal indications, described cost as a significant source of distress and confusion during their termination care. Two participants had not realised that they were liable for the cost of the termination until they had started the process of accessing care. The cost of £185 for a resident and £511 for a non-resident represents an inconsistency in the way that healthcare is funded in Jersey. One participant explained:

"I didn't realise- I kind of presumed- I mean, to see a GP here, you have to pay, but I kind of presumed that because you're at the hospital, you never really pay to go to the hospital. So yeah, I guess, at first, I was like, "Oh wow. Okay." (Laughter) But you have to just sort of pay it, don't you? There's no option." [Participant E]

The exception to self-funding a ToP is for terminations on the grounds of fetal abnormality or where necessary to save the woman's life or prevent grave permanent injury to her physical or mental health. These terminations are fully funded if they are carried out in Jersey, and if patients are required to travel to the UK mainland for care their costs are covered and transport arranged for them. One participant who had to travel to the UK for a termination for medical reasons described how she felt very well *"looked after".*

One participant we interviewed told us that they felt they had to terminate an unplanned but not necessarily unwanted pregnancy because of financial pressures:

"I don't believe I was offered enough support from an emotional perspective. Equally, I think it was more about the practical support. You know, how can the government help me have this child without feeling scared that I'm going to lose my home?" [Participant B]

The termination itself then posed a cost which she struggled to fund. Another participant described how the process for seeking funding support for the termination was confusing, "*dehumanising*", and felt inappropriate (see pinch point 8). Participant A reflected on how the cost of travelling overseas for care had the potential to impact some women on lower incomes:

''Because many, many people, the reason why they might choose to terminate would be financial, and the fact that you then may need to travel to the UK, pay for hotel accommodation, pay for the flights, all of that is additional cost. And when you think that, okay, it's cheaper than the cost of a child over its lifetime, but some women don't have that money up front, to be able to access that service.'' [Participant A]

Travelling overseas for termination of pregnancy

Some patients seeking a termination of pregnancy in Jersey have to travel overseas to access care. These patients are typically seeking a termination after 12 weeks' gestation or for medical reasons which require specialist services that are unavailable at the hospital in Jersey (i.e., fetal anomaly). One participant described the emotional impact of travelling to the UK for a procedure to induce fetal demise before returning to Jersey for an induction and delivery:

"I guess the way I can describe it is feeling like a human coffin. Because you are carrying around your dead baby, knowing they are dead, knowing that you're going to have to deliver them, and you have no control over when that will be." [Participant A]

This participant also described the physical impact of travelling to the UK for ToP care. Whilst she felt *"looked after"*, and the logistics of her travel were covered by the hospital, she described a long, arduous day of travel:

"I think that the way that you're transported backwards and forwards from the hospital is great. The downside is that, sometimes, with the flight times, you'll have an appointment at 9 o'clock in the morning, and then they'll put you on the 8pm flight back from Southampton, and so it can be a really, really, really long day. But, you know, that's just the logistics of living on an island, I think." [Participant A]

Not everyone travelling from Jersey to the UK or other jurisdictions for a termination of pregnancy will receive assistance from the hospital in Jersey in arranging their care. Patients who have a

pregnancy beyond 12 weeks' gestation seeking a termination on grounds of 'distress' are also required to travel, but do not receive any financial or logistical support to do so. One participant recalled her experience of seeking a previous termination when she was a teenager with few resources and little familial support:

> *"Because my parents didn't know, so I had to end up going a week before starting university, having the termination completely on my own, and then going to start university with absolutely no support or anybody knowing about it… it was harrowing as a 17-year-old to not only try to keep it from my parents but also try to pay the money for the flights, for somewhere to stay, being completely on my own"* [Participant B]

Poor provision of information

Participants reported a lack of easily accessible information on how to access termination of pregnancy in Jersey. One participant said:

> *"And when I was googling how I would even go about having a termination in Jersey, I found that there wasn't any direct path. I had to go to the GP, and that's when they explained what the thing was. It wasn't online. I couldn't find any information about the process online, in Jersey, specifically."* [Participant E]

She went on to state that there was *"loads of information about all these classes that you could go to if you were pregnant, and all the things [to] do if you were going to keep it"*, but no information on the termination process, care pathway, costs, or treatment options on the Government of Jersey website. She explained how she found some information on what to expect during a medical termination on the social media platform TikTok.

Some participants also reported a lack of information regarding the termination process particularly regarding medical termination of pregnancy. One explained:

> *"I think if they just clearly said… Just to say what I would experience and how excruciating it would be. Yes, and just [be] realistic about it."* [Participant C]

Stigma and judgement

Several participants expressed feeling that their care was negatively impacted by the stigma associated with termination of pregnancy. One participant who had a termination for fetal anomaly felt that she was not given adequate pain relief during her delivery and attributed this to the fact she was terminating the pregnancy:

> *"I was concerned about the pain relief options during the delivery, because I had done a lot of research into what could be made available to me. That is one element of care that I don't think was managed well in Jersey, because I think that I was treated as a woman who was delivering a healthy baby, and so I wasn't given all of the pain relief that I could have been given, and that, I think, could've been managed better."* [Participant A]

The same participant described receiving insensitive care when she delivered her deceased fetus in the maternity unit, highlighting a need for additional training on compassionate communication:

> *"I think it's more… maybe more staff training around why people might have a termination, and the context that I was delivering it. It wasn't like I'd just decided, at 22 weeks, I was going to have a termination; there were factors involved that meant that it was a grief-filled process, I guess."* [Participant A]

One participant described how she received much better care during and after her miscarriage than she had during her termination:

"It kind of felt like you had a termination so you don't need love as much, and support and time." [Participant B]

Service capacity and waiting times

Participants reported that service capacity issues and waiting times delayed their termination, caused them to miss work and family events, and generated anxiety during their care. On presenting to the service, one participant was told that she might have to *"wait up to six weeks"* for her termination. The anxiety this induced was compounded by an administrative error by the hospital:

"…so the Jersey Hospital called me and said that they'd had a notification or, I don't know, correspondence to say that I no longer wish to go for the termination. She was like, "Is this correct?" I was like, "No, no, no, I really do." …I don't know if it was an error…but they had something to say that I no longer wanted to go for it. I was like, "No, no, I do"…Then I think she said that they'd be in touch with a date or something... Because in my head, I was like, "Oh, my God, imagine if I just never hear back from them." Because as well, when the doctor originally said that I'd potentially have to wait six weeks, I think she said, in my head I was like, "Is that still…? Is that not going to be too late to have a termination?" So, I didn't really know much about how late you can terminate. But by that point, I would've been almost 12-weeks, I think, so I just thought that was too late." [Participant C]

ToP in Jersey is delivered at an outpatient clinic at the hospital on Tuesdays only. This affords patients very little flexibility to plan their terminations around their work commitments, caring responsibilities, and other aspects of their lives. One participant missed a family wedding to attend her appointment, while another described the potential barriers with trying to schedule her ToP around other commitments:

"So if I wasn't able to, for whatever reason- obviously, I haven't told work, I haven't told friends, so if I had meetings at work, or something, on a Tuesday, it would've been really difficult. I would've basically had to have prolonged it another week, and all that sort of stuff." [Participant E]

Patients seeking terminations in Jersey are required to make multiple visits to the hospital to collect the two different medications used to induce a medical termination. For one participant, this requirement intersected with other service capacity issues, creating further barriers to timely termination care. She described how the hospital had run out of the medication required:

"There was actually no more medication, so they were like, "You'll have to come back tomorrow." So, I had to go back the following day to our hospital pharmacy that was only open at certain times. So, yes, that was something as well. Yes, it just turned into a bit of a farce." [Participant C]

All participants in this study had a medical termination (with one also having had a surgical ToP) but it was unclear from the interviews whether they were offered a choice of method. One participant described being told by clinicians that "because it was quite early that I could just do the medical" [Participant C]. She explained to us how her friend had been concerned that a surgical termination was not an option:

"But I did have a friend who had the surgical and she didn't tell me until afterwards. "I didn't want to tell you," she was like, "that I've had that. The medical option is worse pain-wise and everything." She said, "I didn't want to scare you beforehand."" [Participant C]

Care that did not 'fit' with expectations

All participants, apart from Participant A who had a termination for fetal anomaly, described feeling that receiving termination care in the hospital was unnecessary. The referral pathway via

their GP, and the multiple visits to the outpatient clinic and hospital pharmacy were also described as *"a lot of dotting around"* [Participant E]. Participant D described the appointments she had:

"One with my GP and one with, then, like a sort of… It was a couple of hours where I saw a nurse, a doctor, and then I saw the nurse again, that's where I took the first pill. All I had to do then was go to the pharmacy and get the next set of pills." [Participant D]

Participants suggested that locating ToP care in a GP practice, freestanding clinic, or providing care remotely was preferable to attending hospital as *"it's not nice to have to go in there"* [Participant D].

Participant A, who had a termination for fetal anomaly and delivered on a maternity suite, described being concerned she could be exposed to conscientious objectors during her care:

"I was conscious that not everybody would make the same decision that I would, and that people might have religious beliefs, that would think that what I had done was wrong. And I was conscious that you can't control who your midwife is going to be, and what their beliefs might be. And, obviously, you come into contact with a huge number of different midwives, during a delivery, or at least I did, and, as is the case with a normal delivery, it's luck of the draw." [Participant A]

The same participant needed to attend theatre after her delivery to remove a retained placenta. Here, she experienced insensitive comments from theatre staff:

"I went down to theatre for the placenta removal, there was some- I mean, this could've happened to any bereaved parent, but one of the theatre staff was just treating me like I'd delivered my baby, and so was asking me what I'd had, and what I was going to call it." [Participant A]

Finally, participants who sought financial assistance with their ToP felt it was inappropriate to be discussing their private medical details with staff at Social Security:

"Basically my GP said to go to try the Social Security so I went into the building of it. Immediately, right at the doors where everyone is walking in and walking out, there was someone there to help direct you where to go. I just went, "I need help with my medical bill, I'm unemployed." Immediately, she was like, "Okay, what's the medical…?" and asked me what the medical procedure was. Then she sent me to the wrong stall, wrong place to go for help, which was just then a waste of time because it was something to do with housing… I wasn't telling my family, I'm not going to tell some random person just to help me with £185. So that was really stressful. Then from the time I'd wasted, sort of, going to these wrong people, by the time I was then referred to the right person it was then lunchtime and there was over an hour wait. I was just like, "This is really annoying." I felt pregnancy sickness, I was constantly feeling sick and tired. This is not what I wanted. Really frustrated because- I think the main thing is the woman at the door questioning me about it, there were other people walking in as well. I think it was just very dehumanising." [Participant D]

She went on to say, *"I feel like it would've been a lot easier talking to a nurse or a doctor in the hospital when they went through how to pay there".*

Praise for the termination service in Jersey

The aim of this report was to learn about patients' experiences of seeking and accessing termination of pregnancy in Jersey. Participants described some barriers but also described instances where they felt they were provided with excellent care by the Jersey termination service. One participant described good preparation for the pain and bleeding involved in early medical ToP, and welcomed the 'as-indicated' approach to ultrasound scanning that the service had adopted:

"I presumed that they would do a scan, so I was really apprehensive about, sort of- I know it sounds silly, because it was obviously so small, but seeing it. Seeing the baby would have made it much harder, so I was really thankful that, you know, I didn't have to listen to the heartbeat, I didn't have to see something inside of me, if that makes sense." [Participant E]

GPs play an important role in the termination pathway and act as trusted sources of information and support. This is clearly evidenced by the suggestion of several participants to allow GPs to play a greater role in providing terminations of pregnancy. Finally, the current coordination of care for people who are seeking termination for medical reasons was welcomed by Participant A. She explained, *"it was handled very sensitively, and very smoothly".*

Discussion

Prior to the implementation of the 1997 law, termination of pregnancy in Jersey was deemed a criminal act unless conducted "in good faith" to preserve the pregnant woman's life or when the continuation of the pregnancy would jeopardize the woman's physical or mental well-being. To evade potential prosecution in Jersey, about 300 resident women travelled to England annually to terminate pregnancies. The enactment of the 1997 law marked a significant change, making termination of pregnancy in Jersey accessible under specific circumstances, including gestational age limits, and led to the establishment of corresponding services.

To contribute to a consultation by the Government of Jersey regarding the existing legal framework for pregnancy termination, we conducted interviews with women resident in Jersey who had sought termination services in the region. Our presentation included composite narratives, analyses, and participant quotations, aiming to shed light on the experience of accessing and receiving care. Through this process, we identified obstacles to achieving an optimal termination experience, many of which stemmed from the limitations imposed on service delivery by the current legal framework for termination.

According to the Termination of Pregnancy (Jersey) Law 1997, gestational age limits are stipulated based on the reason for the termination. Up to 12 weeks of gestation, ToP may be performed because of 'distress'. Terminations are generally prohibited after the 12th week, except in cases where the termination is necessary to save the woman's life, prevent serious permanent injury to her physical or mental health, or due to a serious risk of the child suffering from such physical or mental abnormalities as to result in a serious disability upon birth. Beyond the 12-week timeframe, the only recourse for a pregnant woman seeking abortion in Jersey for any other reason is to travel off-Island, typically to the UK.

Gestational age limits and grounds-based abortion laws are not uncommon. However, the World Health Organization (WHO) recommends against laws and other regulations that prohibit termination based on such limits (10). Their systematic review identified a number of negative impacts of such laws (8), including that gestational age limits delay access to care and are associated with increased rates of maternal mortality and poor health outcomes, which disproportionately impact more marginalised women (9,10). Furthermore, the WHO state that a pregnancy can be safely ended at any gestation and therefore recommend against "laws and regulations that prohibit ToP based on gestational age limits" (8).

Regarding grounds-based approaches to abortion provision, the WHO similarly concluded these restricted access to care. Thus, they also recommend that ''grounds based approaches to restricting access to abortion should be revised in favour of making abortion available on the request of the woman, girl or other pregnant person" (11).

Maintenance of privacy and confidentiality are often concerns for people seeking termination of pregnancy due to the stigma associated with ToP (12). Lack of confidentiality was a primary concern for all interviewed participants in our work. As in many other jurisdictions, in Jersey during the COVID pandemic temporary measures were introduced to support access to termination and prevent the acquisition and spread of disease. General Practitioners were permitted to provide an initial telephone consultation before referring for a termination, and the second of the tablets given for a medical abortion could be administered at home rather than in a clinic. Building on this to offer medical terminations within a GP practice or via telemedicine seemed favourable to participants in this work, as it would allow for greater choice and a heightened sense of privacy.

Providing telemedical abortion care aligns with care models in nearby jurisdictions, including Britain and France, and is supported by evidence demonstrating safety and effectiveness within clinical guidance (11–14). Qualitative evidence further demonstrates that the telemedical model and medical abortion at home are widely accepted, in part owing to their capacity to safeguard confidentiality (17,18). Clinicians in the Republic of Ireland, which historically had a very restrictive ToP law but repealed its ToP law in 2018, are also exploring delivering care through telemedicine (19,20). Other jurisdictions worldwide also provide termination in primary care settings and through pharmacy provision (21–24).

Many participants expressed concerns about financial barriers faced by paying out of pocket to have a termination in Jersey (or outside of Jersey). The current ToP law intersects with Jersey healthcare policy to have a disproportionately negative impact on the poorer and more marginalised members of the community who may have fewer resources to cover associated costs. Only under strict and limited criteria are the costs associated with termination waived (i.e., under 18 years of age, in full time education, ToP under the grounds of risk of grave permanent injury to a woman's mental or physical health, or receiving specialist care abroad for termination of pregnancy on the grounds of fetal abnormalities). However, the policy regarding which terminations are and are not funded is inequitable and may perpetuate stigma by inadvertently suggesting that there are 'good' and 'bad' abortions.

One of the participants in this piece of work travelled to the UK to receive her ToP feticide before travelling back to Jersey for the remainder of her care. Though the patient received high quality care in the UK, travelling after a feticidal procedure evidently caused immense emotional distress to the patient. Whilst the emotional impact would not be eliminated by providing care on island, it would at least not be compounded by being treated away from home and the patient's support networks.

More broadly, the negative emotional and physical impact of travelling for ToP care in other countries, such as the USA, has been previously documented in the scientific literature (6). Furthermore, for women who may not be exempt from paying for care abroad, having to travel for a ToP can be associated with substantial upfront costs which would place a significant barrier to many wishing to access the service (25). Strategies to reduce the need of patients to travel should be considered and offered to all patients regardless of the indication for the ToP as a way to mitigate the evident barriers that costs and time to travel present to women. These strategies could include reconsideration of the current gestational age limits and expanding provision of ToP in Jersey into the second trimester of pregnancy; bringing additional clinicians to Jersey to provide specialist ToP procedures at more advanced gestations and for medical indications; and expanding financial support to anyone who needs to travel for ToP care, irrespective of the grounds.

Being informed and prepared ahead of a ToP has been shown to be one of the most important factors contributing to patient satisfaction with their ToP care (7). Furthermore, misalignment between information provided around the ToP experience and the actual delivery of care is known to detract from quality of care. Within this work, participants found it challenging to locate information on ToP when seeking information to manage expectations. Participants believed that what information they could find was not well placed within the maternity portion of the Government of Jersey website. Available information was perceived as misleading by participants, citing the underplaying of pain as something that left them ill-prepared for their termination (25). When there is a gap in information made readily available to people seeking ToP, people will attempt to fill it with alternative sources. This can be risky, as there are many sources of misinformation online designed to deter and obstruct patients' access to ToP (6,26,27).

Stigma and judgement related to termination of pregnancy is ubiquitous. However, more restrictive laws regarding termination perpetuate stigma, discourage clinicians from becoming involved in termination care, and ultimately impact the quality of care that a patient receives (7,28). Patients who have terminations also have pregnancies they continue, children they give birth to, and pregnancies that sometimes end in miscarriage or stillbirth. As was the case with the participant who described feeling less deserving of "love", "support and time" when she had an abortion as opposed to a miscarriage, patients can recognise when they are treated differently in the healthcare system and feel the emotional impact of this. One of the participants we interviewed ended up delivering the fetus in the Jersey maternity ward, though her experience was inappropriately managed as if she were delivering a live birth. Careful consideration should be given when treating ToP patients in a non-specialist maternity setting. This might include training staff to be sensitive to the unique needs and experiences of this group of patients (29).

Long waiting times to end a pregnancy create unnecessary anxiety and distress for the patient who may already be experiencing challenging emotions and detract from quality care (7). Delays to ToP care also increase the risk of complications, although the overall risk of the procedure remains low. Therefore, the NICE Guidelines on Abortion Care[2] recommend that terminations are provided within two weeks of presenting to the service (25). Gestational age limits imposed for ToP on the ground of 'distress' in Jersey, may create additional anxiety for the patient and also put pressure on clinicians providing the service within the limits of the law.

Patients seeking terminations in Jersey are required to make multiple visits to the hospital/pharmacy to collect the two different medications used to induce a medical termination. Further, they must navigate appointments that only run once a week at the gynaecology services outpatient department. Multiple visits required along the care pathway increase the chances of delays to waiting times, impacting a patient's access to timely termination care. Streamlining the service to require minimal or no in-person visits has the potential to increase the quality of service provided.

Evidence from the UK demonstrates that patients appreciate the flexibility afforded by service models which allow them to plan when they take their ToP medication (16). This flexibility can be built into both in-person and telemedical service models of ToP care.

Building capacity within the service to offer a choice of procedure should be strongly considered. Choice of procedure for termination is recommended in the World Health Organization (WHO) and NICE abortion guidelines and is linked to greater patient satisfaction (11,25). Pressure within

[2] The National Institute for Health and Care Excellence (NICE) produce evidence based guidelines for use by the National Health Service (UK), and act as a best practice framework for clinical practice.

termination services that leads to capacity issues and waiting times is multifactorial. However, the 'chilling' effect of a restrictive ToP law can often mean that some healthcare professionals may not conscientiously commit to providing termination care (30). This can leave ToP services outside of specialist providers sometimes running on the goodwill of clinicians who feel passionate about providing care but can be subject to limited resources- both human and material. This has a trickle-down effect on patient experience.

Strengths and Limitations

This report represents the first qualitative evaluation of women's experiences of accessing ToP on and off island in Jersey. With a broad inclusion criteria, we sought to capture different pathways under which someone might access ToP in Jersey.

Recruitment for this consultation was led by the Government of Jersey using the outlets identified in the methods section of this report. However, during the recruitment process, we recommended some additional methods to attempt to reach our recruitment target of 20. One proposed method was to consider inviting BPAS patients who were from Jersey, who had also agreed to be contacted for research, to participate in an interview for this consultation. However, too few participants (<5) met this inclusion criteria and given the resources it would take to complete internal research processes to access that BPAS data, we did not pursue this option. Similarly, given time constraints and ongoing internal (GoJ) efforts from the health care service to recruit within the ToP service, the GoJ deemed it not a viable option for BPAS researchers to recruit in-person from the Jersey ToP Service.

Finally, we did not capture data on all factors which may have influenced quality of care, including but not limited to sexuality, ethnicity, and relationship status. Future ToP studies in Jersey should consider the active inclusion of participants from minority groups and enquire about how intersecting identities may affect ToP care in Jersey.

Conclusion

Jersey's 1997 legal framework for ToP has resulted in a ToP service with perceived barriers to high-quality care for Jersey residents, as evidenced by the interviews within this report. Research from Ireland, which similarly operates under a 12-week gestational limit, has demonstrated that delivery of care under this framework comes at a significant cost for women, both financially and with time lost to multiple in-person visits and restricted availability of service provision (31).

We identified eight 'pinch points' during the participants' journeys to accessing ToP care and during their care itself. They were as follows:

1. Challenges posed by Jersey's current ToP law
2. Confidentiality
3. Cost of ToP
4. Travelling overseas for ToP care
5. Poor provision of information
6. Stigma and judgement
7. Service capacity and waiting times
8. Care that did not 'fit' with expectations of ToP care

The findings from this report can be used to form recommendations for the Government of Jersey's revisions to the Jersey 1997 Law and current service delivery, to ultimately improve the lived experience of ToP in Jersey.

Appendix A: In-depth interview guide

SECTION 1: OPENING

PRESS RECORD ON DICTAPHONE

1. The purpose of this interview is to find out more about your personal experiences of termination of pregnancy as part of the wider consultation on the termination of pregnancy (Jersey) 1997 law and its provisions.
You don't have to answer all the questions and can choose to end the interview at any time.
The interview will be recorded and then transcribed. Once transcribed any personally identifying information will be redacted to keep your identity anonymous, and any recordings will be deleted.
If you want to find out more about how we handle personal data for this consultation, let me know and I can share a link to the privacy notice for this consultation with you.
    - Do your consent to take part in this recorded interview?
      YES/NO (if no, interview ends)
    - Do you give permission for your comments to be quoted anonymously in our consultation feedback report and other publications?
      YES/NO

As all transcriptions will be kept anonymously, if you wish for your consent to be withdrawn at a later date, you will need to email TOPreview@gov.je and provide your interview reference number (yours is XXX) and the date of the interview.

2. You're participating in this interview because you **had a termination of pregnancy in Jersey/tried to get a ToP in Jersey/travelled overseas for a termination of pregnancy elsewhere**. Is that right? [Give me one sentence overview of this]

3. Can we start by you telling me a bit about yourself? **[Explore background, age, prior pregnancies, children, where were you born, gender, approximately, what is your total gross household income (before tax and social security deductions)?]**

4. Thinking back to when you found out you were pregnant… can you talk to through that in as much detail as you can remember? **Prompt: How did you feel when you found out you were pregnant? It can be a stressful time, did you have any particular worries or concerns? [Ensure this is focused on ToP experiences whilst living in Jersey]**

SECTION 2: IF THEY HAD A TERMINATION OF PREGNANCY IN JERSEY

1. If it is ok with you, can you talk me through your termination of pregnancy? It might be helpful to start with
    a. When that termination of pregnancy was
    b. How far along in the pregnancy you were
    c. Where you had treatment
    d. What sort of treatment you had (medical vs. surgical)
    e. How many appointments you had as part of your treatment
    f. Additional probes: TOPFA, certificate D, understanding of grounds

2. What were your feelings about termination of pregnancy before you needed the service yourself? [Probe: awareness of legislation, gestational age, grounds, stigma]
3. What research did you do about termination of pregnancy before you booked your appointment?
   a. What information did you find out about termination of pregnancy and termination of pregnancy providers?
   b. Where did you get this information?
   c. How did the information make you feel about the service you were going to access?
   d. How did you feel about the information, could it have been better?
4. How was the process of booking an appointment?
5. Did you have any expectations/worries/fears about how you would be treated at the facility or about having a termination of pregnancy in general? **[Probe: emotional, physical, financial costs of having a** termination of pregnancy**, and other barriers e.g. residency]**
6. Did you have any concerns about what other people at the clinic would think of you? **What about the provider or other clinic staff? Other patients? Protestors? [Probe about Jersey being a small place, protestors, safe zones]**
   a. **If it were an option, how would you have felt about being able to access such services remotely over the phone?**
7. How was the process of travelling to the clinic? **[Probe: ask about multiple visits for mifepristone + scan + consultation in person + limitations of a weekly list at the hospital + picking up miso from hospital pharmacy]**
8. Did you feel judged at the clinic/hospital? **[Probe about negative or positive interactions with staff?]**
9. How did you feel about where the termination of pregnancy was? **[Probe: Clinic/Hospital? Did it feel like an appropriate setting? Ensure this question covers the different parts of the pathway, particularly for EMA- if they could have had aspects of their treatment in different places would they have done it e.g. home use]**
10. How did you feel about who was involved in your termination of pregnancy? **[Probe: number of people, cadre of healthcare professional (ie. Nurses vs doctors)]**
11. Did you have any counselling as part of your termination of pregnancy care? **[Probe: If not, is this something you would have liked? If so, at what point would it have been most valuable to you (ie. When making the decision or after)?]**
    a. **Consider asking about counselling (ie. Decision making) vs mental health support & counselling**
12. Looking back was there anything you wish you had known before you had your termination of pregnancy?

SECTION 3: IF THEY TRIED TO GET A TERMINATION OF PREGNANCY IN JERSEY

1. Can you talk me through what happened when you tried to get a termination of pregnancy in Jersey?
2. I understand this may be very difficult for you to talk about, but can you please explain to me the reasons you weren't able to access a termination of pregnancy? **[Probe: how did that make them feel? How was this explained to them? What happened next? Explore barriers including financial, residency, gestational age, conscientious objection/obstruction, travel issues]**
3. After being turned away by the service in Jersey, did you consider or do anything else to try and end the pregnancy? **[Probe: Did you consider travelling overseas? Buying pills online? Anything else? How did this make you feel?]**

4. Did you continue the pregnancy?

SECTION 4: IF THEY TRAVELLED OVERSEAS FOR A TERMINATION OF PREGNANCY

1. If it is ok with you, can you talk me through your termination of pregnancy? It might be helpful to start with
   a. When that termination of pregnancy was
   b. How far along in the pregnancy you were
   c. Where you had treatment
   d. What sort of treatment you had (medical vs. surgical)
   e. How many appointments you had as part of your treatment
   f. **At what point did you realise you would need to/ wanted to travel overseas for treatment?**

2. What were your feelings about termination of pregnancy before you needed the service yourself? [Probe: awareness of legislation, gestational age, grounds, stigma]
3. What research did you do about termination of pregnancy before you booked your appointment?
   a. What information did you find out about termination of pregnancy and termination of pregnancy providers?
   b. Where did you get this information?
   c. How did the information make you feel about the service you were going to access?
   d. How did you feel about the information, could it have been better?
4. How was the process of booking an appointment? **[Probe about costs of treatment as a visitor, if there was any link up between the service in Jersey and overseas]**
5. How was the process of travelling to the clinic? **[Probe: booking the travel, costs, time]**
6. Did you have to stay overnight? **[Probe: booking, costs, how it made them feel]**
7. Did you have any expectations/worries/fears about how you would be treated at the facility or about having a termination of pregnancy in general?
8. Did you have any concerns about what other people at the clinic would think of you? **[Probe: What about the provider or other clinic staff? Other patients?]**
9. Did you feel judged at the clinic/hospital? **[Probe about negative or positive interactions with staff?]**
10. How did you feel about where the termination of pregnancy was? **[Probe: Clinic/Hospital? Did it feel like an appropriate setting?]**
11. How was the journey home? **[Probe: side effects, pain/bleeding, how they felt emotionally]**
12. Any follow up with provider?
13. Looking back was there anything you wish you had known before you had your termination of pregnancy?

Section 5: CLOSE

1. What would have made your termination of pregnancy experience better?
2. I've come to the end of my questions now. Is there anything that you would like to add?

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