Government of JERSEY

Termination of Pregnancy in Jersey

Public Consultation Feedback Report

March 2024

Contents

1 Executive Summary

A public consultation on termination of pregnancy in Jersey ran from 20 July to 31 October 2023. The aim of the consultation was to gather views on the Termination of Pregnancy (Jersey) 1997 Law to inform the development of proposed changes to the law for consideration by the States Assembly.

- 793 people responded to an online survey (790 individuals and 3 organisations). 196 of those online responses were excluded due to concerns they were from the same person leaving 597 responses for analysis.
- 82% of individual survey respondents were female
- 67% of individual survey respondents were aged 25 to 54
- Just under half (47%) had personal experience of termination (had a termination; supported someone else who was had a termination; considered having a termination)
- 12% had professional experience of termination (they work or worked in an organisation that provides termination services or related care)
- Meetings were held with local professional stakeholders
- the Centre for Reproductive Research and Communication ("CCRC") was commissioned to carry out interviews with women with experience of termination in Jersey

Key survey findings

Key survey findings are summarised below. More detail can be found in section 5.

Grounds for termination

- Almost three quarters (74%) of respondents stated termination should be available on request (ie. without justification of need)
- 95% stated termination should be available where there is risk to the life of the woman; 91% where there is risk of grave permanent injury to the woman's physical or mental health; 85% where there is risk of injury (not grave or permanent)
- 86% supported termination on the grounds of foetal abnormality, where the child, if born, would suffer serious physical or mental abnormalities, but respondents did raise questions as to the type and degree of foetal abnormality.
- 83% supported termination on distress (the ground on which most terminations are currently carried out in Jersey)
- Only 21% supported termination for sexual selection (the intentional aborting of a foetus of a certain gender)

Gestational limits

- Just under two thirds (59%) of respondents stated that the gestational limit at which termination should be permitted (ie. the length of time that a baby has been developing inside the womb) should depend on the grounds for termination. This was higher (74%) for those with professional experience.
- Over 50% thought gestational limits should not apply if there was:
    - risk to the life of the woman (74%) or risk of grave permanent injury to her physical or mental health (69%)
    - risk of foetal abnormality (54%)
    - pregnancy that results from rape (52%) or incest (53%)

Responses were more variable on other grounds.

Consultation

- Most respondents (37%) stated that the number of health care professionals a woman should have to consult with before having a termination should be dependent on the point in gestation, but people with professional experience favoured two at any point gestation (42%)
- Of those who stated that 'the number of health care professionals should be dependent on the point in gestation' most stated there should be one health and care professional (72%) until the 12th week (34%), at which point there should be two (64%)
- For early medical termination (up to end of 9th week of gestation), if there were only one consultation, responses were almost evenly split between consultation by phone / video link (47%) and in person consultation (50%). Almost three quarters (74%) of those with professional experience thought consultation should be in person.
- If there were more than one consultation, 39% of respondents stated that there should be a mixture of phone / video link and in person consultation. Most people with professional experience stated all consultation should be in person (46%), but they were more likely to respond in favour of phone / video link consultation when used in combination with in person consultation.
- Just over a third (36%) stated a woman should be able to self-administer both medications at home. This increased to just over three quarters (74%) if there was at least one in-person consultation.

Criminal Liability

- One fifth (20%) of respondents stated the woman should be liable for prosecution if she had a termination that did not accord with the provisions of the law. Just over two thirds (39%) stated any person carrying out the termination should be liable, and 40% stated no-one should be liable as termination should not be a criminal issue.

Safe Access Zones

- 80% of respondents thought safe access zones should be introduced in Jersey.

The feedback provided in this report will inform the development of a report and proposition to agree in principle changes to the Termination of Pregnancy (Jersey) Law 1997, presented in the States Assembly before the end of 2024.

2 Introduction

A public consultation on termination of pregnancy in Jersey ran for just over 14 weeks from 20 July to 31 October 2023.

The aim of the consultation was to gather views on the Termination of Pregnancy (Jersey) 1997 Law to better understand whether it reflects societal values, meets the needs of women, and takes account of changes in medical practice.

This report describes the consultation process and summarises the responses received including key themes and issues raised by respondents. It does not respond to the themes and issues raised, seek to qualify them or correct any inaccuracies or misconceptions. It simply reports what respondents said for purposes of information and transparency.

The responses to the consultation will help inform the development of proposed changes to the law to be considered by the States Assembly.

3 Consultation process

The consultation process took place between 20 July and 31 October 2023 (just over a 14-week period). Islanders participated via:

- an online survey (the survey questions are included in appendix 3)
- comments by email
- comments by post
- interviews with women who:
    - had a termination in Jersey
    - engaged with the formal healthcare system about having a termination in Jersey
    - travelled from Jersey to have a termination overseas

Public engagement sessions were initially planned but did not take place as feedback from other jurisdictions highlighted a potential risk to staff and participants from organised lobby groups.

Local professional stakeholders including Health and Community Services ("HCS") staff, GPs, and third sector organisations were also invited to give their views by interview.

Promoting participation in the consultation

Islanders were encouraged to participate via:

- general media (press notice and notes to the media)
- social media posts
- advertisements (full page) in the Jersey Evening Post
- posters and leaflets distributed to relevant organisations (for example HCS clinics that women attend, GP surgeries, counselling and other support services)

In addition:

- various stakeholder groups disseminated information about the consultation
- some HCS 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.

See appendix 1 for further details.

4 Overview of responses

Table 1 – Number of responses by method of engagement

Method of engagement	Number of respondents
Survey	793 Organisations – 3 Individuals - 790 196 of the responses were excluded leaving 597 for analysis (see section 4.3.1 below)
Written submissions by email	4 Organisations – 1 Individuals - 3
Written submissions by post	0
Interviews with women who have lived experience of termination	5
Interviews local professional stakeholders	16

4.1 Grouping response by audience

Responses are grouped by the following respondent types:

1. Organisations
2. Individuals, as:
    - all responses ('the general public')
    - people with professional experience of termination
    - people with personal experience of termination

Organisations: includes campaigning organisations locally and overseas who provided their views:

1. Catholic Grandparents Association (Jersey) – by survey
2. National Secular Society (UK) – by survey
3. Other (wished to remain anonymous) (Jersey) – by survey
4. CARE (Christian Action Research and Education) (UK) – written submission

Where the organisation gave consent for their comments to be published, full submissions are available in appendix 4.

People with professional experience of termination - includes people who:

- responded to the survey as individuals and identified themselves as professionals (see section 4.3 below for more details)
- participated in the local professional stakeholder interviews

People with personal experience of termination - includes people who:

- responded to the survey as individuals and identified themselves as having personal experience of termination (see section 4.3 below for more details)
- participated in the interviews for women with lived experience.

4.2 Processing and collating consultation responses

The aim of processing and collating consultation responses is to identify and understand respondent's views on termination of pregnancy, from:

- a quantitative perspective – ie the numbers and proportions of people who responded to survey questions, and
- a qualitative perspective ie. what those people said about termination of pregnancy in the 'free text' section of the survey, written responses, and interviews

It is important to note that people who responded to the consultation chose to do so because of their interest in subject. It must not be assumed that their individual or collective views are representative of wider public opinion.

4.3 Analysis

4.3.1 Demographic information (survey)

Section 1 of the survey collected demographic information to enable understanding of the reach of the survey (e.g. place of birth, age group, gender) and to enable differentiation between respondents.

NOTE: Excluded survey responses

793 survey responses were received; 790 from individuals and 3 from organisations.

Individuals

The survey asked if respondents lived in Jersey; 32 did not. As the consultation objective was to understand islander views, these responses have been excluded from this report.

Responses were checked by IP address to establish if individuals were submitting multiple survey responses to 'skew' the data, or if they were responding from outside of Jersey.

There were 30 IP addresses from which more than one response from received. In most cases no more than two responses were received from the same IP address, suggesting a shared household computer. These responses have not been excluded from this report.

There was one IP address from which 164 responses were received. While it is not possible to determine with certainty these responses came from the same person, as the majority contained marked similarities, they have been excluded from this report to avoid any risk of data 'skewing'.

120 survey responses appear to have been submitted from locations outside of Jersey (see table 2). The accuracy of IP address location differs by jurisdiction and as most of these responses appear to have been submitted from Guernsey or the UK (jurisdictions that are close in proximity to Jersey), it is not possible to determine with certainty they were not submitted from Jersey. These responses have therefore not been excluded from this report.

Table 2 - Responses submitted from IP addresses outside of Jersey

Country	Total
Australia	3
Canada	1
Croatia	1
Finland	1
France	7
Greece	1
Guernsey	40
Japan	1
Poland	1
Portugal	4
Spain	4
Switzerland	1
Turkey	1
UK	50
USA	4
Total	**120**

In total, 196 individual responses have been excluded from this report with 594 remaining for analysis.

Organisations

None of the 3 survey responses received from organisations have been excluded from this report.

Organisations

Table 3 – Does the organisation provide services or care related to termination of pregnancy

Response option	Total	%
No, none	2	67%
Contraceptive or sexual health services	1	33%

Table 4 - Where are the organisation's services and care provided

Response option	Total	%
Jersey	2	67%
UK	1	33%

Individuals

Table 5 – Place of birth

Response option	Total	%
Jersey	309	52%
Elsewhere in the British Isles*	190	32%
France	6	1%
Republic of Ireland	4	1%
Poland	10	2%
Portugal or Madeira	8	1%
Other European country	20	3%
Elsewhere	37	6%
Prefer not to say	10	2%

**British Isles includes England, Wales, Scotland, Northern Ireland, other Channel Islands and the Isle of Man.*

Table 6 – Age group

Response option	Total	%
16 to 19	43	7%
20 to 24	40	7%
25 to 34	166	28%
35 to 44	136	23%
45 to 54	96	16%
55 to 64	68	11%
65 to 74	27	5%
75 to 84	14	2%
85 and over	0	0%
Prefer not to say	4	1%

Table 7 – Gender

Response option	Total	%
Female	488	82%
Male	90	15%
Other	6	1%
Prefer not to say	10	2%

Professional experience of termination

In total, 69 individuals said they had professional experience of termination.

The tables below set out the number of respondents who said they have experience working in termination care or support services, the type of service or care provided and the jurisdiction where the service was provided.

Table 8 – Do you work or have you ever worked, in an organisation that provides termination of pregnancy services or related care?

Response option	Total	% *
Yes	69	12%
No	516	87%
Prefer not to say	9	2%

**Percentages may not add up to 100 because they are rounded*

Table 9 – Of those who answered 'yes' to working in an organisation providing termination services or related care, what services or care does / did your organisation provide?

Response option	Total*	%*
Termination services	32	46%
Contraceptive or sexual health service	39	57%
GP services	30	43%
Counselling service	23	33%
Sexual assault or domestic violence service	9	13%
Legal services	0	0%
Prefer not to say	1	1%
Other[+]	2	3%

**Total responses are greater than total number of people who responded yes to having professional experience of termination as some respondents selected more than one answer (ie. sexual health and counselling service)*

[+]*'Other' services cited included the hospital, maternity, and termination for medical reasons, including fetal abnormalities and missed miscarriage in late gestation.*

Table 10 – Of those who answered 'yes' to working in an organisation providing termination services or related care, where were the services or care provided?

Response option	Total*	%*
Jersey	63	91%
UK	24	35%
Online	1	1%
Prefer not to say	0	0%
Elsewhere[+]	1	1%

**Total responses are greater than total number of people who responded yes to having professional experience of ToP as this question allowed respondents to select more than one answer.*

[+]*Places cited as 'elsewhere' included Africa and America.*

Personal experience of termination

The survey asked individuals if they had any personal experience of termination of pregnancy services and care (not gained professionally through work) and if so, what that experience was.

Table 11 – Do you have any personal experience of termination of pregnancy services and care (not gained professionally through work)?

Response option	Total*	%*
None, I have no personal experience	313	53%
I have had a termination	120	20%
I am currently considering having a termination	1	0%
I considered having a termination but chose not to	17	3%
I wanted a termination but was unable to**	3	1%
I supported / am supporting someone who had a termination	142	24%
I am supporting someone who is currently considering having a termination	5	1%
I supported someone who considered having a termination but chose not to	23	4%
I supported someone who wanted to have a termination but was unable to**	15	3%
Prefer not to say	17	3%
Other+	16	3%

**Total responses are greater than total submissions analysed as this question allowed respondents to select more than one answer.*

+'Other' experiences included: they or someone they knew took the morning after pill, they miscarried prior to termination, they had a family member who provided counselling for crisis pregnancies, they volunteered at an organisation that provided support for victims of sexual abuse, or they are a member of a campaign group.

*** Some respondents who stated they were unable to have termination (or the person they were supporting was unable to) provided information on why this was the case. That feedback is set out in Section 5.1.7.*

As this question allowed respondents to select more than one answer, further analysis was undertaken to determine how many individuals said they had personal experience.

In total, 282 individuals said they had personal experience of termination (see table 12).

Table 12 – Respondents who said they had personal experience of termination

	Total	%
The respondent selected at least one response option indicating they had personal experience	282	47%
The respondent selected 'none, I have no personal experience' only	295	50%
The respondent selected 'prefer not to say'	17	3%

Table 13 – Location of personal experience

Response option	Total	%
I don't have any personal experience	297	50%
In Jersey	201	34%
UK	96	16%
Online	2	0%
Prefer not to say	12	2%
Elsewhere[+]	25	4%

[+]*Places cited included Africa, Australia, Canada, France, Guernsey, IoM, Madeira, Poland, Spain and America.*

4.3.2 Quantitative survey questions

The survey included 14 multiple-choice questions, which allow for analysis of the total number of respondents to each question, and the number and percentage response for each of the multiple-choice options.

4.3.3 Qualitative survey questions

The survey also included 5 free text questions to allow respondents to explain their thoughts in their own words. A thematic analysis approach was used to analyse the responses, which entailed:

- Step 1: reading all the free text responses and identifying emerging themes
- Step 2: assigning each free text response to the most representative theme, allowing the most commonly repeated or key themes to be identified.

4.3.4 Analysis of written submissions

People were invited to send written submissions (by post or email). These submissions were categorised by audience as outlined in section 4.1. A thematic analysis approach was applied.

4.3.5 Analysis of local professional stakeholder interviews

Local professional stakeholders were invited to share their views either face to face or by online meeting. These meetings were not formally transcribed but notes of the meetings were recorded. A thematic analysis approach was applied.

4.3.6 Analysis of women with experience of termination in Jersey interviews

The interviews conducted with women who have experience of termination in Jersey were carried out by the Centre for Reproductive Research and Communication ("CCRC").

It is recognised that the CRRC is situated within the British Pregnancy Advisory Service ("BPAS") which has a clearly stated public commitment to protecting and extending women's reproductive rights and choices. The decision to engage the CRRC was taken on the basis of their expertise in speaking with women about their experiences of termination. It does not indicate support for the position of BPAS.

The findings of these interviews are published in a separate report available here.

5 Summary of responses

5.1 Survey responses and written submissions

This section summarises responses across the 5 key topics set out in the consultation:

1. grounds for termination
2. gestational limits
3. consultation, including consultation for early medical terminations
4. criminal liability
5. safe access zones

Survey participants had the option to leave further comments.

A summary of the quantitative responses submitted by individuals through the survey is included (Note: a separate analysis was not undertaken for responses submitted by organisations as the number of organisations who responded was so low. Full organisational responses are available in appendix 4).

A summary of the qualitative responses received by survey, email or through interview with local professional stakeholders is included (Note: organisational comments are included).

A summary of the themes that emerged from the local professional stakeholder can be found in section 5.2.

5.1.1 Grounds for termination

The consultation asked whether termination in Jersey should be available at the request of the pregnant woman and without justification of need (referred to as “termination on request”).

Table 14 – Should termination on request be legal in Jersey

Response option	Respondent type		
	All respondents	People with professional experience	People with personal experience
Yes, termination on request should be legal in Jersey	74%	72%	77%
No, termination should only be available on grounds set out in law	25%	25%	21%
Don’t know / prefer not to say	1%	3%	2%

Almost three quarters (74%) of respondents thought termination should be available on request. This was slightly higher (77%) for those with personal experience and slightly lower (72%) for those with professional experience.

Numerous comments supporting termination on request were provided, for example::

> *“It’s a personal choice and we all have different values and morals, I should not have to carry a child just because someone else would not agree with my reasons.”*

"Abortions are healthcare, they should be provided should a pregnant person requests it."

"Any abortion freely chosen by the potential mother, without coercion, should be legal. It is their body, their future and it should be their right to chose."

Women's bodies should not be controlled or dictated by others. To believe women's choice is up for discussion is simply dystopian.

Some comments were against termination on request, arguing that abortion should not be available in any circumstances or in all circumstances because *"human life is valuable and must be protected"*.

The survey asked if termination remained legal in Jersey on certain grounds only, what those grounds should be.

Table 15 – On what grounds should termination be legal

	All respondents			**People with professional experience**			**People with personal experience**		
	Yes	**No**	**Don't know / prefer not to say**	**Yes**	**No**	**Don't know / prefer not to say**	**Yes**	**No**	**Don't know / prefer not to say**
Where there is a risk to the woman									
risk to the woman's life (currently lawful in Jersey)	95%	2%	3%	96%	4%	0%	95%	2%	2%
risk of grave permanent injury to the woman's physical or mental health (currently lawful in Jersey)	91%	5%	4%	93%	7%	0%	92%	5%	3%
risk of any injury to the woman's physical or mental health	85%	12%	3%	84%	14%	1%	87%	11%	2%
Where there is a risk to the family									
risk to the physical or mental health of the woman's other children	72%	20%	9%	74%	19%	7%	76%	15%	9%
Where there is a risk to the unborn child / children									
a foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities (currently lawful in Jersey)	86%	11%	3%	86%	13%	1%	89%	9%	2%

	All respondents			People with professional experience			People with personal experience		
	Yes	**No**	**Don't know / prefer not to say**	**Yes**	**No**	**Don't know / prefer not to say**	**Yes**	**No**	**Don't know / prefer not to say**
in the case of multiple pregnancy (ie. twins, triplets etc) reducing the number of multiple foetuses either because of foetal abnormality or to improve the outcomes for some of the foetuses (known as selective termination)	77%	16%	7%	75%	19%	6%	79%	14%	7%
Pregnancy that results from crime									
crime of rape	87%	10%	2%	86%	10%	4%	90%	9%	2%
crime of incest	87%	10%	3%	86%	10%	4%	89%	9%	2%
Other									
the woman's condition causes her distress (currently lawful in Jersey)	83%	15%	2%	80%	16%	4%	85%	11%	3%
for economic or social reasons (ie. a lack of financial security)	75%	22%	3%	71%	25%	4%	79%	18%	4%
where the woman has intellectual or cognitive disability	73%	18%	10%	62%	22%	16%	77%	14%	10%
for reasons of sexual selection (the intentional aborting of a foetus of a certain gender)	21%	71%	8%	16%	81%	3%	21%	69%	10%

**Percentages may not add up to 100 because they are rounded*

Risk to woman

The majority of respondents thought termination should be available where there is risk to the woman, with 95% agreeing termination should be available where there is risk to the life of the woman and 91% where there is risk of grave permanent injury to her physical or mental health. This dropped to 85% for risk of injury (not grave or permanent). Some argued that in these circumstances, health care professionals should be required to do what they can to save the life of the child or protect the foetus from pain in later gestation.

Comments indicated that some respondents were less inclined to support terminations for mental health reasons or where the risk threshold was not clear.

“I do no[t] think that terminations should be allowed on the grounds of mental health impacts. Every pregnancy and birth has some mental health impact, often positive and negative. We need to provide word class mental health care as the solution not termination.”

“The problem with some of these questions lies in the matter of degree. “Termination because of risk to physical or mental health” for example. How great a risk is relevant? Both continuing the pregnancy and termination carry some risk; the risk needs to rise above a certain threshold for it to be considered relevant.”

“any reform should define injury as something imminent and more likely than not to occur”

Risk to family

72% of respondents supported termination on grounds of risk to the family, with some concern being raised about who would determine that risk:

“What does it mean that it causes a risk to the woman's other children? This sounds like other people can pressure the mother into an abortion even if she wants the baby. Only the mother should be able to make the decision.”

Foetal abnormality

86% of respondents supported termination on the grounds of foetal abnormality, where the child, if born, would suffer serious physical or mental abnormalities, but question was raised as to the type and degree of foetal abnormality (with more emphasis on fatal foetal abnormality), the level of support that should be in place for continuing pregnancies, and whether there should be a requirement to uphold the principles under the UN Convention on the Rights of Persons with Disabilities.

“how do you define "serious abnormality/disability"? Often a seriously deformed/abnormal foetus would abort naturally or would die shortly after birth which I think would be easier for a mother to live with rather than taking her child's life. Other disabled people go on to live successful and fulfilling lives.

“Cognitive and physical disabilities are completely different. Ask any adult missing a hand if they think they shouldn’t have been born and given a chance of having a fulfilling life. You can’t group these babies all together into the same bracket.”

“Clear parameters need to be set on this. For example, down syndrome should NOT be considered for termination - children with down syndrome can and do live productive, valuable lives. Termination should only be allowed in the case of extreme abnormality which would detrimentally affect the standard of life of the child.”

“if there are indications of foetal abnormalities, it is the duty of the community to provide the medical, educational and other support necessary to allow the affected individual to live as full a life as possible. No-one has any more right to “terminate” the life of an unborn disabled person than they have in a situation where the person’s disablement becomes apparent in later life.”

“Jersey should provide holistic care for parents with information, practical support and services at a very challenging time, including perinatal palliative care for those

children whose lives are likely to be measured in hours or days, and neonatal palliative care where the child may live for weeks or months."

"concerns that abortion on the grounds of the unborn child's disability gives a negative message about disability in general and is contradictory to the principles under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), albeit that Jersey is not yet a signatory."

Selective termination

77% of respondents supported selective termination, the process by which the number of foetuses are reduced because of foetal abnormality or to improve outcomes for remaining foetuses. Comment was made about the level of risk, and conversely that it should not be allowed where it had resulted from in vitro fertilisation ("IVF").

"only if the risk is unreasonably high for mother or other foetuses if all foetuses are kept or with abnormalities".

"If IVF placed multiple fertilised eggs into the womb then you should not be allowed to kill off multiple successful fetus' (that are also successful) to allow one dominant fetus to remain as the only fetus".

Pregnancy that results from crime

87% agreed that termination should be legal where the pregnancy resulted from crime (rape or incest), although comment was made that with education and the availability of the morning after pill both pregnancy and termination could be avoided. There was also comment made about the need for mental health support in decision making, particularly in these cases, and the practical issue of proving a crime was committed against the woman.

"a pregnancy does not need to result from these crimes. This is a matter of education. If the victim took action within 72 hours, a pregnancy can be avoided and therefore so can an abortion."

"We need to provide word class mental health care as the solution not termination. This is particularly important in the case of rape and incest where to then put the woman through the trauma of a termination can add to the impact and long-term consequences of what is already a tragic situation."

"There are also significant practical issues to be addressed, including proving that a pregnancy was conceived as a result of rape and incest, and if no 'proof' is required how to avoid 'abuses' of the system."

Distress

83% supported termination on the ground of distress, the ground on which most terminations are carried out in Jersey, but there were a number of comments about the term 'distress' and how it is applied.

"Distress is too broad a term and effectively the law currently allows abortion on demand."

“The above question referring to " distress " in the pregnant woman being a reason to terminate is a strange one! The woman may very well be distressed initially and needs to be counselled and supported well.”

Having an abortion is no guarantee that there will be no 'distress " following the termination - indeed many women live with nightmares for years following - I know I did. Initially it was such a relief not to be pregnant, but then the guilt came in for what I had allowed to happen.”

Economic or social reasons

75% thought termination should be available for economic or social reasons although several respondents called for support for families to overcome these challenges:

“At the end of the day most people aren't even financially stable enough to have kids in Jersey anyway.. Plus not everyone wants kids or should have them!!”

“If there are grounds to suspect that a child’s arrival would occasion adverse outcomes for the mother and her family, be they financial, health or social, etc., instead of killing the child, the community should have in place appropriate provisions to support the family and the new child to overcome these adverse outcomes.”

“The government does not provide free contraception past age 23, therefore should be prepared for unwanted pregnancies which could be increasing with cost of living; must think about the quality of life for islanders who cannot afford to have children or medical procedures.”

Woman has intellectual or cognitive disability

73% of respondents supported termination where the woman has intellectual or cognitive disability but it was argued that where the woman has capacity this should not impinge on her choice to continue with the pregnancy.

“*I am firmly against including the woman's cognitive or intellectual disability as grounds for an abortion. I am worried that this would enable people to deny people with cognitive or intellectual disabilities the right to start a family*.”

Sexual selection

Termination for sexual selection (the intentional aborting of a foetus of a certain gender) was least supported with only 21% of respondents agreeing with termination for this reason, and dropping as low as 16% amongst people with professional experience. While some called for termination to be explicitly outlawed on this ground, a number of respondents voiced concern that restricting on this ground would preclude a woman’s ability to access termination on request. Furthermore, question was raised as to how it could be reliably enforced given a woman could simply cite a different reason for termination.

“While I agree with the intention of not allowing terminations for this reason, I do not think this is workable in combination with termination upon request, or even the current law that permits termination when in distress. I think keeping or expanding the law is more important than a clumsy attempt to prevent a small number of terminations for reason of sex.”

Other grounds

The survey asked if there were other grounds on which termination should or should not be legal. Reponses included:

- making the law the more restrictive than it currently by removing some of the existing grounds and prosecuting women who go off island to terminate:

  "Abortion should only be legal when the mother's life or her unborn child's life is in grave danger. All other circumstances should be illegal as the unborn child is a human being with rights."

  "It should be illegal to circumvent the Jersey law by getting an abortion overseas. All these cases should be prosecuted."

- making termination legal in all cases for young women / girls

  "I also believe that if the mother is too young she should have the option to terminate her pregnancy"

  "Termination should be available up to any point in the pregnancy for under 16's"

  "…minors, without the consent of their legal guardians, should have free access to abortion."

- on the grounds of being recently separated

  "If you were to spilt up with the other 'parent' and have a massive change in your living conditions/finances/emotional well-being"

5.1.2 Gestational limits

Gestation is the length of time that a baby is developing inside the womb between conception and birth. Gestation is typically 40 weeks (ie. a woman is pregnant for 40 weeks).

The survey asked:

- whether termination should be legal at any gestational limit, regardless of the grounds for termination, and
- if gestational limits are retained, what limit should apply to the grounds for termination

Table 16 – Should termination in Jersey be legal at any gestational limit, regardless of the grounds for termination

Response option	Respondent type		
	All respondents*	People with professional experience	People with personal experience
Yes, at any gestational limit regardless of the grounds for termination	36%	19%	36%
No, the gestational limit should depend on the grounds for the termination	59%	74%	58%
Don't know / prefer not to say	6%	7%	6%

**Percentages may not add up to 100 because they are rounded*

Retention of gestational limits

Just under two thirds (59%) responded that gestational limits should depend on the grounds for termination. This was markedly higher (74%) for those with professional experience.

Comments provided some insight into why, including:

- rights of the developing foetus

  "*If there are gestational limits it should be when the heartbeat of a child is detected*."

- viability of life; the point in gestation at which a baby, if born, could survive outside the womb.

  "*There have been significant advances in neonatal care since the 1997 Act was passed; any legal reform needs to take into account those changes… That some babies may not survive if born at 22 weeks gestation does not negate the fact that some babies do*."

- the need to be able to differentiate grounds for which no limits should apply (i.e. risk to health, pregnancy resulting from crime), and other grounds for which limits should apply, particularly where 'choice' is weighed against viability of life.

  "I am wary of no gestational limits on all cases, as I can appreciate how some groups may abuse this."

“there should be no gestational limit if continuation of the pregnancy risks the health of the mother, the baby, or the mother's other children. women will intellectual / cognitive issues should be included here, as well as in the case of crime etc. For other reasons, there should be a gestational limit of 24 weeks (i.e. when the baby is viable to survive if it were born at that point).”

“Crimes of rape and incest should be treated separately. These are heinous crimes and need expert handling. Any termination should be done as early as possible. In all other cases it must be remembered that a child (albeit a foetus) is being destroyed. We do not want abortion on demand right up to birth.”

- safety

“The only consideration given should be a balance of safety as would be the case in all other medical procedures. If the procedure cannot be carried out due to scientific/medical limitations”

Removal of all gestational limits

While only one third of respondents thought termination should be available at any gestational limit regardless of the grounds for termination, several comments supported the removal of gestational limits:

“Circumstances change for people in a very short space of time. There should be no ticking time for anyone to make a decision that impacts their life in such a huge way.”

“The vast majority of women would have a termination at an earlier stage of gestation… Anyone who seeks a termination after [24 weeks] likely has exceptional circumstances… I do not think the law should prevent these terminations, or more accurately to force these women to travel a long way to jurisdictions where such terminations are legal.”

“A pregnant person and their doctor will know individual circumstances and medical options far better than anyone looking in from the outside - therefore, these limits should not exist.”

“Regardless of one’s own moral standing on any of these issues I believe it has to be the decision of the woman in every situation, it is her body, her health, her future at stake. It is not my place to tell another woman what this decision should be, the decision to take this action would be traumatic for anyone without the added judgment of the law. And, if it is purely that they are ‘irresponsible’ which is an argument I have heard against abortion then I would suggest more the reason for them not to be forced into taking care of a child.”

“Anytime, it should be anytime they want. A woman should be able to choose what she wants to do particularly when we have the technology to perform the procedure safely.”

Some respondent comments were against termination on request at any point:

“If abortion on demand up to birth was being considered by the law makers, this would in my opinion be abhorrent and has no place in civilised society.“

Table 17 – If termination remains legal in Jersey up to certain gestational limits, what limits should apply (all respondents)*

	Up to end of 12th week	Beginning of 20th week to end of 22nd week	Beginning of 23rd week to end of 24th week	No gestational limit (available at any point in pregnancy)	Other gestational limit	Termination should not be available for this reason in Jersey	Don't know / prefer not to say
Where there is a risk to the woman							
risk to the woman's life (currently lawful in Jersey)	4%	5%	6%	74%	1%	4%	5%
risk of grave permanent injury to the woman's physical or mental health (currently lawful in Jersey)	6%	6%	7%	69%	2%	6%	5%
risk of any injury to the woman's physical or mental health	7%	12%	15%	47%	2%	11%	5%
Where there is a risk to the family							
risk to the physical or mental health of the woman's other children	10%	14%	22%	29%	1%	19%	6%
Where there is a risk to the unborn child / children							
a foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities (currently lawful in Jersey)	3%	7%	20%	54%	2%	10%	5%

	Up to end of 12th week	Beginning of 20th week to end of 22nd week	Beginning of 23rd week to end of 24th week	No gestational limit (available at any point in pregnancy)	Other gestational limit	Termination should not be available for this reason in Jersey	Don't know / prefer not to say
in the case of multiple pregnancy (ie. twins, triplets etc) reducing the number of multiple foetuses either because of foetal abnormality or to improve the outcomes for some of the foetuses (known as selective termination)	7%	11%	18%	40%	2%	15%	7%
Pregnancy that results from crime							
crime of rape	8%	12%	13%	52%	2%	9%	4%
crime of incest	7%	11%	13%	53%	2%	9%	5%
Other							
the woman's condition causes her distress (currently lawful in Jersey)	16%	17%	24%	24%	2%	13%	3%
for economic or social reasons (ie. a lack of financial security)	14%	17%	22%	23%	1%	20%	3%
where the woman has intellectual or cognitive disability	8%	14%	15%	37%	1%	15%	9%
for reasons of sexual selection (the intentional aborting of a foetus of a certain gender)	6%	4%	5%	12%	0%	66%	7%

**Percentages may not add up to 100 because they are rounded*

Table 18 – If termination remains legal in Jersey up to certain gestational limits, what limits should apply (people with professional experience)*

	Up to end of 12th week	Beginning of 20th week to end of 22nd week	Beginning of 23rd week to end of 24th week	No gestational limit (available at any point in pregnancy)	Other gestational limit	Termination should not be available for this reason in Jersey	Don't know / prefer not to say
Where there is a risk to the woman							
risk to the woman's life (currently lawful in Jersey)	3%	12%	7%	71%	0%	4%	3%
risk of grave permanent injury to the woman's physical or mental health (currently lawful in Jersey)	4%	12%	10%	64%	0%	7%	3%
risk of any injury to the woman's physical or mental health	12%	25%	22%	28%	1%	12%	1%
Where there is a risk to the family							
risk to the physical or mental health of the woman's other children	16%	23%	19%	17%	0%	20%	4%
Where there is a risk to the unborn child / children							
a foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities (currently lawful in Jersey)	0%	12%	29%	43%	0%	13%	3%

	Up to end of 12th week	Beginning of 20th week to end of 22nd week	Beginning of 23rd week to end of 24th week	No gestational limit (available at any point in pregnancy)	Other gestational limit	Termination should not be available for this reason in Jersey	Don't know / prefer not to say
in the case of multiple pregnancy (ie. twins, triplets etc) reducing the number of multiple foetuses either because of foetal abnormality or to improve the outcomes for some of the foetuses (known as selective termination)	4%	17%	23%	28%	0%	23%	4%
Pregnancy that results from crime							
crime of rape	4%	29%	16%	35%	1%	12%	3%
crime of incest	4%	29%	14%	38%	0%	12%	3%
Other							
the woman's condition causes her distress (currently lawful in Jersey)	22%	25%	22%	16%	1%	13%	1%
for economic or social reasons (ie. a lack of financial security)	17%	20%	22%	10%	0%	26%	4%
where the woman has intellectual or cognitive disability	7%	32%	9%	19%	0%	22%	12%
for reasons of sexual selection (the intentional aborting of a foetus of a certain gender)	4%	4%	4%	4%	0%	80%	3%

**Percentages may not add up to 100 because they are rounded*

Table 19 – If termination remains legal in Jersey up to certain gestational limits, what limits should apply – (people with personal experience)*

	Up to end of 12th week	Beginning of 20th week to end of 22nd week	Beginning of 23rd week to end of 24th week	No gestational limit (available at any point in pregnancy)	Other gestational limit	Termination should not be available for this reason in Jersey	Don't know / prefer not to say
Where there is a risk to the woman							
risk to the woman's life (currently lawful in Jersey)	5%	5%	6%	75%	2%	3%	4%
risk of grave permanent injury to the woman's physical or mental health (currently lawful in Jersey)	6%	7%	7%	68%	3%	6%	4%
risk of any injury to the woman's physical or mental health	8%	10%	15%	51%	2%	10%	4%
Where there is a risk to the family							
risk to the physical or mental health of the woman's other children	10%	16%	21%	32%	0%	16%	6%
Where there is a risk to the unborn child / children							
a foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities (currently lawful in Jersey)	2%	6%	17%	60%	2%	9%	4%

	Up to end of 12th week	Beginning of 20th week to end of 22nd week	Beginning of 23rd week to end of 24th week	No gestational limit (available at any point in pregnancy)	Other gestational limit	Termination should not be available for this reason in Jersey	Don't know / prefer not to say
in the case of multiple pregnancy (ie. twins, triplets etc) reducing the number of multiple foetuses either because of foetal abnormality or to improve the outcomes for some of the foetuses (known as selective termination)	7%	12%	17%	42%	2%	13%	6%
Pregnancy that results from crime							
crime of rape	7%	11%	15%	55%	2%	8%	3%
crime of incest	6%	10%	14%	56%	2%	9%	3%
Other							
the woman's condition causes her distress (currently lawful in Jersey)	18%	17%	28%	22%	1%	11%	3%
for economic or social reasons (ie. a lack of financial security)	16%	18%	24%	21%	0%	17%	4%
where the woman has intellectual or cognitive disability	9%	14%	16%	38%	1%	12%	10%
for reasons of sexual selection (the intentional aborting of a foetus of a certain gender)	9%	3%	5%	12%	0%	63%	7%

**Percentages may not add up to 100 because they are rounded*

Gestational limits and grounds for termination

Whilst the majority of respondents disagreed that termination should be legal at any gestational limit (ie. they stated that the gestational limit should depend on the grounds for termination), there was nevertheless high levels of support for removing gestational limits for many grounds.

All responses

Over 50% of respondents thought gestational limits should not apply to the following grounds:

- risk to the life of the woman (74%) or risk of grave permanent injury to her physical or mental health (69%)
- risk of foetal abnormality (54%)
- pregnancy that results from rape (52%) or incest (53%)

Responses were more variable on other grounds:

- sexual selection – 12% support no gestational limits with the greater majority of respondents (66%) stating terminal should not legal for sexual selection

- woman's condition causes her distress – 24% support no gestational limits with an equal number supporting a 24-week gestational limit, but no other option gaining greater support

- economic or social reasons - 23% support no gestational limits with 22% supporting a 24-week gestational limit, but no other option gained greater support

- risk to the family - 29% support no gestational limits with 22% supporting a 24-week gestational limit, but no other option gained greater support

- risk of any injury (not grave) to the woman's physical or mental health – 47% support no gestational limits but no other option gained greater support

- where the woman has intellectual or cognitive disability – only 37% support no gestational limits but no other option gained greater support

- reducing number of multiple foetuses – only 40% support no gestational limits but no other option gained greater support

Responses from professionals

Responses from professionals were markedly different, in some cases, to all responses.

Over 50% thought gestational limits should not apply to the following grounds (in line with all respondents):

- risk to the life of the woman (71%)
- risk of grave permanent injury to the woman's physical or mental health (64%)

Responses were lower for other grounds:

- risk of any injury (not grave) to the woman's physical or mental health - only 28% support no gestational limits, with 25% supporting a 22 week gestational limit (with no other option gaining greater support

- risk of foetal abnormality – 43% support no gestational limits. No other option gained greater support, which broadly accords with all responses

- sexual selection – only 4% support no gestational limits with the greater majority of professionals (80%) stating terminal should not be legal for sexual selection

- rape or incest - only 35% and 38% support no gestational limits, compared to over 50% of all respondents (although no other option gained greater support)

- woman's condition causes her distress – only 16% support no gestational limits compared to 24% of all responses, with a 22 week gestational limit gaining greatest support

- economic or social reasons – only 10% support no gestational limits compared to 23% of all responses (with more professionals supporting a 24 week limit, or stating that termination should not be allowed on these grounds)

- risk to family – 17% support no gestational limits compared to 29% of all respondents (with greater support for a 20 to 24 week gestational limit)

- where the woman has intellectual or cognitive disability – only 19% support no gestational limits compared to 37% of all responses (with greatest support a 22 week gestational limit)

- reducing number of multiple foetuses - only 28% support no gestational limits compared to 40% of all respondents (but no other option gained greater support)

People with professional experience were more likely to select 'beginning of 20th week to end of 22nd week' over 'beginning of 23rd week to end of 24th week'.

Responses from people with personal experience

Responses from people with personal experience were similar to all responses.

Other comments

Some additional themes were observed in the comments received:

- Removing or extending gestational limits for young or more vulnerable women

  "If a woman is under the age of 16, she should have the right to a termination up to the 24 week mark. This is because of the delay it takes underaged individuals to discover their pregnancy as well as tell a trusted adult"

  "I had previously stated that "where the woman has intellectual or cognitive disability" should not be a criteria as I believe the other criteria would cover their needs and assumed this meant without their consent. I however feel that someone with such disabilities may need more time to process and decide."

- Making termination available for women who discover their pregnancy later than 12 weeks

  “Some women are unaware of their pregnancies, if a young girl doesn't know she is pregnant via rape or incest, it would be wrong to make her continue the pregnancy.”

  “*On grounds of both distress and financial/ economic reasons, an extension of 2 weeks from 12 to 14, would enable women to have more time to realize they are pregnant.”*

  “A close friend did not know she was pregnant until she was 5 months as she suffered from irregular periods. Another person I knew did not realise at all until she went into labour. I think the gestational period & the circumstances should somehow support women who want an abortion but have perhaps missed the "legal" window.”

- Making termination available later in cases of foetal abnormality (the child, if born, suffering serious physical or mental abnormalities). More than half of respondents thought there should be no gestational limit for termination on this ground.

  “If identifying a gender specific genetic disorder cannot be identified until further along a pregnancy.”

  “I feel that termination on medical grounds (TFMR) should be lawful until full term/active labour. A woman who knows her child will die within hours of birth, or suffer immensely with a life limiting condition she be able to have a termination on request beyond 24 weeks.”

- Introducing termination on request (without justification of need) up to 24 weeks

  “I feel that “termination on request” should be lawful with no caveats until 24 weeks. Beyond that I think it should be necessary to pass some further test by providing a compelling reason to terminate a viable foetus. (I.e: the woman did not know she was pregnant until 25 weeks, so had no earlier opportunity to request termination.)“

- Whether 24 weeks for some grounds is too late

  “Babies are surviving more from 22 weeks due to advancement in medical care”

  “I think the abortion limit of 24 weeks should be lowered to 16 weeks, unless it is proven beyond any doubt the pregnancy is not viable. The reason I say this is because you could have two theatres next door to each other, where in one everything is being done to save a premature baby being born at 24 weeks but in the theatre next door, a baby is being aborted legally at 24 weeks.”

- The importance of a delay free service

  “I think as soon as a woman has made the decision that she needs a termination and it absolutely fits into the criteria, she should be able to get it done as soon as possible. I found out only when I was a few weeks pregnant and I was made to wait until after I was 10 weeks pregnant, which was one of the most distressing times of my life.

- Discrimination against those with disability

  “The law in England and Wales allows abortion up to birth where it is believed the child would have a disability were it to be born, in contrast to a 24-week gestation limit for all

other abortions. [we believe] that this limit discriminates against unborn babies with disabilities and signals that human beings with a disability are worthy of less protection under the law than able bodied human beings."

- Settings

  "[we recommend] that terminations after 20 weeks should only be undertaken within acute sector hospitals since this reflects the requirements of the Care Quality Commission in England that only persons who are suitably qualified, skilled and experienced in the late termination of pregnancies should conduct these procedures."

5.1.3 How many health and care professionals should a woman consult with

Jersey law currently requires a woman consult with two different doctors before having a termination.

The survey asked how many health care professionals a woman should have to consult with, and then asked further questions to understand: the number of health and care professionals a woman should have to consult with in early gestation; at what point in gestation it should change; the number of health care professionals a woman should have to consult with in later gestation, and why.

Table 20 – How many health and care professionals should a woman seeking a termination have to consult with

Response option	Respondent type		
	All respondents	People with professional experience	People with personal experience
One, at any point in gestation	34%	26%	35%
Two, at any point in gestation	22%	42%	22%
The number of health care professionals should be dependent on the point in gestation	37%	28%	37%
Other[+]	5%	4%	5%
Don't know / prefer not to say	2%	0%	1%

[+] *'Other' responses included:*

- *use of, or conversely non-use of GPs*
- *a single sufficiently qualified medical professional*
- *non-healthcare professionals such as a social worker / charity, mental health professionals*

While most respondents thought the number of health care professionals should be dependent on the point in gestation, people with professional experience favoured two at any point gestation.

Several respondents provided further comments:

- the need to involve mental health professionals, both before and after:

  "*There should be full counselling before a decision is made."*

  "someone within the mental health profession should be included within each visit. Even for a 5 minute wind down breather, calm after the storm. Being able to ask questions after everything has sunk in."

- the involvement of specialist doctors over GPs

“I think there should be trained professionals who have time to fully counsel and explore the concerns of patients. GPs are not always best placed for these discussions”

- involving too many people can undermine trust, act as a barrier to women accessing the service, or delay the process,

  “There should not be the number of professionals it takes in jersey under the current procedure via the hospital. This is unnecessary and actually made me feel as if my decision for a request was not trusted.”

  “Consulting with a raft of professionals is humiliating and often the woman will feel judged.”

  “If there is more than one [consultation], a woman may change their mind, not because they want to, but feel too intimidated to go back or not be able to get the time off for a second consultation if they are working.”

- the number and type of health and care professionals should depend on the circumstances, including the mental health needs of the woman, point in gestation, age of the woman and method of termination (i.e. medical / surgical):

  “Should depend on the reason and when in pregnancy.”

  “After 24 weeks a pregnancy is viable, so there may be an emotional impact to the mother along with physical, and a psychological assessment or support should be offered, along with the doctor and or midwife support. Under 12 weeks it is usually only a tablet and doesn't always require a D&C therefore only 1 consultation should be required.”

  “A younger girl with no family support might require more healthcare professionals to provide guidance/support, but an older woman who knows her quality of life, physical and mental health will degrade from having a child might only need one healthcare professional. This should be based on the professional knowledge of the healthcare providers on whether patients require one or more healthcare professionals.”

- women should not have to pay for consultation

  “the consultations should have no cost associated with them”

  “All women must be able to access a termination in good time and without a financial cost.”

Table 21 – Of those who said 'the number of health care professionals should be dependent on the point in gestation', how many health and care professionals should a woman have to consult with in early gestation

Number of health and care professionals (as typed by respondents in free text box)	Respondent type*		
	All respondents	People with professional experience	People with personal experience
0	2%	-	1%
1	72%	63%	76%
2	15%	26%	11%
3	3%	11%	3%
4	<1%	-	-
5	<1%	-	1%
12	<1%	-	-
(blank)	8%	-	8%

**Percentages may not add up to 100 because they are rounded*

Table 22 – Of those who said 'the number of health care professionals should be dependent on the point in gestation', at how many weeks gestation should it change

Number of weeks (as typed by respondents in free text box)	Respondent type*		
	All respondents	People with professional experience	People with personal experience
0	<1%	-	-
1	<1%	-	1%
2	1%	5%	1%
4	<1%	-	-
6	<1%	-	-
8	1%	-	1%
10	1%	-	2%
12	34%	42%	30%
13	4%	11%	5%
14	1%	-	2%
15	<1%	-	1%
16	2%	-	3%
18	1%	-	2%
20	13%	16%	14%
21	<1%	-	-
22	4%	11%	3%
23	3%	-	3%
24	19%	11%	19%
40	<1%	-	1%
(blank)	13%	5%	12%

**Percentages may not add up to 100 because they are rounded*

Table 23 – Of those who said 'the number of health care professionals should be dependent on the point in gestation', how many health and care professionals should a woman have to consult with in later gestation

Number of health and care professionals (as typed by respondents in free text box)	Respondent type*		
	All respondents	People with professional experience	People with personal experience
0	<1%	-	-
1	5%	-	5%
2	64%	68%	68%
3	15%	21%	10%
4	1%	-	1%
5	2%	5%	3%
23	<1%	-	1%
(blank)	11%	5%	13%

**Percentages may not add up to 100 because they are rounded*

The majority of respondents who said 'the number of health care professionals should be dependent on the point in gestation' thought there should be one health and care professional (72%) until the 12th week (34%), at which point there should be two (64%).

Reasons offered included:

- gravitas of the situation:

  "Because it shouldn't be done lightly. It's an important decision and irreversible"

- need for more than one professional to protect / consider the foetus

  "Terminations should be as soon as possible as in my opinion the unborn child develops so rapidly and the later on, the more immoral it becomes."

  "As the pregnancy progresses so does the ethical question of life of the foetus."

- to ensure an informed decision which is right for the woman (not misleading / free of coercion / specialist and second opinions available (especially in later gestation)/ women are safeguarded)

  "To ensure that there is no single point of failure and women know the risks and processes entirely before making a decision."

  "To protect the mother and the foetus in case of misdiagnosis"

  "Of the families I have worked with and look to terminate a later pregnancy, this is usually because of their personal circumstances (abusive relationship, etc.) or foetal abnormalities and a second opinion from another healthcare provider I believe would help them come to a decision easier (a grieving family worries that the doctor they spoke to made a mistake and if they had heard it from another doctor too, they'd have confirmation of the abnormalities which would help them come to terms with their decision)."

“The later the pregnancy is I think a woman really needs to be sure termination is the right option for her. It depends on the doctor as well - some are very supportive and you feel like you've asked all the questions you have, others are quite dismissive and just want you out of their surgery as quickly as possible. I think the later the pregnancy is, it wouldn't hurt to have to speak to two doctors who might offer different types of support.”

- to keep costs low

  “It would reduce the money spent by women who may not be able to afford to see so many doctors, especially if treatment is £185 to £511.”

- there are more risks later in gestation

  “Because of the increased psychological impact of termination at a later stage.”

  “My understanding that as time goes on there are higher risks so I think an additional health care provider could be necessary with later terminations”.

- the effects on staff of performing terminations later in gestation

  “technically more difficult to perform at a later gestation, and affects staff far more considerably. So should involve more thorough confirmation that it is appropriate to do.”

5.1.4 Consultation for early medical termination

The survey asked whether consultation for early medical termination (up to end of 9th week) should be available by phone / video-link as opposed to the current requirement for in-person consultation, if one, or more than one consultation is required.

Table 24 –Should consultation for early medical termination (up to end of 9th week) be available by phone / video-link as opposed to the current requirement for in-person consultation - If there is only one consultation

	Respondent type		
	All respondents	**People with professional experience**	**People with personal experience**
It should be available via phone / video link	47%	25%	49%
It should be in-person consultation	50%	74%	49%
Don't know / prefer not to say	3%	1%	2%

While the responses were almost half and half for all respondents between consultation by phone / video link (47%) and in person consultation (50%), almost three quarters (74%) of people with professional experience thought consultation should be in person.

Table 25 –Should consultation for early medical termination (up to end of 9th week) be available by phone / video-link as opposed to the current requirement for in-person consultation - If there is more than one consultation

	Respondent type*		
	All respondents	**People with professional experience**	**People with personal experience**
All consultation should be available via phone / video-link	28%	12%	28%
All consultation should be in-person	31%	46%	30%
There should be a mixture of phone / video-link and in person consultation	39%	41%	40%
Don't know / prefer not to say	2%	1%	1%

**Percentages may not add up to 100 because they are rounded*

If there were more than one consultation, the majority of respondents (39%) thought there should be a mixture of phone / video link and in person consultation. Most people with professional experience thought all consultation should be in person (46%), but they were more likely to respond in favour of phone / video link consultation when used in combination with in person consultation.

The survey asked whether a woman who is having an early medical termination (up to end of 9th week) should be able to self-administer both medications at home as opposed to having the first medication administered by a doctor at the Jersey General Hospital, and the second self-administered at home, as is currently required.

Table 26 – Should a woman who is having an early medical termination (up to end of 9th week) be able to self-administer both medications at home as opposed to having the first medications administered by a doctor at the Jersey General Hospital, and the second self-administered at home, as is currently required.

	Respondent type		
	All respondents	**People with professional experience**	**People with personal experience**
Yes, in all cases	36%	23%	39%
Yes, but only if there has been at least one in-person consultation	40%	51%	38%
No	20%	23%	20%
Don't know / prefer not to say	4%	3%	3%

Just over a third (36%) thought a woman should be able to self-administer both medications at home. This increased to just over three quarters (74%) if there was at least one in-person consultation.

One organisation argued for consultation in person to enable more accurate determination of gestational age, to provide better safeguards against coercion and for young people, and to check without doubt that the woman requesting the medication is the woman who is pregnant.

They also raised concerns that the self-administration of both medications at home "*is not conducive to the best possible care for women with respect to complications, nor does it provide for adequate oversight with regard to pills being taken at a later date or even given to a third party.*"

5.1.5 Criminal liability

It is a criminal offence for a woman to have a termination in Jersey that is not carried out lawfully (for example, if the termination is at a later gestation period than permitted in law).

Both the woman and any person carrying out the termination (including the administering of any drug for the purpose of inducing a termination), could be liable for criminal prosecution.

The survey asked who should be liable for prosecution if a termination were carried out in a way that was not lawful.

Table 27 – If a termination were carried out in a way that was not lawful, who should be liable for prosecution?

	Respondent type*		
	All respondents	**People with professional experience**	**People with personal experience**
The woman who has the termination	20%	25%	17%
Any person who carries out the termination (ie. performs surgery or administers drugs)	39%	46%	38%
Any person who assists with the termination	23%	28%	20%
No-one (it should not be a criminal issue)	40%	26%	40%
Don't know / prefer not to say	5%	9%	6%
Depends on the circumstances+	15%	22%	16%

** Total responses are greater than total submissions analysed as this question allowed respondents to select more than one answer.*

+The following themes were identified where respondents answered 'depends on the circumstances':

- the need to determine culpability on a case by case basis, dependent on factors including age of foetus, whether the person knowingly broke the law, if any party intentionally withheld information, and if abuse / exploitation / intentional harm were at play
- the need to be able to make exceptions, i.e. a minor who terminations out of fear / women under duress / women being abused
- the medical professional being liable if the woman dies / is harmed due to the procedure
- that liability should extend to a woman who travels off island, and those who help her to arrange it for the purpose of circumventing Jersey law
- where the medical professional fails to establish gestation prior, or where scans have been undertaken but ignored
- it should be an offence where the woman has been physically or psychologically coerced or deceived "e.g. a partner secretly inserts abortifacients into the food of a pregnant woman."

- support for decriminalisation except in the following cases:
    - where termination is carried out against the woman's wishes, including where coerced or presented with misinformation
    - where termination is carried out by someone who is not a trained medical professional and clinical standards are not followed
    - where a person profits financially from illegal termination (i.e. unlicensed abortion clinics)

Only one fifth (20%) of respondents thought the woman should be liable for prosecution. Just over two thirds (39%) thought any person carrying out the termination should be liable, and 40% thought no-one should be liable as termination should not be a criminal issue.

Reponses from people with professional experience differed in that almost half (46%) thought the person who carries out the termination should be liable, and only a quarter (26%) thought no-one should be liable.

5.1.6 Safe access zones

Some jurisdictions have safe access zones to protect people who use or work in termination services from harassment and intimidation by anti-termination protestors including, for example, verbal abuse, filming, following people, unsolicited contact and use of banners or signs containing derogatory slogans.

The survey asked if safe access zones should be introduced in Jersey and, if respondents said 'yes' what types of behaviours should be prohibited in safe access zones.

Table 28 – Should safe access zones be introduced in Jersey

	Respondent type*		
	All respondents	**People with professional experience**	**People with personal experience**
Yes	80%	75%	82%
No	13%	14%	12%
Don't know / prefer not to say	6%	10%	6%

**Percentages may not add up to 100 because they are rounded*

Table 29 – Of those who said 'yes' to safe access zones being introduced in Jersey, which types of behaviour should be prohibited in an area that is a specified distance from a termination service (a safe access zone)?

	Respondent type*		
	All respondents	**People with professional experience**	**People with personal experience**
Harassment	97%	98%	96%
Intimidation	97%	98%	96%
Obstruction	96%	98%	96%
Communicating about termination, in a manner that could be seen or heard by a person accessing or leaving premises providing terminations, where the communication is reasonably likely to cause distress	94%	94%	95%
Impeding a footpath, road or vehicle without reasonable excuse	92%	94%	91%
Intentionally recording a person accessing or leaving premises providing terminations, without consent or reasonable excuse	95%	94%	94%
Don't know / prefer not to say	2%	2%	2%
Other[+]	3%	0%	3%

** Total responses are greater than total submissions analysed as this question allowed respondents to select more than one answer.*

+'Other' responses included broadcasting footage on social media, doxing (publishing private or identifying information about a person on the internet, typically with malicious intent), online harassment and publicly shaming online, deliberate or prolonged surveillance or observation, distribution of flyers of leaflets, protesting, including with placards, any intentional nuisance (including loud music, noise, fireworks) that makes the environment less conducive to medical treatment, extending protections for women and staff after they have left the safe access zone (i.e. following them from the clinic / waiting at their homes), and being broadly in line with those laid out in section 9 of the Public Order Act 2023

Other comments

While 80% of respondents thought safe access zones should be introduced in Jersey, some additional themes were observed in the comments received including the encroachment of safe access zones on human rights, whether they are necessary and how enforceable they would be.

> *"If safe access laws were put in place I would protest at a clinic just to bring it to court. This would be a massive violation of freedom of speech and freedom of assembly and I would be willing to be prosecuted to provide a test case."*

> *"I don't believe safe zones are necessary in jersey as we don't have abortion clinics. If all treatment happens either at the gp or hospital then it will not be obvious why you are going to either"*

5.1.7 Other comments

The survey gave respondents the opportunity to provide final comments. The themes associated with those comments (plus comments from the written submissions which are not already covered) are set out below.

1. Women's rights / freedom of choice - there were many comments calling for the removal of unnecessary regulation and control.

   "Termination is a fundamental healthcare right and the fact that there are restrictions in place is discriminatory."

   "I didn't realise until now that abortions in Jersey were so regulated. I am horrified. A potential mother should be free to choose her own future, without abuse or jumping through hoops to make other people feel better about themselves. I may not agree with every person's reason to terminate but it should not be my choice since it does not affect me, my life or my future. If a person realises too late that they are pregnant then the current law prevents them from fixing a mistake. If someone is willing to go through 35 weeks of pregnancy and then terminate, that is their choice. I don't have to agree with it, nor do I have to make the same choice. I would want to be able to choose for myself what is right for me at that point in my life. Something that would significantly affect my body, my health and my future should not be decided for me."

   "We're in the year 2023 and it in unbelievable to me that still, women's bodies are being regulated by the government who should have no right whatsoever, to tell a person what they can and cannot do with their bodies."

   "At the end of the day regardless of your views, a woman having an abortion is her (and her partners) business and hers alone."

2. Protection of the unborn foetus – several respondents argued for tighter controls to protect the child's right to life.

   "*Protection of all life is fundamental, and Jersey should not encourage or make available abortions offshore to get around the Jersey law."*

   "The survey is biased as it supposes that everyone who completes the form will be in favour of abortion on some level or at least wish to uphold the current law. I think the rights of an unborn child have been grossly neglected since abortion was legalised in the UK in 1967."

   "None of your questions have asked about the child's right to life, which is astonishing."

   "Many jurisdictions are looking to reduce the termination limit from 24 weeks as this is seen as abhorrent given that babies born at 23 weeks, or sometimes earlier, usually survive. It seems a backward step for Jersey to consider raising the limit."

3. Safeguarding women

   "Telephone consultation and posting medication leaves room for forced abortion"

   "Any reform should ensure that a woman is not coerced into abortion, given the recognised association between abortion and abuse."

4. Better support for families

"Bringing up children in Jersey is very difficulty for many families, especially for those on low incomes….. I believe that as a society we have a responsibility to support families with children, including those who are single parents right from the start of a pregnancy, with the father not involved. I would really like to see this wider picture considered more. The demand for abortion reflects society's values in lots of ways and one of those is the increased tendency to see having children as a personal choice and for adults to feel no sense of collective responsibility towards other people's children. I long to see a cultural change away from that."

"Instead of making abortion easier, there should be more support for single parents, mothers with intellectual or emotional problems, and families in difficult circumstances."

5. Restrictions on the type of health care professionals involved – that nurses or other suitably qualify health care professionals should be able to refer women for termination.

6. Residency requirements – the need to review the 90 day residency requirements associated with termination in Jersey.

"I am concerned about the 90 day rule – if a woman has moved to Jersey to live then they should be able to have access to a termination at any stage"

"90 residency limit should be extended to 1year to ensure Jersey is not used by non - residents."

The stipulation that the person is required to be in Jersey for 90 days before they are eligible for a termination should be reviewed. The person may be suffering distress or may not be in a financial position to afford a termination in another jurisdiction. It is discriminatory in my opinion as they deserve access to this treatment if they have moved to Jersey to start a new life. The idea that people are "abortion tourists" is unfounded.

7. Charges – there were many comments calling for termination to be free to women.

"Termination should be free to Jersey residents. Not everyone can afford over £100 to terminate a pregnancy, especially if they are terminating due to financial pressures."

"Charging for terminations is an additional barrier to women accessing healthcare, and seems to suggest that terminations are not being treated as regular healthcare, but are somehow different. This messaging is problematic, and potentially shaming to women."

"Please make it a free service. I struggled paying for my termination."

"If we do not expect a smoker to pay for their lung cancer treatment, why do we expect a woman who is sexually active to pay for her termination? It is another misogynistic stab at half of our population, another cost for the "privilege" of womanhood.

8. Terminology – the importance of language was referenced several times by respondents. Some favoured the use of the term 'women' in the consultation over other terms such as 'pregnant person'. Others felt it was discriminatory and that the law should be gender neutral.

   One organisation cited several studies about the importance of using clear and accurate language in describing the foetus to women to better prepare them for the termination and the products that would be expelled.

9. Contraception – that it should be free, that access to the morning after pill should be better, that long-acting reversible contraception should be more readily available without a long wait, and that improved information and education should be available.

   "There should be no reason why fertile women cannot access free contraception to avoid unwanted pregnancies."

   "I think women should be better educated on methods of contraception to avoid unwanted pregnancies which might lead to terminations."

   "The morning after pill should be free and easy to access. It can be difficult for a woman to go to pharmacy and answer questions if she is a single parent with children so male sexual partners should also be able to obtain this on behalf of the woman. Telephone consults should be available. I believe this would significantly reduce the need for many to consider termination.

   "I think better investment in preventing pregnancy through better access to contraception would be good. There are long waiting lists for coil insertions and not enough investment in incentivising GPs to do these LARC (Long acting reversible contraception) procedures. In my opinion all LARC procedures should be free to women at GP, Le Bas and Brook."

10. Conscientious objection – that doctors should continue to be able to opt out of carrying out terminations. There were opposing views expressed as to whether doctors who object should be required to refer or signpost women to another doctor.

11. Improved information and education

    "The lack of information surrounding abortions in Jersey is very minimal. Women should have the right (as it's their bodies) if they want to terminate a pregnancy, without any delays or unnecessary consultations and this should not be a taboo or shameful topic. I feel as though greater awareness is to be had (and I don't mean promoting abortions) but women should feel properly informed and able to access this information freely."

    "Information about terminations should be more readily available/ taught in schools."

12. Self referral – that women should have direct access to termination centres without the need to see a GP.

    "The cost implication of seeing a GP on top of the cost of a termination may act as deterrent or delay. As a GP I support the legalisation of termination, but morally find it difficult conversation to have with women. I'd prefer others, who have more training and time to be able to have the discussions about risks/ benefits with the women,

rather than me. I find it difficult to 'opt out' of dealing with termination consultations, as patients do not disclose their need at the point of making the appointment."

"I think the requirement to attend the GP is an additional barrier and all terminations should be free and available for self-referral."

13. Additional support for women – before (to assist with decision making) and after termination

"There needs to be more support for women following a termination. For myself i didn't realise how much it affected me until months later, where at the time i just wanted it to be done and get out of hospital. The guilt that arises overtime was for me, intolerable. I also think there should be more support psychologically for women. I had a termination, where by i wanted to keep the pregnancy, but it was not the right choice for my marriage at the time, it would have caused unimaginable torment. I felt that i had to say that i didn't want the pregnancy but in reality i did…."

"There should be a follow up appointment available to women who have had a termination to ensure they are coping with it. In my experience supporting a woman as she had a termination and after, there was no support for her. Even in the hospital she was left in the room whilst the abortion was happening, nobody came to check she was ok & she was in considerable pain. This did not seem right."

"If a family are expecting a child with a disability or life-limiting condition, they may benefit from counselling and/or contact with specialists and other families in the rest of GB, who have children with the same condition."

"There was no emotional support afterwards. I went back to work the next day and cried in the toilet."

"The Dr I saw in the hospital didn't sign me off work afterwards, so I returned to work less than 18 hours after waking from general anaesthetic, still bleeding..."

14. Treating women with dignity

"My experience made me feel judged. I had to justify why I was terminating, to more than one medical professional. The worst part was having to be sat in a public waiting room amongst other people, I presume, also waiting for the same thing (I work in a profession where I encounter many people so could have easily seen someone I knew or vice versa). It didn't feel private or like a protected space at all. I was then forced to make a decision about what contraception I would go on after, to ensure it didn't happen again!"

"I was in a vulnerable state when I discovered I was pregnant. My contraception had failed. I did not want to be pregnant. I did not know how to access termination services. I had to travel to England, on my own, stay in a strange place for several days, have an extremely distressing procedure carried out, with no mental support offered. I also had to pay travel, accommodation costs and £900 for the termination. I was a teenager and had to use my first months pay of my new job to pay for this. I was offered no aftercare when back in Jersey, no one checked if I was ok. Before leaving Jersey, I had to have a scan and sit near happy expectant couples. I have always believed the procedure to access a termination in Jersey is deliberately difficult and as distressing

as it can be, in order to punish the woman or girl as much as possible. This should not be the case and an update to this would be welcomed by me, as I hate to think other girls going through what I went through. I had done nothing wrong and needed help and support. The termination was the correct decision for me, I don't ever regret it, I only wish Jersey could have supported me and treated me better."

15. Ultrasound scanning – there were opposing views on the use of ultrasound scanning. Some respondents called for routine scanning to avoid the risk of incorrect pregnancy dating while others felt that it is unnecessary and insensitive unless there was a clinical need.

16. No change – some respondents do not think the law needs to be changed

"More or less it is suitable for the rights and needs of pregnant women and unborn babies, so don't see an urgency in the necessity to change it, especially only under 10 persons per year went to terminate it in UK, that means Jersey's current law and service are good enough for the majority, as they terminated it here."

"Jersey law does not need tampering with and should be left alone. Evidence clearly shows that the law as it stands is fit for purpose, as evidenced by the number of women accessing its services every year."

17. Concern about 'moving backwards'

"Please do not revoke such an important service like America has. Women should have a right to decide on what happens to their body."

"Let's not follow America back into the dark ages."

18. Reporting – that termination should continue to be certificated and reported on.

NOTE: Reasons for not proceeding with a termination in Jersey

As set out in Section 4.3.1, some respondents stated they were unable to have termination (or the person they were supporting was unable to) and provided information as to why this was the case:

- Because it was illegal due to 12 week time limit in Jersey

  "Was unable at the time to have a termination in Jersey and therefore, despite age and inexperience, had to travel solo to the UK."

- Delays in the system meant they were too far along

  "My friend found out they were pregnant quite late due to antibiotic medication cancelling out the contraception they were on and also masking some of the pregnancy symptoms… There was just about enough time to follow the procedure, however my friend allegedly experienced issues with their GP expressing their personal opinions as well as professional opinions during the initial consultation and not being available for a follow up once the cool-off period was over [the law

previously required a 7 day cool-off period but this has subsequently been removed] As a result, my friend ended up over 12 weeks pregnant and ultimately had to go off island to receive the abortion."

- Coercion by partner or family

  "I wanted to terminate but was told I had to wait 7 days to make sure I really wanted to terminate - my partner of the time (now ex) threatened to kill himself if I terminated in those 7 days so I kept it."

- Cost / the need for a second consultation / judgement by staff involved

  "my friend felt unable to [terminate] due to a judgemental GP, the stress of having to attend a second consultation, and the cost of termination."

- Medical reason, such as a miscarriage or complication

5.2 Local professional stakeholder meetings

Feedback from local professionals focused on the following themes:

1. Criminal offences

   Women and doctors should not be liable for criminal offences; there are already laws to stop doctors stealing kidneys, why does termination warrant specific legislation.

   There is very minimal evidence of illegal or non-consensual termination in Jersey. Only one case was mentioned where a professional has suspected illegal termination. No-one has ever been prosecuted for illegal termination in Jersey.

2. Gestational limits

   Local women do sometimes present after the 12th week and have been left with no choice but to travel off island for termination. The numbers of women presenting after 12 weeks is low and those that do mostly come forward within the 14th / 15th / 16th week.

   It was stated that women, who are more than 12 weeks pregnant, may need to proceed with their pregnancies if they are unable to travel off island because they vulnerable or cannot afford a termination in the UK. This could potentially result in children being taken into care.

   Some professionals believe that the gestational limits should be increased either in line with the UK or other jurisdictions but there is concern about removing them completely and some concern that an increase may result in the loss of staff already working within the service.

   One professional who had encountered women beyond the limits said there is usually a tragic reason why women present late and instead of treating them with dignity and respect we inflict inconvenience and cost on these vulnerable women.

   One professional suggested the government could look to implement financial support for women who present late and have to travel off island (as opposed to changing the limits), particularly for young or vulnerable people.

3. Women's experiences / preferences

   Most women prefer to miscarry in the privacy of their own home and there are no single rooms available at the hospital termination clinic for women to have privacy. Sometimes a single room is used on another ward where required and if available.

   Discretion is an issue as the service runs from the same clinic at the same time on the same day every week.

   For clients of sexual assault, surgical terminations are preferred, even when carried out earlier in gestation as surgical termination makes it easier to preserve forensic evidence.

4. Support, counselling, safeguarding

   Many stakeholders believe counselling should be available as a standard part of termination care, at first point of contact to support the decision-making process as well as later as aftercare.

   Follow up care is regarded as important both in confirming that terminations are complete and in enabling the provision of aftercare.

The learning disability service supports people with learning disability with any aspect of their health. They have guidelines that cover termination including sexual health education, the provision of information about termination and options for women. They also assess capacity for decision making where required.

5. Young people

   Providers should be required to consult with young people in person to better enable the detection of safeguarding risks and to enable ultrasound scanning to determine gestational age more accurately, which can be harder with younger women.

   A good, robust, age-appropriate approach should be adopted that encourages the use of the service locally as opposed to driving young people off island and potentially placing them at greater risk. It should include follow ups with young people to ensure pregnancies have ended as expected and to make emotional support available.

6. Reporting

   It is suspected that not all terminations are notified within 7 days as is the current requirement under the law.

7. Residency requirement

   The residency requirement is a problem, particularly for those on short term work visas who discover they are pregnant but have not been on the island for 90 days. There has been confusion in the past about whether some women have met the residency test or not (for example where they may have been ordinarily resident in the UK for a long period of time but have only been in Jersey for a couple of weeks).

   Proving residency is an added stress for clinicians. If the residency requirement remains, they want better guidance on who qualifies / does not qualify and to be able to escalate individual cases to the Minister for consideration.

8. Charges

   Charges are an issue for those with lower incomes or difficulty accessing money, particularly people liable for the higher charge of £511. Users are expected to pay for the service in advance which is not possible for those who cannot afford it. Payment plans are often set up enabling people to pay by instalment long after their procedure has taken place.

   At least one local charity has seen instances of women accessing food banks because they are using their money to pay off termination charges.

   Dealing with finances distracts from and gets in the way of delivering clinical care.

   Women who are victims of sexual violence are still charged for termination.

   Barriers have been observed to some women seeking financial support for termination (Income Support) such as a controlling partner, not being able to tell their partner about their termination, pride / shame.

9. Consultation and Pathways

   Many think the service should be available to access without referral.

If it were to be accessed without referral, some GPs thought they should be notified so that they could provide after care and support to their patients if required (a question was raised as to how this would be funded).

Some professionals think termination should be offered in the community for early medical terminations within the first 9 weeks, and then by referral into the clinic for surgical and later terminations.

Le Bas Centre, an integrated sexual health service and primary care were commonly suggested as alternatives to the hospital clinic. There is greater preference for a specialist centre over GP surgeries.

Concerns were raised about the availability of GP appointments and how safety, monitoring, complications (such as ectopic pregnancies), the requirement for rapid access to secondary care facilities if required, the general need for 24 hour access for clinical queries, and whether community clinicians would be able to consistently safeguard women to the standard required if the service were to be provided in the community.

There have been previous concerns about prostitution and other areas of exploitation, particularly amongst minority migrant women who are more vulnerable and less likely to access support. The importance of being able to devote time to each woman to fully understand her situation, particularly where she is young or English is not her first language was stressed to be of particular importance. There was concern about how this would be offered consistently, particularly by GPs across primary care.

Some GPs themselves feel they are well placed to safeguard as there is often already an established relationship with patients and their families and every practice has a safeguarding lead.

If the service were to move outside of the hospital, it was emphasised that consideration must be given to training and upskilling the professionals involved both in terms of clinical care but also for counselling and safeguarding purposes.

Telecare and termination at home was trialled during the Coronavirus pandemic and thought to have worked well, however some professionals thought telecare generally would not be positive; doctors have done their upmost to maintain face to face consultation which enables them to read physical cues / body language and is considered to be conducive to better quality of care.

Everything is currently paper based and, if documents get lost in the system, women can be turned away from the clinic. Professionals noted the potential to make the process slicker through digital signature and electronic records.

Women are currently required to return to the hospital the following day to collect the second pill from the hospital pharmacy which is inconvenient and causes confusion (women often turn up on the ward instead of at the pharmacy). Clinic staff would prefer to be able to dispense the drugs to women before they leave the clinic with clear instructions on how and when to take them.

The law requires referring doctors (most usually the GP) to confirm in writing that they have informed the woman of counselling and adoption options. Doctors do so, to progress matters on the woman’s behalf, but given the lack of information and support that is actually available think this provides for poor patient care and that they should be able to use their judgement on when this is appropriate.

The referral form has a free text box to specify the grounds, rather than tick boxes which makes the rules unclear. Some GPs were also unclear on the rules for newly registered or private patients about whether they could be referred and if so what the costs were due to a lack of accessible information.

10. Lack of staff / capacity

    Only one consultant and a small number of doctors are prepared to perform terminations in Jersey which is a significant potential risk to maintaining the service.

    There is a reluctance to provide the service, partly on grounds of conscientious objection but also because clinicians want to feel protected and know they are not going to be inadvertently criminalised due the restrictions in law.

    Practical concerns were raised about any increase in gestational limits as it would be hard to get professionals to participate in the service for later stage terminations, there is already a shortage of beds in the gynae unit and on the surgical floor, and there is a lack of experienced gynae nurses and increased pressures on day nurses. Under the current service model the only option would be for women to go to maternity to be looked after by midwives but there was concern about the willingness of midwives to participate.

    Doctor time and resource at referring sexual health services is often limited. As the law allows for doctors alone to be able to refer women for termination, this puts doctors in these services under increasing pressure. It was felt that the ability for women to self-refer directly to the service, or for other medical professionals to make the referral would ease the burden on doctors considerably.

11. Scanning

    There are challenges with regards to scanning. Ideally the service would have a sonographer but the reality is that often scans are carried out by the consultant.

    Clinicians said they scan to be more certain of gestational age and to detect risk (such as an ectopic or molar pregnancy). In the past scanning has detected risk, avoided women who have already miscarried going through an unnecessary termination and in some instances, where a woman has identified through scanning that she is carrying twins, has led her to continue with the pregnancy.

    Up until recently scanning was provided to every woman undergoing a termination, but more recently has been used only where necessary to determine gestational age, to rule out clinical risk, or where the woman wishes to have a scan.

    Access to ultrasound equipment in primary care was described as ‘appalling’ and was commonly referred to as a barrier to the service moving out of the hospital although it was noted that removing termination from criminal law or extending the gestational limits would give clinicians more comfort about determining gestational age based on a woman’s last menstrual period and reducing the need to scanning.

12. Contraception

    Access to contraception was described as an issue for termination. Professionals believe the majority of women who terminate are not using contraception. Most are embarrassed to admit they are not using it.

While women are referred and followed up for free treatment at the contraceptive clinic after their termination, it was suggested that it would be better if contraception were discussed / prescribed / fitted there and then.

Many believed contraception, including emergency contraception should be free and that charging for contraception, particularly sterilisation and coils was problematic. Sterilisation and coils are expensive and sometimes women who would prefer to use these more reliable options, use other less reliable contraceptives which are cheaper. If charges are removed from termination, they should also be removed from contraception.

There are already existing education programmes in place which provide education from year 7 up to age 21. Education in school and better contraceptive availability were acknowledged as being crucial to remove any reliance on termination as a form of contraception.

Information / resources

There should be opportunity/resources for women/families to understand their options early.

13. Attitudes

Termination is an emotive subject and still associated with a lot of stigma. In the hospital staff refer to it by it initials [“ToP”] and it is generally not talked about.

It should be normalised as an option for women who do not wish to continue with a pregnancy.

It was stated that the health system makes moral judgments on women depending on their circumstances; if they are having a termination on the grounds of foetal abnormality, they are looked after but in other situations they can be left vulnerable and alone to carry the burden and financial implications, and deal with the judgement,.

14. Safe access zones

Many do not feel the need for safe access zones if arrangements stay as they are (ie. the ToP clinic is hidden in the hospital) but acknowledged they may need to be considered if that were changes. Stated they should also be considered in relation to other potentially controversial services (i.e. assisted dying).

6 Next steps

The feedback provided will help inform the development of a report and proposition to be presented in the States Assembly before the end of 2024. The report and proposition, which will also be informed by research into termination services in other jurisdictions, will ask the Assembly to agree in principle changes to the Termination of Pregnancy (Jersey) Law 1997, ahead of law drafting.

The report and proposition will also set out whether additional monies are required to support service improvements.

Appendix 1 – Promoting participation in the consultation

Table 30 - Summary of consultation promotional activity

Media/location	Format	Detail
General media	Press notice	At launch
General media	Note to press	Part way through consultation
Gov.je	Online consultation page	Throughout consultation period
Jersey Evening Post	Full page advertisements	x2 full page, page 3 advertisements
Health and care settings and organisations that provide support to islanders	A3 posters and leaflets	Throughout consultation period
Social Media*	Facebook	X3 advertisements
Social Media*	Twitter	X3 advertisements
Social Media*	Instagram	X3 advertisements
Social Media*	Linked in	X3 advertisements
International Cultural Centre Jersey ("ICCJ")	In meeting / via email	The ICCJ through the ICCJ Steering Group agenda promoted the consultation and shared information by email with the steering group for them to disseminate.
HCS clinics	Verbal	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 where a history of termination was disclosed).

*See appendix 2 for more details

Sample JEP advertisement: Tuesday 19th September 2023

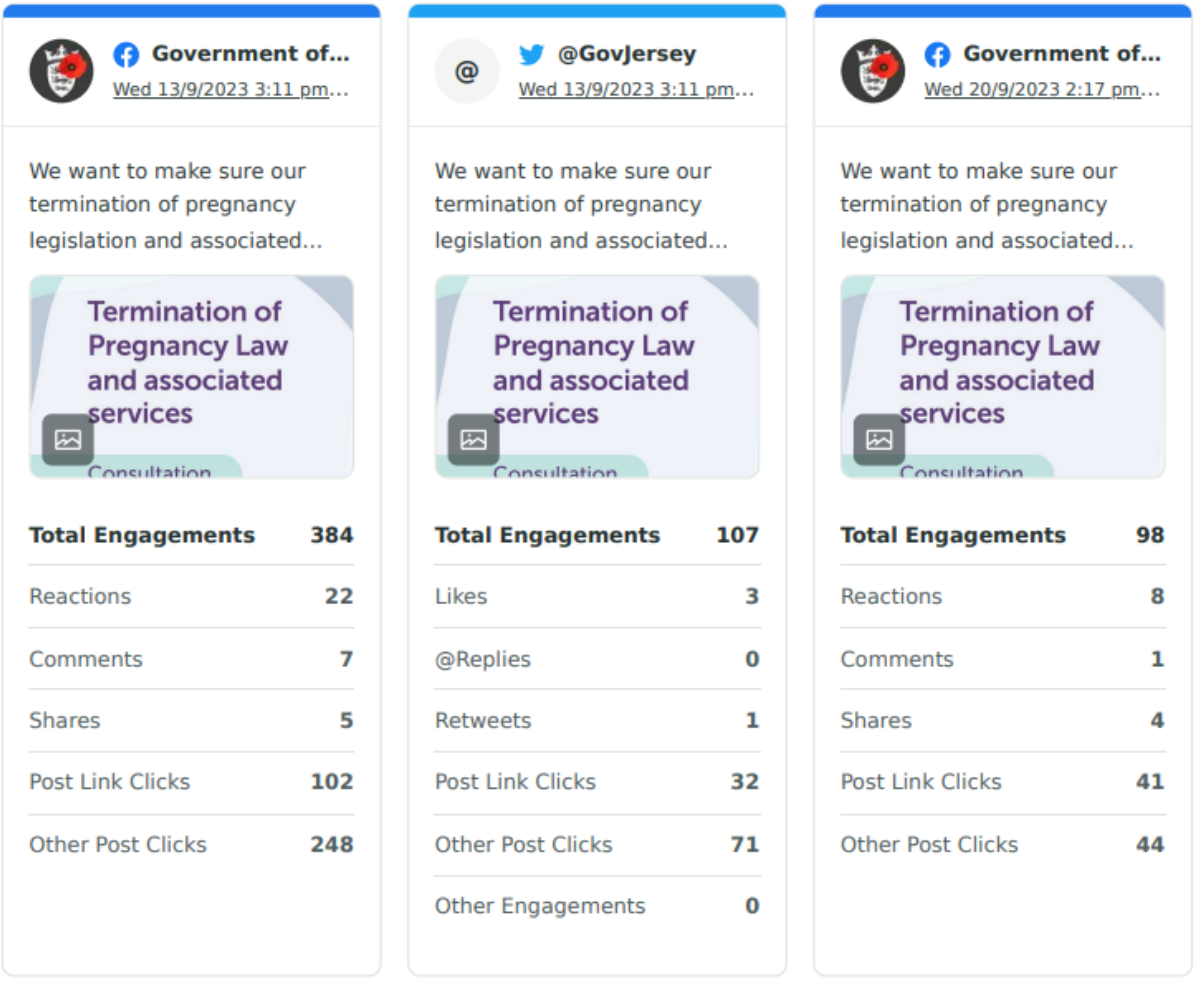
Appendix 2 – Social media analytics

The social media analytics listed below were collected for each post across Facebook, Twitter, Instagram and linked in. They are categorised by:

- **reach**: the number of people who saw each post at least once
- **impressions**: the estimated total number of times each post was seen. This is different to reach as it may include multiple views of a post by the same person
- **engagement**: the number of reactions, comments, shares or clicks on each post

Table 31 – Social media analytics

Tagged published posts	12
Total Impressions	36,063
Average Reach per post	3,680.17
Total engagements	942
Engagement Rate (per impression)	2.6%
Post link clicks	303



governmentofj...
Wed 13/9/2023 3:11 pm...

We want to make sure our termination of pregnancy legislation and associated...

Total Engagements	60
Likes	44
Comments	0
Saves	11

governmentofj...
Wed 20/9/2023 2:18 pm...

We want to make sure our termination of pregnancy legislation and associated...

Total Engagements	58
Likes	42
Comments	0
Saves	3

Government of...
Wed 13/9/2023 3:11 pm...

We want to make sure our termination of pregnancy legislation and associated...

Total Engagements	57
Reactions	2
Comments	1
Shares	1
Post Clicks (All)	53

@GovJersey
Wed 4/10/2023 10:15 a...

We want to make sure our termination of pregnancy legislation and associated...

Total Engagements	52
Likes	0
@Replies	2
Retweets	0
Post Link Clicks	14
Other Post Clicks	36
Other Engagements	0

Government of...
Wed 4/10/2023 10:14 a...

As part of the Government's termination of pregnancy review, women are asked to...

Total Engagements	45
Reactions	10
Comments	0
Shares	1
Post Link Clicks	11
Other Post Clicks	23

@GovJersey
Wed 20/9/2023 2:17 pm...

We want to make sure our termination of pregnancy legislation and associated...

Total Engagements	28
Likes	0
@Replies	0
Retweets	1
Post Link Clicks	13
Other Post Clicks	14
Other Engagements	0

Government of...
Wed 4/10/2023 10:15 a...

As part of the Government's termination of pregnancy review, women are asked to...

Total Engagements	**21**
Reactions	**0**
Comments	**0**
Shares	**0**
Post Clicks (All)	**21**

governmentofj...
Wed 4/10/2023 10:16 a...

As part of the Government's termination of pregnancy review, women are asked to...

Total Engagements	**16**
Likes	**14**
Comments	**0**
Saves	**0**

Government of...
Wed 20/9/2023 2:15 pm...

We want to make sure our termination of pregnancy legislation and associated...

Total Engagements	**16**
Reactions	**0**
Comments	**0**
Shares	**0**
Post Clicks (All)	**16**

Appendix 3 – Survey questions

Overview

The Minister for Health and Social Services has launched a review of the Island's Termination of Pregnancy (Jersey) Law 1997 (“the 1997 Law”).

The 1997 Law has remained largely unchanged for over 25 years, although other countries have revised their legislation over this time period, taking steps to ensure it better supports women.

The Minister is committed to conducting a review of Jersey's legislation to better understand if it reflects societal values, meets the needs of women, and takes account of changes in medical practice.

The purpose of this survey is to gather views on the current law and its provisions. This consultation seeks input from all Islanders, regardless of gender and personal experience. As termination of pregnancy is currently legal in Jersey, the survey does not ask if it should be illegal.

Completing the survey

The survey will take approximately 30 minutes to complete. There are nine sections in total. Section 1 asks demographic questions to help analyse the results of the survey; Section 2 provides background information; Sections 3 to 9 focus on a specific issue related to termination of pregnancy and then ask a number of related questions.

Termination of pregnancy is a sensitive topic. If you find any of the questions upsetting or do not wish to answer, you can move onto the next question.

Section 1 - Demographics and consent

We ask these questions to help us analyse the results of the survey.

1. Do you live in Jersey?
If you split your time on and off island, please tick 'yes' and base your answers on your experiences of living in Jersey.

- ☐ Yes
- ☐ No

2. Are you answering as an individual or on behalf of an organisation?

- ☐ As an individual (**continue to question 3**)
- ☐ On behalf of an organisation (**move to page 7, question 11**)

Complete these questions if answering as an **individual**

3. Do you give permission for your comments to be quoted in our consultation feedback report and other publications?

All quotes will be published anonymously.

- ☐ Yes
- ☐ No

For information on how we handle personal data for this consultation visit: www.gov.je/terminationofpregnancy

4. Where were you born?

- ☐ Jersey
- ☐ Elsewhere in the British Isles*
- ☐ France
- ☐ Republic of Ireland
- ☐ Poland
- ☐ Portugal or Madeira
- ☐ Other European country:

Do not include personally identifying information as part of your answer.

(There are more options on the next page)

- Elsewhere:

  Do not include personally identifying information as part of your answer.

- Prefer not to say

**British Isles includes England, Wales, Scotland, Northern Ireland, other Channel Islands and the Isle of Man.*

5. What age-group are you in?

- Under 16
- 16 to 19
- 20 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 to 84
- 85 and over
- Prefer not to say

6. What is your gender?

- Female
- Male
- Other
- Prefer not to say

7. Do you work or have you ever worked, in an organisation that provides termination of pregnancy services or related care (ie. GP, contraceptive, sexual health, counselling, sexual assault, domestic violence, or legal services)?

We ask this question as we want to understand professional views.

- Yes

- ☐ No
- ☐ Prefer not to say

8. **If yes**, which of the following termination of pregnancy services or care does / did your organisation provide?

Please tick all that apply

- ☐ Termination services
- ☐ Contraceptive or sexual health service
- ☐ GP services
- ☐ Counselling service
- ☐ Sexual assault or domestic violence service
- ☐ Legal services
- ☐ Prefer not to say
- ☐ Other, specify the services provided below:

Do not include personally identifying information (about you as an individual) as part of your answer.

9. Where are / were the organisation's services or care provided?
Please tick all that apply

- ☐ Jersey
- ☐ UK
- ☐ Online
- ☐ Prefer not to say
- ☐ Elsewhere, tell us where below:

Do not include personally identifying information (about you as an individual) as part of your answer.

10. Do you have any personal experience of termination of pregnancy services and care (not gained professionally through work)? If so, what were the circumstances?

We ask this question because we want to understand the views of people who have experience of services.

Please tick all that apply

- ☐ None, I have no personal experience
- ☐ I have had a termination
- ☐ I am currently considering having a termination
- ☐ I considered having a termination but chose not to
- ☐ I wanted a termination but was unable to
- ☐ I supported / am supporting someone who had a termination
- ☐ I am supporting someone who is currently considering having a termination
- ☐ I supported someone who considered having a termination but chose not to
- ☐ I supported someone who wanted to have a termination but was unable to
- ☐ Prefer not to say
- ☐ Other, tell us about the circumstances below:

Do not include personally identifying information as part of your answer.

11. If you have experience, was your experience in Jersey or elsewhere?

- ☐ In Jersey
- ☐ UK
- ☐ Online
- ☐ Prefer not to say
- ☐ Elsewhere, tell us where below:

Do not include personally identifying information (about you as an individual) as part of your answer.

12. If you have experience where you / the person you supported wanted a termination but were unable to, please tell us why you or the person were unable to.

Do not include personally identifying information as part of your answer.

Complete these questions if answering on **behalf of an organisation**

13. What is the name of the organisation?

Do not include personally identifying information (about you as an individual) as part of your answer.

14. Does the organisation provide any of the following services or care related to termination of pregnancy?

We ask this question as we want to understand professional views in Jersey.

Please tick all that apply

- ☐ No, none
- ☐ Termination services
- ☐ Contraceptive or sexual health services
- ☐ GP services
- ☐ Counselling or advice services
- ☐ Sexual assault or domestic abuse services
- ☐ Legal services
- ☐ Prefer not to say
- ☐ Other, specify the services provided below:

Do not include personally identifying information (about you as an individual) as part of your answer.

15. Where are the organisation's services and care provided?

Please tick all that apply

- ☐ Jersey
- ☐ UK
- ☐ Online
- ☐ Prefer not to say

(There are more options on the next page)

- Elsewhere, tell us where below:

Do not include personally identifying information (about you as an individual) as part of your answer.

16. Do you give permission for your comments to be quoted in our consultation feedback report and other publications?

- Yes, attributed to my organisation
- Yes, but not attributed to my organisation
- No

For information on how we handle personal data for this consultation visit: Strategic Planning, Policy and Performance privacy policies (gov.je)

Section 2 - Background

Termination of pregnancy in Jersey

Before the introduction of the 1997 law [1], termination of pregnancy in Jersey constituted the crime of murder or manslaughter unless performed "*in good faith for the purpose only of preserving the life of the mother* … (or) *when the continuance of the pregnancy would make the woman a physical or mental wreck*" [2].

Every year, approximately 300 Jersey resident women travelled to England for a termination to avoid potential prosecution in Jersey.

The 1997 Law, when introduced, permitted termination of pregnancy in Jersey but only in accordance with provisions set out below. Termination of pregnancy in any other circumstances remains a criminal offence in Jersey. The woman, and any person carrying out the termination, could be liable for criminal prosecution.

Note on terminology

Doctor: The 1997 Law refers to registered medical practitioners which includes GPs and medical consultants but not nurses, midwives and pharmacists. For ease, the term "doctor" is used in this document.

Approved doctor: a doctor who has been approved to carry out terminations by the Minister for Health and Social Services under the 1997 Law

Approved place: Jersey General Hospital is currently the only place in Jersey approved by the Minster for Health and Social Services under the 1997 Law for the termination of pregnancy.

Circumstances in which termination of pregnancy is not a criminal offence in Jersey

Grounds for termination	Who can carry out the termination	Where termination can be carried out	When termination can be carried out
Immediately necessary to save the woman's life	Doctor	Any place	Any point in the pregnancy
Necessary to save the woman's life or prevent grave permanent injury to her physical or mental health	Approved doctor	Approved place only	Any point in the pregnancy

[1] Termination of Pregnancy (Jersey) Law 1997
[2] Termination Law reform Proposition, P.30/1994

Grounds for termination	Who can carry out the termination	Where termination can be carried out	When termination can be carried out
The child, if born, would suffer from physical or mental abnormalities as to be seriously disabled	Approved doctor	Approved place only	Before end of 24th week of pregnancy
The woman's condition causes her distress NOTE: A woman must have been resident in Jersey for at least 90 days immediately before the termination.	Approved doctor	Approved place only	Before end of 12th week of pregnancy

Numbers of terminations in Jersey

The most current Jersey annual termination of pregnancy report [3] shows that:

- 240 terminations took place in Jersey in 2022, which is 12% higher than in 2021 (210) and highest since 2002.
- less than 10 terminations were provided to Jersey residents in England and Wales in 2022; this has remained at a similar level since 2008.

[3] Termination of pregnancy report 2022

Section 3 - Grounds for termination

As set out in Section 2, the 1997 Law [4] permits termination of pregnancy in Jersey on the following grounds only:

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

It is a criminal offence for a woman to have a termination in Jersey on grounds not listed above. Both the woman and any person carrying out the termination could be liable for criminal prosecution.

Of the 2,131 terminations carried out in Jersey between 2012 and 2022:

- over 97% were on grounds of 'distress'
- 2% were on the grounds of foetal abnormality
- less than 1% were to save the woman's life or prevent grave injury to her physical or mental health.

The World Health Organisation ("WHO") are opposed to laws that restrict termination by grounds. They recommend that termination should be available at the request of the pregnant woman and without justification of need (commonly referred to as "termination on request") [5].

Termination on request is permitted in 50 jurisdictions including Canada, the Isle of Man, the Republic of Ireland and most states in Australia. It is not permitted in Guernsey, the UK or Jersey.

Whilst termination on request is not permitted in Jersey - as the law requires a woman to state that her condition is causing distress - there is no requirement for the woman to evidence her distress or for the doctor to confirm her distress. Termination on the grounds of distress in Jersey is, therefore, often likened to termination on request, despite this not being the case in law.

Some jurisdictions specifically restrict termination for reasons of sexual selection (ie. the intentional aborting of a foetus of a certain gender [6] [7]). This is not currently a feature of Jersey Law due to the 12 week gestation limit (ie. a person would not know the sex of the child at the 12 week point).

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[4] Termination of Pregnancy (Jersey) Law 1997 (jerseylaw.je)
[5] WHO-Abortion-Care-Guideline-2022.pdf (srhr.org)
[6] Termination of Pregnancy Act 2021 (legislation.sa.gov.au)
[7] Is banning sex-selection the best approach for reducing prenatal discrimination? - PMC (nih.gov)

17. Should ‘termination on request’ be legal in Jersey?

- ☐ Yes, termination on request should be legal in Jersey
- ☐ No, termination should only be available on grounds set out in law
- ☐ Don’t know / prefer not to say

18. If termination remains legal in Jersey on certain grounds only, should those grounds include (tick as applicable):

	Yes	**No**	**Don't know / prefer not to say**
Where there is a risk to the woman			
risk to the woman's life (currently lawful in Jersey)			
risk of grave permanent injury to the woman’s physical or mental health (currently lawful in Jersey)			
risk of any injury to the woman’s physical or mental health			
Where there is a risk to the family			
risk to the physical or mental health of the woman’s other children			
Where there is a risk to the unborn child / children			
a foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities (currently lawful in Jersey)			
in the case of multiple pregnancy (ie. twins, triplets etc) reducing the number of multiple foetuses either because of foetal abnormality or to improve the outcomes for some of the foetuses (known as selective termination)			
Pregnancy that results from crime			
crime of rape			
crime of incest			
Other			
the woman’s condition causes her distress (currently lawful in Jersey)			
for economic or social reasons (ie. a lack of financial security)			
where the woman has intellectual or cognitive disability			
for reasons of sexual selection (the intentional aborting of a foetus of a certain gender)			

19. Are there other grounds, not listed above, on which termination should or should not be legal in Jersey?

Do not include personally identifying information as part of your answer.

Section 4 - Gestational Limits

Gestational limits in law

Gestation is the length of time that a baby is developing inside the womb between conception and birth. Gestation is typically 40 weeks (ie. a woman is pregnant for 40 weeks) although babies that are born earlier than 40 weeks do survive.

The 1997 Law [8] permits termination in Jersey up to the following gestational limits:

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

The law counts gestational age from the beginning of the woman's last menstrual period.

It is a criminal offence for a woman to have a termination in Jersey later than the gestational limits set out above. Both the woman and any person carrying out the termination, could be liable for criminal prosecution.

12 week gestational limit

In 2022, 97% of the 240 women who had a termination in Jersey did so before the end of the 12th week [9].

The **12 week gestational limit** can be problematic for women who may not initially know they are pregnant. This may be due to irregular periods or contraceptive methods that stop or mask periods.

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 the end of the 23rd week (or more in the event of risk to the woman or the child if born) [10].

Travel to another jurisdiction gives rise to additional stress and costs. 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, because she has not lived or worked in Jersey for long enough.

A termination in the UK costs approx. £480 - £1,510 depending on the clinic [11] [12]. The NHS provides for free termination to UK residents, but this does not extend to Jersey residents.

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[8] Termination of Pregnancy (Jersey) Law 1997 (jerseylaw.je)
[9] Termination Of Pregnancy Report 2022.pdf (gov.je)
[10] Abortion Act 1967 (legislation.gov.uk)
[11] https://www.bpas.org/termination-care/considering-termination/prices/
[12] NHS-Funded & Private Abortions | MSI Reproductive Choices UK (msichoices.org.uk)

24 week gestational limit

The Jersey General Hospital does not provide the specialist procedures required for terminations that take place on or after 22 weeks of gestation even though Jersey law permits a termination before the end of the 24th week in cases of foetal abnormality.

In these cases, Jersey General Hospital will refer the woman to the UK and will fund the procedure. The woman will then return to Jersey General Hospital for aftercare.

It remains the case that termination on any grounds, except where necessary to save the woman's life or prevent grave permanent injury to her physical or mental health, remains illegal in Jersey from 25 weeks onwards, including in cases of foetal abnormality.

Other jurisdictions

Gestational limits for terminations vary between different jurisdictions. The reasons for these variations are complex and include:

- ability of jurisdictions to safely provide for later stage terminations which are more complex and higher risk than earlier stage terminations
- acceptability of termination of pregnancy, with different jurisdictions holding different views about a woman's right to choose and protection of the developing foetus.

In addition, consideration is often given to 'viability of life' (ie. the point in gestation at which a baby, if born, could survive outside the womb). The survival of a premature baby is dependent on a range of factors in addition to gestational age including; availability of care, birth weight, gender, underlying medical conditions or whether the pregnancy is a single or multiple pregnancy.

International consensus cites the end of 22nd week as the "cut–off" for viability of life [13], but this does not equate to life always being viable from the beginning of the 23rd week. Whilst advances in medical technology have made it possible for some babies to survive at, or around 23 and 24 weeks gestation, it is the case that few severely premature babies survive without permanent disability.

For this reason some jurisdictions have determined that the gestational limits for termination of pregnancy should be at, or around, 24 weeks. They hold to the view that this balances the need to protect the mother as well as the unborn child.

The UK and Guernsey permit termination up to the end of the 23rd week if the continuation of pregnancy would involve risk of injury to the physical or mental health of the woman (or to any existing children of her family) that is greater than the risk to the woman (or to existing children) if the pregnancy were terminated [10] [14]. No gestational limits are applied on any

[13] Perinatal management of pregnant women at the threshold of infant viability. RCOG scientific impact paper No. 41, 2014

[14] PROJET DE LOI (guernseylegalresources.gg)

other grounds; ie. in the UK and Guernsey termination on the ground of foetal abnormality is lawful throughout the full 40 weeks.

Australia and New Zealand permit 'termination on request' up to 20 / 24 weeks (the number of weeks varies between states in both jurisdictions). After that, termination is still lawful if the doctor determines it is appropriate based on the woman's medical, physical, psychological, economic and social circumstances [15] [16] [17].

The World Health Organisation (WHO) recommend that laws should not prohibit termination based on gestational limits [18].

20. Should termination in Jersey be legal at any gestational limit, regardless of the grounds for termination?

- ☐ Yes, at any gestational limit regardless of the grounds for termination
- ☐ No, the gestational limit should depend on the grounds for the termination
- ☐ Don't know / prefer not to say

[15] Termination of Pregnancy Act 2021 (legislation.sa.gov.au)
[16] Termination of Pregnancy Act 2018 - Queensland Legislation - Queensland Government
[17] Legislation Database (nt.gov.au)
[18] WHO-Termination-Care-Guideline-2022.pdf (srhr.org)

21. If termination remains legal in Jersey up to certain gestational limits, what limits should apply, where there is (tick as applicable):

	Up to end of 12th week	**Beginning of 20th week to end of 22nd week**	**Beginning of 23rd week to end of 24th week**	**No gestational limit (available at any point in pregnancy)**	**Other gestational limit (see next question)**	**Termination should not be available for this reason in Jersey**	**Don't know / prefer not to say**
Where there is a risk to the woman							
risk to the woman's life (currently lawful in Jersey)							
risk of grave permanent injury to the woman's physical or mental health (currently lawful in Jersey)							
risk of any injury to the woman's physical or mental health							
Where there is a risk to the family							
risk to the physical or mental health of the woman's other children							
Where there is a risk to the unborn child / children							
a foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities (currently lawful in Jersey)							
in the case of multiple pregnancy (ie. twins, triplets etc) reducing the number of multiple foetuses either because of foetal							

	Up to end of 12th week	Beginning of 20th week to end of 22nd week	Beginning of 23rd week to end of 24th week	No gestational limit (available at any point in pregnancy)	Other gestational limit (see next question)	Termination should not be available for this reason in Jersey	Don't know / prefer not to say
abnormality or to improve the outcomes for some of the foetuses (known as selective termination)							
Pregnancy that results from crime							
crime of rape							
crime of incest							
Other							
the woman's condition causes her distress (currently lawful in Jersey)							
for economic or social reasons (ie. a lack of financial security)							
where the woman has intellectual or cognitive disability							
for reasons of sexual selection (the intentional aborting of a foetus of a certain gender)							

22. Are there are other gestational limits that you think should apply on other grounds? Please specify the gestational limits and the grounds.

Do not include personally identifying information as part of your answer.

Section 5 - Consultation

In 2022, 97% of terminations were carried out on the **grounds of distress** [19].

The 1997 law [20] requires a woman who wants a termination on the grounds of 'distress' to consult with a doctor (for example, her GP). This consultation must be **in-person** (ie. face-to-face). The woman must, by law, then have a second consultation with an approved doctor (i.e. approved by the Minister for Health and Social Services to carry out terminations).

The law requires a woman who is obtaining a termination for any other reason, to be examined by two approved doctors. This does not apply if the termination is immediately necessary to save the woman's life.

It is a criminal offence for a woman to have a termination in Jersey without having consulted with or been examined by doctors / approved doctors. Both the woman and any person carrying out the termination, could be liable for criminal prosecution.

General Medical Council ("GMC") guidelines set out matters to be considered by doctors when consulting with patients, including informed patient consent [21] and safeguarding considerations [22].

In Jersey, the first consultation is typically carried out at the woman's GP surgery or specialist contraceptive service (for example, at Le Bas Centre). There can be a cost to the woman to access these services. The woman is then referred to the Jersey General Hospital for the second consultation, where an ultrasound scan is usually carried out.

The National Institute for Health and Care Excellence (NICE) recommends that providers should allow women to self-refer to termination services and that services should work together to avoid the need for women to repeat key steps (such as returning to their GP for referral, or repeated assessments or investigations) [23].

In 2007 the UK's House of Commons Science and Technology Committee concluded that the requirement for consultation with two doctors, particularly in the first 12 weeks, did not safeguard women or healthcare professionals "in any meaningful way, or serve any other useful purpose" and instead caused delays in access to termination care [24].

In the UK, a woman is required to consult with two registered health professionals at any point in the pregnancy [25]. Some jurisdictions, such as Australia and New Zealand, allow

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19 Termination Of Pregnancy Report 2022.pdf (gov.je)
20 Termination of Pregnancy (Jersey) Law 1997 (jerseylaw.je)
21 Decision making and consent - ethical guidance - GMC (gmc-uk.org)
22 raising-and-acting-on-concerns-about-patient-safety---english-0617_pdf-48902813.pdf (gmc-uk.org)
23 Recommendations | Abortion care | Guidance | NICE
24 Microsoft Word - HC 1045 FINAL TERMINATION REPORT.doc (parliament.uk)
25 Abortion Act 1967 (legislation.gov.uk)

consultation with one registered health professional only up the point they deem life to be "viable" (between 20 and 24 weeks) and then two after [26] [27] [28] [29].

The Guernsey law requires a consultation with one doctor only throughout the full 40 weeks gestation [30].

23. How many health care professionals should a woman seeking a termination have to consult with?

- ☐ One, at any point in gestation
- ☐ Two, at any point in gestation
- ☐ The number of health care professionals should be dependent on the point in gestation
- ☐ Don't know / prefer not to say
- ☐ Other, tell us below:

Do not include personally identifying information as part of your answer.

24. If the number of health care professionals is dependent on the point in gestation:

a. How many health care professionals should a woman have to consult with in early gestation?

b. At how many weeks gestation should it change?

[26] Termination of Pregnancy Act 2018 - Queensland Legislation - Queensland Government
[27] Health Act 1993 | HTML view
[28] Termination Law Reform Act 2008 (legislation.vic.gov.au)
[29] Contraception, Sterilisation, and Abortion Act 1977 No 112 (as at 01 July 2022), Public Act 11 Provision of abortion services to women more than 20 weeks pregnant – New Zealand Legislation
[30] PROJET DE LOI (guernseylegalresources.gg)

[ ] weeks

c. How many health care professionals should a woman have to consult with in later gestation?

[ ]

d. Tell us why:

[ ]

Do not include personally identifying information as part of your answer.

Section 6 - Consultation for early medical terminations

In Jersey, two methods of termination are available:

1. medical termination
2. surgical termination.

The method used changes at different points in gestation based on clinical guidelines.

Early medical terminations

Medical terminations that are carried out before the end of the 9th week are referred to as '**early medical terminations**'. They involve a woman taking two different medicines, usually within a 48-hour period to terminate the pregnancy.

In 2022:

- 86% of terminations carried out in Jersey were early medical terminations (the greater majority, if not all, on the grounds of distress)

The 1997 Law [31] prescribes the places where termination can be carried out. Jersey's General Hospital is currently the only place approved in law where terminations are carried out. This requirement, alongside the consultation requirements described in Section 5 above, mean that a woman having an **early medical termination** in Jersey is required by law to:

- consult with a doctor **in-person** (ie. face to face)
- consult with an approved doctor **in-person** (ie. face to face) at the Jersey General Hospital
- attend the Jersey General Hospital to be given the first of two medicines by an approved doctor. The second is then self-administered by the woman 48 hours later, usually at home.

In-person consultation allows the approved doctor to examine the woman, scan and verify gestational age. Verifying gestational age helps in determining the safest method of termination and ensuring that the termination is compliant with the gestational limits prescribed in the 1997 Law. In Jersey, women undergoing a termination are usually given an ultrasound scan.

The World Health Organisation (WHO) recommend telemedicine [32] as an alternative to in-person consultations. There is a body of research that indicates that telemedical termination is safe and effective, improves access, reduces waiting times, and increases efficacy with

[31] Termination of Pregnancy (Jersey) Law 1997 (jerseylaw.je)

[32] WHO-Termination-Care-Guideline-2022.pdf (srhr.org)

98% of terminations reviewed requiring no further medical intervention and less than 0.05% experiencing a “serious adverse event” [33] [34].

NICE recommend that consideration should be given to providing termination assessments by phone or video call, for women who prefer a telemedicine consultation and who do not exhibit signs of potential ectopic pregnancy.

NICE also recommend that for early medical terminations (up to the end of the 9th week), both medications can be taken at home or in a clinic or hospital setting [35].

The Royal College of Obstetricians and Gynaecologists (RCOG) advise that routine pre-termination ultrasound scanning is unnecessary as most women can work out the duration of their pregnancy, with reasonable accuracy, based on the date of their last menstrual period; although if there is clinical uncertainty about the gestational age or if there is a suspected ectopic pregnancy, ultrasound should be used [36].

Removing the requirement for ultrasound in all cases has led to some jurisdictions, such as England and France, permitting **early medical terminations** (up to the end of the 9th week) to take place entirely **at home**, with consultation being available via phone or video link and with both medicines being sent to the woman for her to self-administer [37]. The same is available in New Zealand [38].

Some states in Australia allow for consultation by phone / video link, but typically require the woman to attend a local clinic for an ultrasound scan [39].

Consultation by phone / video link, with medication then being posted to a woman at home does carry additional risk. Health care professionals have no opportunity to examine the woman, including no opportunity to confirm gestational age. In March 2023 a woman in the UK was sentenced to jail for knowingly taking termination medication later than the UK limit.

The Guernsey law requires a consultation with one doctor only throughout the full 40 weeks although this must be in person. In Guernsey women can have an early medical termination at home (ie. both drugs can be self-administered at home) [40].

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33 Effectiveness, safety and acceptability of no-test medical termination
34 Telemedicine medical termination at home under 12 weeks’ gestation: a prospective observational cohort study during the COVID-19 pandemic | BMJ Sexual & Reproductive Health
35 Recommendations | Abortion care | Guidance | NICE
36 termination-care-best-practice-paper-april-2022.pdf (rcog.org.uk)
37 Abortion Act 1967 (legislation.gov.uk)
38 Decide (org.nz)
39 Safe Teleabortion Services in Australia | MSI Australia
40 PROJET DE LOI (guernseylegalresources.gg)

25. Should consultation for early medical termination (up to end of 9th week) be available by phone / video-link as opposed to the current requirement for in-person consultation?

If there is only one consultation

- It should be available via phone / video link
- It should be in-person consultation
- Don't know / prefer not to say

If there is more than one consultation

- All consultation should be available via phone / video-link
- All consultation should be in-person
- There should be a mixture of phone / video-link and in person consultation
- Don't know / prefer not to say

26. Should a woman who is having an early medical termination (up to end of 9th week) be able to self-administer both medications at home as opposed to having the first medications administered by a doctor at the Jersey General Hospital, and the second self-administered at home, as is currently required. This would allow for termination at home.

- Yes, in all cases
- Yes, but only if there has been at least one in-person consultation
- No
- Don't know / prefer not to say

Section 7 - Criminal liability

The 1997 Law [41] makes it a criminal offence for a woman to have a termination in Jersey that is not carried out lawfully. This includes, but is not limited to:

- the grounds for termination are not lawful
- the gestation at which the termination takes place is not lawful
- the requirements for consultation and / or examination have not been met
- the termination is carried by a person who is not permitted by the law
- the termination is carried out in a location which is not lawful

Both the woman and any person carrying out the termination (including the administering of any drug for the purpose of inducing a termination), could be liable for criminal prosecution.

27. If a termination were carried out in a way that was not lawful, who should be liable for prosecution?

- ☐ The woman who has the termination
- ☐ Any person who carries out the termination (ie. performs surgery or administers drugs)
- ☐ Any person who assists with the termination
- ☐ No-one (it should not be a criminal issue)
- ☐ Don't know / prefer not to say
- ☐ Depends on the circumstances, tell us more below:

Do not include personally identifying information as part of your answer.

[41] Termination of Pregnancy (Jersey) Law 1997 (jerseylaw.je)

Section 8 - Safe access zones

Some jurisdictions have introduced safe access zones to protect people who use or work in termination services from harassment and intimidation by anti-termination protestors including, for example, verbal abuse, filming, following people, unsolicited contact and use of banners or signs containing derogatory slogans.

This includes:

- women seeking advice and treatment,
- friends or relatives who may accompany them,
- staff at premises where services are delivered.

Jersey has some existing powers [42] [43], but they do not provide specific protections to those impacted by all the behaviours listed above.

Numerous bodies support the implementation of safe access zones and have raised concerns about negative impact that anti-termination activities can have on women and staff. The bodies include the Royal College of Obstetricians and Gynaecologists, the British Pregnancy Advisory Service, and the Royal College of General Practitioners. [44] [45] [46]

Some other jurisdictions have already implemented, or are soon to implement, safe access zones. This includes England [47], Isle of Man [48], Northern Ireland [49], Republic of Ireland [50], Scotland [51], and some states in Australia [52], and Canada [53].

28. Should safe access zones be introduced in Jersey?

1. Yes
2. No
3. Don't know / prefer not to say

29. If yes, which of the following types of behaviour should be prohibited in an area that is a specified distance from a termination service (a safe access zone)?

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42 Crime (Disorderly Conduct and Harassment) (Jersey) Law 2008 (jerseylaw.je)
43 Telecommunications (Jersey) Law 2002 (jerseylaw.je)
44 Joint-pro-choice-briefing-Safe-Access-Zones.pdf (humanists.uk)
45 1962 (parliament.uk)
46 FSRH-RCOG Safe access zones around termination clinics (rcog.org)
47 Public Order Bill: factsheet - GOV.UK (www.gov.uk)
48 Termination Reform Act 2019 (srhr.org)
49 Termination Services (Safe Access Zones) Bill (niassembly.gov.uk)
50 Safe Access to Termination of Pregnancy Services Bill 2021 – No. 130 of 2021 (oireachtas.ie)
51 termination-services-safe-access-zones-consultation-document_final.pdf (parliament.scot)
52 Harassment outside termination services now banned across Australia with historic passing of safe access zone laws in WA | Human Rights Law Centre (hrlc.org.au)
53 2019-05-08_l-rs-note-safe-access-zones-what-do-other-countries-do_en.pdf (oireachtas.ie)

Please tick all that apply

- ☐ Harassment
- ☐ Intimidation
- ☐ Obstruction
- ☐ Communicating about termination, in a manner that could be seen or heard by a person accessing or leaving premises providing terminations, where the communication is reasonably likely to cause distress
- ☐ Impeding a footpath, road or vehicle without reasonable excuse
- ☐ Intentionally recording a person accessing or leaving premises providing terminations, without consent or reasonable excuse
- ☐ Don’t know / prefer not to say
- ☐ Other, tell us below:

Do not include personally identifying information as part of your answer.

Section 9 - Other comments

30. If you have further comments about Jersey's Termination of Pregnancy Law or services, tell us here:

Do not include personally identifying information as part of your answer.

Appendix 4 - Full organisation responses

1. Catholic Grandparents Association

Method - by survey

Section 1 - Demographics and consent

1. Do you live in Jersey?

   Yes

2. Are you answering as an individual or on behalf of an organisation?

   On behalf of an organisation

3. What is the name of the organisation?

   Catholic Grandparents Association

4. Does the organisation provide any of the following services or care related to termination of pregnancy?

   No, none

5. Where are the organisation's services and care provided?

   Jersey

6. Do you give permission for your comments to be quoted in our consultation feedback report and other publications?

   Yes, attributed to my organisation

Section 3 - Grounds for termination

18. Should 'termination on request' be legal in Jersey?

    No, termination should only be available on grounds set out in law

19. If termination remains legal in Jersey on certain grounds only, should those grounds include:

    Grounds - risk to the woman - risk to the woman's life (currently lawful in Jersey):

    Yes

    Grounds - risk to the woman - risk of grave permanent injury to the woman's physical or mental health (currently lawful in Jersey):

    Yes

    Grounds - risk to the woman - risk of any injury to the woman's physical or mental health:

    No

    Grounds - risk to the family - risk to the physical or mental health of the woman's other children:

No

Grounds - foetal impairment - a foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities (currently lawful in Jersey):

No

Grounds - foetal impairment - in the case of multiple pregnancy (ie. twins, triplets etc) reducing the number of multiple foetuses either because of foetal abnormality or to improve the outcomes for some of the foetuses (known as selective termination):

No

Grounds - Crime - crime of rape:

No

Grounds - Crime - crime of incest:

No

Grounds - other - the woman's condition causes her distress (currently lawful in Jersey):

No

Grounds - other - for economic or social reasons (ie. a lack of financial security):

No

Grounds - other - where the woman has intellectual or cognitive disability:

No

Grounds - other - for reasons of sexual selection (the intentional aborting of a foetus of a certain gender):

No

20. Are there other grounds, not listed above, on which termination should or should not be legal in Jersey?

No response given

Section 4 - Gestational Limits

21. Should termination in Jersey be legal at any gestational limit, regardless of the grounds for termination?

No, the gestational limit should depend on the grounds for the termination

22. If termination remains legal in Jersey up to certain gestational limits, what limits should apply, where there is:

Gestational limits - risk to woman - risk to the woman's life (currently lawful in Jersey with no gestational limit):

No gestational limit (available at any point in pregnancy)

Gestational limits - risk to woman - risk of grave permanent injury to the woman's physical or mental health (currently lawful in Jersey with no gestational
limit):

Termination should not be available for this reason in Jersey

Gestational limits - risk to woman - risk of any injury to the woman's physical or mental health:

Termination should not be available for this reason in Jersey

Gestational limit - risk to family - risk to the physical or mental health of the woman's other children:

Termination should not be available for this reason in Jersey

Gestational limits - foetal impairment - a foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities (currently lawful in Jersey up to the end of the 24th week):

Termination should not be available for this reason in Jersey

Gestational limits - foetal impairment - in the case of a multiple pregnancy (ie. twins, triplets etc) reducing the number of foetuses either because of foetal abnormality or to improve the outcomes for some of the foetuses (known as selective termination):

Termination should not be available for this reason in Jersey

Gestational limits - pregnancy from crime - crime of rape:

Termination should not be available for this reason in Jersey

Gestational limits - pregnancy from crime - crime of incest:

Termination should not be available for this reason in Jersey

Gestational limits - other - the woman's condition causes her distress (currently lawful in Jersey up to the end of the 12th week):

Termination should not be available for this reason in Jersey

Gestational limits - other - for economic or social reasons ((ie. a lack of financial security)):

Termination should not be available for this reason in Jersey

Gestational limits - other - where the woman has intellectual or cognitive disability:

Termination should not be available for this reason in Jersey

Gestational limits - other - for reasons of sexual selection (the intentional terminating of a foetus of a certain gender):

Termination should not be available for this reason in Jersey

23. Are there are other gestational limits that you think should apply on other grounds?

No response provided

Section 5 - Consultation

24. How many health care professionals should a woman seeking a termination have to consult with?

Two, at any point in gestation

Section 6 - Consultation for early medical terminations

26. Should consultation for early medical termination (up to end of 9th week) be available by phone / video-link as opposed to the current requirement for in-person consultation?

It should be in-person consultation

All consultation should be in-person

27. Should a woman who is having an early medical termination (up to end of 9th week) be able to self-administer both medications at home as opposed to having the first medications administered by a doctor at the Jersey General Hospital, and the second self-administered at home, as is currently required. This would allow for termination at home.

No

Section 7 - Criminal liability

28. If a termination were carried out in a way that was not lawful, who should be liable for prosecution?

Any person who carries out the termination (ie. performs surgery or administers drugs)

Any person who assists with the termination

Section 8 - Safe access zones

29. Should safe access zones be introduced in Jersey?

No

Section 9 - Other comments

31. If you have further comments about Jersey's Termination of Pregnancy Law or services, tell us here.

Babies are surviving more from 22 weeks due to advancement in medical care

Telephone consultation and posting medication leaves room for forced abortion

Disability discrimination when mum may have disabality or the baby may be disabled

2. National secular society
Method – by survey

Section 1 - Demographics and consent

1. Do you live in Jersey?

   No

2. Are you answering as an individual or on behalf of an organisation?

   On behalf of an organisation

3. What is the name of the organisation?

   National Secular Society

4. Does the organisation provide any of the following services or care related to termination of pregnancy?

   No, none

5. Where are the organisation's services and care provided?

   UK

6. Do you give permission for your comments to be quoted in our consultation feedback report and other publications?

   Yes, attributed to my organisation

Section 3 - Grounds for termination

18. Should 'termination on request' be legal in Jersey?

    Yes, termination on request should be legal in Jersey

19. If termination remains legal in Jersey on certain grounds only, should those grounds include:

    Grounds - risk to the woman - risk to the woman's life (currently lawful in Jersey):

    Yes

    Grounds - risk to the woman - risk of grave permanent injury to the woman's physical or mental health (currently lawful in Jersey):

    Yes

    Grounds - risk to the woman - risk of any injury to the woman's physical or mental health:

    Yes

    Grounds - risk to the family - risk to the physical or mental health of the woman's other children:

    Yes

Grounds - foetal impairment - a foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities (currently lawful in Jersey):

Yes

Grounds - foetal impairment - in the case of multiple pregnancy (ie. twins, triplets etc) reducing the number of multiple foetuses either because of foetal abnormality or to improve the outcomes for some of the foetuses (known as selective termination):

Yes

Grounds - Crime - crime of rape:

Yes

Grounds - Crime - crime of incest:

Yes

Grounds - other - the woman's condition causes her distress (currently lawful in Jersey):

Yes

Grounds - other - for economic or social reasons (ie. a lack of financial security):

Yes

Grounds - other - where the woman has intellectual or cognitive disability:

Yes

Grounds - other - for reasons of sexual selection (the intentional aborting of a foetus of a certain gender):

Don't know / prefer not to say

20. Are there other grounds, not listed above, on which termination should or should not be legal in Jersey?

No response provided

Section 4 - Gestational Limits

21. Should termination in Jersey be legal at any gestational limit, regardless of the grounds for termination?

Don't know / prefer not to say

22. If termination remains legal in Jersey up to certain gestational limits, what limits should apply, where there is:

Gestational limits - risk to woman - risk to the woman's life (currently lawful in Jersey with no gestational limit):

No gestational limit (available at any point in pregnancy)

Gestational limits - risk to woman - risk of grave permanent injury to the woman's physical or mental health (currently lawful in Jersey with no gestational

limit):

No gestational limit (available at any point in pregnancy)

Gestational limits - risk to woman - risk of any injury to the woman's physical or mental health:

Beginning of 23rd week to end of 24th week

Gestational limit - risk to family - risk to the physical or mental health of the woman's other children:

Beginning of 23rd week to end of 24th week

Gestational limits - foetal impairment - a foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities

(currently lawful in Jersey up to the end of the 24th week):

No gestational limit (available at any point in pregnancy)

Gestational limits - foetal impairment - in the case of a multiple pregnancy (ie. twins, triplets etc) reducing the number of foetuses either because of foetal

abnormality or to improve the outcomes for some of the foetuses (known as selective termination):

Don't know / prefer not to say

Gestational limits - pregnancy from crime - crime of rape:

No gestational limit (available at any point in pregnancy)

Gestational limits - pregnancy from crime - crime of incest:

No gestational limit (available at any point in pregnancy)

Gestational limits - other - the woman's condition causes her distress (currently lawful in Jersey up to the end of the 12th week):

Beginning of 23rd week to end of 24th week

Gestational limits - other - for economic or social reasons ((ie. a lack of financial security)):

Beginning of 23rd week to end of 24th week

Gestational limits - other - where the woman has intellectual or cognitive disability:

Don’t know / prefer not to say

Gestational limits - other - for reasons of sexual selection (the intentional terminating of a foetus of a certain gender):

Don’t know / prefer not to say

23. Are there are other gestational limits that you think should apply on other grounds? Please specify the gestational limits and the grounds.

No response provided

Section 5 - Consultation

24. How many health care professionals should a woman seeking a termination have to consult with?

Other, tell us below:

The number of health care professionals a woman seeking an abortion should have to consult with should be based only on clinical need. In the vast majority of cases this will mean only one. Women should not be required to consult with two professionals in order to make abortion more difficult to access or in an attempt to impress the seriousness of the decision upon her.

Section 6 - Consultation for early medical terminations

26. Should consultation for early medical termination (up to end of 9th week) be available by phone / video-link as opposed to the current requirement for in-person consultation?

It should be available via phone / video link

All consultation should be available via phone / video-link

27. Should a woman who is having an early medical termination (up to end of 9th week) be able to self-administer both medications at home as opposed to having the first medications administered by a doctor at the Jersey General Hospital, and the second self-administered at home, as is currently required. This would allow for termination at home.

Yes, in all cases

Section 7 - Criminal liability

28. If a termination were carried out in a way that was not lawful, who should be liable for prosecution?

Don’t know / prefer not to say

Section 8 - Safe access zones

29. Should safe access zones be introduced in Jersey?

Yes

30. Which of the following types of behaviour should be prohibited in an area that is a specified distance from a termination service (a safe access zone)?

    Other, tell us below:

    Prohibitions of behaviour should be broadly in line with those laid out in s9 of the Public Order Act 2023.

Section 9 - Other comments

31. If you have further comments about Jersey's Termination of Pregnancy Law or services, tell us here.

The question of conscientious objection has not been raised in this consultation. The National Secular Society believes doctors who conscientiously object to carrying out terminations of pregnancy should be required to refer or signpost patients to a doctor who is willing to carry out the procedure.

Conscientious objection should be allowed to delay a woman accessing abortion services.

Abortion should be free at the point of access in Jersey, as it is in the UK. The consultation background information states: “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, because she has not lived or worked in Jersey for long enough.” This is despite most healthcare in Jersey being free at the point of access once a person has been resident for six months.

We believe, in line with Royal College of Obstetricians and Gynaecologists guidance, that the routine use of pre-termination ultrasound is unnecessary. The use of ultrasound should be based on clinical need alone and not used as a cudgel to dissuade women from undergoing abortion

3. Anonymous organisation (not published as consent was not given for their comments to be published)

4. Christian Action Research and Education ("CARE")
Method - by email

CARE FOR WHAT YOU BELIEVE

Consultation: Termination of Pregnancy

by email to TOPreview@gov.je

INTRODUCTION

1. CARE (Christian Action Research and Education) is a well-established mainstream charity providing resources and Christian insight and experience to matters of public policy and practical caring initiatives (Questions 13 and 14).

2. We are not based in Jersey (Question 1) but have supporters who are resident on Jersey. We are answering this survey as an organisation (Question 2). We give permission for this response to be quoted (Question 16).

RESPONSE TO REMAINING QUESTIONS

3. **Question 17:** Should 'termination on request' be legal in Jersey? **No, termination should only be available on grounds set out in law.**

   3.1. CARE does not agree with the World Health Organisation position that abortion should be available in any and every situation. CARE believes that every human life is valuable and must be protected. It should not matter how profoundly disabled a baby is, or whether that condition will ultimately limit the ability to survive outside of the womb; nor how the child was conceived. All human life is equal and worthy of protection. Unborn children – whatever the circumstances – require protection and respect. We note that the Preamble to the UN Convention on the Rights of the Child states that a child *"needs special safeguards and care, including appropriate legal protection, before as well as after birth"*[1]. We should invest in care for all our children, by treating those we can and caring for those we cannot treat.

   3.2. The law needs to recognise that a second life is involved and not just **"products of pregnancy"**;[2] that the "*human fetus is of moral value and holds a significance that increases as it grows throughout pregnancy*".[3] The decision to have an abortion should not be made in the same way as having a bunion removed:[4] there should be a process "*to underscore the moral gravitas of the abortion decision*".[5]

   3.3. We note that the consultation on page 11 refers to the Isle of Man having termination on request. This is true only up to 14 weeks gestation.[6]

4. **Question 18:** If termination remains legal in Jersey on certain grounds only, should those grounds include (tick as applicable)

1 Preamble to the 1989 UN Convention on the Rights of the Child, http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx
2 Paragraph 1.2.7 NICE, Abortion Care NICE Guideline, 25 September 2019, https://www.nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693
3 Sheldon S, The Decriminalisation of Abortion: An Argument for Modernisation, *Oxford Journal of Legal Studies*, Volume 36, Issue 2, Summer 2016, Pages 334–365, https://academic.oup.com/ojls/article/36/2/334/2472463/
4 A comment made by RCOG president Professor Lesley Regan http://www.dailymail.co.uk/news/article-4889942/Top-medic-calls-looser-abortion-laws.html 15 September 2017
5 Sheldon 2016, *Op Cit*
6 Section 6(2), Abortion Reform Act 2019

4.1. Our views on the different options set out in the table for Question 18 are as follows:

Where there is a risk to the woman

4.2. Risk to the woman's life

4.3. Risk of grave permanent injury to the woman's physical or mental health

4.3.1. CARE believes that if the life of the mother is at risk or there is the risk of grave permanent injury to the woman's physical or mental health because of her pregnancy, there is justification for intervening to deliver the child early, which may tragically result in his or her death. These are the only circumstances that warrant action after the upper gestation limit, which we suggest below should be 22 weeks. However, in such circumstances the surgeon should be required to actively do whatever is possible to save the life of the child. Furthermore, any procedure after 18 weeks, should take account of the potential for a foetus to feel pain.[7]

4.3.2. It would be appropriate to provide a definition of "injury" and "grave permanent". CARE recommends that any reform should define injury as something imminent and more likely than not to occur.

4.4. Risk of any injury to the woman's physical or mental health

4.4.1. This wording reflects the similar wording to the Abortion Act 1967 which has been used to provide abortion on demand. We would advocate for wording similar to that in the Isle of Man legislation which refers to a "*substantial risk of serious injury to the woman's life or health.*"

Where there is a risk to the woman

4.5. Risk to the physical or mental health of the woman's other children

4.5.1. This should not be a legal ground for an abortion.

Where there is a risk to the unborn child / children

4.6. A foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities.

4.6.1. CARE recognises that this is already the law up to 24 weeks but **raises concerns that abortion on the grounds of the unborn child's disability** gives a negative message about disability in general and is contradictory to the principles under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), albeit that Jersey is not yet a signatory.

4.6.2. It is also important to acknowledge there are differing views on disability in 2023 than there were in 1997, when Jersey's abortion law was last reformed. Jersey's 2017 *Disability Strategy for Jersey "looks to uphold the general principles of the UNCRPD"*[8] so there should not be an automatic inclusion of this ground in any new legislation.

4.6.3. The Discrimination (Disability) (Jersey) Regulations 2018 came into force on 1 September 2018, amended the Discrimination (Jersey) Law, 2013 to include the protected characteristic of disability. These Regulations do not by themselves meet the

7 Foetal Sentience and Pain: An Evidence Review, All Party Parliamentary Pro-Life Group, March 2020, page 25
8 R Disability Strategy For Jersey Standard Version 20170525 DS.pdf (gov.je), May 2017, page 13

requirements of the UNCRPD,[9] as they are exclusively about non-discrimination; whereas the UNCRPD requires positive action to ensure and promote the *de facto* equality of disabled persons. Jersey recognised this in the report accompanying the Draft Regulations and said that, once the disability strategy and disability discrimination legislation were in place, the Council of Ministers may seek to extend ratification of the convention to Jersey.[10] We urge Jersey to do so.

4.6.4. In the spirit of the Convention we note that in the first and, so far, only UNCRPD Committee report on the UK, the Committee said, "*The Committee is concerned about perceptions in society that stigmatize persons with disabilities...and about the termination of pregnancy at any stage on the basis of fetal impairment…The Committee recommends that the [UK] amend its abortion law accordingly…without legalizing selective abortion on the ground of fetal deficiency.*"[11] The Committee has also said, "*Laws which explicitly allow for abortion on grounds of impairment violate the Convention on the Rights of Persons with Disabilities (Art,.4,5,8). Even if the condition is considered fatal, there is still a decision made on the basis of impairment. Often it cannot be said if an impairment is fatal. Experience shows that assessments on impairment conditions are often false. Even if it is not false, the assessment perpetuates notions of stereotyping disability as incompatible with a good life.*"[12]

4.6.5. The UK Supreme Court has given a non-binding judgment that there is **no human right for access to abortion due to disability where the child could survive birth.**[13] Other UN Committees have recommended that provision for disability-selective abortion should be limited to cases of fatal foetal abnormality.[14][15] Elsewhere in GB, abortions are permitted for foetal impairments more broadly than fatal foetal abnormality, for example, in cases of Down's Syndrome, cleft palate and club foot. In 2021, in England and Wales, (the last year of full data) 3,370 abortions were undertaken because of foetal abnormality, of which 859 included Down's Syndrome as a reason for the abortion.[16]

4.6.6. The Parliamentary Inquiry into Abortion on the Grounds of Disability heard from parents about the difficulties of receiving a diagnosis, the attitudes of doctors and others towards abortion and the longer-term difficulties of bringing up a disabled child.[17] A similar experience has been reported on Guernsey of a mother whose child had a foetal abnormality.[18]

4.6.7. We note that the definition of a foetal abnormality in section 2(2)(b)(i) of Jersey's 1997 Law[19] is identical to that in the Abortion Act 1967 where there is no definition of what "*seriously handicapped*" could mean. The UK Government has recognised these definitions are "*subjective*".[20] In the 1967 Act, this definition has been used to cover disabilities which include Down's Syndrome and correctable disabilities like cleft palate

9 Jersey Legislation — Guernsey Disability Alliance
10 Jersey and the United Nations human rights treaties (bedellcristin.com)
11 CRPD/C/GBR/CO/1, October 2017, paragraphs 12 and 13
12 Committee on the Rights of Persons with Disabilities, Comments on the draft General Comment No36 of the Human Rights Committee on article 6 of the International Covenant on Civil and Political Rights, https://www.ohchr.org/EN/HRBodies/CCPR/Pages/GC36-Article6Righttolife.aspx
13 https://www.supremecourt.uk/cases/docs/uksc-2017-0131-press-summary.pdf; para 133 & 331
14 Committee against Torture, Concluding observations on the United Kingdom of Great Britain and Northern Ireland, June 2019, CAT/C/GBR/CO/6, para 47
15 International Covenant on Civil and Political Rights, Human Rights Committee, General Comment No 36, Right to Life, September 2019, para 8
16 Abortion Statistics England and Wales 2021, Tables 2 and 9a
17 Independent Parliamentary Inquiry into Abortion on the Grounds of Disability, 2013, pages 32-34
18 Guernsey woman says abortion booked 'without my permission' - BBC News 5 October 2023
19 TERMINATION OF PREGNANCY (JERSEY) LAW 1997 (jerseylaw.je)
20 Abortion (Northern Ireland) (No 2) Regulations 2020, Explanatory Memorandum, para 7.37, page 12 http://www.legislation.gov.uk/uksi/2020/503/pdfs/uksiem_20200503_en.pdf

and club foot. **These are not necessarily conditions that sit easily under the description of 'suffering serious physical or mental abnormalities.** There has been no-one who has denied that these abortions happen.[21]

4.6.8. The Jersey Termination of Pregnancy Statistics 2022 suggest that 5% of abortions in 2022 occurred after 13 weeks, which suggests that these approximately 12 abortions were for either serious health issues facing the mother or because there had been a diagnosis of a foetal abnormality – there is no transparency on this information.[22] The England and Wales Abortion Statistics report that two abortions were conducted for Jersey residents in 2021, but it does not mention Ground E (the disability provision) as a reason for the abortion;[23] and two abortions in the first half of 2022.[24]

4.6.9. CARE **recommends**:

4.6.9.1. Abortion on the grounds of a foetal abnormality should be restricted to a life limiting condition (a fatal foetal abnormality);

4.6.9.2. there should not be abortion without gestation limit for abortions on the grounds of a fatal foetal abnormality;

4.6.9.3. the gestation limit on the grounds of foetal abnormality should be the same as for other abortions where there is no foetal abnormality;

4.6.9.4. Jersey should provide holistic care for parents with information, practical support and services at a very challenging time, including perinatal palliative care for those children whose lives are likely to be measured in hours or days, and neonatal palliative care where the child may live for weeks or months.12 Academics have said "*the science suggests that perinatal palliative care is welcomed by parents and is a medically safe and viable option.*"[25]

4.7. In the case of multiple pregnancy (i.e. twins, triplets etc) reducing the number of multiple foetuses either because of foetal abnormality or to improve the outcomes for some of the foetuses (known as selective termination).

4.7.1. This should not be a legal ground for an abortion.

<u>Pregnancy that results from crime</u>

4.8. Crime of rape

4.9. Crime of incest

4.9.1. We recognise that rape is a heinous crime which deeply scars women. We do not in any sense underestimate or downplay the trauma experienced by women who are victims of sexual crime. We are fully cognizant of the enormous challenge posed to women who conceive because of rape and the difficulty of carrying a child in such circumstances.

4.9.2. Nevertheless, these proposals would deprive a child of life when that child had no influence over the circumstances of its conception. It would be wrong to deprive a child

21 https://www.theguardian.com/world/2020/may/28/mps-bring-bill-to-ban-late-abortions-for-cleft-lip-cleft-palate-and-club-foot
22 https://www.gov.je/Government/Pages/StatesReports.aspx?ReportID=5695
23 Abortion Statistics England and Wales 2021, Table 12a
24 Abortion Statistics England and Wales, Jan-June 2022, Table 12a
25 Wool C, State of the Science on Perinatal Palliative Care, J Obstet Gynecol Neonatal Nurs. 2013 May-Jun; 42(3):372-82; quiz E54-5. doi: 10.1111/1552-6909.12034. Epub 2013 Apr 11. Abstract

of life because of the character of its father. Abortion is not an 'easy solution' to rape and cannot alleviate or undo in any way the crime committed; it does not bring healing to a rape victim and creating a second victim never undoes the damage to the first victim. It is of great importance that women in this situation are offered every support physically and psychologically and obviously given the option of putting their child up for adoption if that is right for them.

4.9.3. There are also significant practical issues to be addressed, including proving that a pregnancy was conceived as a result of rape and incest, and if no 'proof' is required how to avoid 'abuses' of the system.

Other

4.10. The woman's condition causes her distress.

4.10.1. This should not be a legal ground for an abortion.

4.11. For economic or social reasons (i.e. a lack of financial security)

4.11.1. This should not be a legal ground for an abortion.

4.11.2. CARE firmly believes that the life and circumstances of both mother and child are important and that both should be treated with the best quality of care, dignity and respect. There are no grounds for abortion because of social factors in England and Wales. We advocate support for parents who find themselves in a "social situation" where an abortion might seem an attractive option. We do not consider an abortion in these circumstances to be the best care for either mother or baby. There should be community support for parents in these situations. In terms of legal drafting, CARE is concerned a clause that covers "economic or social grounds" would be impossible to define and have the effect of creating a potentially elastic further category.

4.11.3. CARE notes that in 2023 BPAS have stated there has been a 17% increase in abortions in England and Wales driven by the cost of living crisis,[26] but other evidence shows that 60% of US women who had an abortion would have chosen to continue with their pregnancy if they had received more support from others or had felt more financial security.[27] In 2022, a survey by the organisation Pregnant then Screwed suggested costs of childcare were an important factor in influencing the decision of 60% of those who had had an abortion in the previous five years.[28]

4.12. Where the woman has intellectual or cognitive disability

4.12.1. In broad terms, a woman who has an intellectual or cognitive disability should not face discrimination in any area of life – this includes in accessing abortion on the legal grounds set out in the legislation. However, we are clear that there should not be a specific ground of abortion on the grounds of intellectual or cognitive disability.

4.12.2. We note that the Isle of Man's Act, says the following in section 9(4) and would support a similar proposal in Jersey:

Where the woman is unable to give informed consent due to a mental, medical or physical

26 New government figures show 17% rise in abortions | BPAS 22 June 2023

27 Reardon D C, Rafferty K A, Longbons T (May 11, 2023) The Effects of Abortion Decision Rightness and Decision Type on Women's Satisfaction and Mental Health. Cureus 15(5): e38882. doi:10.7759/cureus.38882

28 6 in 10 women who have had an abortion claim childcare costs influenced their decision - Pregnant Then Screwed, 8 July 2022

incapacity, the registered medical practitioner attending her must not provide abortion services unless the practitioner —

> *(a) obtains the consent of the parent or guardian of the woman, or another person lawfully empowered to give consent on her behalf; or*
>
> *(b) is of the view, formed in good faith, that because of the urgency of the situation and the likely delay in obtaining such consent, it is necessary, in order to protect the health or life of the woman, to proceed without such consent.*

4.13. For reasons of sexual selection (the intentional aborting of a foetus of a certain gender)

4.13.1. CARE strongly opposes any proposal to allow abortion on the grounds of sex selection. Such a move is contrary to many statements made under international law which require prohibition of sex-selective abortion, flowing from clear prohibitions of discrimination, including in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).[29] The UN Commission on Human Rights Resolution 1996/49 calls upon states specifically to '*enact and enforce legislation against… prenatal sex selection…and give vigorous support to the efforts of non-governmental and community organizations to eliminate such practices*.'[30] The UN General Assembly Resolution 52/106 urged: '*… all States to enact and enforce legislation protecting girls from all forms of violence, including female infanticide and prenatal sex selection...*'[31] Such non-discrimination provisions were raised at the International Conference on Population and Development in 1994 and in the associated Programme of Action which called upon states to '*eliminate all forms of discrimination against the girl child and the root causes of son preference*', which include prenatal sex selection.'[32] Notably, a landmark UN conference on women's rights and development, to which the UK has bound itself politically, condemned sex-selective abortion clearly. The Beijing Platform for Action holds that *governments* are mandated to: '*Eliminate all forms of discrimination against the girl child and the root causes of son preference, which result in harmful and unethical practices such as prenatal sex selection and female infanticide; this is often compounded by the increasing use of technologies to determine foetal sex, resulting in abortion of female foetuses*'[33]

4.13.2. When sex selection abortion was debated in Westminster in 2015, the Minister described it as an "*abhorrent practice*", reiterated that sex selection is not a ground for an abortion.[34]

4.13.3. With the advent of non-invasive prenatal testing (NIPT), which is available on Jersey after 10 weeks[35] it is now possible to discern the sex of an unborn child early in pregnancy.[36] [37] A 2019 journal article stated, "*The introduction of NIPT has the potential to*

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29 See also the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Convention on the Rights of the Child (CRC)

30 UN Commission on Human Rights, The elimination of violence against women, 19 April 1996, E/CN.4/RES/1996/49 https://www.refworld.org/docid/3b00f22f18.html

31 UN General Assembly, The girl child, 11 February 1998, A/RES/52/106, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N98/766/45/PDF/N9876645.pdf?OpenElement

32 UN, Population and Development: Programme of Action Adopted at the International Conference on Population and Development, Cairo, Sept. 5–13, 1994, New York: Department for Economic and Social Information and Policy Analysis, UN, 1995.

33 https://www.un.org/en/events/pastevents/pdfs/Beijing_Declaration_and_Platform_for_Action.pdf

34 See House of Commons, 23 Feb 2015, col 120-123

35 https://www.womenshealthhub.je/services/harmony-testing

36 Bowman-Smart H, Savulescu J, Gyngell C, Mand C, Delatycki MB. Sex selection and non-invasive prenatal testing: A review of current practices, evidence, and ethical issues. *Prenatal Diagnosis*. 2019;1-10. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/pd.5555

37 The Nuffield Council on Bioethics say "*NIPT can, in principle, provide earlier results than current screening tests. NIPT usually can be performed at nine to ten weeks of pregnancy, with results being delivered usually within a week of the test.*" *Non-invasive prenatal testing: ethical issues*, March 2017, page 4, http://nuffieldbioethics.org/wp-content/uploads/NIPT-ethical-issues-full-report.pdf. https://www.nidirect.gov.uk/articles/testing-abnormalities says "Blood testing for Down's syndrome can be carried out between 11 and 13 weeks of pregnancy"

make the practice of sex-selective termination of pregnancy (TOP) an even more pressing issue. NIPT can determine the sex of the fetus very accurately and very early in the pregnancy. It is increasingly accurate from 7 weeks' gestation."[38] The potential for early abortions to be on the grounds of sex-selection is no longer theoretical.

4.13.4. The Isle of Man, when they introduced abortion with no conditionality (up to 14 weeks), **explicitly outlawed abortion on the grounds of the sex of the baby** except where there is a reasonable risk that the child would have a genetic condition dependent upon the child's sex.[39] **We recommend that Jersey does the same.**

5. **Question 19:** Are there other grounds, not listed above, on which termination should or not should not be legal in Jersey?

5.1. No. CARE believes that the grounds for abortion should be limited.

6. **Question 20:** Should termination in Jersey be legal at any gestational limit, regardless of the grounds for termination? **No, the gestational limit should depend on the grounds for the termination.**

7. **Question 21:** If termination remains legal in Jersey up to certain gestational limits, what limits should apply, where there is (tick as applicable)

Where there is a risk to the woman

7.1. Risk to the woman's life – no gestational limit (see above)

7.2. Risk of grave permanent injury to the woman's physical or mental health – no gestational limit (see above)

7.3. Risk of any injury to the woman's physical or mental health – 22 weeks

7.3.1. See our comments above about the grounds for physical or mental health.

7.3.2. There have been significant advances in neonatal care since the 1997 Act was passed; any legal reform needs to take into account those changes. Indeed, the Republic of Ireland law limits abortions on similar grounds to an upper limit of 'viability'.[40]

7.3.3. Since 1997, there have been continued improvements in the outcomes for extremely premature babies. One study based in a single neonatal intensive care unit in central London showed survival at 22 and 23 weeks was zero in the period 1981–1985, but steadily improved to around 50% of babies born alive at this gestational age in the period 1996 to 2000.[41] A further report, which focuses on survival up to one year of age of all babies born in 2016 in Great Britain at 22–26 weeks gestational age, found that 54% of babies born at 22+0 to 22+6 weeks gestation who were admitted to a Neonatal

38 Bowman-Smart H, el al *Prenatal Diagnosis*. 2019;1-10, *Op Cit*

39 See section 13, https://legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/2019/2019-0001/AbortionReformAct2019_1.pdf?zoom_highlight=abortion+reform Providing an exception in the case where there is are "reasonable grounds to believe that the foetus will suffer from a genetic disorder which is more likely to occur in a foetus of one sex than the other."

40 Section 9, Health (Regulation of Termination of Pregnancy) Act 2018

41 Riley K, Roth S, Sellwood M, Wyatt JS. Survival and neurodevelopmental morbidity at 1 year of age following extremely preterm delivery over a 20-year period: a single centre cohort study. *Acta Paediatrica*. 2008; 97: 159-65

Intensive Care Unit survived.[42] Whilst overall survival rates for babies born at 22 weeks gestation are lower than those born at 24 weeks, evidence suggests that a proactive policy of obstetric and neonatal staff make a significant difference to the chances of survival of these babies; compared with not providing active care.[43] The 2019 Framework for Practice for *Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation* states that, *"international data…show a trend towards increasing survival at 22 weeks of gestation, with reported survival rates of approximately one third in babies who receive active care at birth."*.[44]

7.3.4. That some babies may not survive if born at 22 weeks gestation does not negate the fact that some babies do. It is inappropriate that some viable babies would receive proactive life-ending medical intervention at the same gestational ages as others receive proactive life-saving interventions. It is surely an oddity in law that some babies are granted the full rights and protections of personhood at the same gestational age that others are treated as medical waste. It is also commonly recognised that the estimated gestation of the fetus could be one to two weeks out, hence a pregnancy estimated to have reached the 22nd week of gestation may, in fact, have reached the 24th.[45] Therefore, any legislation ought to be conservatively drafted in accordance with the precautionary principle to ensure that viable babies are not terminated for social reasons. Moreover, decisions should not be made about whether to provide care simply based on whether the baby may have a disability as this reinforces stereotypes about the value, and quality of life of persons with disabilities.

Where there is a risk to the woman

7.4. Risk to the physical or mental health of the woman's other children - Termination should not be available for this reason in Jersey.

Where there is a risk to the unborn child / children

7.5. A foetal abnormality that would result in the child, if born, suffering serious physical or mental abnormalities. Up to 22 weeks regardless of whether the disability is life threatening or not.

7.5.1. The law in England and Wales allows abortion **up to birth** where it is believed the child would have a disability were it to be born, in contrast to a 24-week gestation limit for all other abortions. CARE believes that this limit discriminates against unborn babies with disabilities and signals that human beings with a disability are worthy of less protection under the law than able bodied human beings. CARE is recommending a lower gestation limit of 22 weeks for all abortions,

7.5.2. The charity Disability Rights UK, commenting on the Westminster Abortion (Disability Equality) Bill [HL] 2017-19,[46] which sought to **remove the discriminatory gestation limit in GB**, said "*fundamentally it is about equality. Wherever Parliament sets the number of weeks after which abortion is not permitted, it should be exactly the same whether the*

[42] MBRRACE-UK Supplementary report on survival up to one year of age for babies born before 27 weeks gestational age — For Births in Great Britain from January to December 2016, Maternal, Newborn and Infant Clinical Outcome Review Programme, Table 2

[43] A study from Sweden compared outcomes from two different regions of the country in which neonatal staff were known to have different ethical attitudes to the care of extremely premature infants. The interventionist hospitals were had significantly improved survival rates compared with the non-interventionist hospitals. Håkansson S et al. Proactive Management Promotes Outcome in Extremely Preterm Infants: A Population-Based Comparison of Two Perinatal Management Strategies. *Pediatrics* 2004; 114: 58-64

[44] Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation, Framework for Practice, British Association of Perinatal Medicine (amazonaws.com), October 2019, page 7

[45] https://johnwyatt.com/2018/11/28/article-twenty-three-week-babies-the-price-of-life/

[46] https://services.parliament.uk/Bills/2017-19/abortiondisabilityequality.html

pregnancy is likely to result in a disabled or a non-disabled child. All lives are equal".[47]

7.5.3. Lord Kerr in a 2018 Supreme Court judgment said "*UNCRPD is based on the premise that if abortion is permissible, there should be no discrimination on the basis that the foetus, because of a defect, will result in a child being born with a physical or mental disability".* [48]

7.6. In the case of multiple pregnancy (ie. twins, triplets etc) reducing the number of multiple foetuses either because of foetal abnormality or to improve the outcomes for some of the foetuses (known as selective termination) – the time limits for selective reductions should reflect the relevant separate grounds for an abortion.

Pregnancy that results from crime

7.7. Crime of rape - Termination should not be available for this reason in Jersey

7.8. Crime of incest - Termination should not be available for this reason in Jersey

Other

7.9. The woman's condition causes her distress - Termination should not be available for this reason in Jersey.

7.10. For economic or social reasons (i.e. a lack of financial security) - Termination should not be available for this reason in Jersey.

7.11. Where the woman has intellectual or cognitive disability - Termination should not be available for this reason in Jersey

7.12. For reasons of sexual selection (the intentional aborting of a foetus of a certain gender) - Termination should not be available for this reason in Jersey.

8. **Question 22:** Are there other gestational limits that you think should apply on other grounds? Please specify the gestational limits and the grounds. **No.**

8.1. However, CARE recommends that terminations after 20 weeks should only be undertaken within acute sector hospitals since this reflects the requirements of the Care Quality Commission in England that only persons who are suitably qualified, skilled and experienced in the late termination of pregnancies should conduct these procedures.[49]

9. **Question 23**: How many health care professionals should a woman seeking a termination have to consult with? **Two, at any point in gestation**

9.1. CARE believes that only fully trained doctors, not other medical professionals, constitute appropriate practitioners and that two doctors should assess the pregnancy, checking gestation and determining whether an abortion can take place. This ensures safety and accountability for the woman, e.g. with regard to coercion and her overall health, as well as ensuring legal safeguards on abortion are upheld and that doctors are acting professionally. We do not believe it would be appropriate for other "registered healthcare professionals" to conduct abortions. Considering the seriousness of what happens when an abortion occurs, the ending of another

47 https://www.disabilityrightsuk.org/news/2017/january/dr-uk-welcomes-debate-abortion-and-disability
48 [2018] UKSC 27 https://www.supremecourt.uk/cases/docs/uksc-2017-0131-judgment.pdf Lord Kerr at paragraph 331
49 Regulation 20 of the Care Quality Commission (Registration) Regulations 2009.

human life, and the potential health risks involved for some women, the standard of two doctors is important. It is also important that all doctors and other staff involved in abortion provision should be covered by the proposed new conscience provisions.

10. **Question 24:** If the number of health care professionals is dependent on the point in gestation...

    10.1. This question is not relevant as we have answered Two at Any Point to Question 23.

11. **Question 25**: Should consultation for early medical termination (up to end of 9th week) be available by phone / video-link as opposed to the current requirement for in-person consultation?

    If there is only one consultation: **It should be in-person consultation.**

    If there is more than one consultation: **All consultation should be in-person.**

    11.1. CARE believes that Jersey should have a system of in-person consultations for any abortion because an in-person consultation:

        11.1.1. means there can be accurate determination of gestation which protects against abortions outside of the 9-week period, since an abortion later than 9 weeks can have significant impact on a woman if they take pills at home and deliver a baby at a later gestation;

        11.1.2. ensures that women who may feel coerced into an abortion are able to discuss their concerns;

        11.1.3. verifies the woman requesting pills is the woman who is pregnant, and verifies her age and whether additional safeguarding is needed;

        11.1.4. ensures the woman has provided informed consent to treatment, which is particularly crucial in cases where English is not the woman's first language; in the case of severe learning difficulty or learning disability, and if the woman or girl is under 18, in all of which eventualities informed consent may be difficult to ensure via a phone or video call; and

        11.1.5. gives face-to-face contact with doctors that can give women confidence in the case of any complications (see our response to Question 23 about appropriate medical professionals and our response to Question 26).

12. **Question 26:** Should a woman who is having an early medical termination (up to end of 9th week) be able to self-administer both medications at home as opposed to having the first medications administered by a doctor at the Jersey General Hospital, and the second self-administered at home, as is currently required. This would allow for termination at home. **Don't know/prefer not to say**

    12.1. For the reasons set out under Question 25, we believe that an in-person consultation for an abortion is essential.

    12.2. If abortion pills at home is to be allowed, there needs to be follow-up with the woman to ensure that any short or long term complications are identified and resolved; and women need to be able to access easily medical advice during the time the abortion is occurring should complications occur.

12.3. Complications arising from medical abortions at home should be comprehensively recorded and reported.

12.4. We believe that the situation is more nuanced than the consultation suggests, and remain concerned that taking abortion pills at home is not conducive to the best possible care for women with respect to complications, nor does it provide for adequate oversight with regard to pills being taken at a later date or even given to a third party.

13. **Question 27:** If a termination were carried out in a way that was not lawful, who should be liable for prosecution? Don't know/prefer not to say.

13.1. Our answer does not fit any of the six options set out on page 26 of the consultation document.

13.2. CARE **recommends** that where an abortion is carried out that is not lawful, any persons involved – including any person who carries out the termination (i.e. performs surgery or administers drugs) and the woman obtaining the abortion – should be considered to be committing an offence under any revised legislation. We recommend that proceedings under any reformed legislation should be brought only with the consent of the Attorney General.

13.3. There should also be an offence for an abortion that has taken place because of physical or psychological coercion or deception, e.g. a partner secretly inserts abortifacients into the food of a pregnant woman.

14. **Question 28:** Should safe access zones be introduced in Jersey? **No.**

14.1. We accept and agree that women seeking to obtain advice or to access abortion services may be vulnerable and experiencing distress. We likewise agree that any woman in this position should be treated with grace and compassion. CARE is deeply concerned by any behaviour which compounds vulnerability or distress, and which constitutes harassment, alarm, or distress for anyone who is seeking to gain access to an abortion clinic or to utilise its services.

14.2. Whilst we are clear that harassment or behaviour contributing to distress or alarm for women seeking to access abortion services is unacceptable, in 2018, the Home Office conducted an extensive review on the need for buffer zones in England. The then Home Secretary, Sajid Javid, stated before Parliament: *"Anti-abortion activities are more passive in nature. The main activities reported to us that take place during protests include praying, displaying banners and handing out leaflets. There were relatively few reports of the more aggressive activities."*[50]

14.3. When debating the merits of access zones, people who wish to express their opinion outside clinics, are often referred to as 'protestors.' However, this does not accurately capture the reality or the motivation for many, who may be there to pray, offer support and to provide an option for women who may wish to consider an alternative. Such offers of support (whether practical, financial or of some other kind) are often welcome and provide women with the means to consider other ways forward, for both them and their unborn child.[51]

14.4. These matters are sensitive and cut across several articles contained in the European Convention on Human Rights (ECHR),[52] including the right to freedom of expression and association. When law reform is proposed on areas that impinge on convention rights, the

50 Statement made on 13 September 2018 https://questions-statements.parliament.uk/written-statements/detail/2018-09-13/HCWS958
51 http://behereforme.org/alinas-story/ and http://behereforme.org/sarahs-story/
52 Human rights and the law in Jersey (gov.je)

European Court of Human Rights is clear that such reform should demonstrate balance.[53] We are concerned that legislation on access zones does not contain balance.

15. **Question 29:** If yes, which of the following types of behaviour should be prohibited in an area that is a specified distance from a termination service (a safe access zone)?

15.1. This question is not relevant as we have answered No to Question 28.

16. **Question 30:** If you have further comments about Jersey's Termination of Pregnancy Law or services, tell us here:

16.1. It is essential that any reform includes **comprehensive conscientious objection provisions** in line with Article 9 of the ECHR, which states that everyone has the right to freedom of thought, conscience and religion.[54]

16.1.1. **We believe the current standard adopted in the United Kingdom is too narrow and places a number of individuals who conscientiously object to abortion in an invidious position.** Narrowing the definition of conscience, as in the Doogan Judgment,[55] to "hands-on" involvement could lead to many talented individuals either not entering the medical profession in the first place or in the loss of those who have been accommodated hitherto and spent years in the field,[56] leaving them without a livelihood and the need to either retrain or move to another country to practise where there is a different regulatory framework. Given the shortage of medical staff post pandemic, this would seem short-sighted and detrimental to the individuals involved and the wider population of Jersey.

16.1.2. CARE believes that healthcare professionals should be protected if they wish to exercise a conscientious objection to **any part of a procedure**, where the objective is the termination of a pregnancy (except in emergency situations). We suggest that any future legal drafting should reflect that in section 38 of the UK's Human Fertilisation and Embryology Act 1990 which states that "*No person who has a conscientious objection to participating in any **activity** governed by this Act shall be under any duty however arising, to do so*"[57]

16.1.3. **CARE also believes that all individuals engaged in any medical, administrative, ancillary or managerial tasks should be able to utilize a right to conscientious objection (except in emergency situations) and have advocated for legislative change in the rest of the United Kingdom to this effect.**

16.1.4. CARE also **recommends** that there should be no requirement to make a referral to another doctor since many professionals with a conscientious objection believe that referring to another doctor helps to facilitate the provision of abortion and therefore makes the person doing the referral complicit in the provision of abortion, hence

53 The issue of balancing rights of buffer zones and the ECHR was considered in the case of Annen v Germany ANNEN v. GERMANY (coe.int) which held that the art 10 rights of a Mr Annen who was handing out leaflets at the door of a clinic were violated because the government had failed to balance the rights of Mr Annen and the clinic staff.

54 http://www.echr.coe.int/Documents/Convention_ENG.pdf, p.10

55 *Doogan and Wood v NHS Greater Glasgow Health Board* [2013] CSIH 36, http://www.bailii.org/scot/cases/ScotCS/2013/2013CSIH36.html.

56 All Party Parliamentary Pro-Life Group, A Report into Freedom of Conscience in Abortion Provision, July 2016, para 89, page 29, http://www.conscienceinquiry.uk/wp-content/uploads/2016/12/Pro-Life-APPG-Freedom-of-Conscience-in-Abortion-Provision.pdf

57 http://www.legislation.gov.uk/ukpga/1990/37/section/38

There should also be a **notification process** is put in place and a requirement to produce an **annual report** on the data collected which includes transparency about the grounds on which abortions are sought; and in the case of abortions on the grounds of disability, the conditions for which they are sought and detailed data on complications,

16.3.1. Abortions wherever and by whoever they are carried out, should be properly recorded on women's health records for future hospital stays or other medical treatment and care. This should include all medical abortions, wherever they are conducted. There should be monitoring and notification of complications for all abortions, regardless of gestation period.

16.4. We support **only approved premises being allowed to conduct abortions**. Any approved premises should be subject to regulations similar to the RSOPs that operate in England for private clinics[63] and should be subject to **inspection,** as occurs in England with the Care Quality Commission in England has powers to regulate and inspect private abortion clinics.[64]

16.5. Any reform should ensure that a woman is **not coerced into abortion**, given the recognised association between abortion and abuse.

16.5.1. A World Health Organisation report states: "*In the majority of settings, ever-pregnant women who had experienced partner physical or sexual violence, or both were significantly more likely to report having had at least one induced abortion than women who had never experienced partner violence.*"[65]

16.5.2. A study from the Australian and New Zealand Journal of Public Health indicates that "*partner violence is the strongest predictive factor of pregnancy termination among young Australian women.*" [66]

16.5.3. Similar findings were also exhibited in Canada. "*In a study of 4,750 Vancouver, BC residents who gave birth over a two-year period, 32.9% who experienced physical abuse or feared their partner had one or more previous induced abortions in contrast with 20.9% of those who were not abused or fearful.*"[67] Also "*some women are forced under threat of violence, even death, by their partners to terminate their pregnancy.*"[68]

16.5.4. A study of women in North East England, meanwhile, published by the Journal of Obstetrics and Gynaecology in 2014 showed that women requesting an abortion were six times as likely to suffer physical abuse in the current relationship and were five times as likely to suffer emotional abuse, than those attending anti-natal care.[69]

16.5.5. The Royal College of Obstetricians and Gynaecologists in their guidance on *The Care of Women Requesting Induced Abortion* advise the following (relevant words highlighted) said, *The rate of domestic abuse is higher in women seeking abortion, especially repeat abortion, and this has child protection implications. Abortion services offer an opportunity to identify such vulnerable women and enable them to receive support from or referral to trained*

63 https://www.gov.uk/government/publications/update-to-procedures-for-the-approval-of-independent-sector-places-published/procedures-for-the-approval-of-independent-sector-places-for-termination-of-pregnancy-abortion-in-england, May 2023

64 Regulation 20 of the Care Quality Commission (Registration) Regulations 2009.

65 Garcia-Moreno C, et al. Executive Summary. WHO multi-country study on women's health and domestic violence against women. Geneva: World Health Organisation, 2005, xv. apps.who.int/iris/bitstream/10665/43309/1/924159358X_eng.pdf

66 Taft AJ and Watson LF. Termination of Pregnancy: associations with partner violence and other factors in a national cohort of young Australian women. Australian and New Zealand Journal of Public Health." Aust N Z J Public Health 2007 Apr;31(2):135-42. https://www.ncbi.nlm.nih.gov/pubmed/17461004

67 Janssen et al, pages1341-7 Intimate partner violence and adverse pregnancy outcomes: a population-based study.

68 *Ibid*, page 1346

69 Wokoma TTI, Jampala M, Bexhell H, Guthrie K, Lindow S., A comparative study of the prevalence of domestic violence in women requesting a termination of pregnancy and those attending the antenatal clinic, BJOG. 2014 Apr;121(5):627-33.

violating their conscience. This would be in line with the GMC Guidance.[58]

16.2. We note the consultation does not refer to the **issue of counselling** for women seeking abortions; or for post abortion counselling.

16.2.1. CARE believes it is essential that a woman be given all the information she needs to make an informed decision when faced with a pregnancy which it would be legal to terminate. Any reform should require the provision of the option of appropriate pregnancy counselling from an organisation that does not have any kind of financial interest in the woman choosing to terminate. We **recommend** that women and their partners are offered a menu of different options including the option of free NHS counselling *before* deciding to have an abortion and post-abortion counselling as needed.

16.2.2. If a family are expecting a child with a disability or life-limiting condition, they may benefit from counselling and/or contact with specialists and other families in the rest of GB, who have children with the same condition.

16.2.3. The counselling should include alternatives to abortion, including the support available should the mother decide to keep the baby, or proceed with an adoption, and how to access that support; what happens during an abortion; potential short and long-term complications and physical, mental and emotional consequences; and information about the development of the baby.

16.2.4. Counsellors should be trained appropriately and accredited for crisis pregnancy counselling.

16.2.5. In providing counselling and/or gaining consent for an abortion, there should be **clear and accurate language provided to women**. The importance of describing the foetus accurately was highlighted in several studies looking at women's experiences of passing a foetus at home.[59] Participants described how *"women were not given enough information to prepare them for the abortion, which is a responsibility of the caregivers: "I was not prepared for the "little human being" about 12 in."*[60] Another study found women reacted similarly to a lack of information: "*Women stated that all patients should be informed at the clinic about what the products expelled would look like. Two women pointed out that they had been unprepared to see the amniotic sac and the embryo: '. . . saw something that looked like a small amniotic sac . . . hard . . . was not prepared for it . . .' and '. . . I put a paper in the toilet so I would see that I had aborted . . . was totally unprepared for seeing the embryo . . . became very sad . . . I could clearly see that it would be a human being . . ."*[61] Another study described how "*The picture of the fetus was something they would never forget. "You could see fetus, where the ears were, the arms, I was really frightened."*[62] Practitioners need to use accurate language to describe the foetus, ensuring that descriptions are not overly clinical and express the humanity of the foetus.

16.3. **Certification should be required** for any abortion proposed to demonstrate that the pregnancy is within the appropriate gestation limit and meets the criteria for a legal abortion.

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58 See para 12, https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice/personal-beliefs-and-medical-practice

59 https://www.nice.org.uk/guidance/ng140/evidence/b-information-needs-of-women-undergoing-an-abortion-pdf-6905052974

60 *Ibid*, pages 40-21

61 *Ibid*, page 62

62 *Ibid*, page 68

There should also be a **notification process** is put in place and a requirement to produce an **annual report** on the data collected which includes transparency about the grounds on which abortions are sought; and in the case of abortions on the grounds of disability, the conditions for which they are sought and detailed data on complications,

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16.5. Any reform should ensure that a woman is **not coerced into abortion**, given the recognised association between abortion and abuse.

16.5.1. A World Health Organisation report states: "*In the majority of settings, ever-pregnant women who had experienced partner physical or sexual violence, or both were significantly more likely to report having had at least one induced abortion than women who had never experienced partner violence.*"[65]

16.5.2. A study from the Australian and New Zealand Journal of Public Health indicates that "*partner violence is the strongest predictive factor of pregnancy termination among young Australian women.*" [66]

16.5.3. Similar findings were also exhibited in Canada. "*In a study of 4,750 Vancouver, BC residents who gave birth over a two-year period, 32.9% who experienced physical abuse or feared their partner had one or more previous induced abortions in contrast with 20.9% of those who were not abused or fearful.*"[67] Also "*some women are forced under threat of violence, even death, by their partners to terminate their pregnancy.*"[68]

16.5.4. A study of women in North East England, meanwhile, published by the Journal of Obstetrics and Gynaecology in 2014 showed that women requesting an abortion were six times as likely to suffer physical abuse in the current relationship and were five times as likely to suffer emotional abuse, than those attending anti-natal care.[69]

16.5.5. The Royal College of Obstetricians and Gynaecologists in their guidance on *The Care of Women Requesting Induced Abortion* advise the following (relevant words highlighted) said, *The rate of domestic abuse is higher in women seeking abortion, especially repeat abortion, and this has child protection implications. Abortion services offer an opportunity to identify such vulnerable women and enable them to receive support from or referral to trained*

63 https://www.gov.uk/government/publications/update-to-procedures-for-the-approval-of-independent-sector-places-published/procedures-for-the-approval-of-independent-sector-places-for-termination-of-pregnancy-abortion-in-england, May 2023

64 Regulation 20 of the Care Quality Commission (Registration) Regulations 2009.

65 Garcia-Moreno C, et al. Executive Summary. WHO multi-country study on women's health and domestic violence against women. Geneva: World Health Organisation, 2005, xv. apps.who.int/iris/bitstream/10665/43309/1/924159358X_eng.pdf

66 Taft AJ and Watson LF. Termination of Pregnancy: associations with partner violence and other factors in a national cohort of young Australian women. Australian and New Zealand Journal of Public Health." Aust N Z J Public Health 2007 Apr;31(2):135-42. https://www.ncbi.nlm.nih.gov/pubmed/17461004

67 Janssen et al, pages1341-7 Intimate partner violence and adverse pregnancy outcomes: a population-based study.

68 *Ibid*, page 1346

69 Wokoma TTI, Jampala M, Bexhell H, Guthrie K, Lindow S., A comparative study of the prevalence of domestic violence in women requesting a termination of pregnancy and those attending the antenatal clinic, BJOG. 2014 Apr;121(5):627-33.

advocates"[70]

16.5.6. In a 2023 study of women who had experienced abortion, 10% indicated that they had suffered coercion.[71]

16.5.7. The National Institute for Health and Care Excellence (NICE) guidance on Antenatal care for uncomplicated pregnancies says, "*The environment in which antenatal appointments take place should enable women to discuss sensitive issues such as domestic violence, sexual abuse, psychiatric illness and recreational drug use.*"[72]

16.6. Any reform of the law in Jersey should consider how to **manage foetal pain**.

16.6.1. In England, the NHS now recommends pain relief for unborn babies undergoing surgery for spina bifida from 20 weeks gestation[73] – which raises questions about the practice of abortion by dismemberment of babies – "*where the fetus is removed in fragments*"[74] – at similar gestations without pain relief.

16.6.2. The UK Government said about this spina bifida surgery. "*Pain relief for the unborn baby will be delivered intra-operatively. This is administered before the fetal surgery, after the uterus is opened. The fetus will be monitored during the procedure by ultrasound to check the fetal heart rate. The surgery takes place between 20 and 26 weeks of gestation.*" [75]

16.6.3. Scientific opinion regarding fetal pain is shifting. In 2020, the *Journal of Medical Ethics* published *'Reconsidering Fetal Pain'*,[76] by Dr Stuart Derbyshire, who previously argued that the scientific evidence did not support a case for fetal pain.[77] In the article, he stated that research may now indicate the potential for "*an immediate and unreflective pain experience mediated by the developing function of the nervous system from as early as 12 weeks.*" He suggests the "*clinical team and the pregnant woman can consider whether fetal analgesia makes sense based on the clinical requirements for the abortion, the age of the fetus and the conscience of the parties involved.*" His co-author John Bockmann, suggests "*Fetal analgesia and anaesthesia should thus be standard for abortions in the second trimester, especially after 18 weeks...*".[78]

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70 RCOG, The Care of Women Requesting Induced Abortion, November 2011, page 31 https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf

71 Reardon D C, Rafferty K A, Longbons T (May 11, 2023) The Effects of Abortion Decision Rightness and Decision Type on Women's Satisfaction and Mental Health. Cureus 15(5): e38882. doi:10.7759/cureus.38882

72 NICE. (2021). "Antenatal care". *Natoinal institute for Health and Care Excellence*. Available at: https://www.nice.org.uk/guidance/ng201/resources/antenatal-care-pdf-66143709695941, para 1.2.1 [Accessed 05/10/2023]

73 An NHS service specification advises this may take place from 19+0 weeks gestation, when gestational limits were raised in the form of a Prime Minister's Question it was suggested the lower limit was 20 weeks gestation. NHS England, *Service Specification: Open fetal surgery to treat foetuses with open spina bifida*, December 2018, 3, 8, https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2018/12/Open-fetal-surgery-to-treat-fetuses-with-open-spina-bifida.pdf. House of Commons Written Question 214478, answered 6 February 2019, https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2019-01-30/214478/.

74 Royal College of Obstetricians and Gynaecologists, *Fetal Awareness Review of Research and Recommendations for Practice*, Report of a Working Party, March 2010, page 21

75 An NHS service specification advises this may take place from 19+0 weeks gestation, when gestational limits were raised in the form of a Prime Minister's Question it was suggested the lower limit was 20 weeks gestation. NHS England, *Service Specification: Open fetal surgery to treat foetuses with open spina bifida*, December 2018, 3, 8, https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2018/12/Open-fetal-surgery-to-treat-fetuses-with-open-spina-bifida.pdf. House of Commons Written Question 214478, answered 6 February 2019, https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2019-01-30/214478/.

76 Stuart W.G. Derbyshire and John C. Bockmann, "Reconsidering Fetal Pain," *Journal of Medical Ethics* 46, no. 1 (January 2020): 3–6, https://10.1136/medethics-2019-105701.

77 For example, in 1996 Dr Derbyshire co-wrote an article describing foetal pain as a 'misnomer', see Stuart W.G. Derbyshire and Ann Furedi, "Do Fetuses Feel Pain? "Fetal Pain" is a Misnomer," *British Medical Journal Clinical Research* 313, no. 7060 (September 1996): 795, https://doi.org/10.1136/bmj.313.7060.795a. In 2006, he argued against informing women of any risk of foetal pain. Stuart W.G. Derbyshire, "Can Fetuses Feel Pain?" *British Medical Journal* 332, no. 7546 (April 2006): 909–12, https://doi.org/10.1136/bmj.332.7546.909.

78 Derbyshire and Bockmann, *Op Cit*