The RCM welcomes the opportunity to speak with the Committee today. We responded to both the consultation by the NIO on a new legal framework for abortion services in Northern Ireland and to the call for evidence related to the Severe Fetal Impairment Abortion (Amendment) Bill. The RCM has a particular interest in this Bill as the majority of women impacted by it will be receiving maternity care and be supported by a midwife. I have a short briefing but look forward to exploring the issues directly with you.

The greatest impact of this Bill will be felt by the unfortunate women who find themselves in the situation of needing to access an abortion later in pregnancy. Many women impacted by this Bill will have planned pregnancies and very much wanted babies, but when something changes during the course of the pregnancy they may decide to have an abortion. This is never an easy option. The decision may be delayed beyond 24 weeks may be because of late presentation into maternity services, changes in circumstances, maternal health and wellbeing or due to delay in diagnosis of fetal anomaly.

Any indication of an abnormality has a devastating impact for the woman, her partner, and her family. Women's reasons for terminating a pregnancy on grounds of fetal anomaly may include the emotional and financial cost of raising a disabled child; the effect on a woman's ability to care for her existing children; and the feeling that it is cruel to have a child that will need constant medical intervention and may live in pain.

Ultimately the woman must make a judgement as to what she, in her particular circumstances and at that point in her life, can cope with. The shock of receiving such a diagnosis can make these women very vulnerable, they may be tipped over the edge into serious mental health or physical health problems if forced to continue with a pregnancy or if forced to travel to England to access services. The decision that a women makes is not a value judgement about people living with a disability, but rather a judgement about her own ability to cope in this situation.

Each woman needs to have sufficient time to receive all the information pertinent to her situation, to consider and review options, likely outcomes, treatment options and come to a reasoned decision that is right for the individual woman and her family. They deserve access to non-directive, evidence-based information and access to health care professionals who are skilled in discussing pregnancy related diagnoses in a sensitive, non-judgemental way. Information needs to be available in a format that is easily accessible and ultimately there must be respect for the woman's autonomous decision making. The impact of this Bill means that there is a cut off for abortion by the 24th week of pregnancy. This places significant time pressures on women in relation to the complex clinical and personal decision making required in these circumstances.

Midwives are central to the care these women receive. All women have the right to exercise choice over every aspect of their maternity care, including whether to have a baby or not. They have the right to be given the necessary information to make informed decisions about their care and midwives have a duty of care to ensure that women receive all the appropriate information and advice they need to do this. Midwives are best placed to provide continuity of compassionate women centred care regardless of the decision they make. Midwives work with women who are considering or have made a decision to terminate their pregnancy. They will care for women during the process of termination of pregnancy and will care for women before and after a termination, in the same way as they will care for women who decide to continue with their pregnancy. Midwifery practice will always comply with the legal framework relevant to the provision of such services.

In Oct 2019 I wrote to RCM members in to outline their rights and responsibilities in relation to conscientious objection. They were directed to the NMC Code for guidance on matters relating to this issue. Several sections of the code are applicable but specifically paragraph 4.4;

> *'Tell colleagues, your manager and the person receiving care if you have a particular conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care'*

Conscientious objection has been defined in both legislation and through case law as only applying to the actual procedure of abortion. If a midwife has a conscientious objection, they must make it known to their manager well in advance of any woman presenting for care. Midwives cannot object to providing care before the procedure or after and must continue to provide care in an emergency situation.

However, failure to commission services as outlined in the Abortion (Northern Ireland) Regulations 2020 leaves my members working to provide safe effective care without a clear framework for service delivery, clear care pathways to guide quality care, and clear guidance, including guidance about how to exercise their right to conscientious objection. The enquiries I receive to the office are frequently related to practice issues, seeking guidance about providing care based on a desire to do the best for these women.

I have regular ongoing contact with midwives across Northern Ireland, and, at no point in time did Mr Givan or anyone from his office approach the RCM and ask for our professional input into the potential effect or impact of his Bill. The RCM will expect to be part of the working group to develop the policy framework in which services will be provided so that we can contribute our expertise to its development.

Denying abortion after 24 weeks will not stop it happening, but will lead to already traumatised and devastated women being forced to travel to access healthcare that they should rightfully expect locally.