Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Severe Fetal Impairment Abortion (Amendment) Bill:
Royal College of Midwives;
Northern Ireland Abortion
and Contraception Taskgroup

10 June 2021

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Jonathan Buckley
Mr Gerry Carroll
Mr Alan Chambers
Ms Órlaithí Flynn
Ms Cara Hunter
Ms Carál Ní Chuilín

Witnesses:

Ms Michele McGrath	Northern Ireland Abortion and Contraception Taskgroup
Ms Karen Murray	Royal College of Midwives

The Chairperson (Mr Gildernew): I welcome Ms Karen Murray, director of the Royal College of Midwives (RCM). Good morning, Karen. Are you able to hear us OK?

Ms Karen Murray (Royal College of Midwives): I can indeed, Chair. Thank you very much.

The Chairperson (Mr Gildernew): Thank you, Karen. You are very welcome. I also welcome Ms Michele McGrath, who is a member of the NI Abortion and Contraception Taskgroup (NIACT). Can you hear us OK, Michele?

Ms Michele McGrath (Northern Ireland Abortion and Contraception Taskgroup): Yes, I can. Thank you, Chair.

The Chairperson (Mr Gildernew): Tá fáilte romhaibh go dtí an Coiste. You are very welcome to the Health Committee. I will hand back to each of you for five minutes to give an outline briefing, and then we will go to questions from members.

Karen, I think your camera is facing the wrong way, so could you reverse it, please?

Ms Murray: Yes, I am happy to go ahead with the briefing and to see what I can do about the camera. First of all, I would like to say —.

The Chairperson (Mr Gildernew): Would you like if I went to Michele first and gave you a couple more minutes to see if you can sort the camera out?

Ms Murray: That is perfect, Chair. I will try to sort the camera situation out. Thank you.

The Chairperson (Mr Gildernew): I will go to Michele. Are you content to go ahead and give your briefing to the Committee?

Ms McGrath: Yes, Chair, that is fine, thanks.

The Chairperson (Mr Gildernew): Thank you.

Ms McGrath: Thank you for your time this morning. I am here representing the Northern Ireland Abortion and Contraception Taskgroup. NIACT is a group of multidisciplinary professionals who came together in March 2020 to give professional guidance on bringing about the conditions and services required to minimise the need for abortion in Northern Ireland but, when it is required, to provide a compassionate and caring abortion service within the framework of the Abortion (Northern Ireland) Regulations 2020. The group is chaired by consultant Ralph Roberts and includes obstetricians and gynaecologists; sexual and reproductive health (SRH) doctors and nurses; a GP; the chair of the Northern Ireland committee of the Royal College of Obstetricians and Gynaecologists (RCOG); the Northern Ireland regional committee chair of the Faculty of Sexual and Reproductive Healthcare (FSRH); the current and past directors of the Royal College of Midwives in Northern Ireland; representatives from Informing Choices NI (ICNI) and Common Youth; and academics with a research and policy interest in abortion. There is representation in the membership from each of the five health and social care trusts.

In the early stages, the work of the group focused largely on setting up early medical abortion (EMA) services in response to the travel restrictions imposed due to the COVID-19 pandemic. Within weeks, EMA services were set up across all five trusts in line with the new legal framework. NIACT then turned its attention to writing its report on sexual and reproductive health in Northern Ireland, which was published on 31 March 2021. I am not sure whether the Committee has seen that report, but it is available, and I can get copies to you if you so require. The report provides an evidence base and sets out a strategy to inform the funding and commissioning of relationships and sex education and integrated sexual and reproductive healthcare for the population of Northern Ireland. It is based on a six-point vision encompassing the themes of reproductive justice; relationships and sexuality education (RSE); awareness and provision of contraception and emergency contraception; and provision of non-stigmatised, safe and compassionate abortion care. I will read that vision to you this morning:

> *"We have a vision that every child in Northern Ireland is born into a family that has both the will and means to support their needs and nurture their development ... .*
>
> *It is our vision that all children and young people should be provided with a high-quality education that teaches about healthy relationships, consent, sexuality and the ability to decide when, and if, to start a family.*
>
> *We believe that all young people and adults should be educated about the benefits and effectiveness of different methods of contraception.*
>
> *Women and girls should be empowered to take control of their fertility and contraception should be easily accessible and freely available.*
>
> *When a pregnancy is unintended, women and girls should be supported with decision-making in a way that is unbiased, non-judgemental and devoid of stigma.*
>
> *Where abortion is needed, services should be accessible, high-quality and designed to deliver safe compassionate care".*

The report makes 38 recommendations, two of which are particularly relevant to the proposed amendment that is being considered by the Committee. Those are recommendation 28, which states:

"The UK National Screening Committee recommendations for first trimester screening should be introduced so that women in Northern Ireland have equity with women in other parts of the UK and, for those who choose abortion, that this can happen at an earlier gestational age.",

and recommendation 29, which states:

"Services should be adequately resourced to ensure that there is the capability to provide abortion within Northern Ireland at all gestations."

NIACT's report can be used as a blueprint for the development of services, including the approval of telemedicine for providing EMA and the introduction of buffer zones around clinics in order to diminish the adverse impact of protests on patients, many of whom are not seeking abortions. We have particular concerns about the lack of commissioning of abortion services and the resultant fragility and geographical inequity of the current non-commissioned service. We also have serious concerns about the activities of private clinics that pose as abortion providers but the purpose of which is to delay and obstruct women who wish to have an abortion.

In addition, we have profound reservations about the amendment that is being considered. First, we believe that its authority is greatly undermined by the fact that it was brought forward without any consultation with the doctors who might provide the services that it seeks to deny. We assert that this is a complex medical matter, and approaching it with a lack of medical consultation is not a good starting point for changing legislation.

The Bill appears to be founded on an emotive link between the abortion regulations and disability discrimination. If a woman is carrying a baby with severe fetal impairment, she will be aware of the impact that that will have on her existing family. We believe that the compassionate view is to let her decide the fate of that pregnancy. NIACT also contends that the Second Reading of the Bill was supported by arguments that are not based in reality. The suggestion that clinicians in Northern Ireland would facilitate the late termination of pregnancy due to club foot, cleft palate or even uncomplicated Down's syndrome is totally erroneous and misled those taking part in the debate. Medical staff perceive that as a lack of trust in the very same doctors whom we all rely on to bring about successful outcomes in many medically complicated pregnancies. Parents are always supported in their decisions to continue with a pregnancy following a diagnosis of severe fetal impairment.

NIACT point out that the number of cases affected by the proposed change in the regulations is very small, but, for those involved, the impact may be profound. There are cases that either present later in pregnancy or where there are difficulties in diagnosis that may lead to properly considered decisions overrunning the 24-week limit. Rushing diagnosis and decisions to beat the 24-week deadline may result in more decisions to terminate and, thus, be counterproductive. If late terminations occur, it is important that they are performed locally and not exported to England. That will reduce the stress and distress that are suffered by those families and will facilitate proper local psychological and bereavement supports.

Finally, NIACT believes that the amendment would mean that the abortion regulations would no longer be compliant with the UN Committee on the Elimination of Discrimination against Women (CEDAW) recommendations. Thank you, Chair.

The Chairperson (Mr Gildernew): Thank you, Michele. When you began to speak, I realised that your camera was off as well.

Ms McGrath: Oh.

The Chairperson (Mr Gildernew): I think that Karen has her camera sorted. Yours is on now.

Ms McGrath: Sorry.

The Chairperson (Mr Gildernew): No problem. Your presentation was very clear, and we were able to follow it without a problem. It is useful to have you on camera for the question-and-answer session.

Thank you, Michele. I will go back to you now, Karen. Karen, if you would like to go ahead with your presentation.

Ms Murray: Thank you very much, Chairperson. I apologise for the technical difficulties, but we got them sorted.

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

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

Any indication of an abnormality has a devastating impact on 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 who will need constant medical intervention and may live in pain. Ultimately, the woman must make a judgement about what she, in her circumstances at that point in her life, can cope with.

The shock of receiving such a diagnosis can make those women very vulnerable. They may be tipped over the edge into serious mental or physical health problems if forced to continue with a pregnancy or to travel to England to access services. The decision that a woman makes is not a value judgement about people who live with a disability; rather, it is a judgement about her ability to cope with the situation. Each woman needs sufficient time to receive all the information that is pertinent to her situation, to consider and review options, likely outcomes and treatment options and to 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 healthcare professionals who are skilled in discussing pregnancy options in a sensitive and 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 the Bill would mean that there would be a cut-off for abortion by the twenty-fourth week of pregnancy. That would place significant time pressures on women in relation to the complex clinical and personal decision-making that is required in those circumstances. Midwives are central to the care that those women receive. All women have the right to exercise choice over every aspect of their maternity care, including whether to have the baby. They have the right to be given the necessary information in order 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 that they need in order to do that.

Midwives are best placed to provide continuity of compassionate, woman-centred care, regardless of the decision that the woman makes. Midwives work with women who are considering or who have made a decision to terminate their pregnancy. They will care for women during the process of termination of pregnancy and 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 that is relevant to the provision of such services.

In October 2019, I wrote to RCM members to outline their rights and responsibilities on conscientious objection. They were directed to the Nursing and Midwifery Council (NMC) code for guidance on matters relating to the issue. Several sections of the code are applicable, but specifically paragraph 4.4, which states that they must:

> *"tell colleagues, your manager and the person receiving care if you have a 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 legislation and in case law as applying only 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 or after the procedure and must continue to provide care in an emergency. 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 that I receive in my office are frequently related to practice issues, seeking guidance about providing care and based on a desire to do the best for women in those circumstances.

I have regular contact with midwives across Northern Ireland. At no point did Mr Givan or anyone from his office approach the Royal College of Midwives and ask for its 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 it will lead to already traumatised and devastated women being forced to travel to access healthcare that they should, rightly, be able to expect locally.

The Chairperson (Mr Gildernew): OK. Thank you, Karen and Michele. I want to pick up on a couple of issues. Can you outline the difficulties with screening and what the knock-on effects are on women here?

Ms Murray: Yes, Chair. The screening scheme in Northern Ireland does not replicate the screening system across the UK, so we do not have routine access to early screening tests. Usually, the first indication for a woman that there may be an issue with the pregnancy is at the 20-week scan. That is purely a screening tool. Structural abnormalities may be identified, but the woman needs more diagnostic methods of identifying the anomaly. That takes time. The woman needs to be referred to fetal medicine specialists, have further tests, await the outcome of those tests, and have conversations with the medical team about the expectations of the impact of the anomaly on the baby.

All that takes time. It is important to highlight the fact that, although we talk about abortion up to 24 weeks, those decisions need to be made by the twenty-third week in order to facilitate sufficient time to organise the procedure and for the procedure to be completed. The biggest issue with screening is time. The Bill would create significant time pressures for the clinicians and, importantly, for the women who have to deal with very complex clinical information and to think about that from a personal perspective, consider how it is going to work in their family and come to a decision that they are comfortable with. I think that comfortable is the word. It is never a decision that any woman wishes to make, but it is a decision that they need to think about and a judgement that they need to make. The time pressures are our biggest issue at the moment, given the current screening programme in Northern Ireland.

The Chairperson (Mr Gildernew): Thank you, Karen. My second question is more for Michele. Before I go to that, Michele, please pass on the report with the six-point vision that you referred to earlier. That information will be useful for Committee members.

You pointed out that:

> *"the number of cases affected by the proposed change in the Regulations is very small but, for those involved, the impact may be really profound."*

You go on to say:

> *"These are cases which either present later in pregnancy or where there are difficulties in diagnosis which may lead to properly considered decisions overrunning the 24week limit. Rushing these diagnoses and decisions to beat the 24week deadline may actually result in more decisions to terminate and may thus be totally counterproductive."*

Can you elaborate on your thinking on that?

Ms McGrath: Karen covered that very well when she explained that the 20-week scan is only a scan; it is a routine process. By the time patients go through all their diagnostic tests and see the fetal medicine specialists, there are only three weeks between that 20-week scan to get all the investigations done, see the fetal medicine team, and make a decision. When a woman receives

traumatic information — it is traumatic, because most of these are very much wanted pregnancies — it is like receiving any shock: it takes time to process. That is very much along the lines of what Karen stated. There will be women who feel pressurised into making decisions that they later regret, and they may well have continued with their pregnancy if they had had time to consider their options and receive support and information not only from the fetal medicine specialists but also from charitable bodies that provide support to families with children with disabilities and impairments.

The Chairperson (Mr Gildernew): Thank you. I will go to other members now. First, I will bring in Deputy Chair Pam Cameron and then Cara Hunter, Paula Bradshaw and Gerry Carroll, who have indicated that they have questions. Go ahead, Pam.

Mrs Cameron: Thank you, Chair, and thank you, ladies, for your presentation. My party's stance on abortion has always been clear. However, I hear, respect and appreciate other opinions on an incredibly difficult subject. Why is it justifiable to protect the life of babies who do not have Down's syndrome but not those that do? Are you not supporting discrimination against babies with disabilities?

Ms Murray: I am happy to take that question.

Ms McGrath: Go ahead, Karen, yes.

Ms Murray: It is important to recognise that it is about a woman's individual choice. From a midwifery perspective, when we are providing care for those women, we provide care regardless of whether a woman wishes to continue with a pregnancy where there is a diagnosis of Down's syndrome or any other disability. We will provide that care to a high standard, compassionately and with empathy. Equally, we will provide compassionate and empathetic care to those women who feel that, for their own reasons, they are unable to proceed with a pregnancy at that point in time. We have to be careful: it is not about health professionals making a decision about which pregnancies to continue and which not to continue. It is about reasoned decisions that are based on evidence and information from medical professionals and women making decisions, given their own personal circumstances. That is our stance and the stance of the college.

The Chairperson (Mr Gildernew): Were you looking to come in there as well, Michele?

Ms McGrath: No, Karen has answered that very well.

The Chairperson (Mr Gildernew): Anything else, Pam?

Mrs Cameron: Not really. I appreciate where you are coming from, which comes back to the choice issue, but the Bill is dealing with the discriminatory issues around disabilities.

Ms Murray: I do not want to labour the point, but, as I pointed out in my initial briefing, women are not making those decisions based on any value statement about disability; they are making judgements based on their own personal circumstances and the position that they find themselves in. As midwives, the one thing that we appreciate is that women come from a very wide set of circumstances with lots of issues going on in their own lives, and we are very conscious of that. It is not a value statement about disability; it is about an individual woman's circumstances and her ability to cope with the situation at a given time.

Ms Hunter: Thank you to Michele and Karen for being here. Your contributions really help to shape the debate. I find them very helpful.

Michele, you made a fantastic point about the need for increased and improved relationship and sexuality education. I certainly feel that what is there at the minute really is not reflective; it is not built for a purpose; it is a pick-and-mix approach. Not every classroom gets the same level of education on these crucial topics, specifically consent. That is important, so thank you for raising that.

Ladies, I have two questions. One, which I raised last week as well, is about screening, and I thank the Chair for raising it previously. I am mindful that there are barriers to prenatal screening based on socio-economic status. Last week, we touched on the IONA test and its cost, so there are definitely financial barriers. What more can we do to improve our screening here?

My second question is that with the focus on the welfare of the mother, whether you decide to keep or to terminate, what is your assessment and experience of the current counselling provision?

Ms McGrath: Karen, if you are happy to answer the screening question, I am happy to answer the second question.

Ms Murray: Yes, that is fine. Screening is an important issue, Cara. There probably is sense in bringing the Northern Ireland system into line with the rest of the UK to provide equity for women in the screening processes. In terms of maternity services and how midwives work, it is all based on choice. Even if we had the same full screening service as the UK, women could choose to opt in or out of it. If they choose not to have the screening test, they do not have to have it. There is something about aligning ourselves with the wider system.

Midwives are very well placed to communicate complex information on screening tests and their purpose, explaining that it is screening and not diagnostic but that it will give indications and that it also gives information about the diagnostic processes if there are concerns raised as part of the screening programme. I suppose that my thoughts are to reduce the inequity, especially in the availability of screening tests in Northern Ireland for a fee. It is about widening screening access to a similar level as the rest of the UK and enabling women to choose whether they wish to avail of it.

Ms McGrath: In response to your question on assessment and counselling, I believe that you had a presentation from Informing Choices Northern Ireland last week. ICNI is our central access point. Anyone wishing to access an abortion would ring them and go through a process of counselling where all options are discussed, not just termination of pregnancy. This is non-directive, non-judgemental counselling. When the patients decide that they want to go ahead, they are referred to whatever trust they are resident in.

Following that, they will be put onto our Lilie system, which is a confidential sexual and reproductive health system. The doctors and medical staff involved in the service make contact with the patient via telephone and they have a telephone assessment. That includes medical history. There is discussion about whether the women feel under pressure or are being coerced. If women need more time to think about it, that is fine as well. All that is done in the medical assessment before they are eventually booked in for treatment.

We still do have women who arrive for treatment and change their minds. They are very much supported in their decisions. Nursing, particularly, is all about patient-centred care and focusing on the patients' needs. Our professional role as nurses is to be advocates for our patients; it is about supporting them in their decisions. It is about their having a voice when they feel that they cannot speak up. Patients get a high level of assessment and counselling prior to coming for treatment.

Ms Murray: One of the issues that I have been talking to midwives recently about is counselling services. ICNI provides excellent post-pregnancy counselling services. One of the big issues that midwives are raising is bereavement counselling. It is important to recognise that, in those circumstances, women are bereaved. They are bereaved of a normal healthy pregnancy, and they also have the bereavement after the birth because they still have to go through the processes of arranging funerals etc for babies. One of the pleas from maternity services is to strengthen bereavement services by making sure that we have sufficient midwives in bereavement posts in each of the trusts to provide good services for women. The circumstances are slightly different for those women, and their experience of bereavement is slightly different as well.

Ms Hunter: Thank you, Michele and Karen. Those were detailed and helpful answers.

Ms Bradshaw: Thank you, Karen and Michele, for coming this morning and for your written briefing. Both were helpful and to the point. I thank Michele and her healthcare professional team across all the trusts for stepping up to deliver abortion services in Northern Ireland when the Department of Health has failed to do so. I welcome your report — you called it a blueprint — for how abortion services could be commissioned in Northern Ireland. I am not sure whether you heard the Human Rights Commission's presentation last week, but it indicated that, off the back of the legal challenge, the Department of Health said that it has established a project board and that it could take eight to 10 months to do exactly what you have produced in your blueprint. I know that in-depth work went into that. Has the Department of Health engaged with you, as a group, to work through the blueprint — the report — that you produced?

Ms McGrath: Preliminary meetings have been arranged to set up a project board, but the Department indicated a timescale of six to nine months. The problem is that we are operating services on the ground now, and we need a framework and guidance. Trusts and staff need guidance. That needs to be done as a matter of urgency, alongside the commissioning process.

Ms Bradshaw: I am not sure whether you heard the first debate in the Chamber on the Bill. Accusations were made of coercive language being used by healthcare professionals towards women who had received a diagnosis. I raised that issue last week with Informing Choices, but, obviously, you are the healthcare professionals. You referred to non-directive information and support and advice. Will you outline for the Committee the time and the qualifications it takes to bring a consultant to the point where they are a fetal medicine consultant in order to demonstrate their professionalism and tenure?

Ms McGrath: To be honest, I am probably not best placed to answer that question because I have a nursing background rather than a medical one, but fetal medicine specialists come up through the normal medical training route. They serve their time as junior house officers, although they are not called that now, right the way up through registrars. To reach a specialist level at that stage, they will have years of paediatric experience. I think that you have had a submission from our fetal medicine specialists over here. They are very highly skilled. They are developing new techniques all the time in the provision of entry uterine surgery and things to improve outcomes for babies. They are very much on the front line in supporting women and trying to advance medical practice so that women may deliver safely and have as healthy a baby as possible. They are very experienced along those lines.

Ms Bradshaw: Thank you. Thank you to Karen for your robust report as well. I really appreciate it. I have no questions for you.

Ms Murray: Thank you very much.

Mr Carroll: Thanks, Michele and Karen. Karen, the fact that the proposer of the Bill, in your words, did not consult you or midwives' representatives in the RCM is, in my view, quite telling about the aims of the Bill. Despite the claims about it protecting people with disabilities, in my view it is appealing to a particular narrative that does not want any control for women over their bodies or agency for them. It really wants to hold back and restrict abortion in all cases. You can agree on that or not, but I think that that has to be said.

I have two quick questions and a follow-up question. Can you elaborate on the private clinics and the role that they play in obstructing abortion either by giving out false information or by delaying, as either Karen or Michele said, the ability of women to access termination? I think that that is quite a cruel practice and something that happens below the radar. Can you expand on that and on the pain that that causes?

Last week, I raised this point with Amnesty and the Human Rights Commission. In your presentation today, you said that the Bill, if it proceeds, could lead to an increase in terminations because, with the time restriction, people would feel forced to make a decision that they may not choose if they had a longer time to consider their options. Maybe you can expand on those questions about private clinics and the increased numbers of terminations, and I will then have a quick follow-up question.

Ms McGrath: I will respond to your question on private clinics. If you google "abortion in Northern Ireland", you will see that one of the private clinics comes high up on the Google list. It is a clinic that, I believe, is funded by pro-life organisations in the States. Because there is not a lot of information around in Northern Ireland about how to access early medical abortion services and no public health information has been given out, patients tend to do what people do: they google. That clinic comes quite high up on the Google list.

This is information that is coming from patients directly. When patients ring to that clinic, they are booked in for a scan. Sometimes it takes them some time to realise that this clinic is not an abortion provider. They are made to have a scan and are then told that they have to come back in another few weeks and have another scan. It is probably only as they are leaving, with the persuasive language that is used with them, that they realise that this actually is not an abortion provider. We have had patients come into the service extremely distressed because they have been delayed for so long that they are now over the nine weeks plus six days for treatment. They have either had to travel to England in the middle of a pandemic, which, obviously, is not ideal, or they have had to access unregulated services on the web. So, it is extremely distressing for patients. We believe in patient

advocacy and patient choice, so, as nurses, it is very difficult to try to protect these patients from the damage that these clinics are doing.

Ms Murray: I am happy to pick up on time frames. I think that we have discussed this at various points. We are talking about women who have received traumatic information. They are devastated, and they need time to process that. We have also talked about the length of time that it takes for diagnostics *[Inaudible owing to poor sound quality]* to be provided. I think that *[Inaudible owing to poor sound quality]* potential to terminate a pregnancy. I am aware of women in the Province who are continuing with pregnancies and are going ahead to donate organs. I am aware of women who have continued with pregnancies and have had superb support from the Northern Ireland Children's Hospice.

Those women make a range of choices. However, they need time to think it through, to get information about what the potential outcome of the pregnancy will be, and then consider the options available to them. On the issue that Paula raised about accusations of medical staff's use of language, I go back to the fact that, often, a midwife is involved who will support women and sometimes help them to understand and process the information that they are receiving. There are checks and balances in the system to make sure that women have the right information, understand it, and can make judgements and reasoned decisions for themselves.

Mr Carroll: Thank you, Michele, and thanks, Karen. As you said, people should be given the choice, time and space rather than the stigma. The Bill would increase the stigma and hurt for women. My understanding is that countries that have no criminalisation of abortion and no restrictions beyond medical guidance and guidelines have some of the lowest abortion levels in the world. It is ironic that people can be against abortion but, by increasing regulations and restrictions, will make people more likely to access terminations.

Do you have any comment to make on the limited services for terminations at the minute — some trusts are without services or with services that have been scaled back — and the difficulty for women in getting terminations after 12 weeks? That is my final question. Thank you for joining us today.

Ms McGrath: At one point, I think, three out of the five trusts had stopped delivering services. The South Eastern Trust had stopped for a month, the Northern Trust had stopped for three months, and, in the Western Trust, the service is suspended. When the EMA service was first developed, it was led by conscientious, committed medical staff, some of whom worked single-handedly with no admin or nursing support, and the service was unsustainable. At the height of lockdown, trusts could do that because there was a slight downturn in our normal sexual reproductive health clinics because of the pandemic. We were therefore able to divert our resources to that. We have now restarted services, however, so it is very difficult to juggle everything. Being funded from the public purse, we are expected to meet budgets and things like that, so at the minute it is extremely difficult. I do not think that any of the trusts would have been able to carry on without the committed staff that they have.

On the 12-week limit, in reality, in Northern Ireland women can access termination of pregnancy only up to nine weeks and six days; there is no service for termination beyond that. If women are between 10 and 12 weeks, they have to travel to England to access services. Alternatively, a lot of women opt to use unregulated services and obtain medication online. I am not saying that that is not safe, but we prefer to see terminations happening within regulated services.

The Chairperson (Mr Gildernew): OK. Thank you, Michele and Karen.

Carál Ní Chuilín, Órlaithí Flynn and Jonathan Buckley are indicating that they want to come in. Carál, gabh ar aghaidh, le do thoil.

Ms Ní Chuilín: Karen and Michele, thank you very much for your professional, objective and compassionate presentation to the Committee. As other members have commented, it is telling that consultation with health professionals, whom I trust, was not availed of on this occasion. I want to put that on record. This was raised last week with Amnesty, Informing Choices and the Human Rights Commission, but you mentioned that even women who are not accessing abortion services but are instead accessing reproductive healthcare are being subjected to people protesting, which those people have a right to do. It is not just those women and their partners but the staff, so I would like to hear your views on that. We often talk about safe staffing legislation. That has been absent and, unfortunately, is not going ahead, but what is your opinion on safe staffing and the safety of staff? We started today's meeting by discussing, and rightly so, attacks on our Ambulance Service. Healthcare

professionals have been providing healthcare, advice and compassion in every field of medicine. They will bring those skills and that compassion with them regardless of where they are working. I would therefore like to hear your comments on what women, their partners and, indeed, staff have had to endure. Regardless of whether the legislation passes or not, there will be pregnant women who will have to access an abortion, if that is their choice. When we talk about healthcare for all, it means, in reality, healthcare for some.

I will finish by expressing my gratitude, as a mother and grandmother, to midwives. We have a fantastic midwifery unit in the Mater in North Belfast, and our midwives in the Royal — indeed, across the trusts but certainly in Belfast — are unreal. They contact us about poverty, housing, nutrition and mental health. They go well above and beyond, and I want to put that on the record. Thank you very much.

Ms McGrath: It is lovely to hear that about the midwives. I am sure that Karen is absolutely delighted. Karen is probably the best person to answer the question on the protests. At the minute, in the Northern Trust, we have two groups of protesters outside the clinic every week. We absolutely recognise people's right to protest, but, at the outset, I will say that the right to protest does not trump a woman's right to access healthcare safely and without intimidation. It is the same with staff. Staff have a right to enter and exit their workplace without intimidation.

I will describe a typical situation at the clinics at the minute. One group in particular will come across the road, stand outside the clinic doors and try to prevent patients from coming in. They force them to take leaflets. If patients decline the leaflets, they are told to take them and pass them on to somebody else. Patients leave the clinic and are followed to their cars, again while protesters try to force leaflets on them. They carry signs that say "We love you" but then also call the women "Murderers". The whole thing is extremely distressing for patients, and staff have had to escort patients to their car.

It is a difficult situation. Recently, that group has been approaching all women of child-bearing age coming in and out of what is a busy health centre. Women who have previously suffered a miscarriage could be exposed to graphic images that could re-traumatise them. You could have women who are having trouble with their fertility, and it is traumatic for them to see those. Different people come in and out of that health centre. As I said, they have started approaching any woman of child-bearing age, not realising that some of them are staff. Staff are beginning to find that quite distressing as well. It is a difficult situation and a very clear indication of the need for buffer zones around clinics, not only for staff and patients but for everybody who uses the health centre. Where we work, there is also a mental health team, and it can be very distressing for them. When the Bill is next debated, we urge all of the Committee to support the need for buffer zones, because the situation is extremely distressing.

Ms Murray: I will follow on from that, Carál, if you do not mind. Michele spoke very well about the health centre piece. We are also aware that we have protests at one hospital, and, as a college and a member organisation, we have distinct concerns around the distress that that is causing the workforce. Nurses, midwives and children see signs that basically say "You are a murderer". Children then come home and say, "Mummy, do you kill babies?". That is difficult for midwives, nurses and doctors working in those situations. The right to protest is there, but there is something about respectful protest and about protesting that without causing harassment or intimidation. That issued has come up, and it will be discussed at the health committee of the Irish Congress of Trade Unions (ICTU) in the next few weeks. It is therefore being picked up as a workers' issue on which we will follow through.

Your point around late abortions and the potential for women to travel is well made. We have to recognise that we do not want to go back to the position that we were in before, in which we had women travelling to access abortion services in England at a later stage in pregnancy and then having to deal with the issues around a post-mortem, returning remains for burial and all the trauma that goes with that, never mind the trauma that they were already experiencing with a pregnancy that was very much wanted and wished for but with which there was a significant anomaly. Those are real issues for people.

Often, if it is a genetic anomaly, the post-mortem is central to determining future pregnancies and to thinking about the risks in future pregnancies of a recurrence. The issue of travelling for an abortion is one thing, but all the other logistics around it is another. We certainly do not want to end up back in situations in which we have parents having to think of inventive ways in which to bring a baby's remains back to the Province to facilitate a burial.

Ms Ní Chuilín: I will finish off by saying that, although I certainly made a plug for the midwives, I want to thank all healthcare professionals, including Michele. I am acutely aware that, even in Belfast, paediatric consultants have raised issues around poverty and perinatal mental health, and I thank them for that, because it is a healthcare issue that people have twisted. I spoke to a constituent a couple of years ago who carried on with her pregnancy despite receiving a really devastating diagnosis, and she still fills up when she talks about the healthcare and support that she got, so thank you.

Ms Flynn: Karen and Michele, thank you for the written briefings that you provided to the Committee and for this morning's oral briefing.

First, I will go back to the issue that Gerry touched on around private clinics and that you mentioned, Michele, in your opening comments. I found it really worrying to listen to, given that there are already limited services here for people who need that type of healthcare. As you rightly said, a lot of women go on the internet and google things when they are unsure about how to access different services. I find it concerning if there are clinics out there that offer services that are, in a way, misleading, because it is daunting enough mentally for a woman to have to consider that decision without her having to go through the additional process of trying to be convinced or talked around to changing her mind when she is in an awful period in her life. I find that really worrying.

The fact that there was a lack of consultation on the Bill with the doctors who provide the service is a big gap. I am not sure whether any of that has been communicated to you as healthcare professionals. What conversations or communications have you had with the Minister of Health on those concerns about that lack of consultation?

Michele, in your correspondence, you commented on the Second Stage of the Bill and some of the suggestions were made about clinicians' decisions, which, in your opinion, were wrong, showed a massive lack of trust and were insulting to those doctors. That is not a good place to be in at a time when we are trying to support our health and social care workers for all the great work that they do. I would therefore like to know, from what you are picking up from your colleagues and in your environments, whether how your staff and colleagues feel about that lack of consultation is being fed back centrally to the Department of Health.

Ms McGrath: NIACT has attempted to correspond with the Minister and the Department of Health. Early on, there was quite a bit of communication, because the Department of Health had given us the go-ahead to start providing EMA services when lockdown happened. Those were then ceased temporarily but then restarted. At that stage, there was a fair bit of communication. In the absence of a framework and direction, the trusts went into this using the abortion regulations as a framework, but there was no guidance on anything: on clinical stuff, on conscientious objection or on how to frame services. Things have been done very much as a response to the pandemic. I think that the communication will now improve.

You touched on the clinics, but I should have explained that the clinics that I was talking about promote abortion reversal treatment. The Minister of Health issued a statement very recently to say that that is unsafe. Not only are we therefore dealing with clinics that try to obstruct women from having terminations but they are promoting an abortion reversal treatment that is unsafe and has been demonstrated to be so. There is also that issue, which I perhaps should have mentioned earlier.

There is also a need for public health information to go out so that these women do not go to these clinics as the first line. We therefore need some sort of public health campaign to get the information out there that the services are available locally. I am hopeful that it will all come together over time, but the problem is that we need guidance sooner rather than later.

Ms Murray: Yes. I support Michele on that. The need for frameworks, guidance and proper care pathways for women at all gestations is hugely important.

As a college, we have reached out to the Minister on a number of occasions, both independently and with the Irish Congress of Trade Unions women's committee. We have written to him on the issue on a number of occasions. With NIACT and a concerted group of health professionals, I am hopeful that that dialogue will improve over the next period.

Ms Flynn: Thank you.

Mr Buckley: Thank you, Michele and Karen. My views on the pro-life position are well on the record, as is my support for the Bill's intentions. First, I will focus on the screening element. I think that it was Karen who talked about the checks and balances that are in place and about some of the misleading quotations and misrepresentations that were put out about the Bill. I am sure that you will agree that screening results and advice should be given in a highly supportive environment, with accurate information provided. With that in mind, will you comment on the experiences that were provided to all MLAs by the Don't Screen Us Out campaign of women who did not want to have a termination but were repeatedly asked, even after they had made their decision to carry on with their pregnancy? How is that a supportive environment for an individual who has made a choice?

Ms Murray: Those are the experiences of those women. It is not the experience that I hear about from my members. From a midwifery perspective, we are there in a supportive way, and we base our care around being woman-centred. Our role is to provide information, to interpret complex information for women, and to ascertain and be sure that those women have understood the information and are making a decision based on it. Any woman who has the experience that you describe and finds that the communication that she is having with the service is not what she expects should escalate that within the service. There are mechanisms available to raise that within the service, and that is what should be happening.

Mr Buckley: Is Michele coming in?

Ms McGrath: No. I am happy with Karen's response.

Mr Buckley: Karen, those are obviously the experiences of some women in our society. That therefore highlights the fact that there is a problem. People cite a generic circumstance with the situation and say that the support and package is there for women who wish to carry on with their pregnancy, but they simply are not. It is not only me and Don't Screen Us Out who are saying that; surveys by the Down's Syndrome Association have demonstrated that women did not recall being provided with enough information about Down's syndrome during their pregnancy. We could go on about the stigmatism being attached to, and the stereotypes being presented about, those with disabilities. That is, rightly, what we have been hearing from people such as Heidi Crowter, who feel that their life is of less value because of the discriminatory elements in the abortion regulations that have been foisted on the people of Northern Ireland.

Furthermore, from the midwifery perspective, I ask whether there been any response from your members etc about how we deal with conscientious objection. It was touched on by Karen. It is an issue that is being fed back to me continually by those in the medical profession who are uncomfortable with the ongoing conversations.

Ms Murray: Thank you for that question. As I said in my briefing, I wrote to all our members in October 2019, when decriminalisation was on the cards, and advised them of their rights and responsibilities around conscientious objection. At that point, we were clear that, if we felt or if a midwife felt that she was not being reasonably afforded her right to conscientious objection, we would represent her. Since that point, I have received no queries about conscientious objection from midwives and our members. I took an opportunity yesterday, on a call with activists and workplace reps, to check in with them and see whether they were receiving any questions on the matter. Again, they confirmed that it was not an issue that is being raised with them. That having being said, I still believe that we need a framework and clear guidance around conscientious objection in order to make sure that members understand their rights and responsibilities and that they know how to record appropriately their conscientious objection with their managers. Managers need to be clear and have guidance on how they record the conscientious objection and use that information. We are quite clear about that, but it is not being raised by my members to my office as an issue at the moment. As I said earlier, the issues that I hear about are more on practical matters to do with providing safe and compassionate care for those women.

Ms McGrath: May I add something? When you consider the health service as a whole, conscientious objection in the services that we are talking about affects a small minority of the workforce: those who work in sexual and reproductive health, obstetrics and gynaecology theatres and midwifery. As nurses, we are committed to respecting our conscientious objectors, because we have them in all our services. Certainly in SRH, our conscientious objectors are facilitated 100%. That having been said, the guidance from all the professional bodies is very clear on conscientious objection, and SRH staff will have absolutely no problem with seeing the women for contraception after their treatment. The professional guidelines from nursing, midwifery, the RCOG and GPs all say the same thing. As Karen

said, however, we need a framework so that we can roll out how we record that, what we do and how we cover theatres for staff who have conscientious objections. Hopefully, all those matters will be resolved when we get a framework and some guidance.

Mr Buckley: We have many testimonies *[Inaudible owing to poor sound quality.]* When we get them, we hear that they were pressurised into having abortions for many reasons and therefore feel a sense of regret following that initial decision. Michele, I think that it was you who mentioned the abortion reversal treatment that was being offered by some. You made some statements about it being an unsafe and unfit practice. Do you have any specific evidence to back up those claims? I would be interested in hearing it.

Ms McGrath: Yes. A study was done several years ago of a clinical trial that had to be abandoned because of the issue of haemorrhaging. A lot of women were bleeding badly, so the clinical trial had to be abandoned. The Minister of Health went on Twitter yesterday, I think, to say that the practice is unsafe.

Mr Buckley: I would be interested in seeing the specific evidence for that, because I know that it is a live debate in other parts of the world, particularly in the United States. It is something that I would like to see factually backed up before statements are made about it.

Ms McGrath: I will see whether I can get hold of that information for the Health Committee, as well as the NIACT report.

The Chairperson (Mr Gildernew): Thank you, Karen and Michele, for attending the Committee this morning, for that useful and informative session on the issues that the Committee is considering on the Bill and for your expertise and compassion. We wish you the very best in the time ahead.

Ms McGrath: Thank you.

Ms Murray: Thank you.