NIACT
The Northern Ireland Abortion and Contraception Taskgroup

MAY 2022

Report on Sexual and Reproductive Health in Northern Ireland

Annual Review

Introduction

1 The Northern Ireland Abortion and Contraception Taskgroup (NIACT) is a group of multidisciplinary professionals formed in response to the Abortion (Northern Ireland) Regulations 2020 to give professional guidance on bringing about the conditions and services required to minimise the need for abortion in Northern Ireland and, when it is required, to provide a compassionate and caring abortion service within the framework of the Regulations.

2 In March 2021, we published a detailed report to provide an evidence base to inform the funding and commissioning of Relationships and Sexuality Education (RSE) provision, and integrated Sexual and Reproductive Healthcare (SRH) for the population of Northern Ireland. The report can be accessed here https://www.fsrh.org/documents/niact-full-report-31st-march-2021/ and the executive summary here https://www.fsrh.org/documents/summary-niact-report-sexual-reproductive-health-northern-ireland.

3 In this Annual Review we consider progress on the recommendations made since March 2021. These are considered under the following themes:

- Relationships and Sexuality Education
- Sexual and Reproductive Health Services
- Contraception
- Abortion
- Conscientious Objection

In the pages that follow we provide the original recommendations for each theme followed by commentary on progress. Please note where the text says 'women', this includes 'girls, women and pregnant people'.

Relationships and Sexuality Education (RSE)

1 **RSE should be evidence based and delivered in a consistent, high quality, inclusive and sex positive manner across all schools in Northern Ireland, including Special Educational Needs schools, and be included as part of a school's inspection report.**

The implementation of guidelines on RSE and the provision of training were both previous actions included within the Sexual Health Promotion Strategy and Action Plan 2008-2013. These continued within the subsequent Addendum which expired in December 2015. No new Strategy or Action Plan has subsequently been introduced by the Department of Health. The Education Minister has stated that the current statutory curriculum represents, "a coherent, legal framework, which is specifically designed to give schools autonomy to choose their own curriculum." As such, the topics discussed within RSE will vary from school to school, as will the standard of information and support pupils receive. The overall situation within schools therefore falls significantly short of our recommendation.

2 **Organisations in receipt of public funding should provide a consistent and standardised approach to the delivery of RSE in school and community settings.**

The Public Health Agency (PHA) commissions RSE programmes within community settings. In 2015 ACET NI, Common Youth, Love for Life and a consortium comprising the Rainbow Project, Nexus and Relate NI received funding to deliver programmes to children and young people aged between 11 and 24 years of age. Service delivery was evaluated by the PHA and, after this evaluation, they decided to divide the age range into three distinct categories, 12–14 year-olds, 15–16 year-olds and 17–19 year-olds. This programme recently went out for tender and Common Youth were awarded the contract for 12-14-year-olds, a consortium of Relate NI, the Rainbow Project and Nexus were awarded the 15-16-year-olds category, and ACET NI 17-19-year-olds. New programmes will begin in April 2022. No similar funding is provided within school settings. Schools can deliver their own RSE programmes or bring in outside organisations of their choosing. An evaluation of RSE in Post-Primary Schools in Northern Ireland conducted by the Education and Training Inspectorate (ETI) was published in 2011. It found that in a significant minority of schools, the arrangements for evaluating the quality of the provision of RSE and the subsequent planning for sustained self-improvement are underdeveloped. As a result, there are inconsistencies in the quality of provision both within and across the year groups, particularly at Key Stage 4 and beyond. An ETI evaluation of RSE in Primary Schools and Special Educational Needs (SEN) Schools published in 2016 found that 63% of the schools indicated that they are not undertaking any monitoring and evaluation of their RSE programme.

3 **RSE should start early and be relevant to the individual at each stage of their development and maturity.**

Despite the recommendations contained within the 2018 inquiry report from the United Nations Committee on the Elimination of Discrimination against Women now being enshrined in law, including a recommendation on RSE, there is still no consistent approach to its the delivery within schools. The current guidance for post primary schools published by the Council for Curriculum, Examinations and Assessment (CCEA) states that, "Issues such as abortion, same-sex marriage, sexual orientation, gender identity, sexual abuse and family lifestyle all have the potential to be sensitive, depending on the personal experiences, opinions and values of each individual within the classroom and on the distinctive ethos of the school. Schools may wish to deal with such issues differently, depending on their distinctive ethos." Therefore, and often to the detriment of pupils, the ethos of a school can be a significant factor in the provision and development of RSE.

4 RSE should be delivered by trainers who are confident in talking about all issues relevant to RSE with an equal emphasis placed on all areas of the programme.

The Belfast Trust Sexual Health Training Team provide regional RSE training courses for teachers in Post-primary and SEN Schools. The courses are designed to increase teachers' confidence and knowledge in order to facilitate effective RSE within their schools. For the Primary sector, the courses are provided for Belfast and South Eastern Trust areas only. A wide range of community and voluntary sector organisations can also provide RSE training and support to schools. The NSPCC Keeping Safe programme is designed to help primary schools integrate important messages about issues such as bullying: and, sexual and domestic abuse into all aspects of school life. The programme includes training for all school staff and ensures teaching staff, school governors, support staff and volunteers all understand the part they play in delivering the programme. ICNI provides specialised Open College Network (OCN) accredited training for SEN Schools. Despite the training that is available for teachers, research published by the Belfast Youth Forum in 2019 in a report entitled 'Any Use?' found that young people described the RSE they received in school to be 'basic', 'unhelpful', 'useless' and 'biased'. 60% felt that the information they received was either 'not very useful' or 'not useful at all'. One of the recommendations made within the report was that specialist staff deliver the subject. Given these findings, it is clearly not appropriate to assume that teachers are best placed to deliver RSE, and external input may be of great value to ensure that all children and young people receive high quality RSE.

5 RSE programmes should be offered to parents and carers with the view to alleviating their fears and assisting them to support children and young people in making informed choices.

Working with parents and carers enables children and young people to receive support outside of school and creates an environment conducive to open conversations around what are often seen as difficult topics to discuss. The Destination Adolescence resource provided by the Belfast Trust's Sexual Health Training Team helps parents and teachers prepare their children for puberty and adolescence. The Sexual Health Team also offers short training programmes to support all trust staff who are caring for adolescents. Informing Choices NI (ICNI) provides an RSE programme called Speakeasy which encourages and supports parents and carers to talk openly and confidently with their young people about growing-up, puberty, sexuality and relationships. This programme is currently only available in Belfast and South Eastern Trust areas. There is a need now to scale up and spread these good practice examples around the region, alongside work to embed these existing programmes.

6 Young people should play a key role in formulating RSE programmes in schools and communities.

Involving young people in the content and design of RSE programmes encourages buy-in and ownership and ensures that the language is appropriate. The report 'Any Use?' recommended that policy makers and service providers co-produce RSE interventions with young people to enhance relevance and applicability of programmes to the reality of their lives. The ETI evaluation of RSE in Post-primary schools found that 80% of schools who responded to the online survey had a policy to support the RSE programme. Only 25% consulted parents when drafting the policy and a smaller minority consulted pupils. 14% of schools stated that their RSE policy was drawn up solely by their senior leadership team. The ETI evaluation of RSE in Primary Schools and Special Schools found that 25% of schools responding to the online survey did not have an RSE policy. While a majority of the schools reported that they engage in some consultation with staff about the content of their RSE programme, only a minority of schools consulted with governors and with parents. There was recognition from only a few of the schools visited that there is a need to ensure that the children are consulted in relation to RSE, and the impact of the teaching on their learning and development is evaluated.

7 On-line resources should be used in school, community and home settings.

A wide range of resources have recently been developed and are available on the CCEA RSE Hub. A resource for relationships, sexual health and parenthood has also been produced in Scotland for teachers and early years practitioners, which includes information for parents and carers, ideas about communicating between school and home, reading lists for school libraries and reading at home. While good online resources are useful tools for delivering RSE, it is vital that those using them are confident in discussing the materials. Information on organisations who provide RSE training and support is also available on the CCEA RSE Hub. As a school's ethos plays a significant factor in the delivery of RSE, barriers remain regarding the effective use of online resources.

8 All training delivered should be assessed and evaluated to ensure consistency, and that gaps are identified and current trends are incorporated.

The previous evaluations of RSE in Primary, Post-primary and SEN Schools were published in 2011 and 2016. The Department of Education has recently commissioned the ETI to undertake an evaluation of the 'Approaches and Challenges in Delivering Effective Preventative Safeguarding Practices in Schools'. This is currently underway and will provide an evidence base in relation to the delivery of RSE in the curriculum. As well as the teacher training provided by the Belfast Trust's Sexual Health Training Team, they also provide youth and community programmes, an HIV Awareness Project, and training for those involved in caring for looked after children and young people. ICNI provides OCN accredited RSE training courses at Levels 1 to 3 for professionals working with individuals with a learning disability and difficulty, and autistic people. ACET NI provides regional OCN accredited training courses at Levels 2 and 3 for health and caring professionals, volunteers and others working with adults or young people. These courses are designed to develop knowledge around sexual health, skills around communication, and signposting to local sexual health services.

Summary

Limited progress has been made on the RSE recommendations. There has been no Sexual Health Strategy in place since 2015. A new Strategy or Action Plan which places RSE at its core is urgently required.

We believe the Education Minister should commission updated evaluations of RSE in Primary, Post-primary and Special Educational Needs schools as a matter of priority, given the length of time that has lapsed since they were previously conducted. New evaluations would provide an opportunity to assess a schools' knowledge of the RSE Hub launched in 2019, teacher's confidence in using the resources provided within it effectively, and any additional resources they would wish to see developed. It would also provide an ideal opportunity to get feedback from children and young people regarding the curriculum, the quality of the sessions delivered, and any additional topics they would wish to see included.

We would also recommend that the Minimum Content Order is reviewed and updated to outline key elements of RSE such as consent.

Finally, it should be noted that the Northern Ireland Human Rights Commission (NIHRC[1]) is currently investigating the provision of RSE to establish the extent to which the Department of Education and other relevant public authorities are fulfilling their obligations to make "age-appropriate, comprehensive and scientifically accurate education on sexual and reproductive health a compulsory component of curriculum for adolescents covering prevention of early pregnancy and access to abortion" in Northern Ireland in accordance with the CEDAW recommendations.

1. https://nihrc.org/uploads/publications/Terms-of-Reference-FINAL_2021-1y -17-163334.pdf

Sexual and Reproductive Health Services (SRH)

9 **Investment in a sexual and reproductive training programme for doctors within Northern Ireland with emphasis on recruiting into the field from hospital and GP training programmes.**

There remains no investment in a Northern Ireland based training programme for either hospital doctors or GPs. There are community SRH training programmes in the rest of the UK leading to eligibility for Consultant posts. There are no consultants in SRH in Northern Ireland, so there is no training programme or funding for one.

10 **Within every Trust there should be a minimum of two SRH consultants. SRH consultants should not work in isolation, and should be supported by other consultant colleagues, as well as a team of specialised healthcare professionals.**

Despite a Review of Specialist Sexual Health Services in Northern Ireland conducted by the Regulation and Quality Improvement Authority (RQIA) in 2013 recommending that sexual and reproductive health services should have consultant leadership put in place as a matter of priority, nine years on there is still not a single SRH consultant in Northern Ireland and as yet there has been no attempt at recruitment.

11 **The role of nurses and midwives should be further developed to include provision of long acting reversible contraception (LARC) and abortion care.**

There is variation between trusts. In the Northern Trust, training for nurses has progressed well for LARC, whereas in the Belfast Trust no additional nurses have been trained and the one nurse who did provide LARC has left Northern Ireland (this nurse won UK Nurse of the Year in 2021). In relation to abortion provision, nurses and midwives have been involved in care, but this could be expanded. Further development has stalled as this is largely reliant on the commissioning of services and the finance that it would provide.

12 **Improved access to contraception services, especially in underprivileged and rural communities, and for particular groups including the homeless, those with disabilities, and people for whom English is not their first language.**

Again, there is regional variation between trusts, but there are several examples of good practice. In Belfast, despite the pandemic, there is only a two week wait for LARC, and in all five trusts emergency contraception is a same day or next day service. SRH clinics are offered by the Northern Trust in a number of further education settings including the Northern Regional College and Ulster University. Across all trusts, referrals via the Family Nurse Partnership provide intensive support for teenage mothers and their babies, and these are fast tracked along with referrals from social services, learning disability services and local women's shelters.
There have been quality improvement projects to improve access to particular groups such as Black, Asian and Minority Ethnic (BAME) women, postnatal patients, and outreach clinics for the homeless. Another project (PAUSE) has targeted women who have two or more children in care (Belfast, Northern and Western Trusts). Those accessing early medical abortion (EMA) in each of the trusts providing this service have the option to be fast-tracked to access a form of LARC.

13 Improved access to contraception for young people.

Common Youth continues to offer contraception for young people from its clinics in Belfast and Coleraine. The Belfast Trust has started a clinic for contraception alongside genito-urinary medicine (GUM) at Queen's University.

14 An ongoing public health campaign, involving the Public Health Agency (PHA) and associated bodies, promoting sexual and reproductive health for all age groups.

In February 2022, the PHA announced a pilot service provided by SH:24 on behalf of Health and Social Care (HSC) to provide contraception in the form of the combined contraceptive pill, progesterone only pill, and oral emergency contraception free of charge by post. Apart from during Sexual Health Week, the last public sexual health campaign was the 'Choose to protect yourself - always use a condom' initiative which ran in 2015.

Summary

There remains a lack of investment in SRH professionals. Despite this there is evidence of good practice within the limited resources available. The Faculty of Sexual and Reproductive Healthcare (FSRH) and Royal College of Obstetrics and Gynaecologists (RCOG) have continued to lobby for the development of SRH resources in Northern Ireland.

The PHA has recently advertised the online contraceptive service provided by SH:24 on behalf of HSC. This has the potential to greatly improve access to contraception across Northern Ireland.

Contraception

15 There should be a more visible and far-reaching Public Health campaign raising awareness of the effectiveness and benefits of LARC, and where and how to access emergency contraception.

There has been no PHA-driven health campaign regarding LARC within the last year. However, the recent promotion of the pilot postal oral and emergency contraception service provided by SH:24 is to be welcomed.

16 LARC should be more easily accessible within general practice and EMA services.

There is considerable regional variation. Within individual GP services there is no additional funding for service development. There is service provision within some GP Federation clinics; however, some of these have long waiting lists. We are aware of some patients who have become pregnant whilst on a waiting list and had to access EMA as a result.

17 There should be increased provision of postpartum contraception within maternity services, including access to LARC following the birth.

There has been limited progress on this in a number of trusts. There is an ongoing quality improvement project within the Belfast and South Eastern Trusts, but this isn't available for all women and doesn't provide access to all contraceptive methods. Overall, the provision of postpartum contraception is poor and there has been no concerted effort to involve midwives in this process. This lack of progress is reflected in many presentations for EMA within a year of childbirth.

18 The Progestogen only Pill (POP) should be made available as an over-the-counter medication. This would involve the Medicines and Healthcare Products Regulatory Agency (MHRA) reclassifying it from 'prescription-only' to 'pharmacy product'.

This has been progressed, and the medications (Lovima and Hana) are available for purchase in high street pharmacies and online following a consultation. It is our experience that there is limited knowledge about this in the community. We would recommend that the medication should be free of charge and its use be promoted via a PHA-led campaign.

19 The most effective form of oral emergency contraception, ulipristal acetate, should be available free of charge and without prescription from every pharmacy within the region and from all SRH clinics within each Trust.

Plans for the introduction of free oral emergency contraception in pharmacies have been placed on hold following the collapse of the Northern Ireland Executive in February 2022.

20 **The MHRA should be asked to reclassify oral emergency contraception to the General Sales List to enable it to be provided without consultation.**

This has not progressed; UK-wide collaboration would be required to effect a change in the law.

21 **There needs to be improved awareness, access and referral pathways for emergency intrauterine contraceptive device (IUCD) insertion. This should include investment into training more GPs in coil insertion and investment into SRH services within all five Trusts in NI.**

There has been no regional initiative to progress access to emergency intrauterine contraceptive devices (IUCD). There is therefore variation between trusts, and the overall provision reflects the lack of investment in the development of SRH services.

Summary

We welcome the availability of the POP to purchase, and the progress on inserting IUCDs at the time of caesarean sections in some trusts. However there has been no investment in midwife led LARC in the postnatal period. This is something which could be achieved with a relatively small financial investment.

Abortion

22 There should be a funded regional central access point to which women can self-refer, and to which they are directed by a public health information campaign.

Despite the Secretary of State for Northern Ireland issuing a Direction in July 2021 which included an immediate requirement for the Department of Health to continue to support the Central Access Point provided by ICNI, no additional funding was provided and their service ceased on 1st October 2021. Since then there has been no local service; the British Pregnancy Advisory Service (BPAS) has provided an interim referral point, based in England, which is also unfunded.

23 There should be an adequately resourced framework to ensure availability of pregnancy choices counselling if requested.

Whilst pregnancy choices counselling is provided by ICNI, there has been no additional funding to match the increase in demand for services.

24 Commissioners should ensure that service providers have adequate capacity and resources to ensure waiting times do not exceed one week.

Commissioning of services has yet to occur. Interim EMA services are currently delivered within four trusts. The service within the Western Trust was suspended in April 2021. From 16 May 2022 people living within this area can access EMA in the Northern or Southern Trusts. Local EMA services are often provided within a one-week waiting time. This has only been made possible due to the commitment of very dedicated staff who are overworked and under-resourced.

25 The option for telemedicine abortion care should be made available within Northern Ireland, as in the rest of the UK and the Republic of Ireland.

In England, Scotland and Wales, telemedicine abortion care was made available in response to the Covid-19 pandemic. In Scotland and Wales, it was made permanent. After an initial delay, England also agreed to make telemedicine permanent. In Northern Ireland, telemedicine abortion care has never been made available, notwithstanding a direct appeal by the RCOG and FSRH to the Department of Health and the Health Minister during the Covid-19 pandemic. This is despite telemedicine being preferred by many service users, and the reduced costs its introduction would have on the health service.

26 Abortion services should be part of an integrated sexual and reproductive health service which provides a seamless pathway from the community / primary care sector to hospital based obstetric and gynaecology services, and also ensures optimal access to contraception.

There is no commissioned abortion provision, and therefore integration of services has not been progressed. As outlined above, access to contraception varies across each trust.

27 There should be a commissioned surgical abortion service to enable choice of method; this will require some investment in training.

There has been no progress on the provision of a surgical abortion service in the absence of commissioning. Those who require or would prefer this method are required to travel to England to receive care.

28 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.

There has been no progress on the introduction of first trimester screening, which is available throughout the rest of the UK. This results in later diagnosis and therefore an increased number of late abortions, even though early abortion is safer for women.

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

In the absence of commissioning, there are no specific resources for abortion provision at any gestation. Many women over 10 weeks gestation continue to travel to England. Some women continue to purchase pills online which, although being safe when accessed from reputable providers, does not allow for follow-up contraception. As surgical abortions have not been provided to date, it is vital to provide training to staff in order to enable future provision of this service. We note that both Ulster University and Queen's University have introduced abortion awareness sessions into undergraduate programmes for nursing and midwifery.

30 There should be access to post abortion counselling. Bereavement counselling should be extended to include all pregnancy loss.

Whilst post abortion counselling is available via ICNI, they have seen an 80% increase in referrals for the service since April 2021. For the majority of women who seek support following an abortion, it is more often for the existing stressors in their life which have been exacerbated by a crisis/unplanned pregnancy than for grief in relation to the pregnancy loss itself. It is not uncommon for a stressful situation to trigger previous traumas, for example one third of women who have referred into the service have been impacted by historical sexual abuse/violence. As there has been no additional funding provided to match increased demand, despite repeated requests made to the Department of Health, waiting times have increased to nine months. Bereavement counselling through trusts has also not been extended.

31 There should be training for all healthcare professionals, administrative and support staff engaged in abortion services to ensure non-judgmental communication with service users.

Limited training has been provided within HSC organisations. In the interim, it has been left to advocacy groups such as Doctors for Choice NI, in partnership with Ulster University, to provide this training.

32 There should be a public information campaign about abortion to counteract anti-abortion organisations posing as abortion providers.

In the absence of a public information campaign, women are being given misleading information and advice emanating from both GPs and rogue crisis pregnancy agencies. This often delays timely access to abortion services. Therefore, public information campaigns should be directed at GPs as they are the first point of contact for many women. Google advertising is also key in directing individuals away from rogue agencies.

33 There should be legal provision for exclusion zones to protect women and staff from intimidation and harassment when seeking access to information, support or services.

Since the introduction of EMA services, anti-abortion protest groups have congregated outside SRH clinics. In the Belfast Trust, many clients have been too frightened to attempt clinic entry and have relied on the healthcare professionals providing assistance in accessing the facility. As a result, staff have been subject to verbal abuse and called murderers. In one trust, a doctor reported that a woman failed to attend for a follow up despite prolonged heavy bleeding, reporting that she, "could not face seeing the protestors again." The PSNI has highlighted that in the 12-month period from January 2021 to January 2022, police were requested to attend 55 incidents at such premises across Northern Ireland. The Abortion Services (Safe Access Zones) Bill, successfully progressed through the Northern Ireland Assembly. However, the Bill has been delayed from becoming law and has been referred to the Supreme Court by the Northern Ireland Attorney General to determine whether part of the Bill is within the legislative competence of the Assembly. The concerns raised relate to the omission of a 'reasonable excuse' defence within the legislation. If enacted, the Bill would make provision for the introduction of safe access zones outside facilities where abortion services are carried out, or other premises where information or counselling in relation to abortion is provided. For the women accessing abortion services, and the healthcare professional providing them, the introduction of this vital legislation cannot come soon enough.

34 Suitable premises for abortion should be identified and secured for each Trust.

No purpose-built facilities are available for providing these services. Two trusts have been forced to move SRH clinics as a result of persistent intimidation and harassment of service users by anti-abortion protestors. The Northern Trust reported costs of £2,173 as a result of the relocation of services to alternative premises. The Belfast Trust reported costs of £22,000 relating to security personnel, CCTV installation and window tinting at its clinic. All current locations providing abortion services are doing so on a temporary basis.

35 Interpreter services are required for all stages of service provision.

Interpreter services have been made available for face to face and telephone consultations.

36 Pathways should be developed for each trust to easily obtain healthcare numbers for those not already registered with the NHS.

A single point of contact has been established to rapidly assign healthcare numbers for those not already registered with the NHS. However, this is only available to those who are ordinarily resident in Northern Ireland.

Summary

The lack of commissioning has severely hindered the development of local services, and has resulted in breaks in the EMA service in three trusts. The Western Trust service has been suspended since April 2021. From 16 May 2022 people living within this area can access EMA in the Northern or Southern Trusts.

Following intervention by the Secretary of State, some progress has been made on planning for a commissioned service.

ICNI suspended their central access point due to a lack of funding. A referral point is now being provided by BPAS on a temporary basis.

The Abortion Services (Safe Access Zones) Bill was successfully passed by the Northern Ireland Assembly; however, it has been delayed from becoming law following referral to the Supreme Court.

Despite the issues highlighted above, the Department of Health has indicated they received 2794 notifications of terminations between 31st March 2020 and 31st January 2022.

The Severe Fetal Impairment Abortion (Amendment) Bill was defeated following a majority vote in the Assembly. NIACT provided evidence and key witnesses to oppose the progress of the Bill.

Since the initial NIACT report was published, the World Health Organisation has issued new guidelines on abortion (2022[2]). The guidelines stress the importance of telemedicine and access to quality health care.

2. https://www.who.int/news/item/09-03-2022-access-to-safe-abortion-critical-for-health-of-women-and-girls

Conscientious objection

37 Training in conscientious objection should be provided for all HSC and primary care staff working in SRH and maternity services, including professionally regulated clinical staff, managers, administrative and other support staff.

Non-structured training has been provided in some trusts. However, in general, training is lacking and, as a result, we have seen evidence of staff either being misinformed about the scope of conscientious objection or misinterpreting its legislative provision.

38 We recommend that professional leads within the relevant departments should keep a secure record of the position of their staff with regard to conscientious objection to allow for service planning and delivery.

In the absence of commissioning, service provision is limited to a small number of people in specified areas and no progress on this has been made within the wider staff community.

Summary

There has been limited progress in this area which reflects the perceived lack of need due to the failure to commission and the absence of a full service.

Conclusion

The NIACT report published in March 2021 provided a template for comprehensive RSE and SRH services, including contraception and abortion. The report made 38 recommendations on how this might be achieved. This review of the year since the publication of the report highlights advances which have been made, but the overriding theme is a lack of progress. With no improvement in the provision of RSE and access to contraceptive services remaining suboptimal, it is not surprising that there has been no reduction in demand for abortion. The failure to commission abortion services in the two years since Regulations were issued has resulted in a fragile service, and even this has only been possible through the dedication of a small number of SRH staff.

The lack of commissioning has meant that there is no Service Framework within which trusts can obtain funding to train staff and to provide comprehensive SRH services, including contraception and abortion. In addition, there has been no public health awareness campaign for women seeking abortion. Women are still having to travel to Great Britain to access abortion services despite all legal barriers being removed in 2020, and some women are again resorting to using pills purchased via the internet to procure their own abortions.

It is now almost twenty years since the Northern Ireland Court of Appeal directed the health minister to provide guidance on abortion for healthcare staff. It then took the Executive twelve years to agree guidance. However, that guidance is no longer relevant and requires updating following the law change in 2019 and new Regulations introduced in 2020. Furthermore staff and service users continue to suffer harassment and intimidation outside healthcare premises.

It is our hope that the issues highlighted in this review can be used as a lever to provide the women in Northern Ireland with local services that they so badly need.

About

The Northern Ireland Abortion and Contraception Taskgroup (NIACT) is a group of multidisciplinary professionals formed in response to the Abortion (Northern Ireland) Regulations 2020 to give professional guidance on bringing about the conditions and services required to minimise the need for abortion in Northern Ireland and, when it is required, to provide a compassionate and caring abortion service within the framework of the Regulations.

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