Our Health, Our Voices

Women's Experience of Healthcare in Ireland Listening Forum

Report 2: Insights from Targeted Listening Sessions with Priority Groups of Women

October 2025

National Women's Council

Acknowledgments

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Acronyms

AAAQ Framework: Availability, Accessibility, Acceptability and Quality Framework

ADHD: Attention Deficit Hyperactivity Disorder

A&E: Accident and Emergency

CPD: Continuous Professional Development

DPO: Disabled Persons' Organisation

DSGBV: Domestic, Sexual, and Gender-Based Violence

GP: General Practitioner

HRT: Hormone Replacement Therapy

HSE: Health Service Executive

LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer + (The '+' denotes the wider range of sexual orientation and gender categories)

NICU: Neonatal Intensive Care Unit

NWC: The National Women's Council

PA: Personal Assistant

PRSI: Pay Related Social Insurance

SATU: Sexual Assault Treatment Unit

STI: Sexually Transmitted Infections

WHO: World Health Organisation

Executive Summary

In *Our Health, Our Voices: Findings from the Forum for Women's Experiences of Healthcare in Ireland* presents insights from Workstream B of the Women's Health Forum, a project led by the National Women's Council (NWC) in partnership with the Department of Health to fulfil Action 1E of the Women's Health Action Plan. The aim of this work was to hear directly from women about their healthcare experiences, with a focus on groups who are often underrepresented in policy discussions and face structural barriers to equitable access, experiences, and outcomes in healthcare.

Building on the 2021 Women's Health Taskforce "radical listening" exercises, this project comes at a time of major public investment in women's health, including menopause clinics, ambulatory gynaecology services, state-funded IVF, and the Free Contraception Scheme. Through 73 listening sessions and interviews, and a Collective Event, the project engaged Traveller women, Roma women, migrant women, disabled women, LGBTQ+ communities, older women, women experiencing homelessness and addiction, and survivors of domestic, sexual and gender-based violence (DSGBV). An intersectional and participatory methodology was used, guided by the AAAQ framework – Availability, Accessibility, Acceptability, and Quality.

Key Findings

Availability

Women described serious challenges accessing healthcare due to a lack of services – particularly in primary care and specialist areas like gender-affirming care. While some praised their GPs, many had waited months or years to be able to access one. Even where services existed, long waits and inconsistent eligibility criteria meant access was not guaranteed. In a system with limited availability, some women described rushed appointments and a lack of women-centred approaches which left them feeling dismissed and unsupported.

The two-tier health system was widely viewed as deepening inequalities. Participants who could afford private health insurance described faster and more responsive care, while others – especially those relying on medical cards – spoke of delays, refusals by GPs to take them on, and restrictive prescribing practices. Initiatives like the Free Contraception Scheme were seen as positive steps in removing barriers, but Traveller and Roma women raised concerns about eligibility criteria that made some services, like cancer screening or fertility treatment, functionally inaccessible to their communities.

Accessibility

Many women described serious barriers in accessing healthcare, not because services didn't exist, but because they couldn't afford, reach, or navigate them. Financial inaccessibility was a key theme, with participants across all groups sharing stories of forgoing treatment, prescriptions, or regular care due to cost. Rigid eligibility rules for medical cards and social protection supports left some women just outside the threshold but still unable to pay for essential care. Women living rurally and disabled women struggled to reach services or found that facilities lacked the equipment, accessibility, or staffing needed to meet their needs. Even when care was technically "available," long waiting lists and overburdened systems created real delays and stress, particularly for those relying on the public system. Health literacy gaps, lack of interpretation, and digital exclusion further compounded these accessibility issues – especially for the Traveller, Roma, and migrant women who took part.

Acceptability

Many women reported experiencing discrimination based on ethnicity, disability, age, gender identity or sexual orientation. Their experiences reflected a lack of culturally competent, gender-sensitive, and trauma-informed care. Women from minority ethnic groups described being treated differently because of their race or nationality, while disabled women felt they were seen only through the lens of their impairment. LGBTQ+ women spoke of health professionals who were uninformed or openly discriminatory, and young and older women described being either dismissed as "too young" to be taken seriously or assumed to have family members to support them in older age.

Quality

Participants across all groups raised concerns about the quality and responsiveness of care, particularly the lack of meaningful feedback or complaints processes. Many women described not knowing how to make a complaint, receiving no response when they did, or fearing negative consequences for speaking up – especially those in more precarious or vulnerable situations, like migrant women in Direct Provision. This lack of follow-up eroded trust and left many women feeling unheard by the health system. Women also highlighted a lack of training among healthcare staff – especially in trauma-informed, anti-racist, culturally competent, and gender-sensitive care.

Conclusion

This report makes clear that, while there have been significant and important advancements in women's healthcare in Ireland, these improvements have not reached all women equally. Many continue to face overlapping barriers – ranging from limited-service availability and unaffordable care, to discrimination, and inaccessible systems. The voices of women who participated in this research called for a more inclusive, equitable, and women-centred healthcare system. Their voices offer clear direction for meaningful reform – rooted not only in service delivery but in structural changes that can influence key determinants of women's health.

Values and Next Steps

01.

Universality
– Equal access for every woman

Women spoke of wanting a health system that's there for them when and where they need it, not based on how much money they have.

1. Make women's healthcare free.
2. Address the gaps for groups like Roma women who can't get a medical card.
3. Make it possible for migrant women to be assigned a GP by the HSE.
4. Create an informed consent model for trans healthcare.

02.

Equity
– Meeting women where they're at

Women said they wanted the health system to recognise how barriers to housing, employment, education, racism and discrimination affect their health.

1. Make sure the next Women's Health Action Plan looks at women's health inequalities through a gender-sensitive and intersectional lens.
2. Take action to improve the health outcomes of women most impacted by health inequalities.
3. Integrate women's health policies with broader national strategies.

03.

Accessibility – Information and services that women can use

Women want health services and information that are clear, inclusive, and easy for everyone to understand and access.

1. Co-produce and design information materials with women and share widely across diverse communities.
2. Provide good quality interpretation services for anyone who needs them.
3. Make all public health infrastructure fully accessible to all.

04.

Respect & Inclusivity – healthcare workers who understand and reflect women's needs

Services should actively recognise and respond to the diverse experiences, identities, and needs of all women, ensuring that care is inclusive, person-centred, and free from bias.

1. Make training in gender-sensitive, trauma-informed, and anti-racism and discrimination compulsory for everyone working in healthcare.
2. Ensure healthcare staff are trained to provide, respectful, informed and inclusive care to trans women.
3. Proactively ensure the staff in healthcare settings reflect Ireland's diversity.

05.

Accountability – A system that listens, learns, & improves

Women want a healthcare system that actively collects and uses information and feedback to improve services.

1. Ensure equality data - inclusive of ethnic data - is collected in all health and social care services.
2. Analyse and publish this data regularly to show where inequalities exist and how they are being addressed.
3. Make sure every health service has a clear and accessible way for women to give feedback and make complaints.

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Introduction

This report, developed by the National Women's Council (NWC) for the Department of Health, examines the experiences of priority groups of women facing well-documented health inequalities in Ireland.

This body of work builds on the insights from the "Radical Listening" exercises published in 2021. These radical listening exercises supported the development and publication of the *Women's Health Action Plan 2022-2023*, marking a pivotal moment in the evolution of women's healthcare in Ireland. Conducted by the Women's Health Taskforce in collaboration with NWC, these exercises brought to light a stark reality: women across Ireland consistently felt dismissed or not taken seriously when seeking healthcare. This sentiment resonated across diverse communities, as over 278 participants – both women themselves and representatives from advocacy groups – shared their experiences, frustrations, and hopes. Their voices shaped the priorities of the Women's Health Taskforce, providing a foundation for the first Action Plan to be anchored in lived realities.

Since the launch of the first Women's Health Action Plan, there have been several pioneering and transformative advancements in women's healthcare services in Ireland. As a member of the Women's Health Taskforce, NWC has supported these initiatives and has welcomed the investment of over €180 million of additional funding allocated specifically towards women's health initiatives, resulting in the introduction of:

- **Specialist Menopause Clinics** were established across six locations, offering holistic and comprehensive care for women experiencing complex menopause symptoms. These clinics provide much-needed support that acknowledges the diverse experiences of menopause, supporting women to no longer feel isolated or overlooked.

- **Endometriosis Hubs** were set up to deliver specialised care for a condition that affects one in ten women yet has historically been underdiagnosed and misunderstood. These hubs, supported by two supra-regional centres, are helping women receive earlier diagnosis and tailored treatment.

- **Ambulatory Gynaecology Clinics** were developed with a "see`-and-treat" model, reducing waiting times and supporting more women's concerns to be addressed quickly and effectively.

- **State-Funded Assisted Human Reproduction (AHR) Services**, including IVF, were introduced for the first time, breaking down financial barriers to fertility treatment. This significant step acknowledges the emotional and financial toll of infertility on women and their families.

- The **Free Contraception Scheme**, launched in 2022 for women aged 17 to 25, was expanded to include all women aged 17-35 years. This initiative empowers women with greater autonomy over their reproductive health, reducing cost-related barriers to contraception. This scheme has been very successful, with the HSE reporting that around 320,000 women, girls and other people identifying as transgender or non-binary accessed free contraception in 2024.

Continuing this momentum, the *Women's Health Action Plan 2024-2025 Phase 2: An Evolution in Women's Health* builds on the successes of its predecessor, reinforcing the commitment to inclusive and equitable healthcare. Central to Phase 2 is Action 1E, which outlines the establishment of a "Patient Voice Forum", which was renamed the "Women's Health Forum" to provide greater inclusivity. The Forum was conceived to amplify the voices of women in all their diversity, ensuring that future health policies can be responsive to the needs of all women and girls.

To achieve this, the Women's Health Forum project was divided into two distinct **Workstreams:**

- **Workstream A**, led by the Department of Health, focused on broad engagement with women from various backgrounds. This included women in all their diversity in both online and in-person engagements, however, the recruitment process was not targeted at specific communities or to women with specific experiences.
- **Workstream B**, primarily driven by NWC, was designed as a targeted initiative to capture the experiences of women facing significant structural and health inequalities and who are often categorised as "priority" groups in national policies. This included Traveller women, Roma women, migrant women, women experiencing homelessness and addiction, disabled women, LGBTQ+ communities, older women, and survivors and victims of Domestic, Sexual, and Gender-Based Violence (DSGBV).

This report presents the key findings of Workstream B, shedding light on the realities faced by these women, whose healthcare experiences are often shaped and determined by systemic barriers. To ensure a collaborative and inclusive process, the Women's Health Forum project was overseen by a Steering Group consisting of members from the Women's Health Taskforce. While this Steering Group provided oversight, a larger Working Group was established to support the design and delivery of the Forum. This Working Group was co-chaired by the NWC and the Department of Health. It included a broad membership of patient advocacy groups, civil society organisations, service providers, and other key stakeholders.1 Importantly, the listening sessions, facilitation plan, and recruitment processes were co-designed with input from these groups, ensuring that the project was rooted in needs and experiences of the communities who were the focus of the engagement.

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[1] Members of the Working Group included HSE Patient Partners representatives, the Department of Children, Equality, Disability, Integration and Youth, Age Action, AkiDwA, the Dublin Rape Crisis Centre, Independent Living Movement Ireland, the Irish Cancer Society, LGBT Ireland, the National Traveller Women's Forum, Pavee Point Traveller & Roma Centre, in addition to the Department of Health and NWC.

The ethos of this approach was one that aimed to listen and amplify the voices of women who often experience marginalisation, in such a way that could be empowering and recognising of their agency and expertise. Workstream B also sought to acknowledge the intersectional experiences of all women – inviting participants to take part in a **Collective Event** towards the end of the project to create an inclusive space where the preliminary findings could be shared, and further gaps could be identified.

This commitment to co-design and collaboration is central to the process NWC strives to achieve in all our women's health policy work – ensuring that women's own voices are central to healthcare reform.

Methodology

Methodology

The primary objective of this report is to capture and highlight the healthcare experiences of women from communities whose voices are frequently underrepresented in mainstream health policy. While NWC-led on all the sessions with support from various relevant organisations, the engagement with Traveller women and the second engagement with Roma women was led by Pavee Point and the National Traveller Women's Forum. The engagement with the total 73 participants of this project took place through a combination of listening sessions (focus groups), in-depth interviews, and a Collective Event. This includes:

- **Traveller women** and **Roma women**, who experience health inequities due to the social determinants of health, including racism and discrimination (Pavee Point, 2024).
- **Migrant women**, whose experiences are often complicated by language barriers, stigma, immigration or international protection status, and an absence of local knowledge required to navigate health services (ESRI, 2022).
- **Women experiencing homelessness and/or addiction**, whose healthcare needs are intertwined with other complex social determinants of health (NWC, 2018).
- **Disabled women**, who can encounter a health service that is often not designed to meet their needs and does not recognise the intersection of disability and gender (ILMI, 2025).
- **LGBTQ+ communities**, whose healthcare experiences are often shaped by heteronormative assumptions about women's health (The LGBT Ireland Report, 2016).
- **Older women**, who are at a greater risk than men of poverty and social exclusion yet encounter a health system where their needs are often overlooked or under-prioritised in policy (Age Action, 2022). While no targeted listening session was organised for older women exclusively, efforts were made to include older women in all of the listening sessions to ensure their experiences were included and captured.
- **Survivors and victims of Domestic, Sexual, and Gender-Based Violence (DSGBV)**, whose healthcare experiences are deeply impacted by trauma and stigma (NWC, 2024).

While the scope of this report primarily focuses on the lived experiences of participants from the above groups, it also considers the intersectional nature of identity, acknowledging that many women belong to more than one of these communities and may face compounded challenges as a result. This intersectional approach ensures a nuanced understanding of how various social, cultural, and structural factors influence women's health experiences. The design and delivery of Workstream B also benefited from NWC's intersectional feminist lens and social determinants perspective on women's health. This recognises that our health is primarily shaped by non-medical factors, like economic opportunities, access to education, housing status, and social inclusion in society. For women, particularly those from marginalised and minority ethnic groups, these determinants of health are further impacted by systemic inequalities. Gender-based violence, poverty, disproportionate unpaid care responsibilities, racism, and discrimination create additional barriers, deepen health disparities and limit access to healthcare (Marmot, 2015). This intersectional feminist approach to understanding healthcare experiences and the impact of the social determinants of health on participants was supported by our use of the AAAQ framework.

The AAAQ Framework: A Guiding Lens

In addition to this intersectional feminist lens, the AAAQ Framework – a common tool in rights-based evaluations of health – was used to structure the data collection and analysis in this project. This framework is used to evaluate four interrelated dimensions of healthcare: *Availability, Accessibility, Acceptability,* and *Quality*. As a human rights-based framework which is grounded in international health policy, the AAAQ Framework is widely used to assess and improve healthcare services by ensuring they are equitable, inclusive, and responsive to the needs of all individuals.

The AAAQ Framework was first articulated by the Committee on Economic, Social and Cultural Rights (CESCR) in General Comment No. 14 (2000), which interprets the right to health as outlined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). The framework is internationally endorsed, including by the World Health Organisation (WHO) and the United Nations Population Fund (UNFPA), for its comprehensive and equitable approach to health systems evaluation. The Framework has also been widely applied in global health research that critically assesses healthcare systems (Hunt, 2016), this research has often looked at gender-specific health needs of women with respect to reproductive healthcare (Kähler et al., 2024), and the needs of women who experience marginalisation (Munakampe et al., 2024).

1. **Availability**
   Availability refers to the presence and supply of sufficient healthcare services and infrastructure, including medical facilities, trained health professionals, and essential medicines. According to the World Health Organisation (WHO), healthcare must be available in adequate quantity to serve the entire population (WHO, 2018).

2. **Accessibility**
   Accessibility addresses the need for healthcare to be physically, economically, and informationally accessible to all individuals without discrimination (i.e. irrespective of race, gender, age, ethnicity, disability, or socio-economic status). This includes:

   - Physical accessibility: Healthcare facilities must be within safe reach, particularly for women living in rural areas or experiencing homelessness. Healthcare facilities and infrastructure must also be accessible to individuals with disabilities or impairments.

   - Economic accessibility (Affordability): Services should be affordable for all, with particular attention to marginalised groups facing financial constraints.

   - Information accessibility: Access to healthcare-related information must be clear, accurate, and culturally appropriate.

Accessibility is especially pertinent for migrant women, Traveller women, Roma women, and disabled women in Ireland, who frequently encounter language, literacy, financial, and physical barriers to healthcare services (FRA, 2021; IHREC, 2020).

3. **Acceptability**
   Acceptability focuses on ensuring that healthcare is free from discrimination, respectful, and sensitive to gender, age, ethnicity, cultural backgrounds, and other identity factors. Services should respect patients' dignity, beliefs, and privacy, while being responsive to their cultural and social needs. For instance, several research reports have identified Traveller women and Roma women's experiences of racism and discrimination when engaging with mainstream health services (All Ireland Traveller Health Study, 2010; FRA, 2020); with service providers acknowledging this reality in the All Ireland Traveller Health Study. By prioritising acceptability, the AAAQ framework encourages the development of respectful, inclusive healthcare practices that foster trust and engagement.

4. **Quality**
   Quality encompasses the need for healthcare to be scientifically and medically appropriate, meeting established safety and efficacy standards. It involves delivering care that is timely, effective, and evidence-based, supported by trained healthcare professionals and adequate infrastructure. In instances where the quality of the service comes into question, there must be a robust, transparent, and accessible complaints system available.

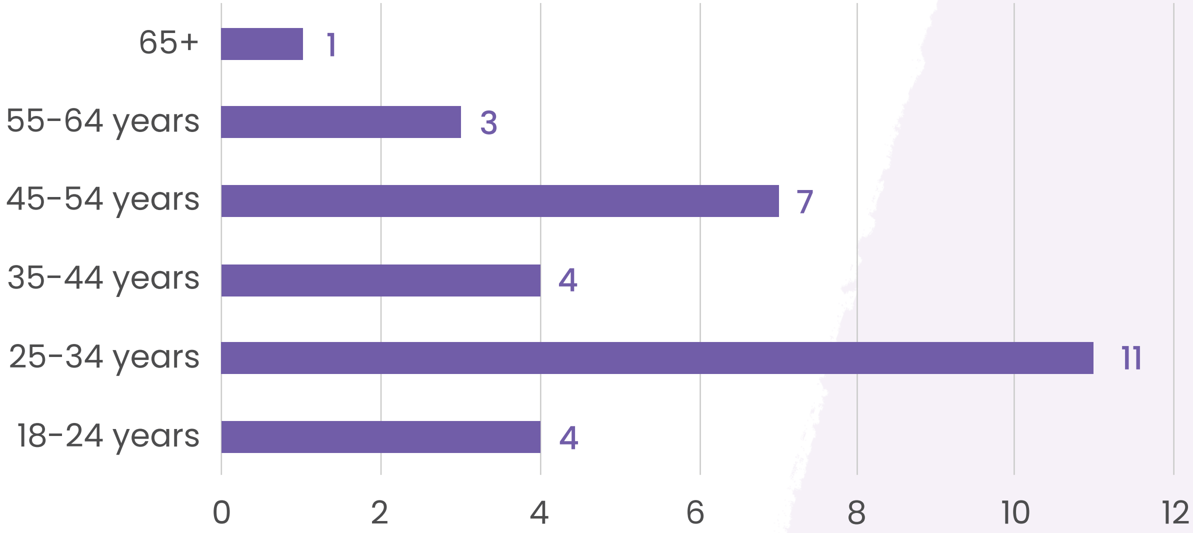
   By adopting the AAAQ Framework, this report provides a structured, human rights-based lens to evaluate women's healthcare experiences, ensuring that availability, accessibility, acceptability, and quality are considered holistically. This approach allows for a nuanced understanding of how intersecting inequalities shape healthcare access and outcomes, making it particularly suitable for capturing the lived experiences of marginalised groups of women in Ireland.

Sample Size

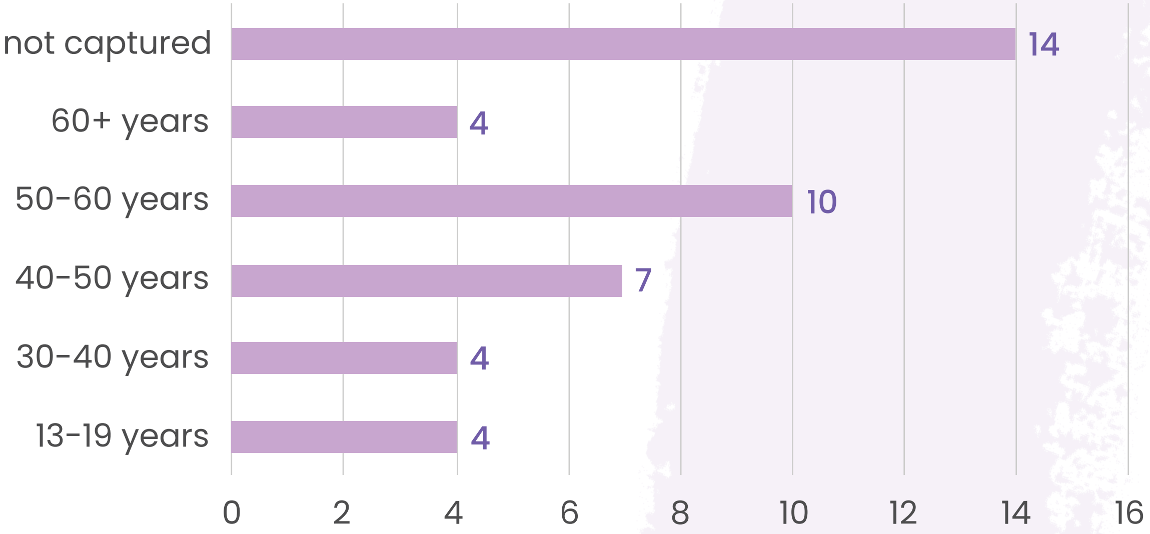
The Workstream B project engaged with 73 women across the 8 priority groups identified. Furthermore, 6 women attended a Collective Event online.

Efforts were made to ensure the listening sessions were representative across the life cycle, so that the findings could illuminate experiences from younger and older women. The breakdown of the age profile of the 73 participants can be found below. As the Pavee Point and the National Traveller Women's Forum session with 36 Traveller women and 7 Roma women captured age differently, a second graphic depicts that session.

Age of participants from NWC-led listening sessions (n=30)

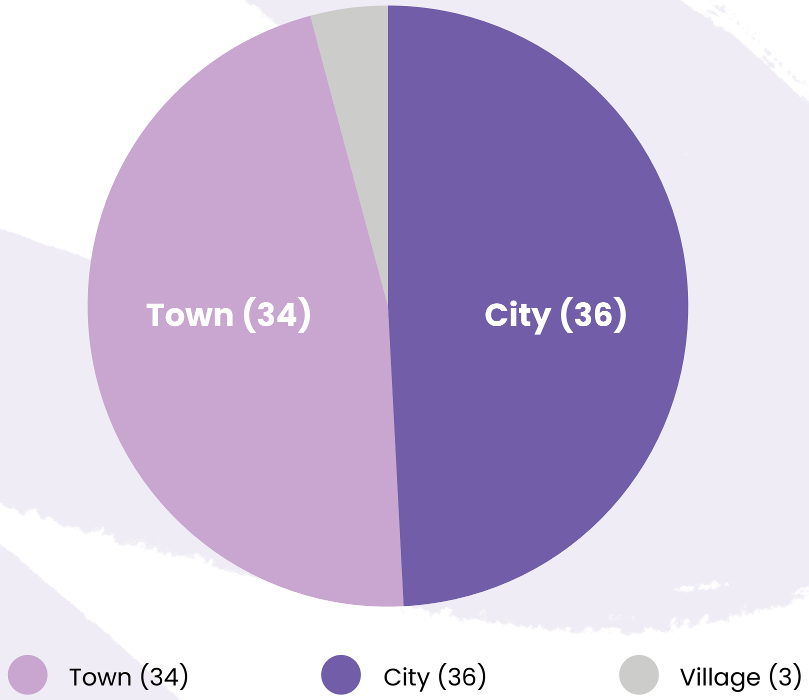


Age of participants from Pavee Point & National Traveller Women's Forum led listening sessions (n=43)



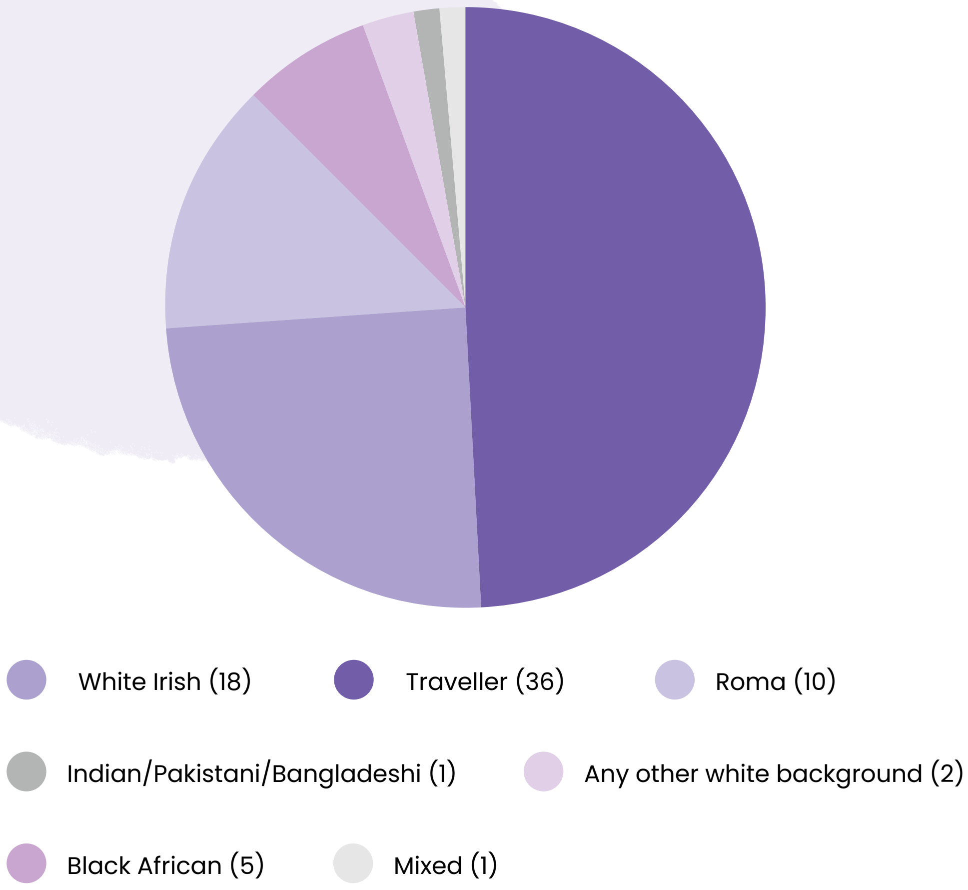
NWC was also committed to engaging with participants across the country, ensuring there would be adequate representation of participants who lived in urban and rural locations.

Location where participants are currently residing in Ireland n= 73



Using the recommended Census question, the ethnicity of the 73 participants was also captured.

Ethnicity of participants n= 73



Co-Design & Collaboration

The methodology for Workstream B was rooted in participatory and community-led research principles, ensuring that the women's voices were not only heard but also valued as central to the design of the research process. This approach is fundamental to NWC's mission and values and is reflected in how we work to ensure policy discussions are informed by women's lived experiences and the collective analysis of our nearly 200 member groups. This co-design process was developed and facilitated through close collaboration with members of the project's Working Group.

The Working Group included representatives from patient advocacy groups, civil society organisations, service providers, and other key stakeholders. Since the purpose of Workstream B was to listen to and amplify the voices of priority groups of women, the collaboration with Working Group members who represent and work with these groups of women was particularly important. This collaborative approach ensured that the research design, engagement strategies, and recruitment processes were informed by those with lived experience and those working directly with the communities involved.

In many cases, representatives of various advocacy and representative organisations led on the design and delivery of the listening sessions. A particularly good example of this is with respect to Pavee Point Traveller & Roma Centre and the National Traveller Women's Forum. These organisations jointly led on a listening session with Traveller and Roma women, after having worked with NWC to adapt facilitation guides from previous sessions. This ensured the engagements were culturally appropriate and Traveller and Roma-led.

Recruitment & Engagement

A targeted recruitment strategy was employed to reach women from the priority groups identified. This was achieved through a collaborative approach with members of the Working Group. For example, for the listening session with disabled women, NWC was supported by a representative from Independent Living Movement Ireland (ILMI) to publish a call for participants through their existing network of disabled women. This targeted recruitment and co-design process ensured accessibility and flexibility to respond to the needs of each priority group identified. NWC also received support from relevant Working Group members to draft the supporting materials, such as the participant information booklet and facilitation guide, ensuring they were tailored to each specific group.

In the case of survivors and victims of DSGBV, it was agreed that there may be too many sensitivities among participants to facilitate a shared space. It was therefore decided that in-depth interviews would be more appropriate. NWC worked with a representative from the Dublin Rape Crisis Centre to develop an Expression of Interest poster, which included a link to the participant information booklet and a short form that participants could complete. This was circulated widely across nearly 30 national, regional, and local support services and advocacy groups working on various issues relating to violence against women.

To ensure that the sessions were as practically accessible as possible, participants were reimbursed for all travel expenses incurred to attend the listening sessions. Where required, this reimbursement also included childcare. Catering and refreshments were also provided to ensure the participants were comfortable for the duration of the session.

Data Collection Methods

To capture a comprehensive understanding of women's healthcare experiences, a combination of qualitative data collection methods was employed, including:

- **Listening Sessions:** These sessions followed the traditional semi-structured format of a focus group discussion. The locations were carefully selected to ensure participants felt comfortable, ranging from NWC's offices to neutral third-party venues and familiar service providers or organisations where participants were already connected. These discussions allowed women to share their experiences collectively, fostering solidarity and shared learning.
- **In-Depth Interviews:** Conducted with women to share their individual experiences, providing a more private space for personal narratives and deeper exploration of sensitive topics.
- **Collective Event:** Towards the end of the project, a Collective Event was held online. This invite was sent to previous participants as an optional additional engagement in the project. This inclusive space enabled preliminary findings to be shared, to explore issues of intersectionality, and additional gaps to be identified, fostering a collaborative interpretation of the data.

Ethical Considerations

Ethical integrity was prioritised throughout the research process. Informed consent was obtained from all participants, ensuring participants fully understood the purpose of the research, how their data would be used, and their right to withdraw at any time. Confidentiality and anonymity were maintained, particularly given the sensitive nature of some of the experiences shared. In addition, trauma-informed facilitation was employed, ensuring that discussions were conducted with care, sensitivity, and appropriate support mechanisms in place. Furthermore, a list of supports was also made available to each participant after the session. This list of supports was shared with members of the Working Group for input, to ensure the supports being signposted to each group were relevant and culturally appropriate.

Data Analysis & Interpretation

Data analysis was conducted using a thematic analysis approach, enabling the identification of key themes and patterns across the experiences shared. This analysis was heavily shaped by the AAAQ (Availability, Accessibility, Acceptability, and Quality) framework, which provided a structured lens for assessing the data in relation to human rights principles. Additionally, through engagement with experts on the Working Group and through the Collective Event, the process of examining the findings was participatory, as there were opportunities to provide feedback on the analysis and identify gaps. This aided the interpretation of the data gathered, allowing for greater confidence in the accuracy of the findings and their wider relevance beyond the sample represented in Workstream B. This participatory approach also helped to contextualise the analysis within cultural and community knowledge, further aligning it with the AAAQ framework's emphasis on equitable and rights-based access to services.

Limitations

While this report provides valuable insights into the healthcare experiences of marginalised women, certain limitations must be acknowledged:

- **Inclusion and Representation:**
    - Although efforts were made to engage women from diverse backgrounds and there is a high representation of women from each group, the findings still cannot be generalised to all women within each community. In particular, NWC did experience challenges engaging with survivors and victims of DSGBV. Despite ongoing engagement over a 6-month period with nearly 30 national, regional, and local organisations working in this space, we only managed to speak to 2 women who openly identified as a victim or survivor DSGBV. While this difficulty with access was not unexpected, it demonstrates the need for more funding and supports for survivor-led structures to ensure the voices of all women can be meaningfully included in similar research projects. It also highlights the need for a more structured engagement process with DSGBV survivors across government departments and strategies. The report also acknowledges that there were groups who could also be considered as priority groups, but were not the focus of this report, this includes but is not limited to, women detained in the Irish penal system.
    - While 65+ years is the typical definition of older age in Ireland and in other developed western countries, this categorisation does not fully capture the lived realities of all women, particularly those from marginalised communities. For example, the Census 2022 demonstrates that 15% of the total population of Ireland was aged 65 years and over. For Travellers, the equivalent figure was just 5%. This has been acknowledged by the Department of Health previously, with a 2019 commissioned report by the Healthy and Positive Ageing Initiative redefining Traveller ageing at 40+ years. Research on other groups identified for this project shows a similar difference in the age profile. For example, the standardised mortality ratios for homeless women are 6-10 times higher in Dublin, than non-homeless women living in Dublin (Ivers & Barry, 2018). In this context, mid-life and older years must be understood more flexibly, acknowledging the earlier onset of age-related challenges, health disparities, and socio-economic disadvantages experienced by certain groups.
- **Complexity of Intersectionality:** While the report adopts an intersectional approach, it is challenging to fully capture the complexity of women's intersecting identities and the nuanced ways these influence healthcare experiences.
- **Accessibility and Participation:** While great efforts were taken to ensure each stage of the project was accessible to participants, the report acknowledges that structural barriers, such as language, digital access, and geographical constraints, may have influenced who was able to participate, potentially excluding the most marginalised voices.

- **Interpretation and Scope of Participant Experiences:** Not unexpectedly, participants of this research focused on the challenges and barriers they encountered in the healthcare system. This tendency to focus on negative experiences is expected when individuals are asked to reflect on their healthcare journeys, as difficulties often leave a more lasting impact. While this feedback provides crucial insights into gaps in care, it is important to acknowledge that it does not provide a fully comprehensive picture of all healthcare services. Additionally, while participants noted that it was positive there had been so much investment in women's healthcare services in recent years, many participants did not have direct experience using them (e.g. with respect to new services for the menopause, endometriosis, gynaecological health, etc., which were established in recent years through the Women's Health Action Plans). This is a significant finding in itself – highlighting potential gaps in awareness or accessibility – but it also means that the report cannot directly assess the impact of some specific recent investments in women's healthcare. It is also important to note that the accounts shared reflect participants' own interpretations and experiences of healthcare services, which may not always align with how services are intended to operate or current policy provisions. However, such discrepancies may themselves indicate a need for greater awareness, communication, or accessibility around these services.

Despite these limitations, this report represents a significant step towards understanding the healthcare experiences of women who face structural inequalities in Ireland. By embedding participatory methods and an intersectional analysis, the findings offer a nuanced perspective that can inform future health policies, services, and whole-of-government responses to address gaps in supports and services.

Findings

Findings

This chapter presents the key findings from the listening sessions, structured around the Availability, Accessibility, Acceptability, and Quality (AAAQ) framework. While some positive experiences were highlighted by participants – including their relationships with their GP, the treatment they received by medical staff during hospital visits, and the availability of certain specialist services – the following challenges were highlighted too.

- **Availability:** Women reported severe shortages in essential services, particularly within primary care. Women discussed their experiences of delays, waiting lists, difficulties securing appointments, and a sense that essential services were either overstretched or entirely absent in their communities. For migrant women, there were significant challenges accessing GP services at all. Another area of unavailability was evident for trans women, who described not being able to access appropriate gender-affirming care.
- **Accessibility:** Even when services were technically available, practical barriers often made them inaccessible. Women spoke of financial constraints, navigating systems in an informational, language, or literacy gap, in addition to descriptions of how services can be physically inaccessible for disabled women.
- **Acceptability:** The attitudes and approaches of healthcare providers played a crucial role in determining whether the women we spoke to felt heard and respected in medical settings. Many participants described feeling dismissed and discriminated against – whether due to ethnicity, disability, age, gender identity, sexual orientation, or socioeconomic status.
- **Quality:** Women reported their perception that healthcare providers were unprepared to meet their diverse needs. This included insufficient training for both clinical and non-clinical staff on gender-sensitive, trauma-informed, and culturally competent or appropriate care. Many women encountered healthcare providers who lacked awareness of the social model of disability, the unique needs of LGBTQ+ individuals, or the specific challenges faced by Traveller and Roma women. Complaint mechanisms also emerged as a key issue, as many participants did not know how to file complaints, feared retaliation, or found their concerns dismissed without follow-up. This perceived lack of accountability created mistrust and disengagement from the health system.

The findings from these listening sessions reveal a healthcare system that, for many women, can be difficult to access, unresponsive to diverse needs, and lacking the necessary resources and training to deliver high-quality, person-centred care. The impact of these failures is not just individual but systemic, disproportionately affecting the most marginalised communities.

Participants' names and other identifying information they mentioned (e.g. their workplace, town where they live, etc.) have been changed or removed to protect their anonymity.

1. Availability

In the AAAQ framework, availability refers to the existence and sufficiency of services in terms of both quantity and type. For many women we spoke to, readily accessing the necessary and appropriate healthcare services they required was described as challenging due to a well-known lack of supply in primary care and specialised services in Ireland. In a busy and stretched healthcare setting, "availability" also spoke to a perceived lack of emotional capacity healthcare staff had to provide women with the best quality care with respect to compassion, explanations and discussions about diagnoses and treatment plans.

For some of the migrant women, women experiencing homelessness and addiction, and Roma women we spoke to, access to healthcare was primarily through targeted health services, for instance, Inclusion Health Hubs, which inevitably removed them from more mainstream healthcare systems. Underpinning these discussions were also conversations about the challenges navigating Ireland's two-tier health system, which can segregate the availability of healthcare resources differently depending on whether an individual has private health insurance. Participants also described what they perceived to be differences in the availability of services and supports between medical card and non-medical card holders. Lastly, Traveller and Roma women also discussed several women's health services and how they could not equally avail of them due to their design and eligibility criteria.

1.1 Two-Tier Health System

A discussion about public and private healthcare was common across all the listening sessions. Laoise, a participant in the LGBTQ+ group, reflected on the disparity between those who can afford private health insurance and those who rely on the public system,

> *"It is a two-tier health system, I unfortunately have to pay for my health insurance and that means I get a better standard of care than my wife who does not have health insurance."*

Áine, a woman from the same listening session, also spoke about how financial circumstances shaped healthcare decisions, sharing,

> *"The reason that I have insurance, and my wife doesn't, is because we are trying to have a baby, and I am the one who is going to carry. So that is why it's like an investment, but that's terrible."*

Similarly, Aoife from the LGBTQ+ group highlights how private insurance can facilitate faster access to essential care:

> *"I have [a private health insurance provider]...that covers a lot but not everything....what I do know is that being covered means you can go private too, particularly to see consultants, whereas it might take you 2 years, 3 years, to see a consultant...because you are going to be paying, you can get it in a month or two months."*

This was echoed by a Traveller woman, who described how delaying access to care without private health insurance was particularly concerning for her community, given the significant health inequalities,

> *"If you pay privately things are quicker and it stops diagnosis from being prolonged...particularly because we know Travellers have a shortened life span than settled people."*

This hierarchy of care was also evident at times when participants across the various listening sessions shared their experiences of being a medical card holder, with many feeling that those who can afford to pay receive better care. Fatima shared her experience, saying,

> *"healthcare is expensive in Ireland and there have been a few GPs who have actually refused to take patients who are on the medical card, they only want patients who can pay the full fees."*

This message was reinforced by Emily, who identified as a survivor of DSGBV, who described how the GP and pharmacy changed how they prescribed and dispensed her HRT once she became a medical card holder:

> *"I have a medical card. Without a doubt, the way the medical card dispenses HRT for trauma-survivors and someone with ADHD, it is a measure of cruelty towards women. I've had days where I've been to my pharmacy, crying looking for my progesterone. It used to be that I could just ring up and get the 6-month prescription filled. But now I have to be there in person and can only get it filled monthly. Now, a hand-written note has to be dropped in and if the GP has time that day, it could get sent to the pharmacy...there's a punishment, it makes me feel undeserving. There's a feeling of shame, that they know I was the woman who was in here [pharmacy] crying last month because I needed my HRT."*

1.2 Targeted & Mainstream Health Services

For some priority groups we spoke to, particularly migrant women, women experiencing homelessness and addiction, and several Roma women, their circumstances and the lack of availability of mainstream primary care services meant their healthcare was primarily being provided by Inclusion Health Hubs and other targeted clinics and services. In most cases, these services were managed by homeless charities.

In the NWC-led listening session with Roma women, one woman explained that,

> *"We go to the clinic in [Open Access Inclusion Health Hub in City Centre], near where we live. When I first arrived [in Ireland] it was hard to get a GP, but now I have one who can give me what I need...On Mondays there is a translator, and it is possible to get an appointment on that day if you ring in the morning."*

Another participant commented on how being in Dublin makes accessing these services easier for Roma families:

> *"In other parts of Ireland, people are not so lucky with their GPs, I know some people in [county in west of Ireland] still waiting for a GP after 3 years."*

These services and targeted clinics were described as limited to a particular day or time in the week, which further restricted the availability of appointments.

Roma women participating in that listening session all shared the same GP and spoke positively about their experiences. When asked about access to other women's health initiatives and services, like CervicalCheck and BreastCheck, participants explained that they had not heard of these services and had not attended, despite being of age for cervical screening and living in the country for several years.

While participants spoke of the value of these specialised services, there were examples of struggles when trying to integrate or reintegrate into mainstream health services. Áine reflected on this with respect to trans healthcare:

> *"There are people who are going to the National Gender Service for 10 plus years, they do not need to see a specialist, that care should be handed back to their GP."*

1.3 Healthcare for Trans Women

For the trans women we spoke to, the unavailability of suitable healthcare emerged as a strong theme. In particular, participants shared their experiences of the lack of appropriate gender affirming care in Ireland.

Fatima described the difficulty she has had seeking gender-affirming surgery, mentioning,

> *"I am getting a massive surgery...it's a gender affirming surgery. They don't even offer it in Ireland or the UK, so they are sending me to Germany by myself for 6 weeks."*

This experience suggests the scarcity of gender-affirming healthcare services within Ireland.

Áine shared the experience of another trans woman who had undergone surgery with the same surgeon in Germany and faced serious challenges accessing post-operative care upon her return to Ireland.

> *"She went to the same surgeon in [Germany] and when she came back, she just developed a bacterial infection, went to [named hospital] and she was refused by gynaecology. They sent her to urology, and they sent her to plastics, and she was refused by all three and told to go to [named hospital]. They did not get her an ambulance, they did not ring [the hospital] to say she was coming – she had to get her own taxi there. And then [the hospital] was like, 'We are a maternity hospital', but they were like, this is just a bacterial infection so we will give you the IV [drip] and put you in a private room.'"*

Participants also highlighted the reluctance of some GPs in Ireland to provide care for trans patients, which created additional obstacles for those undergoing medical transition. Áine, who worked in LGBTQ+ advocacy, shared the distressing reality faced by many trans women, stating,

> *"When people ring us in panic because they are getting care overseas and they need to get their blood level monitored for their own health, I have to give them a list of GPs who will see them because not every GP will see them, so I have to say look this is going to cost more money."*

Pádraigín, a participant in the LGBTQ+ session described the difference in her experience accessing Hormone Replacement Therapy as a cis woman, versus friends and colleagues who required hormone therapy as part of their gender-affirming care,

> *"I am a menopausal cis woman I have been prescribed hormonal treatment over 12 months ago and I was resistant because of my own thing around it, do I need it do I not, I don't want to take medication every day and they were kind of coming at me to take it and it's just so opposite to the experience to my colleagues who are trans, who are bending over backwards and have to buy it, have to buy it on the internet or just guess the doses."*

The participants also spoke about the perceived shortcomings of the current Model of Care for trans healthcare in Ireland, highlighting how it remained rooted in a psychological approach. They described how the process was shaped by a medicalised and psychiatric framework that required trans people to undergo lengthy and unnecessary assessments. Aoife summarised these concerns, stating,

> *"There is an absence of staff, there is an absence of resources, so on so forth, but there is also a problem with the Model of Care… so suppose by some miracle there was to be a National Trans Health Action Plan, it would still not really work because it will be based on the old Model of Care."*

Fatima also shared a positive experience that indicates a more thoughtful and open approach by healthcare professionals, she recalled,

> *"Even if it's a new experience for a doctor, there is a correct way to go about it. When I started my [gender] affirming care, my mum took me to my GP. My GP was like, 'I haven't heard about this, I am going to go research, and we are going to get you back in.'"*

1.4 Primary Care for Migrant Women

One theme that emerged strongly in conversations about the availability of healthcare services and supports was the struggle women faced getting a GP. Women across all the listening sessions described this as the significant barrier to healthcare to varying degrees, as a GP offers a gateway to diagnoses, prescriptions, and being referred to other specialised services.

Women often spoke of creative and extreme lengths they went to try to get access. Emily, for example, described how it took her more than 6-months to find a GP when she moved to a new county in Ireland:

> *"I was constantly following up, I was ringing around other GPs, I eventually rang the Parish priest because they are influential locally. I don't know for sure whether it had an impact, but the next time I followed up with the primary care centre they said that they could let me send in a new patient form."*

Similarly, Phoebe, a woman who participated in the migrant session explained that she eventually got a GP by paying for a private STI test that she did not need:

> *"That's how I got to a GP, I wasn't sick, I just needed a GP. So, I decided that I will go and do STI tests, which I could have done in a public hospital for free of charge, that is how I got into the system and that's how I got retained."*

While all groups discussed concerns with the availability of primary care services, it was clear that migrant women's routes to primary care were particularly difficult. Rosa, one migrant woman, shared her experience, *"Getting a GP is hard… I tried so many… and they said they are full".* Rosa also described how there were inconsistencies in how new patients were assigned, and how she knew other women from her Direct Provision Centre got a GP before her even though they were below her on the waiting list. Rosa explained that a testament to the challenges within primary care were the stories of women in the international protection system who kept their GPs even when they moved county. She described her own experience of this: *"We had to move, we really wanted a closer GP, but some of us kept our old one [GP] even though it was far."*

Some migrant women we spoke to discussed how they resorted to travelling back to their country of origin to access healthcare services. Pooja's experience of being without a GP for over two years reflects this,

> *"I still do not have a GP and it's been 2 years in this country, whenever I go [to a GP/primary care centre] I have a similar experience where they say they are full, and they don't have space. The only medical assistance I get is back home. I wait to go home and get my medical checks done and get bulk medicines. The thing I'm scared of is what if the medicines expire and how would I be able to get them again."*

Similarly, Phoebe struggled to get a GP in Ireland, even after obtaining one, she found their capacity so stretched that she readily relied on her previous doctor in her country of origin:

> *"Initially I had a delay to get an appointment… I was given an appointment in 3 weeks, I couldn't eat or swallow, so I had to call my doctor back home and I told him the symptoms I had and he asked to tell him everything I had in my first aid kit… by the time my appointment was due I was okay."*

Without reliable access to a GP, Phoebe also described how she would resort to attending A&E:

> *"I decided to attend the public hospitals even if I didn't have an emergency, I just go to the A&E because that is the only way I got medical attention, pay 100 euros, very expensive. The challenge was and still is the long waiting queues… the first time was 7-8 hours, and the second time was 12 full hours. You get sick from the waiting."*

However, despite the long waits and the challenge of navigating the system, Phoebe also shared a positive aspect of her A&E experience:

> *"The only thing I appreciated that, despite the waiting, I really got good service in terms of the tests that they had done, they did comprehensive tests on me, and I got medical treatment. I was really well examined."*

Gloria, another migrant woman, recognised the pressure on GPs, but also expressed her frustration at the long waiting time:

> *"My GP is good, I am not going to discredit my GP to be honest. Sometimes the GPs are overcrowded because I know they are putting in their best. But sometimes, if you are trying to get an appointment with the GP, like getting an assessment for a blood test for your child...you will be calling and calling, and they would say there is no appointment for you."*

She also described how the demand on GPs limited how much care patients could receive in a single visit: *"Doctors say come with one issue at a time, but you see, you're waiting for weeks, and you have like six issues, and it's not easy to get an appointment!"*

Bridget, who had recently moved to Ireland and was experiencing homelessness at the time of the interview, did not have a GP and spoke of the challenges understanding how to navigate services without one. This led to Bridget googling services and ending up at private clinics, before being redirected to more targeted health services for people experiencing homelessness. These targeted pathways were not without their difficulties, as there was a lack of availability of appointments: "*The service starts at 9am, but people start queuing up from 7:30am. The doctor can see five people, so you are there on time, but you actually can't be seen."* For Bridget, this service was the only option available, yet the demand far exceeded its capacity, making it unreliable and often unavailable to her despite her best efforts.

Another consequence of this limited availability within GPs was a description of how their limited capacity influenced the perception of the care patients received. Migrant women, along with participants in other sessions, described feeling dismissed or unsatisfied with the diagnosis or treatment, feeling like the consultation was rushed or not properly explained. Rosa told her story of this:

> *"When I went to meet my GP for the first time, I had a problem with my leg, I could feel pain here on this bone [pointing to calf], when I went to her I showed her both legs and the difference in size and she said, 'I'll just give you pain killers'. And then, I had a problem when I try to pee and I have a pain in my tummy, if I sit down, I think I could die. I can't sit or stand, both are painful. I went to the GP and explained to her, but she still said she could just give me painkillers...later on I ended up being taken to St James's Hospital." While the GP may have determined painkillers to be an appropriate treatment, Rosa felt like the GP did not have the capacity "to believe me or listen to me."*

1.5 Availability & Eligibility for Women's Health Services for Traveller & Roma Women

In the listening session led by Pavee Point and the National Traveller Women's Forum, Traveller and Roma participants discussed several specific services funded by the Women's Health Action Plans and their perceived unavailability to their communities. This included concerns about the age thresholds for key screening programs, such as BowelScreen and CervicalCheck, which do not align with the health realities of Traveller and Roma women. As one participant explained, *"Bowel screening at 60 [years], but many Travellers don't reach that age…CervicalCheck is from 25 [years], but many Traveller women have had a few children by then."* With research consistently showing that Traveller women have a life expectancy more than ten years lower than women in the general population, these services were seen as becoming available too late to provide meaningful preventative care. While these services were technically available to Traveller and Roma women, they were seen as structurally exclusionary. The same sentiment was reflected in discussions around supports for older women, including with respect to the menopause and chronic diseases. One participant noted: *"Old age can be 40+ [years] in the Traveller community – more chronic conditions earlier, earlier in menopause"*

This perceived exclusion also extended to publicly funded fertility treatments, as one participant noted,

> *"Traveller women are not entertained when seeking reproductive health because they are seen as too 'young' to need help. Travellers may need IVF at a younger age but come up against barriers because they are young."*

While IVF eligibility begins at 18 years old, women discussed how in practice it was difficult for young Traveller women to get a referral. They felt this was because these policies assume a universal timeline for starting a family that did not align with the norm in the Traveller community, leaving women essentially locked out of those publicly funded supports until they were older.

Conclusion

The availability of healthcare services for the participants was hindered by several issues, including the lack of supply in Ireland. This was relevant for all the women who participated in this project, but specific challenges arose for migrant women, Roma women, and trans women with respect to availability of primary care and gender-affirming care. This overall lack of supply, and the increasingly specialised health needs within Ireland due to an ageing and growing population, has provided a market for the outsourcing of care to many specialised providers who often work within an inclusion health framework. This targeted approach appeared to meet the immediate needs of several Roma women and women experiencing homelessness and addiction, however, their accounts and their lack of knowledge about certain women's health services and initiatives (e.g. Free Contraception Scheme, CervicalCheck, etc.) suggests this model can further segregate marginalised women and make it difficult for women to enter or re-enter the mainstream health system. Participants also discussed how the two-tier health system, issues concerning continuity of care, and long waiting lists were noted across all the listening sessions as impacting the availability, reliability and quality of healthcare. Lastly, Traveller and Roma women reflected on the availability of some new services funded by the Women's Health Action Plans, as essentially unavailable to them because the eligibility ranges were modelled on the general population.

2. Accessibility

Accessibility in the context of healthcare refers to the ability of individuals to obtain the services they need in a timely and effective manner. For the women who participated in this project, we observed that there were several intersectional struggles with respect to financially, physically, and informationally accessing services. Furthermore, the social determinants of health with respect to housing, education, employment, all emerged in these conversations when women discussed the accessibility of healthcare.

2.1 Financial Inaccessibility

Financial barriers played a significant role in limiting access to healthcare services for the women we spoke to, including those experiencing homelessness and addiction, LGBTQ+ women, migrant women, Traveller women, Roma women, and disabled women. A key finding within this section relates to participants being forced to go without healthcare appointments or treatments due to unaffordability. Furthermore, challenges surrounding the processes and eligibility for potential financial supports – like medical cards and disability allowance – were also discussed.

For participants experiencing homelessness and addiction, women described overcoming significant barriers to healthcare, only to find out once they had received a diagnosis and prescription that they could not afford it. Sorcha, who had been receiving mental health support following a suicide attempt, was told after a long hospital admission that her care should now be taken over by her primary care team. Sorcha explained how this did not work in practice, as she could not afford the GP fees: *"All my files were simply transferred over, but the actual link between me and the doctor now was little to none because, you know, I did not have the money to go."*

Bridget, who was experiencing homelessness after arriving to Ireland, described her experience of not being able to afford her antibiotic prescription for mastitis after giving birth:

> *"I ended up with mastitis, that started on a Friday night, and it was like, right, I was literally crying in pain like where can I go, it's the weekend, it's like you are on your own. When I eventually got seen on the Monday, even though the pain started on Friday, then it was like here's a prescription that you can't afford."*

Financial inaccessibility extended to other prescriptions for medical devices, like eyeglasses. Sorcha, whose glasses were being held together by tape, described her experience: *"There aren't enough services for those who have glasses, do you know that? Because to get a medical card, I need a PRSI stamp; if I don't, I need to pay for it."*

While some participants had positive stories of accessing various social protection measures, others discussed how the bureaucratic and rigid constraints impacted their access to such supports. As Joanna, a disabled woman explained:

> *"If the women have some disability or illness, she cannot apply for disability allowance because her husband is working, and her income is depending on her husband. She cannot apply for a medical card because the income of the husband is over the limit."*

Similarly, Adra a participant in the LGBTQ+ session and a third-level student, described how she was deemed ineligible for a medical card, resulting in her not being able to adhere to the medical advice from her GP:

> *"I have asthma but because I am 5 euro above the threshold, I am not entitled to a medical card. So, I have to pay for doctor visits every month they say, but I don't because it's way too expensive, I just go every six months so that I can get a prescription for my inhaler… and [it's] 30 euros a month for meds."*

Fatima, a trans woman, described how she found her monthly medication bills expensive, but without the availability of the Drugs Payment Scheme, they would be more than six times more expensive and potentially prohibit her access as a student without a full-time job:

> *"Even the medication I am on…I went to the pharmacist the other day and it's 600 euros just to get the medication because it is considered hi-tech. So, I have to apply for the Drug Payment Scheme Card, and that, like, I think brought the cost down to 90, but that's still extortion."*

There were also positive examples where women described previously not being able to afford medication, but this has changed following the introduction of women's health initiatives by the Department of Health. Phoebe, a migrant woman, reflected on the difficulties she faced before the extension of the Free Contraception Scheme. She explained,

> *"Before the extension of the free contraception scheme, it was really difficult, and really expensive. First of all, even the emergency pill, if I had to access it from a pharmacy, I had to pay 30-40 euros."*

The introduction of the Scheme made contraception more accessible to her and women she knew.

2.2 Geographical & Physical Inaccessibility

Geographical, spatial, and physical barriers also emerged as a challenge to women's equitable access to healthcare services during the listening sessions.

Laoise, shared her experience of living in a rural area in Ireland,

> *"We would be in [county in South-West Ireland], and it's really, really rural. Like when the flooding happened last year, my mother was in getting a procedure, and I had to stay overnight – not because she was unwell but because she couldn't get home. So, like, accessing the services is really difficult."*

Laoise also shared the experience of a young woman who faced delays in accessing urgent care: *"She had to wait a full day to go to a SATU clinic because the nearest one was not open."* This highlights the challenge of accessing vital care when such services are not available locally. As Laoise described it, *"It's not equal healthcare because it's not equally distributed."*

Geographical challenges were more pronounced for disabled women, who could face additional barriers when travelling long distances to healthcare services. Eilish, a disabled woman, shared her experience with Ireland's mental health services, describing how the lack of nearby services made her journey more difficult. She explained,

> *“I’m from [a town in southeast Ireland] – we don’t have mental health hospitals; we don’t have anything. We go to the local hospitals, and they say, ‘okay, off to [nearest county].’ And you drive from [town in southeast Ireland] – to [nearest county]. You know nobody living there, so you are waiting, you can’t get anyone to bring you anything, and you’re sitting in the hospital.”*

In addition to geographical inaccessibility, the physical inaccessibility of healthcare settings, services, and equipment also emerged strongly as a significant barrier for disabled women. Women described how many facilities and public spaces lacked the necessary infrastructure to accommodate disabled people – creating an environment that negatively impacted their health and well-being – and affected their ability to access equitable healthcare services and supports. Mairéad described the daily challenges she faced when using public transport, which directly impacted her ability to access healthcare and other essential services. She explained how a lack of consideration for disabled people made commuting an exhausting experience, saying, *“I have been on buses completely packed in the morning going to work, standing with my cane and no one would get up and give their seat.”*

Similarly, Méabh shared her experience of attending a health information session that was not physically accessible. She explained that the lack of proper infrastructure made it difficult for her to navigate the space independently, saying, *“I went to attend a [Health] information session a while ago and it wasn’t accessible, there was only one bar on the other side, and I had to come down on my own.”*

Fiadh also stressed the importance of physical accessibility in healthcare, especially for women needing specific screenings. *“Physical accessibility for disabled women is a huge issue, mammograms, cervical checks, not having the right table, or like not being given the choice around, you know like how we can creatively do a mammogram, there is no sort of thinking outside the box!”* she said. Another participant, Caroline, shared her experience of attending her BreastCheck appointment with her PA but was told after a few attempts that the machine could not be adjusted to provide an accurate x-ray of her chest while she was in her wheelchair. Without the proper equipment onsite, Caroline left that appointment without having her mammogram. Caroline described the disappointment and shame she felt, but also her lack of surprise as this had previously happened to her with a CervicalCheck appointment too.

Joanna, who had observed the inaccessibility of hospitals in Dublin, reflected on how unprepared many healthcare facilities were for disabled patients. She said,

“The hospitals are not prepared for disabled people. There are no bathrooms for disabled people because I remember I was in two different hospitals in Dublin – there is no bathroom for disabled people, no beds, no corridors, no lift, you know? Anything. So, they need to be mindful that services have to be available for everybody and the same respect.”

Caroline and Joanna’s accounts highlight that even when health infrastructure and women’s health services are technically available, it does not necessarily follow that they can be equally accessed.

2.3 Informational Inaccessibility

Women participating in the listening sessions, particularly those experiencing homelessness and addiction, migrant women, Traveller women, Roma women, and LGBTQ+ women described barriers that arose due to a lack of local knowledge and social capital, as well as language, literacy, and an emerging digital divide which left them without adequate knowledge or supports to access healthcare services.

In the NWC-led listening session with Roma women, participants described how advocacy organisations served as a vital resource for guidance on how to access health services. Participants expressed uncertainty in seeking information independently and felt more secure when accessing knowledge or supports through organisations who work with migrants and the Roma community. This also emerged strongly amongst the Traveller and Roma participants in the session led by Pavee Point and the National Traveller Women's Forum. Participants described how they overcame barriers in accessing health services through the support and signposting provided by Traveller Primary Health Care Workers employed in local Traveller Primary Health Care Projects. For Roma women, they described relying on similar peer supports via Roma Health Workers.

2.3.1 Lack of Social Capital and Local Knowledge

Participants, particularly those who were new to Ireland, described their difficulties navigating an unfamiliar healthcare system which they felt often required previous experience or local knowledge to understand. Joanna, a migrant woman, highlighted how the lack of information affected not only minority ethnic groups but also broader segments of the population, saying, *"There is a lack of information for women, especially ethnic minority groups and Travellers. But even Irish women have asked me for help, saying, 'How do you know that?'"*

Participants in the migrant listening session also noted how their expectations of how the health services should operate did not always match their experience. This was particularly difficult when women were used to a specific approach from their country of origin. Phoebe shared her experience of accessing sexual health services, saying,

> *"No news is good news with the Irish public services, but when you're a migrant woman, you want your results to have documentation. Most people take the test because their partners want to know."*

When we spoke to Bridget, a migrant woman experiencing homelessness, she had recently given birth in an Irish maternity hospital, but her baby had not survived. Bridget described how this life-changing event was made worse by not having the knowledge or support to navigate the health system on her own. Bridget tried to seek treatment and support in A&E, but was advised she had to return to the maternity hospital to receive follow up care:

> *"In the maternity hospitals there are pregnant women and lots and lots of babies like I don't have my baby, my baby is gone, it's not fair to put me in this environment with babies."*

2.3.2 Language, Literacy, and Interpretation Barriers

While the Irish healthcare system was described as complex to navigate by many participants, women who had language or literacy barriers had more complex challenges.

Health literacy emerged as a strong theme in the session with Traveller women. Participants described how this can be more pronounced in the older generations who may have a lower level of educational attainment: *"Older women often can't read or write and going to hospital can be a scary experience not able to understand what is written on signs, and they often need someone to go with them."*

Traveller women also noted how follow-on care can often involve being provided with written materials and information, which they often seek help from local Traveller Primary Health Care Workers to understand. Literacy can also be a barrier in accurately understanding prescriptions, as one participant explained:

> *"Women who have literacy issues can't read their prescriptions and try to hide this because of internal shame and this feeling also means women don't feel confident enough to ask questions about their health."*

Roma women in the Pavee Point and National Traveller Women's Forum session explained how this health literacy gap can result in women missing appointments or lead to a lack of awareness of screening services: *"Women throw away the breast and cervical checks sent in the post. They don't understand the importance of the checks because of language and health literacy."* Similarly, the Roma women in the NWC-led listening session explained how common it was to bring a family member to an appointment for extra support with understanding any relevant diagnoses or treatments. As Leonora explained:

> *"If I am going to a different clinic [not the Open Access Inclusion Health Hub with translators], I must bring my sister-in-law, her English is very good...she also does this for her own husband and other family"*

The Roma women who took part in the session led by Pavee Point and the National Traveller Women's Forum discussed how they felt some GPs did not want to access HSE interpretation services and therefore insisted that patients bring their own interpreters, otherwise they could not be seen. This was described as problematic, particularly when needing to describe potential intimate or sensitive health concerns. As one Roma woman said, *"It's not right for women to have family interpret when discussing women's health issues."* In cases where a HSE interpretation service was available, participants described the quality as inconsistent, as interpreters could be from a different country and speak a different dialect. Women said they were often offered interpretation over the phone or via Google Translate. Participants also mentioned how there are some clinics who provide interpretation for Roma women, but the limited time the clinic is available makes it difficult to access. As one woman explained, *"Roma women can't attend if the clinic is every Monday morning when she's bringing kids to school."*

2.3.3 Digital Divide

The shift toward digital healthcare services has created significant barriers for some communities, particularly Traveller and Roma women. The move to online medical card renewal and digital appointment booking has made accessing essential healthcare more difficult for those with limited literacy, language barriers, or restricted digital access. Without the necessary skills or resources to navigate these systems, some women described how they were left without access to services or had to pay out-of-pocket for services they should be entitled to. As one participant shared, *"I had to pay €60 for a doctor's visit because I wasn't able to work out the [medical card] renewal process."* This highlights the unintended exclusionary effects of digitalisation in healthcare, reinforcing the need for accessible, alternative pathways to ensure equitable access for all.

Conclusion

The accessibility of healthcare services remains a significant challenge for the women participating in this project, with financial, geographical, physical, and informational barriers limiting equitable access. Financial constraints frequently forced women to forgo essential medical care, while rigid eligibility criteria for medical cards and social protection measures left many struggling to afford healthcare. Geographical and physical inaccessibility further compounded these issues, particularly for those in rural areas and disabled women, who faced difficulties reaching services or encountered healthcare infrastructure that failed to accommodate their needs.

Informational barriers, including health literacy gaps, language difficulties, and a growing digital divide, disproportionately affected Traveller women, Roma women, and migrant women, making it harder for them to navigate the system and secure timely care. While some positive policy developments were reported to have improved access to specific services, such as the Free Contraception Scheme, other systemic barriers persisted. This underscored the need for targeted community-based supports, an example of which participants reflected positively on were Traveller Primary Health Care Projects and Roma Health Workers.

3. Acceptability

Acceptability here refers to healthcare services being respectful of women's diverse cultural identities, lived experiences, and dignity, while upholding ethical standards and being sensitive to gender, age, and cultural backgrounds. Many participants described experiences of discrimination, exclusion, and a lack of gender-sensitive approaches to their care. Issues such as racism, ableism, homophobia, transphobia, ageism, and inadequate person-centred approaches also emerged.

3.1 Discrimination and Exclusion

3.1.1 Racism & Lack of Cultural Competency

Many women from minority ethnic backgrounds that participated in this project spoke of systemic and structural racism being pervasive in healthcare settings in Ireland. Penny, a migrant woman, emphasised how *"your nationality or your background, where you come from, it matters on how you receive care."* This was echoed by Gloria, who described the health service as perpetuating *"systemic and silent racism."*

The Roma participants from the NWC-led session recounted examples of being discriminated against when shopping, including being dismissed and told not to touch items in pharmacies when buying paracetamol for their children. One

Roma woman described a similar incident of racism in A&E:

> *"I was waiting in A&E and the security guard came up to me and was asking me questions, like why I am here and why am I waiting, I did not see them do this to anyone else. It makes you feel like everyone is staring at you and you have done something wrong."*

Roma and Traveller women from the Pavee Point and National Traveller Women's Forum session also identified racism and discrimination as a common theme. Participants believed this was *"the big reason we don't get the same standard of care as settled women."* Women recounted experiences of feeling their health concerns were not taken seriously because of their ethnicity and that their culture was not respected in healthcare settings. One Traveller participant gave an example of hospitals appearing not to respect Traveller traditions in end-of-life care:

> *"In Traveller culture, the whole family will gather when someone is dying but we often face abuse from the hospital security and staff who only allow a handful of visitors at a time."*

3.1.2 Ableism & Stigma

In the listening session with disabled women, participants reflected on the ways in which they were often made to feel invisible and dehumanised when seeking healthcare. Helen, a disabled woman, described her experience:

> *"We are human beings at the end of the day, when we go in to access healthcare, we are seen as burden, we are seen as an inconvenience, and we are seen as our impairment labels."*

She also highlighted the lack of individualised care within the system, explaining that assumptions were often made about disabled people based on their impairments. She said,

> *"At the moment it's the one size fits all, if you go in with a certain impairment and that's obvious, they are going to assume that everyone who has a similar impairment has similar needs, well that's not the case."*

Other disabled women agreed with idea that there is often a *"hierarchy of impairment",* adding:

> *"If you come across as well spoken, if you don't look disabled, or don't look that disabled compared to somebody else, that can drastically impact your experience of the healthcare system."*

Mairéad shared her experience with institutionalisation and the lack of control that disabled women often had over their own lives within the healthcare system. She said,

> *"The system places disabled women in nursing homes and settings they shouldn't be in, that they don't have control of themselves, of their own environment or who they are interacting with, and they keep them in the state of that you need to be cared for by other."*

She also spoke about the deep-rooted lack of autonomy that disabled women experienced, saying, *The autonomy over our own decisions and our own bodies still isn't embedded within the system because they have us held in the medical model."*

Fiadh reflected on how healthcare systems often failed to accommodate disabled women, treating them as outsiders rather than individuals with equal rights. She said, "*Normal is non-disabled.*" She also described the reluctance of disabled people to disclose their impairments due to bias in medical treatment,

> *"Disabled people do not feel safe in declaring an impairment because the doctor might be biased against the treatment or assuming it's a mental health condition or an emotion that distracts [from] the condition or 'go, you will be okay in a month's time' or whatever, and that's dismissive. But it's also disempowering, and it doesn't help disabled women receive the healthcare they need."*

Some participants emphasised the importance of independent living and the right to self-determination. Ciara explained what independent living meant for disabled people, saying, *"Independent living is not living on your own, but living life self-determined, it means needing directed support."*

3.1.3 Homophobia & Transphobia

The women in our LGBTQ+ listening session reflected on their experiences encountering discrimination, ignorance, and other barriers to women-centred care in health services. Fatima, a trans woman, recounted a disturbing experience where a doctor explicitly told her, *"Doctors who don't feel comfortable seeing trans women don't have to."* She described her shock that medical care could be conditional on a provider's personal beliefs rather than a professional obligation to treat all patients equally.

She also recalled being told by a doctor at 18 years old that, "*autistic people or neurodivergent people don't have the mental capability of being trans.*" This statement unsettled her, as it suggested that some individuals could be denied recognition of their gender identity based on stereotypes and other diagnoses. Áine, who works for an LGBTQ+ organisation, shared similar concerns:

> *"If you are autistic, they won't treat you, where you will have extra appointments because they don't believe that autistic people can be trans, now at least 50% of trans people are autistic in our experience."*

She also witnessed healthcare services discriminating against trans patients, highlighting one clinic in Dublin had a sign in the waiting room that read, *"Blood tests €50, trans blood tests €150."*

Aoife, who was +65 years of age, reflected on her experiences of medical professionals often felt unprepared to support her needs, "*I keep hoping it's changed, but in my own experience, so many GPs, consultants, and hospital doctors really didn't know how to deal with me when I said I was a lesbian.*"

Laoise shared her experience of how sexual orientation inevitably became the focus when trying to support her partner to access mental health services,

> *"I went to a hospital, to the mental health services with my partner, after an attempt on her own life and we sat in A&E for 17 hours...The assumption [by the psychologist] was that because her parents were not accepting her sexual orientation, she was suffering from depression."*

3.1.4 Ageism

Young and older women we spoke to for this project shared their experiences of age-based discrimination in healthcare settings. Sorcha, a young woman in her early 20s experiencing addiction and homelessness, felt that her concerns were sometimes dismissed simply because of her age. Although her GP is generally good, when she sought help for her irregular periods, the doctor didn't prescribe a treatment, citing her age, Sorcha felt, *"I don't get taken seriously because I am still young."*

Katherine, a young LGBTQ+ participant, described how seeking medical care felt like a battle, saying,

> *"Going into a doctor's appointment as a young person, it feels like you have to be battle-ready with all your points, like you don't want them to go like you are fine and get out of the door."*

She further shared the dismissive behaviour of GPs when younger individuals seek mental health support, "GPs are like, '*oh well now all young people are saying that they have mental health problems'*".

Meanwhile, older women face the assumption that family will care for them, leaving them unsupported. Aoife from the LGBTQ+ group noted,

> *"The big one I get all the time is, 'Can't your family look after you?' Before they even know my situation, they assume I have family to care for me."*

Aoife also described how because of this assumption, health services are often designed in such a way that you need someone else with you, as it is not always possible to be in a position where you can simultaneously receive treatment and be able to advocate for yourself, noting

> *"Lying there on the bed and having to stomp your foot at the same time is not always easy or possible... so I always feel like I need someone with me when going into a hospital in Ireland"*

3.1.5 Lack of Gender Sensitivity & Person-Centred Approaches

Many participants shared that healthcare systems fail to recognise their individual experiences, applying a one-size-fits-all approach that leaves them struggling to receive appropriate care. This included perceptions that women's health or pain was not taken seriously. As Alanna said,

> *"the bit about you getting hysterical, I don't know if men get as often [as] women do. Women's pain is underestimated, women's trauma is underestimated, the continuing, compounding impact that is done over multiple years."*

For the trans women we spoke to, healthcare interactions were overwhelmingly focused on their gender identity, even when unrelated to the medical issue. Fatima shared her frustration:

> *"I have broken my legs three times, and whenever I bring my gender identity that is all it is, they disregard your leg....like one time I had hurt myself with a wine glass and wrist was literally open and they were like that doesn't matter, tell us more about this [gender identity]."*

Similarly, Eilish, a disabled woman, described how healthcare professionals often oversimplified her health concerns, attributing everything to her pre-existing conditions.

> *"I had many experiences, like they know that I have fibromyalgia and bipolar disorder, it's one or the other, it can't be anything else. Like I am going into the hospital saying my foot is really sore and they are like 'yeah maybe it's anxiety.' And I am going, no [then they said] 'maybe it's the fibromyalgia.' No, I fell and hurt my foot, can we please sort this out!"*

Alana, another disabled woman described how she was dismissed until her condition became undeniable:

> *"It's a complete absence of clinical diagnosis. I literally had to collapse on the floor for them to say that, 'Yes, you are in pain.' And it turned out to be cysts attaching things in all the wrong places. But up to that point, it was in my head."*

Phoebe, a migrant woman working with migrant women in Ireland, highlighted that women who have experienced traumatic sexual experiences, including Female Genital Mutilation (FGM), face significant barriers in accessing culturally appropriate, trauma-informed care. She further highlighted how inadequate support can prevent women from undergoing essential procedures,

> *"There is a huge barrier in terms of cultural appropriateness and trauma-informed kind of assessments and supports. We have had women go in for procedures such as cervical cancer screening, and then they fail to go through it because of the trauma, they just walk out and say, 'I can't do this anymore, let's go back.'"*

Bridget, a migrant woman experiencing homelessness reflected on the lack of trauma-informed care she had recently received in a maternity hospital: *"They treated me so badly, and I have a very extensive complaint about the hospital that was horrendous. I am traumatised."* Bridget highlighted how a lack of trauma-informed bereavement supports affected her when she had to go to go back to the maternity hospital for post-delivery follow ups after losing her baby:

> *"In [country of origin] we have sort of general hospitals that would do everything, maternity is part of the main general hospital. Here there is a separate building for like anything gyno or after giving birth you have to go to the maternity hospital, where there are pregnant women and lots and lots of babies."*

Conclusion

The testimonies shared with respect to acceptability of healthcare services highlight some deep-rooted systemic issues with respect to nearly all forms of discrimination, resulting in exclusion and a lack of gender-sensitive care within the healthcare system. Women from minority ethnic backgrounds, disabled women, LGBTQ+ individuals, and young and older women all recounted experiences of bias, dismissal, and systemic barriers to equitable treatment. These accounts reveal a healthcare system that often fails to respond in a way that upholds the Public Sector Duty with respect to non-discrimination.

4. Quality

In this context, quality refers to the standard of care provided by health services, including the necessary skills and training of service providers and the appropriateness of the healthcare environment. It also refers to the responsiveness of services and supports patient feedback and complaints.

4.1 Complaints & Feedback

A recurring theme within the listening sessions was women's dissatisfaction with complaints processes. This ranged from testimonies about people not knowing how to make a complaint, to people who had made one with no follow up, and women who spoke about their fear of making a complaint in case it impacted on their care. The latter was particularly true for migrant women who were living in Direct Provision centres, who feared speaking up could negatively affect their asylum process. As Gloria put it, *"There are people in the asylum process who feel that if they tell the manager [about healthcare complaints], then maybe my asylum will be affected."*

Aoife, a member of the LGBTQ+ community we spoke to, explained,

> *"It's really hard to make a complaint because you may feel, you are speaking up for, advocating for may very well suffer as a result and it can be really difficult to know where to complain."*

She shared her own experience of trying to escalate a complaint within the healthcare system,

> *"I made a complaint in one of our very big public hospitals here for something that happened to me and nothing happened. So, I wrote and made a verbal complaint to one of the senior managers and I thought that is not good enough, so I actually wrote to them and put it in an envelope with a stamp and sent it because I thought an email could go amiss. I didn't hear anything back, so I wrote again and asked for at least an acknowledgement that they received the letter, but I never heard back."*

Despite her repeated efforts, she never received a response, an experience echoed by other participants.

Bridget shared her frustration about being ignored when trying to raise concerns about her daughter's treatment in a NICU. "*I asked them how do you make a complaint; they said do it online, I said I don't have internet service, they said do it online, I said [you're] not listening, are you?"* Despite explaining that she was homeless and had no internet access, Bridget was told an online form was the best way to make her complaint.

Eilish also spoke about her negative experience when she filed a complaint,

> *"I have an experience where I was seeing a psychiatrist and I had to make a complaint about what was said to me, and it made me afraid to go and make another complaint because that person [psychiatrist] decided to ring and ask – not ask, basically demand – that I take back my complaint. Like, how would you trust that person again, or make a complaint, or how would you ever feel safe around that person again and tell them what's going on in your life?"*

Fiadh, reflected on the barriers to lodging complaints at the Collective Event, she highlighted how even existing support services were difficult to navigate,

> *"The Patient Advocacy Service (PAS), just for an example, is very hard to navigate, and I don't think they are very well placed to understand the lived experience of people making a complaint. They actually don't know how to put it through because they usually pass the buck to somebody else."*

This inability to lodge a complaint or receive a response negatively impacted the trust women had in the health service. As Sorcha described her experience of submitting several complaints without hearing a response:

> *"If you [the health service] don't want to help me and listen to the fact I'm not liking this medication and how it's not helping, then why am I bothering...I felt let down, didn't really trust the service."*

The accessibility of any complaints systems also needs to be considered in the context of the English language and low literacy concerns that emerged in the previous section.

4.2 Lack of Necessary Training and Skills

A key finding with respect to the perceived quality of services was the lack of appropriate training and skills by employees and healthcare providers. This point was broader than just clinicians, but extended to all staff, as Laoise explained:

> *"In training often times, it is the most overlooked thing, admin and support staff not being trained and in reality, those are often people you talk to the most!"*

Participants demonstrated this in stories ranging from A&E medical staff to those working in hospital security or in administrative positions. These experiences highlighted the lack of dedicated training and accountability in gender-sensitive approaches, trauma-informed care, anti-racist and inclusive approaches, and the specific needs of Traveller women, Roma women, migrant women, disabled women, and those in the LGBTQ+ community, among others.

Phoebe, a migrant woman, pointed out the importance of culturally sensitive approaches when providing sexual and reproductive services, saying,

> *"Cultural appropriateness especially when dealing with migrant women... for example, if you went for sexual and reproductive services, some of the questions are legitimate, they should be asked but they should be packaged in a certain way to address the cultural sensitivity around migrant communities."*

Gloria echoed this concern, adding, "*Doctors, nurses need to be aware of the diverse individual in the country."*

For disabled women, there is a significant gap in understanding the social model of disability. Helen, a disabled woman, explained,

> *"When we are accessing healthcare services and surgeries, it needs to be centred around informed consent, there needs to be training around the social model of disability, we start from the medical model, I know for me, I do not need to be fixed, I do not need to be cured, I love my body, I am perfectly fine, I am happy in it."*

The medical model often views disability as something to be cured, whereas the social model recognises that disability arises from societal barriers, not individual impairments.

Furthermore, Helen emphasised the need for better training for healthcare professionals on disability equality, stating,

> *"Disability awareness training is not effective, it focuses on the impairment, impairment is an individual experience, disability is a universal experience... getting young, training, healthcare professionals, doctors, nurses disability equality training needs to be delivered by DPOs."*[2]

Conclusion

The quality of healthcare services was a significant concern for the participants. Inadequate training in gender-sensitive approaches, lack of cultural sensitivity and competency, and a perceived lack of transparency and effectiveness of feedback and complaints processes.

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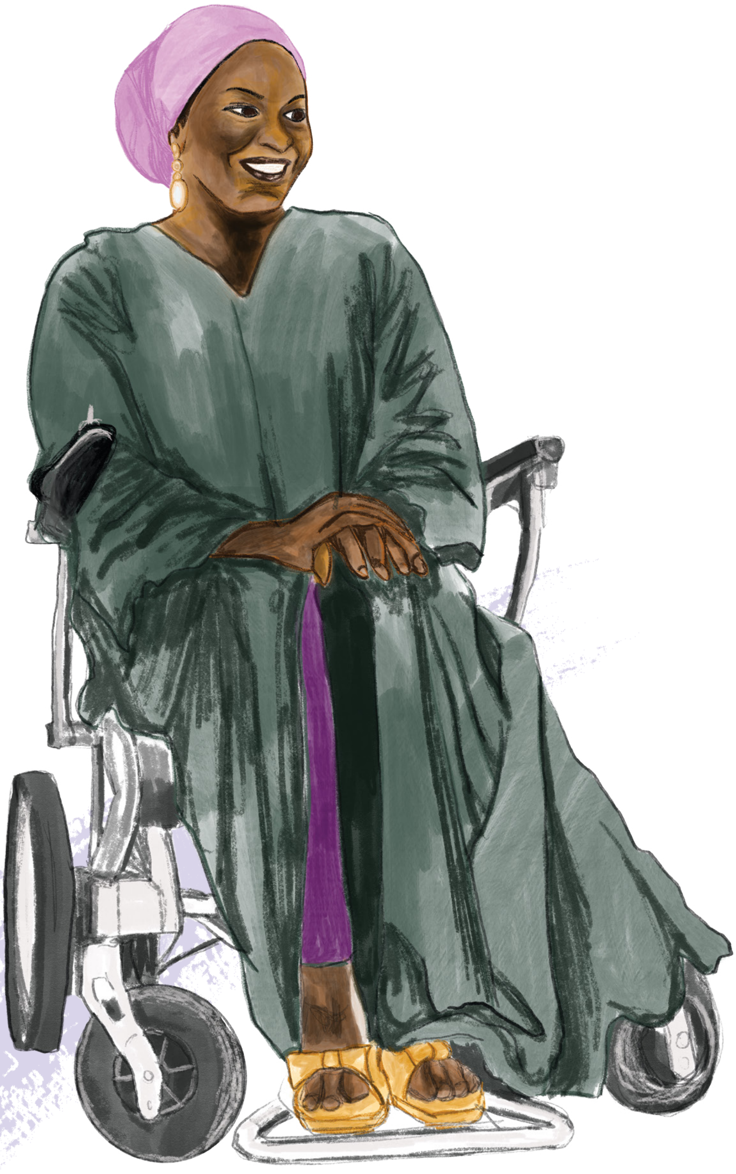
[2] DPOs, or Disabled Persons' Organisations, are groups that focus on promoting the rights and inclusion of disabled individuals. They play a crucial role in providing training and education to healthcare professionals on the lived experiences of disabled people, ensuring a more inclusive and equitable healthcare environment.

Conclusion



Conclusion

Using the AAAQ framework, this report highlights key experiences of healthcare as voiced by priority groups of women in health policy in Ireland.

The 73 women who took part in listening sessions and in-depth interviews shared their experiences of limited-service availability, with gaps in primary care, trans-inclusive healthcare, and gender-sensitive services. Many spoke about the difficulty of navigating services that were designed with a "one-size-fits-all" approach, which made certain women's health services like publicly funded IVF and cancer screenings incongruent with the needs of Traveller and Roma communities. This inaccessibility of certain services and supports was echoed by disabled women, in addition to women who struggled to navigate the health system due to literacy and language barriers. There were also accounts of various forms of discrimination, ranging from ageism, racism, and transphobia. Finally, concerns about quality were evident in accounts of inadequate training, culturally insensitive care, and inaccessible complaints processes.

The findings suggest the need for targeted and mainstream interventions that address these systemic inequities. This could include increased investment in community-based and culturally competent services, in addition to enhanced training for healthcare staff. It is important to acknowledge that participants in this research largely focused on where they saw the gaps in care to be. While this does not mean that all services fail to meet the needs of women, it does highlight ongoing disparities and the need for continued evaluation and improvement.

While this report identifies pressing challenges, it also presents an opportunity: by addressing the barriers outlined here, policymakers, healthcare providers, and advocacy organisations can build a more inclusive, responsive, and effective healthcare system – one that ensures all women, particularly those most at risk of exclusion, receive inclusive care.

Key Areas for Change – In Women's Own Words

Women who took part in this project identified recurring values that they wanted to see in their health services and supports. While the HSE already commits itself to providing a service that is underpinned by values of "Care", "Compassion", "Trust" and "Learning", the following additional values and next steps were proposed:

Value 1: Universality – Equal Access for Every Woman

Women spoke of wanting a health system that's there for them when and where they need it, not based on how much money they have. Women identified that this could be achieved through the rollout of Sláintecare.

What women said should happen next:

1. Make women's healthcare free. Build on existing supports like the free HRT arrangement and the Free Contraception Scheme, in addition to developing new women's health services and initiatives.
2. Make it easier to get health services in our communities – including realising Sláintecare, expanding primary care capacity and community health services.
3. While we wait for the full rollout of Sláintecare, address the gaps for groups like Roma women who can't get a medical card. Also, make it possible for migrant women who've been turned down by multiple GPs to be assigned one by the HSE, similar to the current system for medical card holders.
4. Create an informed consent model for trans healthcare, which would mean trans women get access to gender-affirming care without unnecessary barriers.

Value 2: Equity – Meeting Women Where They're At

Women said they wanted the health system to recognise how barriers to housing, employment, education, racism and discrimination affect their health.

What woman said should happen next:

1. Make sure the next Women's Health Action Plan looks at women's health inequalities through a gender-sensitive and intersectional lens, by further acknowledging that not all women in Ireland have equal access to health services. This focus on the needs of women in their diversity could also be further reflected in the membership of the Women's Health Taskforce, which would support its continued work with the priority groups in this report.
2. Take action to improve the health outcomes of women most impacted by health inequalities – this should include resourcing and strengthening organisations and community-led initiatives that already support these women – e.g., Traveller Primary Health Care Projects.
3. Integrate women's health policies with broader national strategies, including:
   - The National Traveller Health Action Plan
   - The National Action Plan Against Racism
   - The National Strategy for Women & Girls

  - The Third National Strategy on Domestic, Sexual, and Gender-Based Violence
  - Sharing the Vision: A Mental Health Policy for Everyone

Value 3: Accessibility – Information and Services That Women Can Use

Women want health services and information that are clear, inclusive, and easy for everyone to understand and access.

What woman said should happen next:

1. Co-produce and design information materials with women and share widely across diverse communities. Make sure they're written in plain English, translated into different languages, and available in easy-read or other accessible ways.
2. Provide good quality interpretation services for anyone who needs them in healthcare, making sure that women know they have the right to ask for this service.
3. Make all public health infrastructure – including hospitals, screening equipment, and healthcare facilities – fully accessible to all, with a focus on the needs of disabled persons.

Value 4: Respect & Inclusivity – Healthcare Workers Who Understand and Reflect Women's Needs

Women want to be treated with respect by people who are properly trained and committed to delivering care that is free from discrimination. Services should actively recognise and respond to the diverse experiences, identities, and needs of all women, ensuring that care is inclusive, person-centred, and free from bias.

What woman said should happen next:

1. Make training in gender-sensitive, trauma-informed, and anti-racism and discrimination compulsory for everyone working in healthcare – when they initially train and throughout their careers. Work with organisations representing priority groups of women to design and deliver this training. Make sure training includes areas such as:
   - The Public Sector Duty
   - Gender-sensitive healthcare approaches
   - Social determinants of health
   - The social model of disability
   - Addressing racism and structural discrimination in healthcare
2. Ensure healthcare staff are trained to provide, respectful, informed and inclusive care to trans women.

3. Proactively ensure the staff in healthcare settings reflect Ireland's diversity. Create fair job opportunities for underrepresented groups like Traveller and Roma women, disabled women, and migrant communities by improving access to jobs. Support them with inclusive recruitment and training processes.

Value 5: Accountability – A System That Listens, Learns, & Improves

Women want a healthcare system that actively collects and uses information and feedback to improve services.

What woman said should happen next:

1. Ensure equality data is collected in all health and social care services. This means gathering information about people's backgrounds – such as ethnicity, gender, disability, and other characteristics – so services can better understand who is using them, who is being left out, and how to make healthcare access experience and outcomes fairer for everyone.

2. Analyse and publish this data regularly to show where inequalities exist and how they are being addressed – this could relate to data on gender, ethnicity, disability – and other factors contributing to healthcare inequalities.

3. Make sure every health service has a clear and accessible way for women to give feedback and make complaints. This should be simple to use, well publicised, and result in meaningful follow-up.

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