An Investigation into Women's Experiences of the Free Contraception Scheme

Research Report

National Women's Council

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An Roinn Sláinte
Department of Health

Citation: Sweeney, L-A., Flynn, S., Callan, A. and Nudo, M. (2026) An Investigation into Women's Experiences of the Free Contraception Scheme: Research Project Report. **Ireland:** The National Women's Council.

Table of contents

List of tables

Table of figures

List of abbreviations

BIPOC: Black, Indigenous, and People of Colour

CAMHS: Child and Adolescent Mental Health Services

DSGBV: Domestic, Sexual and Gender-Based Violence

DPO: Disabled Persons Organisation

FCS: Free Contraception Scheme

OCP: Oral Contraceptive Pill

FGM: Female Genital Mutilation

GP: General Practitioner

HCP: Healthcare Provider

HSE: Health Service Executive

IPAS: International Protection Accommodation Service

IUD: Intrauterine Devices

IUS: Intrauterine Systems

LARCs: Long-Acting Reversible Contraceptive(S)

LGBTIQ+: Lesbian, Gay, Bisexual, Transgender, Intersex and Queer

NSHS: National Sexual Health Strategy, 2025-2035

NWC: National Women’s Council

NWIHP: National Women and Infants Health programme

PPSN: Personal Public Insurance Number

PTSD: Post Traumatic Stress Disorder

SATU: Sexual Assault Treatment Units

SRH: Sexual and Reproductive Health

Acknowledgements

The National Women’s Council, the Department of Health and Trinity College Dublin would like to acknowledge and thank the research team and the research advisory members for their support and work on this project. We are sincerely grateful for the input into this research from the participants who identified as from the Traveller community, migrant women, disabled women, and LGBTIQ+ people who graciously gave their time to the research and to women across the country who completed the survey. By sharing their awareness and experiences of the Free Contraception Scheme (FCS) and contraception more broadly, their commitment will endeavour to improve access to the FCS for all women in Ireland.

Research team

Name	Organisation	Role
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01. **Executive Summary**

1. Executive summary

1.1 Introduction

Access to contraception is a fundamental component of reproductive health and gender equality. In Ireland, despite significant progress in expanding access to free contraception, marginalised groups may face disproportionate barriers. This research sought to understand marginalised groups' awareness and knowledge of the Free Contraception Scheme (FCS) and their experiences of accessing contraception more broadly. This included disabled women, those from the Traveller community, migrant women and LGBTIQ+ people who require contraception. The research highlights key challenges, incorporates testimonies from women, based on their lived experience, and provides targeted recommendations to ensure equitable access to contraception for all women in the Republic of Ireland.

1.2 Methodology

Prior to commencing the empirical research for this study, a narrative literature review was completed to establish the background and context for the research. For the study overall, the principal research question was: *What awareness and experiences do contraception users from marginalised communities have of the Free Contraception Scheme?* After the literature review, we conducted the research using a survey and focus groups. A survey questionnaire was distributed to women aged 18-35 years to gather preliminary data on their experiences of the FCS to date. This was statistically analysed using Qualtrics software. Additionally, four focus groups were conducted to gather marginalised women's views and experiences with respect to the FCS. Focus group discussions were transcribed and thematically analysed.

We improved understanding of barriers to contraception access, by meeting the following objectives:

1. By gathering the experiences of a diverse group of contraception users from marginalised communities.
2. By establishing what the key factors are in the awareness held by marginalised community contraception users about the FCS.
3. By producing clear, actionable and realistic recommendations toward promoting awareness, engagement and quality in the provision of the FCS for marginalised communities.

1.3 Voices from the research

- Traveller woman:

  'It's individually personal, to say to a Traveller girl, you shouldn't have any more children, we are not God, God only blesses you with the children he thinks you should have, it's against our religion you know … we are all different, even though we all come from one culture, we are all different'

- Migrant woman:

  'The reason why, didn't get a chance to use it here, is because I don't have a GP, eh, it's been 3 years [In Ireland], I still don't have GP and just to have, or use the Scheme for the first time, you need to go through the GP'

- Disabled woman:

  'I'm obviously a disabled woman myself. I was born with my impairment. But I think for other disabled women, the assumption is that well, because of their impairment or their clinical label, well, you're not going to need to use the Free Contraception Scheme'

- LGBTIQ+ person:

  'I couldn't even say that my partner was trans. I knew not to mention it. I knew just to say 'right ok let's just use he - him pronouns, because if I had even brought up the idea of having a girlfriend at the time who was trans, my doctor wouldn't be able to wrap his head around it... so, I had to say my partner was a cis-man'

These testimonies illustrate systemic barriers, such as inaccessible systems and practices, stigmatising cultural and social discrimination, and barriers to effective healthcare. Urgent policy and service reform is needed to address these barriers, also noting that significant challenges may arise in seeking to remove these barriers.

1.4 Key challenges

1. **Eligibility gaps:** Age-based schemes exclude older women from 36 upwards. Additionally, the scheme excludes undocumented migrants, asylum seekers and International Protection Accommodation Service (IPAS) residents.

2. **Cultural and linguistic barriers:** Limited provision of materials in accessible languages and formats.

3. **Discrimination and stigma:** Negative and misinformed attitudes toward some marginalised groups among some healthcare providers.

4. **Geographical Barriers:** Rural communities can lack sufficient access to General Practitioners (GPs), specialist family planning clinics and other services pertaining to contraception needs and choice.

5. **Service capacity and access barriers:** GP shortages in some areas, long waiting times, limited appointments, inaccessible facilities or booking systems for people with disabilities, and fragmented referral pathways.

6. **Data gaps:** Limited research on contraception access among minority groups.

1.4 .1 Key findings

Key findings emerged from the survey and from the focus groups. The evidence from findings has led to the formulation of evidence-informed and evidence-based recommendations.

1.4.2 Key findings from the survey

- Marginalised women generally welcomed the Free Contraception Scheme.
- Key factors that contributed to marginalisation in women's lives included living with mental health difficulties (e.g., depression, anxiety, post traumatic stress disorder PTSD) (18%, n=167) and not having enough money or resources (17%, n=153). Common factors included living in a county or rural area with fewer services (10%, n=92), living with a long-term illness (9%, n=82), and being part of the LGBTIQ+ community (8%, n=69).
- The most commonly-used form of contraception identified by marginalised women was the oral contraceptive pill (39%, n=110) followed by the hormonal coil (intrauterine device) (23%, n=64).
- Nearly half of participants who identified as marginalised women said a reason for their choice of contraceptive was following their doctor's recommendation (47%, n=113) and/or that it helps with other health problems (46%, n=111). Other key reasons for choice of contraceptive including that the contraceptive worked for their lifestyle (39%, n=95) and was easy to use (39%, n=94).
- Over two-thirds (67%, n=163) of participants received their contraception via their GP.
- Nearly half of participants reported learning of the FCS on social media (46%, n=138) and/or online (41%, n=124).
- When asked about barriers to accessing the FCS, nearly half (44%, n=153) of participants thought there were no barriers to using the FCS, while 36% (n=127) thought that there were barriers, and 18% (n=63) were unsure if barriers existed.
- Sixty-nine per cent (n=216) participants cited no challenges or difficulties accessing the FCS, while 31% (n=99) participants reported experiencing challenges or difficulties.

1.4.3 Key findings from the Focus Groups

1) **Awareness of the FCS:**

- For Traveller and migrant communities, awareness is often built from information sharing within their communities about the FCS.
- Traveller and disabled women reported confusion about the relationship between medical cards and the FCS[1].
- Cultural values and beliefs may shape attitudes toward contraception, influencing awareness of and engagement with the FCS among Traveller and migrant women.

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[1] To note, the FCS enables access to free contraception for all women within the eligible age range. The Medical Card scheme is means-tested; for those eligible, it enables access to medical appointments free of charge and to prescriptions subject only to the €1.50 prescription charge. Women outside the age-range for the FCS, but who hold a medical card, can access contraception subject only to the prescription charge. Women who hold GP Visit cards can attend their GP free of charge but will be asked to pay for dispensing and medication/device costs at the pharmacy. Everyone ordinarily resident in Ireland is entitled to access the Drugs Payment Scheme, which can be used to limit family expenditure on medications and devices to €80 per month.

- Migrant women report low general awareness of the FCS.
- Disabled women highlighted how information on the FCS is often not available in a range of accessible formats for women with various impairments.
- For LGBTIQ+ people, universities were found to play an important role in spreading awareness of the FCS.

2) Accessing the FCS

- Migrant women spoke of exclusion from accessing the FCS for many reasons such as not having a PPSN or because of their migration status.
- Traveller women shared they had experienced stigma and prejudice from healthcare providers in the past which affected willingness to access the FCS.
- Disabled women explained how mobility, visual or other impairments often acted as a barrier in accessing healthcare providers and certain forms of contraceptives.
- Past medical traumas related to disabled women's impairment(s), migrant women's experiences of female genital mutilation[2] and LGBTIQ+ people's gender dysphoria treatments and supports were among reported impediments to accessing the FCS through healthcare providers.

3) Barriers to contraception

- Traveller, disabled and migrant women reported a reluctance amongst women within their communities to discuss contraception with male GPs.
- Reported barriers to accessing contraception included prejudicial views about disabled women held by some healthcare professionals, and deficits in the necessary equipment or skills to meet disabled women's specific needs.
- Impairment-related barriers to using contraception safely were reported, including the incompatibility of some medication, prescribed in connection with a disability, with prescription hormonal contraception.
- Traveller women discussed how women in their community do not prioritise their health in general with knock-on effects for contraception usage.
- LGBTIQ+ people reported intrusive questioning and prejudicial assumptions by healthcare providers (HCPs), which caused them to have concerns about homophobia or transphobia which subsequently acted as barriers to them seeking contraception and also created a sense of their needing to justify their use of contraception to HCPs.

4) Areas for improvement

- Traveller women suggested young girls should be provided with information in schools with an emphasis on culturally appropriate and age-appropriate information[3].

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[2] There are some services in Ireland available for survivors of female genital mutilation available through the Health Service Executive such as the Free FGM Treatment Service (ifpa.ie).

[3] To note, schools have significant supports in place as part of the Social, Personal and Health Education (SPHE) curriculum, under which Relationships and Sexuality Education is taught. However, additional resources specific to Traveller and Roma contexts may be helpful.

- LGBTIQ+ people and disabled women highlighted the need for better understanding of the distinction between medical and social dimensions of their healthcare.
- Traveller women discussed the need for solutions and ideas for meeting the contraception needs of women experiencing DSGBV and coercive control in their community.
- English language and literacy issues could be better supported for Traveller, Roma, and migrant women; these were perceived as barriers to accessing the FCS.
- More training, sensitivity and flexibility around language for conversing with LGBTIQ+ people is needed in healthcare[4].
- The importance of technological skills and digital literacy in accessing information on the FCS was noted as a barrier by Traveller women and LGBTIQ+ people and could be experienced as a significant barrier more widely.
- The need for a disability-aware and disability-sensitive approach to administration and delivery of the FCS was highlighted by disabled women.
- The eligible age-range for the FCS should be broadened, in line with policy commitments.

1.5 Recommendations

Recommendations arose from the evidence provided by this research project, which pertain to various thematic areas for improvement.

Policy and funding

- Extend the Free Contraception Scheme to include all people who need its provisions, regardless of age, and migration status.
- Guarantee sustained and expanded Government funding for equitable sexual and reproductive healthcare.

Service accessibility

- Widen provision of accessible information and services in multiple languages and formats to meet diverse needs.
- Widen provision of culturally sensitive and inclusive consultations with access to interpreters and women practitioners when preferred.
- To establish mobile and community-based contraception clinics for rural communities, and onsite clinics for IPAS centres housing asylum seekers.
- Improve access to GP services.

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[4] To note, our understanding is that training is available to GPs through the HSE National Social Inclusion Office, but it is voluntary and not mandatory.

Information and education

- Widen provision of culturally sensitive, multilingual resources.
- Further develop inclusive and targeted sexual health education and information for marginalised women and girls.
- Further develop partnerships with grassroots non-governmental organisations (NGOs) to deliver trusted community-based education and supports, with access to interpreters and information resources and audio/visual formats in a wider range of languages.

Equity and inclusion

- Develop the co-design of reproductive health strategies with community leaders.
- Ensure accessible formats for women with disabilities.
- Guarantee confidential, supportive and stigma-free care.

Healthcare provider training

- Implement initial and ongoing anti-racism, anti-bias, LGBTIQ+ inclusion, and cultural competency training for GPs, nurses, pharmacists and other relevant HCPs.

Monitoring and accountability

- Continue to collect and publish gender equality data on contraception in the context of existing and planned research initiatives such as repeated data collection under the Healthy Ireland Survey[5] or the nationally representative Irish National Survey on Sexual Health (INISH)[6]. These will provide disaggregated data on contraception access by gender, ethnicity, migration status, disability, LGBTIQ+, and socioeconomic status.
- Establish and enhance continuous, independent oversight mechanisms to monitor and evaluate equity in reproductive health.
- Further engage marginalised women in the design, implementation, and evaluation of reproductive health services.

1.6 Conclusion

Marginalised women's experiences make clear that contraception access in Ireland, while significantly improved, can still be shaped by various forms of inequality. Expanding equitable access is essential for Ireland to advance gender equality, reduce health disparities, and uphold human rights. By addressing systemic, cultural, and cost barriers that can result in exclusion risks, Ireland can create a reproductive healthcare system that is inclusive, just, and responsive to the needs of all women, as per the stated aims of the *National Sexual Health Strategy 2025-2035*.

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[5] Healthy Ireland Survey 2025

[6] https://www.universityofgalway.ie/inish/

02. **Introduction**

2. Introduction

The *Women's Health Action Plans*[7]*, 2022-2023 and 2024-2025*, recognised that marginalised women experience the most significant challenges when engaging with the health care system. The 2023-2024 Plan made specific commitments to rethinking how marginalised women can access healthcare in ways that are appropriate and convenient to them (Department of Health, 2022). Action 6D of the 2024-2025 Plan further specifies the requirement to *"engage with partners with a view to undertaking research into access to the contraception scheme amongst marginalised groups"* (Department of Health, 2024, p.39). This formed the basis for the commissioning of the present study, funded by the Department's Women's Health Fund.

By focusing our engagement on marginalised women, this research captured a diverse sample of women's experiences accessing the Free Contraception Scheme. In addition, the research provides further insights into barriers which may impede participant access to the Free Contraception Scheme, and how best to provide women with the necessary supports and improve their experience of the Scheme overall. In this context, our study specifically focuses on Traveller, migrant, disabled, and LGBTIQ+ women. The aim of the research was to investigate marginalised women's awareness and experiences of the Free Contraception Scheme in the Republic of Ireland and, in addition, to explore women's attitudes in Ireland towards contraception more broadly.

Note on the language used within the report:

- We acknowledge evolving limitations and criticisms around language on sex and gender in the light of changing recommendations and conventions.
- We use the term 'woman' and 'women' to refer to people who identify as women, and we recognise that transgender and non-binary people may have experiences relevant to discussions traditionally framed around women.
- We acknowledge the importance of language when referring to disability and accept that there are limitations documented in the literature surrounding all terms for disability and impairment. We conceptualise disability in a way that aligns with a social model of disability, thus disability arises from interactions between a woman's impairment(s) and societal and structural barriers to equality. To support this position, we use identity-first language (e.g., disabled women) to emphasise that disability is imposed on disabled women by inequality in society. We acknowledge, however that there are multiple valid ways in which disabled women can choose to identify. We use the term 'impairment' to refer to actual conditions, illnesses or injuries a woman has. We separate 'impairment' from 'disability' as the latter arises from discriminatory and unjust treatment and environments and/or the lack of necessary supports.

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[7] The *Women's Health Action Plans 2023-2024 and 2024-2025* aim to improve the health services and supports for women and girls across Ireland (Department of Health, 2022; 2024)

- We acknowledge the conceptual limitations of the term “marginalised women.” The term is used here as a pragmatic shorthand to refer to women who experience systemic and structural inequalities that impact their access to, and experiences within the health system. We recognise that many women may not personally identify with this descriptor. For example: terms could include ‘racialised’ or ‘minority ethnic’ for migrant women, and the term marginalisation can risk oversimplifying the complexity and diversity of women’s lives. However, in the context of policy and research, it provides a useful, if imperfect, framing to highlight how intersecting social, economic, and structural factors can create disadvantage and exclusion within health systems.
- We use the term ‘domestic, sexual and gender-based violence’ (DSGBV) in line with the HSE Policy on Domestic, Sexual and Gender Based Violence (2010, p.11) to refer to physical and non-physical violence and abuse perpetrated in these contexts against any gender.

2.1 Research preface

This project results from an Action set out in the *Women’s Health Action Plan 2024-2025, Phase 2, An Evolution in Women’s Health*, as follows: “Action 6D: We will engage with partners with a view to undertaking research into access to the Free Contraception Scheme amongst marginalised groups”. This project, funded by the Department of Health’s Women’s Health Fund, is a collaboration between the National Women’s Council and Trinity College Dublin.

The National Women’s Council (NWC) is the leading representative organisation working for women’s rights and equality across the island of Ireland, founded in 1973. NWC work together with almost 200 member groups across Ireland and a growing community of individual supporters to deliver on their purpose to achieve women’s rights and equality. NWC is a feminist organisation, and they define feminism as a movement striving for the social, cultural, political, and economic equality of women and men. The School of Social Work and Social Policy at Trinity College Dublin is an established centre of research and innovation.

Together, the project partners share a vision and commitment to improving sexual reproductive healthcare and reproductive rights for marginalised groups in society. We are committed to using robust information and peer-led data to strive for social change. An Advisory Committee of experts from not-for-profit and governmental organisations in the Republic of Ireland, with experience of working directly with communities of marginalised women was also formed to advise on conducting the research.

2.2 Research advisory

Name	Organisation	Project Role
Doireann Crosson	National Women's Council	Chair/Project Advisory
Dr Paula Pinzon Hernandez	National Women's Council	Chair/Project Advisory
Kate Mitchell	National Women's Council	Project Advisory
Maya Tsapayi	National Women's Council	Project Advisory
Poushali Kundu	National Women's Council	Project Advisory
Dr Catherine Conlon	Trinity College Dublin	Project Advisory
Dr Fiona Mansergh	Department of Health	Project Advisory
Cathal Gaynor	Department of Health	Project Advisory
Dr Nicola O'Connell	Health Service Executive	Project Advisory
Anne Burke	AkiDwA	Project Advisory
Binta Kyauta Salam	AkiDwA	Project Advisory
Marie Mongan	Donegal Traveller Project	Project Advisory
Julia Splopecka	Dublin Well Woman	Project Advisory

03. **Context**

3. Context

3.1 Review of recent research and academic literature

Contraception is important to women's physical, mental and social well-being, both to support family planning choices, but also to manage a range of adverse menstrual symptoms, for which hormonal contraception is also effective. However, research, particularly involving women from minority ethnic or marginalised groups, remains limited. This gap in the literature is significant, as health is not solely defined by physical markers but also by the broader social factors that shape a person's well-being (World Health Organisation, 2025).

The social construction of health has evolved to encompass physical, mental, spiritual, and social dimensions rather than simply the absence of disease or infirmity (Schramme, 2016; World Health Organisation, 2025). This perspective is particularly relevant for marginalised women, whose experiences of poverty, discrimination, and restricted access to resources profoundly affect every aspect of their health.

Notably, while gender shapes the health experiences of everyone, discrimination against women results in health disparities across nearly all societies, including the Republic of Ireland (Doherty, 2019). For example, studies found that many women's voices highlighted feeling dismissed, encountering barriers to access, and experiencing unequal treatment within Irish healthcare services, particularly among marginalised groups such as migrant, Traveller, Roma, and disabled women and pointing to persistent inequities in how women's health needs are understood and addressed in the Irish health system (Department of Health & National Women's Council of Ireland, 2025).

Whilst change is needed to resolve inequalities, it is also important to note positive strides made in enhancing equality within Irish healthcare provision, and to acknowledge that health disparities and inequalities are experienced across all genders and identities. However, the primary purpose of this report is to explore those experienced by women, with efforts made to capture experiences from women in all their diversity in both the survey and focus groups.

Prescription contraception is currently limited to methods designed for cis-gender women; research to develop a "male Pill" has been undertaken but no successful products have been made widely available to date. Women require full access to contraception and the freedom to choose their preferred method to protect their sexual and reproductive health (Congy et al., 2023). Women's use of contraception often also supports their partner's family planning choices as well as their own; the wider benefits of schemes such as the FCS are not restricted to women.

Recognising the importance of this, the United Nations considers universal access to contraceptive care to be a key initiative for achieving the Sustainable Development Goals by 2030 (Starbird et al., 2016). Despite this global priority, the availability of contraception services continues to vary significantly across countries (United Nations, 2013). In recent years, free access to contraception has emerged as a leading topic of discussion internationally. A number of countries, including the United States of America (see Darney et al., 2020), the United Kingdom (see Bentley et al. 2017), Norway (Sæbø & Skjeldestad, 2024), Sweden (Envall et al. 2022) and Spain (Ortiz-Gómez & Ignaciuk, 2016) provide free contraception through national schemes. It is also important to recognise that access to contraception occurs in a wider context of decreased choice for people of all genders in making decisions about family planning (Kantorová et al., 2025).

In the Irish context, the 2019 Report of the Working Group on Access to Contraception identified several key challenges affecting equitable access to contraception in Ireland. While overall usage rates were stable, many individuals, particularly young people, those in rural areas, and marginalised communities faced significant barriers, including cost, lack of local services, embarrassment, limited information, and workforce constraints.

The report emphasised that cost not only restricted access for some but also influenced the type of contraception chosen, often discouraging the uptake of more effective long-acting methods.

Long-acting reversible contraceptives (LARCs), which include sub-dermal implants, intra-uterine devices such as the copper coil and intra-uterine systems (hormonal coils) are actually cheaper over their lifetimes than the Pill (LARCs typically last 3-7 years, depending on the device). However, consultation, dispensing and device costs, insertion, and checks typically present large up-front costs of between €300 - €400 euro for patients not eligible for State schemes. Removal costs, on expiry, are also significant.

Recognising issues and barriers including, but not limited to cost, the group recommended a comprehensive, state-funded contraception scheme. These findings laid the groundwork for the Free Contraception Scheme, which was launched in 2022 and sequentially expanded subsequently (Department of Health, 2025).

Current access to contraception in Ireland

Free Contraception Scheme (FCS)

From the 14th of September 2022, contraception was made freely available in Ireland to women ordinarily resident in Ireland and aged between 17 and 25. The scheme was initially supported by a €7.1 million allocation in the 2022 Budget under the *Women's Health Action Plan 2022–2023* (Department of Health. 2022, p.4). This initiative aimed to enhance all aspects of women's healthcare, including access to GP consultations, emergency contraception, LARCs, intrauterine systems (IUS) and devices (IUDs), contraceptive injections, the contraceptive patch, and combined oral contraception (the pill).

The FCS is currently open to 17–35-year-olds, inclusive, with policy commitments to expand the scheme further in due course. The FCS is open to women, transgender or non-binary individuals, who are ordinarily resident in Ireland, hold a Personal Public Insurance Number (PPSN) to access services, and for whom prescription contraception is deemed suitable by their doctors.

Approximately 2,450 GPs and just under 2,000 pharmacies have provided services under the Scheme up to November, 2025, with approximately 223,000 women accessing the service in 2024[8]. The annual budget for the scheme in 2026 is approximately €44m. Contraceptive options available under the FCS are all available on prescription and included in the Re-Imbursement List (Health Service Executive, 2024). Contraception options included on the HSE Re-Imbursement List[9] are made available free of charge under the FCS and, subject only to the €1.50 prescription charge, to those who hold means-tested General Medical Scheme (GMS) cards (also known as medical cards). Options include combined, progestogen only and emergency oral contraceptive pills, the contraceptive patch and ring, implants, hormonal and copper coils and contraceptive injections.

Emergency contraception (the morning-after pill) is accessible under the FCS through pharmacies without needing to first attend a GP. Emergency contraception in the form of coil insertion is available in sexual assault treatment units (SATUs), family planning clinics and from GPs who have undertaken the specialist training to enable insertion, checks and removal of long-acting reversible contraceptives.

Long-acting reversible contraception

LARCs, such as intrauterine devices (IUDs) and contraceptive implants, are documented to be highly effective, with failure rates of less than 1% per annum[10] and they are easily reversible. Moreover, implants and hormonal coils are very effective in treating adverse menstrual symptoms such as period pain or heavy bleeding, often stopping periods entirely while in use. However, despite their advantages, uptake remains relatively low in Ireland (Sweeney et al., 2015), despite the removal of cost barriers for those with access to free contraception, for a myriad of reasons which the research addresses.

Barrier methods of contraception and other family planning supports

The FCS does not include non-prescription barrier methods such as condoms, spermicide and diaphragms; condoms in particular are sold in many retail outlets and are not restricted to pharmacies, meaning that a different mechanism must be used to distribute these, free of charge.

The **National Condom Distribution Scheme** supports both STI prevention and accessible non-prescription contraception. Free condoms can be accessed through the national network of STI clinics, participating charities and NGO partners and on participating 3rd level campuses. Since 2023, free condoms have also been supplied with orders for free home STI testing kits. The NCDS is open to those aged 17 and above. Over 1.2m condoms were distributed in 2025.

Permanent options such as sterilisation (tubal ligation and vasectomy), are available in Ireland, but not currently covered under specific schemes (HSE, 2024; McConnell, McConnell & O'Donoghue, 2021; Irish Family Planning Association, 2024), although the National Sexual Health Strategy commits to scoping further access to these services. Advice can be provided on natural family planning methods such as fertility awareness and withdrawal, if needed.

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[8] Dept of Health figures
[9] https://www.sspcrs.ie/druglist/pub
[10] National Sexual Health Strategy, 2025 – 2035

Research on access to contraception in Ireland

The 2025 Healthy Ireland Survey examined awareness and use of contraception in Ireland, also assessing awareness of the Free Contraception Scheme. The Healthy Ireland Survey, delivered annually since 2015, is a nationally representative Survey of approximately 7,500 respondents, carried out on behalf of the Department of Health by Ipsos Ireland.

The Survey found that 45% of heterosexual women aged 18 to 55 were not currently using any form of contraception. Six to seven per cent of women aged 25-44, and three percent overall, reported not using contraception as they were trying to conceive (Healthy Ireland, 2025[11]).

Of those using contraception, prescription contraceptives were most popular (25%). The contraceptive pill was used by 11%, with hormonal coils used by 7% and implants and copper coils used by 3% each, with the patch, ring and injection used by less than 1% in each case. Condoms were used by 9% of women and sterilisation by 2%. Changes in needs and preferences were noted with different age-cohorts.

The Survey found that LARC use varies across age-cohorts, rising slightly with age. 13% of people aged 18-34 and 15% of people aged 35-54 report using LARCs. Looking at responses from women alone, LARC uptake is highest in women aged 45-54, at 22%, and lowest, at 17-18% in 25-44 year-olds, of whom 6-7% report not using any forms of contraception as they are trying to conceive[12]. To note, the use of combined hormonal contraception is not clinically recommended after the age of 50 (and can be stopped earlier where significant risk factors are identified, e.g. smoking, where use is restricted after 35). Options for women aged 50 and over are therefore reduced to progesterone only Pills and LARCs.

Sixty-one per cent of respondents overall were aware of the Free Contraception Scheme, with more women (75%) than men (46%) aware. Within the eligible age-range, however, 86% of 18-25s and 74% of 26-35s were aware of the scheme and 49% and 36% of the same age-cohorts had been accessing it.

Demographics of the Republic of Ireland

The resident population of Ireland was estimated at approximately 5.46 million (CSO Population Estimates, 2025), of whom 4.57 million (83.7%) were Irish citizens. Similarly, the 2022 National Census had found that 84% of people resident in Ireland held either Irish citizenship alone or dual citizenship.

However, while population proportions have remained relatively steady, Ireland has benefitted from significant population growth since 2022, increasing from 5.15 million as measured by the Census in 2022, to 5.46 million in April 2025. Migration is a more significant contributor to population growth than natural increase in recent years but includes a significant level of return by Irish people previously resident abroad.

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[11] Healthy Ireland Survey 2025

[12] https://www.gov.ie/en/healthy-ireland/publications/healthy-ireland-survey-2025/

In terms of ethnicity, the 2022 Census found that 87% of people identified as "White or White-Irish". This included Traveller and Roma populations, who represented just under 1% of the total population in aggregate. 1.5% of the population identified as Black or Black Irish, with just under 4% identifying as Asian (including both East Asia and the Indian sub-continent) or Arab. The remaining 7% either identified as mixed background or did not provide a background (Central Statistics Office, Census 2022[13]).

In summary, given significant demographic increase in recent years, it can be noted that the health service now has significant responsibility to care for and include many Irish residents who may not have grown up within Ireland, whose first language may not be English and who may not be familiar with navigating the healthcare system.

The Health Service Executive also highlights other groups who often experience social exclusion, such as disabled people, older people, lone parents, low-income individuals, people experiencing homelessness, addiction, and the criminal justice system, all of whom can face discrimination and limited access to resources (Health Service Executive, 2010).

While the HSE National Social Inclusion Office (NSIO) works to make sure that people in vulnerable groups have an equal level of access to health services, there is always a need, in the context of rapid demographic change, for targeted policies and interventions to reach out to new groups, including those at risk of marginalisation, and try to address their specific needs, evolving with the changing context.

Also significant are the needs of LGBTIQ+ people. The National Social Inclusion Office (2021, p.14), for instance, highlights the relevance and importance of free contraception to trans and non-binary people. In addition to the continued relevance of contraception for the purposes of birth control and family planning, which can be of relevance for LGBTIQ+ people in some of their relationships (see examples below), hormonal contraception also plays an important role in managing menstrual symptoms and gynaecological conditions.

The overarching aim of this narrative review research is to examine marginalised groups' awareness and experiences of the Free Contraception Scheme to date, while also exploring broader attitudes towards contraception.

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[13] Migration and Diversity Census of Population 2022 - Summary Results - Central Statistics Office

3.2 Narrative literature review method

A narrative literature review provides a structured yet flexible approach for critically examining and synthesising existing research on a specific topic. The aim of the narrative review is to establish the context and background of the study and to ensure that the study is informed by up-to-date literature in advance of commencing the empirical data collection work through the survey and focus groups. Unlike systematic reviews, which adhere to rigid inclusion criteria and methodological protocols, narrative reviews allow for interpretive depth and adaptability, making them especially well-suited for investigating complex, evolving, or under-researched issues (Baumeister & Leary, 1997). Drawing on this approach, the present review explores the barriers experienced by marginalised women in accessing contraception under the Free Contraception Scheme.

A structured search of Social Services Abstracts, PubMed, and JSTOR was conducted using keywords such as "marginalised women," "contraceptive access," "barriers to contraception," and "Ireland." The strategy, developed in collaboration with an academic librarian at Trinity College Dublin, ensured a comprehensive and targeted approach. An overview is presented in Figure 1. This search was supplemented by grey literature searches to overcome 'file drawer problem' or 'publication bias's (Silverman, 2020).

Thematic analysis was employed to identify recurring challenges, including cost, stigma, and structural barriers. As no primary data were collected, ethical approval was not required for this secondary analysis.

Search Strategy

Search Concept	Keywords/Terms
Population	"marginalised women" OR "disadvantaged women" OR "vulnerable women" OR "at-risk women" OR "women in poverty" OR "socially excluded women" OR "women from minority groups" OR "women facing discrimination"
Barrier/Access Concepts	"access barriers" OR "barriers to healthcare access" OR "barriers to contraception" OR "contraceptive access" OR "healthcare inequality" OR "health access barriers" OR "reproductive health access" OR "contraceptive service barriers" OR "social barriers to healthcare" OR "health equity" OR "equity in healthcare" OR "equitable health" OR "health inequality"
Intervention/Program	"free contraception scheme" OR "free contraceptive services" OR "state-funded contraception" OR "public contraception scheme" OR "contraceptive program" OR "government-provided contraception"
Geographic Context	"Republic of Ireland" OR "Ireland" OR "Eire"

3.3 Contributing factors

Factors that contribute to marginalised women's access to the Free Contraception Service

Barriers for marginalised women extend beyond financial barriers and affect access to the Free Contraception Scheme. Significant differences exist between the views of contraceptive users, general practitioners, and pharmacists regarding prescription contraception. For instance, in regions experiencing higher social deprivation, women continue to face challenges in exercising autonomy over their reproductive health (Sweeney et al., 2015).

Where contraception may be free, or available at low cost, for those eligible for various Government schemes including the FCS, medical and GP Visit cards, not all women have equal choice when deciding on their GP. For example, women living in direct provision, women living in emergency accommodation, women of lower socio-economic status holding medical cards, women living in rural areas, and Traveller women are often allocated a GP, which may significantly impact on their experience and options (Sweeney et al, 2015).

While eligibility and access routes can be complex, it is important to note that some emergency and interim provision is available. Access to free contraception, funded through an FCS allocation, is now available through the National Women and Infants Health Programme (NWIHP), in maternity units, hospitals, postnatal clinics, and SATUs for patients. These include people attending postnatal or post-termination of pregnancy appointments, those accessing SATUs in emergency situations, and those facing barriers to accessing contraception through primary care or facing other social challenges that limit access (e.g., variously, transport problems, GP access or shortages, childcare availability, caring responsibilities, remote living, DSGBV). Care is provided irrespective of status or ability to pay.

Similar avenues for accessing free contraception are in place with the Women's Health Service, which supports women working in the sex trade. Since 2024, the Women's Health Service has been supported in offering GP clinics that provide prescription contraception, including long-acting reversible contraceptives (LARCs), to patients under the Free Contraception Scheme. This measure ensures access to essential sexual and reproductive healthcare, and to reliable methods of hormonal contraception in addition to condoms. These pathways offer limited but critical access to care, particularly in urgent or high-risk situations, and operate alongside mainstream access to the Scheme through Primary Care.

Cultural barriers exist in Ireland for many women when discussing or seeking contraception advice and options (Conlon 2012; D'Souza, 2022). Some of these factors remain for women accessing emergency contraception also. From previous research, we found that young women in rural areas were less likely to access emergency contraception from their GP or pharmacist as they may know them in the community (Sweeney et al, 2015). Barriers also include preference to access a female GP in rural locations.

Moreover, evidence suggests that GPs and pharmacists can often assume that adherence is good when using the oral contraceptive pill and that contraception users fully understand the implications of their chosen method. Yet a documented rise in gastrointestinal conditions (e.g. inflammatory bowel disease, colitis, Crohn's disease, poorly controlled coeliac disease, irritable bowel syndrome, allergies and intolerances, in addition to seasonal infections such as norovirus) means absorption of ingested oral medication can be compromised, particularly in those experiencing vomiting or diarrhoea on a regular basis; IBS alone may affect as many as 20% of the population (Stillhart et al., 2020). This is one example of many reasons that oral medication efficacy can be negatively affected (non-oral options such as the patch or ring, or LARCs would be recommended in such instances).

These factors are particularly relevant in the context of marginalised women accessing the Free Contraception Scheme (FCS), as socially excluded groups are more likely to experience chronic health conditions, barriers to continuous primary care, and inconsistent follow-up. Where healthcare access is fragmented, women may remain on oral contraception despite reduced efficacy, increasing the risk of unintended pregnancy. Ensuring equitable access to information on the full range of contraceptive options available under the FCS and medical card schemes is therefore critical to addressing structural health inequalities, rather than simply providing free medication.

Misinformation can be an issue. Cycle-tracking and fertility awareness–based apps are frequently marketed, including on social media currently. While some digital fertility awareness methods report typical-use failure rates of approximately 7–8% (NICE, 2023), broader evidence on fertility awareness-based methods indicate typical-use failure rates closer to 24% per year, substantially higher than many other contraceptive methods (Polis et al, 2016; World Health Organization, 2018).

Over time, this equates to a high cumulative risk of unintended pregnancy when such methods are relied upon as sole contraception. These discrepancies underline the need for policy, counselling and public information to clearly distinguish between perfect-use claims and real-world effectiveness, and to support informed decision-making based on realistic risk profiles. However, ineffective communication with women about their prescription contraception can be an oversight because of factors like age, social status, legal status, language barriers and culture (Moos et al, 2003). This is significant given the known extent of non-adherence (Castano, 2013; Potter, 1996; Sweeney et al., 2015) and that the oral contraceptive pill remains the most prescribed form of contraception in Ireland (Sweeney et al., 2015; McGuiness & Foley, 2025; Healthy Ireland, 2025).

The intention is to support consideration of how certain complex and intersecting social, practical, economic and cultural factors may affect marginalised communities, in ways that both undermine and promote awareness and engagement with the Free Contraception Scheme. Marginalised groups experience unique challenges and factors pertaining to their engagement with contraceptive health care services. Socio-economic disadvantage of marginalised groups may affect education and knowledge also. Experiences of disadvantage may undermine trust in healthcare authorities, whilst structural health care disadvantage such as systemic oppression can have instrumental effects on experiences of and engagement with contraceptive care (Lodor & Solomon, 2022; Yee & Simon, 2011).

Traveller women

The Traveller community in Ireland is a small indigenous ethnic minority, distinguished from the settled population by its unique cultural values, language, and nomadic traditions (Reid et al., 2025). The most recent data from the Census of Population suggests that the Traveller community in Ireland is estimated to number over 32,949 (CSO, 2022). This community have a younger demographic profile than the general population, with their culture strongly influenced by patriarchy, Catholicism, and pro-natalist values that emphasise chastity for girls, early marriage, and motherhood (McGaughey, 2017). Despite their cultural richness, the Traveller community faces significant social exclusion and stigma, which can have detrimental effects on the sexual and overall health outcomes of Traveller women (Kavanagh & Lawless, 2006).

One of the most significant research studies in Ireland was based on self-reports from 9,056 Traveller families in the Republic of Ireland (ROI) and 1,562 in Northern Ireland (NI), totalling 10,618 families across the island. Among respondents in ROI, 40.8% reported having ever used the contraceptive pill. However, the study also highlighted critical barriers to accessing sexual health services, including lengthy waiting lists (62.7% in ROI), feelings of embarrassment (47.8%), and a lack of information (37.3%) (All Ireland Traveller Health Study, 2010).

Additionally, the language used in sexual health leaflets was found to require a higher literacy level, creating an additional barrier for early school leavers, young disabled women, and young Traveller women in understanding their contraception options (Kavanagh & Lawless, 2006)

In line with these findings, nationally representative data collected from 4,494 schoolchildren aged 15-18 years in Ireland reveals significant differences between Traveller and non-Traveller communities. Despite the small sample size for Traveller respondents (n = 38), the study shows that girls from Traveller communities reported significantly lower condom use at last intercourse compared to their non-Traveller peers (1.6% vs. 97.2%) (Young, Burke & Nic Gabhainn, 2018).

Similar issues emerged in Irish focus groups with 32 Travellers. This revealed widespread gaps in sexual health knowledge, with sex and sexuality remaining taboo topics. Travellers expressed a strong need for better contraception education and access. Young men were particularly concerned about preventing sexually transmitted infections (STIs), while women sought more information on family planning (McGaughey, 2017).

Progress in promoting Traveller sexual health has, however, been made through initiatives such as the Primary Health Care for Travellers Project (PHCTP). A core part of the work of predominately female Irish Traveller Primary Health Care Workers in the PHCTPs is to work toward empowering the Traveller community to access healthcare (Stamp, 2025). *The National Traveller Health Action Plan 2022-2027* also indicates significant progress made in Traveller healthcare such as increased engagement with healthcare initiatives (Health Service Executive, 2022).

Similarly, Irish Traveller women report significant discrimination and lower access to Primary Care and reproductive health services compared with the general population, which can further impede informed decision-making and autonomy in reproductive health (National Women's Council of Ireland, 2019; O'Regan et al., 2023). These experiences illustrate that structural, cultural, and interpersonal factors can restrict reproductive autonomy among ethnic minority women in Ireland, comparable to findings from international studies of Roma populations (Dullat et al., 2025).

These findings align with those observed in Traveller and Roma populations who share a similar history of marginalisation (Hayes and Acton 2007). A study in Bulgaria found that 59% of Roma women interviewed reported not using any contraceptive method (Krumova & Ilieva, 2008). Other research has highlighted that Roma women have limited knowledge of contraception, disease prevention, and their entitlements to sexual health services in Ireland (O'Sullivan et al, 2013). We acknowledge similar barriers for ethnic minority groups in Ireland. Roma women, one of the largest ethnic minority communities in Ireland, face multiple structural and cultural barriers to accessing reproductive and maternal healthcare. These include limited English proficiency, lack of interpretation services, financial constraints, and discrimination in healthcare settings, which can delay or reduce access to care and limit autonomous decision-making regarding contraception and pregnancy care (Dullat et al., 2025).

Disabled women

Disabled women, who can experience dual marginalisation due to both their gender and disability, also face challenges in accessing adequate contraception care. Historically in Ireland the fertility of disabled women has been subject to coercive control including eugenic practices that were based in discriminatory attitudes that some disabled women should not be allowed to procreate (Sperrin et al., 2020).

Moreover, despite high rates of sexual violence against disabled women in Ireland, prejudicial ideas about disability have led to misconceptions about whether disabled women are attractive to sexual partners and can be sexually active (Flynn et al., 2024). International research also highlights significant issues with the accessibility of contraceptive healthcare such as information on contraception not being available in accessible formats for disabled women (Horner-Johnson et al., 2022). A core strand of the National Disability Authority (2025) Annual Conference in 2025 was sexual and reproductive rights, reflecting the topical nature of this issue in Ireland currently.

An international study with 31 women with motor disabilities provided significant challenges in accessing reproductive health services. These included structural barriers in healthcare facilities, financial constraints, inaccessible transportation, distant clinics, long wait times, and discrimination from healthcare providers. Overall, many disabled women (61%) reported feeling inadequately informed about contraception use (Soule & Sonko, 2022).

Migrant women

Migrant women in Ireland face intersecting structural and systemic barriers to contraception access, despite policy changes such as the rollout of the Free Contraception Scheme. Cost, GP registration and access challenges, and varying eligibility criteria disproportionately affect asylum seekers, undocumented migrants, and those living in Direct Provision. These structural constraints are compounded by the geographical isolation of some accommodation centres, limited transport options, and restricted autonomy within the Direct Provision system, which together hinder timely and confidential access to reproductive healthcare (IFPA, 2021; Nasc, 2023).

Language barriers, limited health literacy, and the absence of culturally and linguistically appropriate information further constrain contraceptive access. Migrant women are often not provided with translated materials or professional interpreting services, leading to misunderstandings about available methods, entitlements, and where to obtain services (HSE, 2019). Cultural and religious norms, as well as partner or family influence, can strongly shape contraceptive choices, with some women avoiding local services due to stigma or travelling abroad for preferred methods (BMC Public Health, 2024; O'Donnell et al., 2016).

Trust in healthcare providers plays a pivotal role, yet qualitative studies and service reports highlight experiences of rushed consultations, judgemental attitudes, and assumptions about sexuality and fertility that can deter service use (Liamputtong, 2010; Scoping Review on Migrants' Sexual and Reproductive Health, 2022). These factors, combined with a lack of proactive contraceptive counselling and limited access to LARC insertion and follow-up, contribute to higher rates of interrupted contraception, unmet need, and unintended pregnancy among migrant women (BMC Public Health, 2024).

The literature consistently recommends targeted interventions: ensuring free contraception schemes explicitly include all migrants regardless of status, integrating professional interpreting services, and providing culturally tailored information through trusted community channels (IFPA, 2021; Nasc, 2023). This is positive in the context of significant diversity in migration pathways for migrant populations. Training healthcare providers in culturally competent, non-judgemental care, expanding mobile or outreach clinics, and systematically collecting disaggregated data on migrant contraceptive uptake are also identified as priorities to close equity gaps and measure the real-world impact of policy reforms (HSE, 2019; Department of Health, National Sexual Health Strategy 2015–2020, 2019; Scoping Review on Migrants' SRH, 2022).

LGBTIQ+ individuals

It is widely documented that marginalised populations in reproductive healthcare include lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) individuals. This includes those who are assigned female at birth (AFAB), such as lesbian and bisexual women, as well as transgender men (individuals assigned female at birth who identify as male) (Wingo et al., 2018). A study by Cipres et al. (2017) examined 26 transgender men, identifying 13 as 'at-risk' for pregnancy. Among this group, 11 individuals (85%) expressed a desire to avoid pregnancy. However, despite this preference, few utilised effective contraceptive methods, and many did not use any form of contraception, indicating an unmet need for contraceptive care.

In addition, Wingo and colleagues' (2018) interviewed 39 individuals assigned female at birth (AFAB) who identified as lesbian, bisexual, queer, genderqueer, or transmasculine and highlighted that, while they shared some needs with cisgender heterosexual groups, such as contraception access, they faced unique challenges, including limited LGBTIQ+ competent care, identity erasure, and discrimination.

Participants reported a persistent focus on fertility over contraception, inflexible intake forms that misrepresented their identities, and experiences of misgendering or intrusive questioning. In many cases, healthcare encounters centred on future fertility preservation or assumptions about reproductive capacity rather than immediate contraceptive needs, particularly for transgender and non-binary individuals.

Some participants described clinician uncertainty regarding the compatibility of hormonal contraception with gender-affirming hormone therapy, or incorrect assumptions that testosterone alone prevents pregnancy. Such encounters created significant barriers to contraception access and fostered mistrust of reproductive health services within LGBTIQ+ communities. There remains a paucity of literature in the Irish context which gives credence to understanding LGBTIQ+ needs more acutely in response to the Free Contraception Scheme and contraception use more broadly.

It should be noted that, in Ireland, as well as elsewhere, the evidence for best practice in this area is developing but is incomplete. Meanwhile, the demand for gender related healthcare services has increased. Recognising that gender diversity is part of the human experience and of human society and gender diverse people should be respected in their identities, and in their right to express themselves, a new clinical programme for gender healthcare has been initiated by the HSE and an updated clinical model for gender healthcare services is being developed.

The HSE is committed to building gender healthcare services in Ireland based on experience and the best clinical evidence. The expected date of completion for the HSE Model of Care for Gender Healthcare is 2026[14].

3.4 Additional barriers impacting marginalised women in Ireland

This research does not have capacity to address the needs of all marginalised women in Ireland. Nevertheless, we offer a brief overview of the literature, acknowledging that it cannot fully encompass the significant, varied and sometimes individual barriers that continue to hinder access to reproductive care. The reasons extend to include geographical location and wider socio-economic determinants of health such as homelessness, and consistent poverty, as well as circumstances that might be more individual in nature, such as cultural and religious factors driving choices. Complex healthcare needs, disabilities and chronic conditions, other medications being taken in response to these, and their collective possible interaction with prescription contraception, are also significant factors.

Living in a rural location

Research indicates that geographical location, particularly living in rural areas, significantly affects contraception access. Irish studies have found that young women in rural communities face barriers despite available services, including fear of judgment, stigma around sexual activity, confidentiality concerns, and embarrassment at local health centres (Sweeney et al., 2015; Kavanagh & Lawless, 2006). Our findings within this research also confirm that location remains a barrier

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[14] An outline of the HSE National Clinical Programme for Gender Healthcare is available online at www.hse.ie/eng/about/who/cspd/ncps/gender.

to accessing the Free Contraception Scheme and contraception more broadly, a trend reflected internationally, where privacy concerns in close-knit towns and societal stigma similarly hinder effective use of prescription contraceptives among young women (Hacker et al., 2000; Noone & Young, 2009). Using the Barriers to Contraception Use Scale (BCUS), key challenges were identified, including concerns about anonymity and confidentiality, conservative community values, limited access to inclusive and women-centred healthcare, travel distances, social isolation, medical apprehensions, and stigma. BCUS scores were higher among rural participants, supporting the conclusion that they experience greater difficulties accessing contraception than urban counterparts (Geske et al., 2016).

Experiencing homelessness

Homelessness in Ireland has risen sharply in recent years, with women and children representing a growing proportion of those affected. Family homelessness is often driven by factors such as unaffordable rents, housing shortages, domestic, sexual and gender-based violence, and relationship breakdown (Focus Ireland, 2024). Women, particularly lone parents, are disproportionately represented among homeless families, and many experience homelessness alongside children in emergency accommodation such as hotels, hubs, or family shelters (Department of Housing, Local Government and Heritage, 2024).

For women, homelessness often intersects with healthcare needs making it both a housing crisis and a gendered social issue that requires coordinated housing and healthcare support services (Women's Aid, 2023). Few studies have explored the relationship between homelessness and access to reproductive healthcare (Gelberg et al., 2004; Shah, Koch & Singh, 2019). However, existing research indicates that women experiencing homelessness often face restrictions in making their preferred contraceptive choices, primarily due to the urgent need to address more immediate concerns like food and shelter (Alspaugh et al. 2020).

This is further reflected internationally in interviews with 47 homeless women, who identified several perceived barriers to birth control. They reported that health was not a priority, transportation and scheduling posed challenges, and feelings of stigmatisation from professionals influenced their decisions (Gelberg et al. 2004). Similar findings were reported among other cohorts of homeless women (Shah, Koch & Singh, 2019).

Low-income disparity

Despite free access to contraception in Ireland for women between the ages of 17-35, and for those holding medical cards, low income and poverty disparities continue to impact access to the Free Contraception Scheme and contraception more broadly because low income and poverty are fraught with intersecting complexities (Doherty, 2019). Poverty and deprivation in Ireland remain significantly gendered issues, with women being more likely than men to experience income inadequacy due to factors such as the gender pay gap, occupational segregation, unpaid care responsibilities, and higher rates of part-time or precarious employment (CSO, 2023).

Lone parent households, 86% of which are headed by women (Census, 2022), are particularly vulnerable, with consistent poverty rates several times higher than the national average (Department of Social Protection, 2024). A recent ESRI study (2024)[15], found 38% of lone parent families are living below their expenditure needs, as opposed to 11% of households in general. Poverty affects women's health outcomes, with reduced access to healthcare, including reproductive and maternity services (WHO, 2022). Structural inequalities mean that poverty interacts with other forms of marginalisation like migrant status, disability, or membership of ethnic minority groups to limit life opportunities for women (NWCI, 2021; ESRI, 2020).

The literature identifies women with limited financial resources, often earning below a government-defined income threshold, as a marginalised group facing significant barriers to accessing contraception (Arousell et al, 2019). This is consistent with how financial cost is frequently cited as a major barrier to contraception use (Eisenberg et al. 2013). Irish data focused on exploring women's marginalisation indicate that financial insecurity, inadequate housing, and limited access to affordable childcare, services, and transportation are contributing factors (Barry, 2020).

In the Irish context, those aged over 35 who are not eligible for the Free Contraception Scheme may still qualify for other supports depending on their income. Those with incomes below the means-tested threshold can apply for a Medical Card, which provides free healthcare and medications at a low cost, subject to a €1.50 prescription charge. Those with incomes above the threshold for the medical card but earning below the median income may be entitled to a GP Visit Card. This means-tested support, combined with the Drugs Payment Scheme, which is open to everyone ordinarily resident in Ireland, may assist those who have a participating GP and a PPSN, in that GP consultations are free of charge and family medication costs are capped at €80 per month under the DPS currently (Connolly et al., 2023).

However, for those aged over 35 with incomes just above the means-tested thresholds for medical and GP Visit Cards do face significant cost barriers to accessing LARCs in particular, given high up-front costs. This is compounded by increasing clinical restrictions on combined hormonal contraception with age. Its use is not recommended in smokers and others with significant thromboembolic (blood clotting) or other risk factors over 35 and not recommended for low-risk women over 50. These barriers are recognised in national policy, with the *Programme for Government, 2025, Securing Ireland's Future*[16], and the *National Sexual Health Strategy, 2025-2035*, recommending inclusion of the entire reproductive age-range (17-55 year-olds)[17] in the FCS in due course.

Gender disparities in healthcare and contraception misconceptions

Gender norms were widely documented as affecting women's contraceptive choices, often placing decision-making power with men. Traditional gender roles and attitudes towards masculinity and femininity, strongly influenced expectations around relationships and family planning. For individuals outside conventional gender and

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[15] https://www.esri.ie/news/lone-parents-households-with-children-single-working-age-adults-and-renters-are-the-groups

[16] Programme for Government 2025 - Securing Ireland's Future

[17] 17 is the legal age of consent for sexual activity in Ireland; the prescription of contraception beyond the age of 55 is not typically recommended.

sexuality norms, these dynamics often created alienating experiences with healthcare providers contacted with respect to sexual and reproductive healthcare (Alspaugh et al. 2020).

A recent qualitative literature review (n = 19) found that women were often reluctant to choose contraceptive methods they perceived as potentially harmful to their fertility (Alspaugh et al., 2020). Notably, both decreased and inflated fertility perceptions contributed to reluctance to use contraception. Women described avoiding certain methods due to fears that contraception could either reduce their future ability to conceive or, conversely, increase the likelihood of subsequent infertility or unintended pregnancy (Alspaugh et al., 2020).

Many participants also expressed a preference for "natural" contraceptive approaches and mistrust of hormonal methods due to concerns regarding safety, side effects, and long-term health implications. These findings are consistent with broader international evidence. A global synthesis of systematic reviews examining factors influencing contraceptive choice identified concerns about side effects particularly perceived effects on fertility as one of the most consistently reported determinants of method selection and discontinuation across diverse settings (D'Souza et al, 2022).

The review also highlighted additional influences including misinformation, partner and family attitudes, cultural norms, access barriers, and quality of counselling. Similarly, a qualitative study conducted in Canada found that young women often felt overwhelmed by the complexity of contraceptive options and reported insufficient or unclear information about comparative effectiveness and side effects (Marshall et al, 2018). Concerns about delayed return to fertility following hormonal contraception were common, even when not clinically substantiated. Together, these findings suggest that fertility perceptions, informational gaps, and sociocultural influences interact to shape contraceptive decision-making across different contexts.

Unproven but perceived risk levels pertaining to mood and weight issues undermine uptake of hormonal contraceptive methods. This is encouraged by social media platforms, which can lead women to choose marketed cycle tracking applications because women are led to believe that these have no side effects and a lower failure rate than the real rate (Black, Vrommon & French, 2025). For example, the National Sexual Health Strategy (2025) notes that cycle-tracking apps claim an approximate 7% failure rate, yet international data suggest unplanned pregnancy rates for natural family planning methods (which these apps essentially provide) are closer to 24–25% in typical use, considerably higher than both condoms and most hormonal contraceptives (Sung et al, 2025)

Misunderstandings, peer influence, and informal networks also shaped their perceptions and decisions, particularly regarding IUD devices (Alspaugh et al., 2020). For example, homeless women may hesitate to use LARCs due to practical concerns, such as the discomfort of insertion and removal, and the difficulty of accessing medical care when needed (Shah, Koch & Singh, 2019). Additionally, peer influences or misconceptions such as beliefs that LARCs are unsafe or unnatural can further discourage their use, whereas condoms are seen as simpler and more accessible. (The language employed by healthcare providers has the potential to significantly reduce misconceptions, however, dismissive language or transphobic communication can, conversely, create barriers to care and perpetuate oppressive power dynamics (Alspaugh et al., 2020).

04. **Methodology**

4. Methodology

This section outlines the research methodology and the methods we employed to carry out the research and our rationale for doing so.

Principal research question

The principal research question for the study is the following:

What awareness and experiences do contraception users from marginalised communities have of the free contraception scheme?

We intend to achieve this by meeting the following objectives:

1. To gather the experiences of a diverse group of contraception users from marginalised communities.
2. To establish what the key factors are in the awareness held by marginalised community contraception users about the free contraception scheme.
3. To produce clear, actionable and realistic recommendations toward promoting awareness, engagement and quality in the provision of the free contraception scheme for marginalised communities.

4.1 Research methods

The project included two different research methods to understand the experiences of marginalised women and contraception use more broadly in Ireland. The methods included a survey and four qualitative focus group interviews. The quantitative survey was aimed at women aged 18-35 years to gather preliminary data on their experiences of the Free Contraception Scheme to date (2025). The survey was inclusive and accessible to all women, including marginalised women in Ireland.

Secondly, four focus groups were carried out to gain a deeper understanding of marginalised women's awareness and knowledge of the Free Contraception Scheme and their experiences of contraception more broadly. The focus groups were analysed thematically.

4.2 Inclusion and exclusion criteria

In keeping with the study aim and objectives, a protocol for participant recruitment was designed at the outset of this project. The inclusion and exclusion criteria for all sets of participants are outlined below.

Study element and inclusion and exclusion criteria:

Survey:

Inclusion criteria

- All women in Ireland eligible to access the Free Contraception Scheme between the ages of 18-35.
- Women who face barriers to accessing the Free Contraception Scheme due to factors such as age, marginalisation, or other social, economic, or structural obstacles.
- Must have a good level of English reading and writing competency.
- Must provide informed consent.

Exclusion criteria

- Women who have never lived in the Republic of Ireland.

Focus groups:

Inclusion criteria

- Women who identified as being from the Traveller community, migrant women currently living in Ireland, LGBTIQ+ individuals, and disabled women.
- Eligible to access the Free Contraception Scheme.
- Majority aged between 18-35*.
- Must have a good level of English-speaking competency.
- Must provide consent.

Exclusion criteria

- Women living outside of Ireland.
- Women who did not identify as being from the Traveller community, or who were neither migrant women currently living in Ireland, nor LGBTIQ+ individuals, and disabled women.

We note that a significant proportion of the participants in the* ***focus groups* *were over the age of 35 but wished to participate and share their experiences of exclusion from the FCS which we permitted.*

4.3 Participant recruitment

The National Women's Council and the Project Advisory Group were central to the sampling and recruitment of the participants. The survey was circulated throughout the networks of the National Women's Council networks, this includes their membership of nearly 200 member organisations, their mailing list of additional supporters and Feminist Changemakers, and other civil society organisations that aren't members but with whom they often work closely on research projects.

The survey was launched at the very end of March 2025, completed anonymously online, and analysis was undertaken in June 2025. Participants were not reimbursed for the survey. The National Women's Council disseminated the call for participation in the focus groups through its networks, with the support of the project advisory group. The focus group participants were recruited similarly through the National Women's Council networks with the support of the Project Advisory Group. Focus group participants were posted a One4All Voucher as a token of appreciation for their time.

05. **Analyses**

5. Analyses

5.1 Survey analysis

The survey was conducted using Qualtrics, a survey administration and analysis software. A report produced by Qualtrics was used to interpret the results of the survey. Further, Microsoft Excel was used to conduct statistical analysis of the survey results.

5.2 Focus group analysis

This research utilised qualitative thematic analysis to analyse and interpret the focus group interview data aiming to provide a comprehensive account of marginalised women's awareness and experience of the Free Contraception Scheme and contraception more broadly. The analysis adhered to Braun and Clarke (2006) guidelines. Online qualitative interviews were carried out through Trinity College Zoom and recorded and transcribed verbatim. In-person focus groups were recorded and transcribed verbatim. Transcripts were reviewed and cross-checked by the research team. The focus group transcripts were coded, and main themes were identified.

5.3 Ethical approval

The survey and focus groups did not proceed until full ethical approval was granted by the Research Ethics Committee at the School of Social Work and Social Policy at Trinity College Dublin in November 2024. Participants provided informed consent after reviewing information on the study including provisions around confidentiality, data protection and privacy. This information was provided at the beginning of the survey. Hard copies of the consent form were distributed and signed at the start of in-person focus groups, while electronically signed consent forms were submitted to the researcher in advance of the online focus groups. Accessibility measures were taken to ensure women with a diversity of experiences and needs could participate in the research such as facilitating focus groups in locations of convenience that were accessibly designed and using inclusive language.

06. **Findings**

6. Findings

6.1 Survey findings

Description of the survey

A survey was administered to understand marginalised women's experiences of the Free Contraception Scheme. The survey instrument was designed so that the eligibility criteria had to be met before participants could provide consent. From the outset, the survey provided a short introduction to the project and its collaborators, establishing basic terms of the Free Contraception Scheme, asking for voluntary consent to participate in the survey for the study. Although the survey title refers specifically to marginalised women, participation was open to all women, ensuring that the study could capture a broader range of experiences and perspective.

Of the 510 participants, 505 participants agreed to participate in the study, while five declined to participate in the survey. Only participants who consented to participate were able to complete the survey. For the remaining survey questions, participants were given the opportunity to select a response or specify a unique response if not otherwise listed. Rounded percentages, to the nearest whole number, have been applied to survey analysis. When presenting findings, in any case where the result refers to less than five participants, instead of a statistic, the figure <5 is reported. This is to safeguard against accidental statistical disclosure.

Gender identity

Participants were asked, where comfortable to do so, to inform us of their gender identity. Participants were provided categories including woman, man, non-binary, genderfluid, and other; whereby they were asked to specify, and 'prefer not to say' for those wishing to not disclose their gender identity. Of the 498 participants, 95% of participants self-identified as women, while the remaining 5% self-identified as men (2%), non-binary (1%), genderfluid (1%), of which 1% opted to 'prefer not to say', and another 1% selected 'Other'.

Trans identification

Participants were further asked to identify if they are trans or have a trans history. 96% of participants do not identify as trans, or as having a trans history, while 3% identified as trans or having a trans history. Some participants (1%) chose to not disclose if they are trans or have a trans history.

Sexual orientation

Participants were further asked to identify their sexual orientation. Most participants identified as straight/heterosexual (78%), followed by bisexual (17%), and gay or lesbian (3%), while nine participants identified as *Other* with further specification within which queer, pansexual, asexual, and 'None' were selected at various frequencies.

Age group

Participants were asked to identify their age group. Of the 482 participants who progressed to this stage of the survey, the most prominent age groups included those between 25-34 (35%) and 41 and above (34%). Subsequent age groups reported those between 35-40 (17%) and 18-24 (13%). Of these groups, owing to the valuable insights from participants outside the age range of the Scheme but reporting on their past experience, they remained in the study's inclusion criteria.

Location

The various locations of survey participants across Ireland were explored. Three questions sought to find out about where participants were living, for instance, whether they lived in an urban place like a city or in a rural place like the countryside.

Area (City, Town, Village, Countryside)

Before determining region and county, participants were asked to identify if they lived in the countryside, village, town, or city. Nearly half of participants (44%) reported living in a city, 29% reported living in a town, followed by 17% in the countryside, and 10% in a village.

Province/area

Participants were then asked to identify which area they currently reside in. Nearly two-thirds of participants (65%) live in Leinster, followed by Munster (14%), Connacht (11%), and Ulster (Republic of Ireland) (7%).

For those who selected other, areas identified included Ulster (Northern Ireland), Greater London and Palestine. Five responses indicated 'Other'.

County

Within the four areas, participants were then asked to identify their county. For those who reside in Leinster, nearly two thirds (64%) live in county Dublin, followed by Meath (7%), Wicklow (7%), Kildare (7%), and Louth (4%). Lower numbers were resident in counties Wexford (2%), Kilkenny (2%), Carlow (2%), Laois (1%), Offaly (1%), Westmeath (1%), and Longford (1%,).

For those residing in Munster, nearly half (45%) of participants live in county Cork. Lower proportions live in Limerick (18%), Kerry (12%), Waterford (11%), Tipperary (9%), and Clare (5%).

Among participants residing in Connacht, nearly half live in county Galway (49%). Participants were also identified as residing in Mayo (22%), Sligo (14%), Roscommon (10%), and Leitrim (4%).

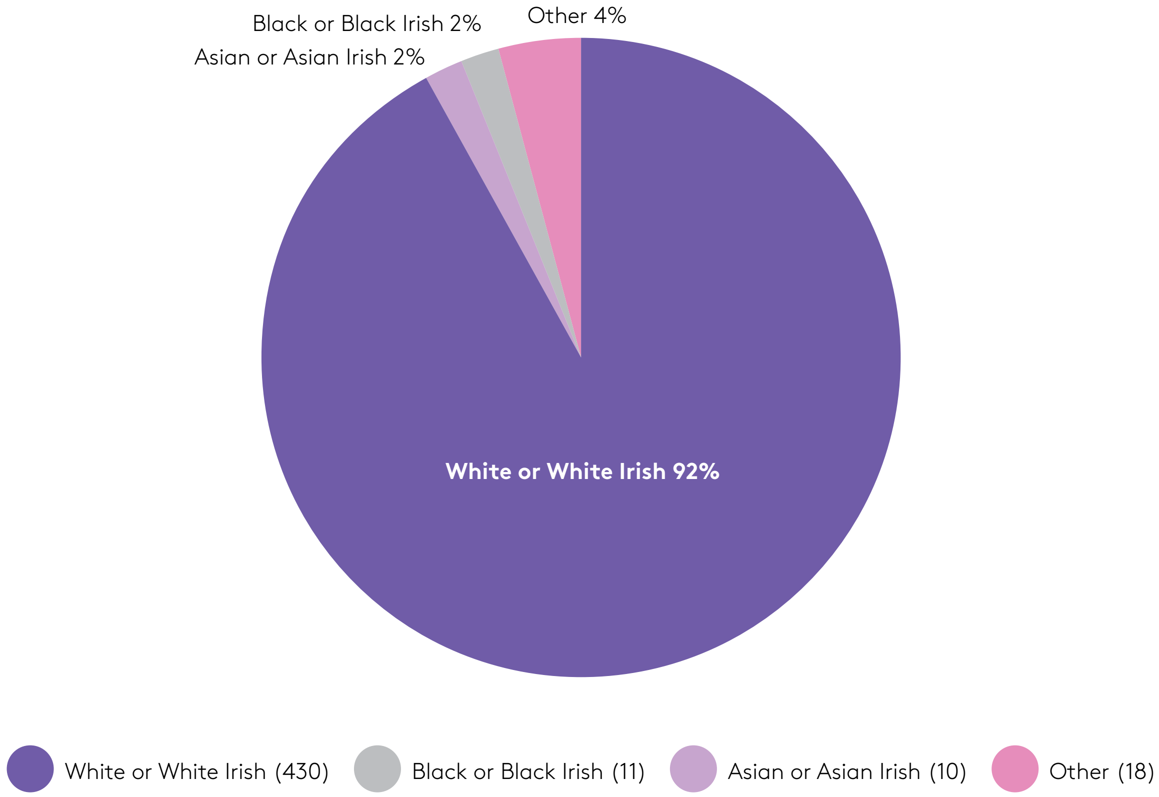
Within the Ulster area, a total of 26 participants live across the three counties in the Republic of Ireland. Participants live in Donegal (58%), Cavan (23%), and Monaghan (19%) with a small minority of respondents selecting 'Other'.

Ethnicity

Participants were then asked to select a description that best describes their ethnic background. The makeup of survey participants is demonstrated in Figure 1.

The majority of participants self-identified as White or White-Irish (92), while 2% identified as Black or Black Irish (2%) and 2% identified as Asian or Asian Irish (2%). A total of 18 participants (4%) identified as 'Other' – which included mixed and other ethnic backgrounds.

Figure 1: Primary ethnic breakdown



Further analysis commenced to determine participants' ethnic background further to the four primary ethnic categorisations.

Of the 430 participants who identified as 'White', 87% identified as Irish, 11% as 'Any other White background', and 2% identified as Irish Travellers.

Of those who identified as Black or Black Irish, all participants identified as African.

Among the Asian and Asian Irish participants, Indian, Pakistani, and Bangladeshi ethnicities featured.

Among those who selected 'Other – including mixed and other ethnic background', 12% identified as Arabic, while 53% identified 'Other', and 35% identified as 'Mixed', whereby Other and Mixed participants were asked to specify their ethnicity. For those who specified 'Mixed' or 'Other' ethnicities, 10 additional ethnicities were identified.

Selected factors

Turning to lifestyle factors, participants were asked to identify factors which impact their livelihood and social conditions. Participants identified a range of factors impacting their lifestyle. The most common factors include living with mental health difficulties (e.g., depression, anxiety, PTSD) (18%) and not having enough money or resources (17%). Further factors include living in a county or rural area with fewer services (10%), living with a long term illness (9%), being part of the LGBTIQ+ community (8%), living with a physical disability or impairment (6%), having problems with housing or being homeless (6%), experiencing DSGBV (4%), and problems resulting from gender, gender identity, or sexual orientation (4%).

Less common factors, which represent 10% of participants or less, include belonging to an ethnic minority group or racial group (4%), being a lone parent with little support (3%), being a caregiver with little support (3%), having problems because of one's religion, culture, or beliefs (2%), being a member of a migrant, refugee, or asylum seeking community (1%), and addiction (1%). Some participants (2%) chose to elaborate further on their factors. These include age, demanding work schedules, institutional prejudice, and systematic oppression.

Table 1: Select social factors

Selected Factor(s)	Count
Living with mental health difficulties (e.g., depression, anxiety, PTSD)	**167**
Not having enough money or resources	**153**
Living in a country or rural area with fewer services	**92**
Living with a long-term illness	**82**
Being part of the LGBTIQ+ community (This stands for Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, and other diverse gender identities and sexual orientations)	**69**
Living with a disability or impairment (e.g., physical, sensory, or learning difficulties)	**56**
Having problems with housing or being homeless	**53**
Experiencing violence (such as domestic violence) because of your gender or in your relationship or in your family.	**39**
Problems because of your gender, gender identity, or sexual orientation	**38**
Belonging to an ethnic minority group or racial group	**33**
Being a lone parent with little support	**30**
Being a caregiver with little support	**28**
Problems because of your religion, culture, or beliefs	**20**
Being part of a migrant, refugee, or seeking asylum community	**13**
Addiction	**13**
Other	**19**

Active contraception use

The participants were then asked if they are actively using any form of contraception. Just over half (56%, n=248) of participants are using contraception, while the remainder of participants are not (44%).

Type(s) of contraception

Further to their use of contraception, participants were asked to identify which forms of contraception(s) they are using. As demonstrated in Table 2, the most commonly used form of contraception identified was the oral contraceptive pill (39%). Other notable forms of contraception use include the hormonal coil (IUD) (23%) and male condoms (14%), sub-dermal implants (7%), copper coil (IUD) (4%), emergency contraception pill (2%), natural methods (2%), contraceptive patch (2%), sterilization (2%), female condom (1%), vaginal ring (1%), and contraceptive injection (1%).

Table 2: Commonly used types of contraception

Type of contraception	Percentage
Oral contraceptive pill	**39%**
Hormonal coil (IUD)	**23%**
Male condoms	**14%**
Implant under the skin	**7%**
Copper coil (IUD)	**4%**
Emergency contraception pill	**2%**
Natural methods	**2%**
Contraceptive patch	**2%**
Sterilization	**2%**
Female condom	**1%**
Vaginal ring	**1%**
Contraceptive injection	**1%**
Contraception choice factors	**1%**

Contraception choice factors

Elaborating on their deciding factors determining contraception choice, participants were asked to identify the reason for choosing their type(s) of contraception. As noted in Table 3, nearly half of participants selected reasons such as following their doctor's recommendation (47%) and that it helps with other health problems (46%). Subsequent reasons include, working for their lifestyle (39%), ease of use (39%), working well to stop pregnancy (35%), good for their health (31%), it lasting a long time (28%), not having to think about it or remember it (26%), ease of access (26%), because it is low cost or free (26%), easy to stop or change (23%), agreeing with their partner on it (14%), it is permanent (3%), and their nurse recommending it (3%).

For those who selected 'other' (4%), selected reasons include selecting a contraceptive due to unique medical conditions or chronic illness, not being able to afford sterilisation, or having a poor reaction to other forms of contraception, such as the copper coil.

Table 3: Selection reasons for contraception type[18]

Contraception choice factor(s)	Percentage
My doctor recommended it.	**47%**
It helps with other health problems (e.g., period pain, heavy periods, acne, headaches).	**46%**
It works well for my lifestyle.	**39%**
It was easy to use.	**39%**
It works well to stop pregnancy.	**35%**
It's good for my health (e.g., doesn't cause side effects).	**31%**
It lasts a long time.	**28%**
It was easy to get.	**26%**
I don't have to think about it or remember it.	**26%**
It does not cost much or is free.	**26%**
I can stop or change it anytime.	**23%**
My partner and I agreed on it.	**14%**
Other.	**4%**
My nurse recommended it.	**3%**
It is permanent.	**3%**

Contraception provider

Participants were further asked to identify their contraception provider. Over two-thirds (67%) of participants received their contraception via their GP. Subsequent providers include the Pharmacy (24%), Hospital Specialist, including a Gynaecologist or Endocrinologist, (11%), Online Provider (5%), Family Planning Clinic (5%), Student Health Service (4%), Community Health Centre (3%), GP Nurse (3%), and Sexual Health Clinics (2%). Four percent of participants do not currently have a contraception provider.

Of those who selected 'Other', specific family planning and women's health clinics, NHS care in the UK and care in the United States were all noted.

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[18] Respondents were asked to select all factors that applied to them.

Contraception satisfaction

Participants were then asked if they were happy with the current form of contraception. For 75% of participants, they reported that they were happy with their form of contraceptive, 19% identified that they were unsure, while 7% were not happy with their current choice of contraception.

Among those who opted to explain their reason for being unhappy or unsure of their happiness with their current choice of contraception, participants offered a range of explanations. Many reported unintended side effects such as causing irregular menstrual cycles, heavy periods, acne, abdominal pain, weight-gain, and bloating. Citing wishes to change their current choice of contraception was frequent, with some selecting the cost of the change, accessibility of procedures, and fear of implantation, as reasons they have yet to change their contraception.

Awareness of the Free Contraception Scheme

Participants were asked if they were aware of the FCS. Findings demonstrate that most participants (85%) were aware of the FCS, while 15% were not. Those who were using contraception were 7% more likely to be aware of the FCS. In terms of ethnicity, White participants were more likely to know about the scheme than Black or Black Irish and Asian or Asian Irish participants.

Use of the Free Contraception Scheme

Participants were then asked to identify if they have previously, or are currently, using the FCS. 62% of participants indicated that they have never used the FCS, 36% have, or are currently using the Scheme, while 2% are unsure if they have or are currently using the Scheme, and <5 participant(s) selected to not share their usage.

Upon further investigation, the rate of FCS usage presented differently across rural and urban locations. Those in cities, towns, and villages were similarly likely (40%, 35%, and 41%) to have used the FCS, whereas those in the countryside less likely (26%) to have used the Scheme. Such findings may suggest further investigation into rural contraception accessibility.

Returning to ethnicity, while usage rates among those who identified as White or White Irish, Black or Black Irish, and ‘Other’, were comparable (37%, 36%, and 35%), usage by those identifying as Asian or Asian Irish was lower than in other ethnic groups. These findings may warrant additional research into Scheme awareness and accessibility for those groups. Beyond primary ethnic identities, there were no statistically significant differences between sub-identifications. However, it should be noted that, as a result of relatively low participation rates of BIPOC (Black, Indigenous, and People of Colour) in this study, there is a possibility that broader investigation may demonstrate different findings.

Knowledge of Free Contraception Scheme

Participants were then asked about their knowledge of the FCS. Nearly half of participants had learned of the FCS on social media (46%) and/or online (41%). Other sources included their healthcare provider (32%), friends (15%), family (7%), posters (7%), leaflets (2%), magazines (<5), and from this project or survey.

Of those who identified ‘other’ means of learning about the FCS, 14 participants (5%) learned of the FCS on from the news (print, radio, and TV), and <5 participants also learned from school, work, and from the non-profit AkiDwA Network of Migrant Women.

Potential barriers to accessing the Free Contraception Scheme

Regarding their utilisation (or non-engagement) with the FCS, participants were asked to identify if they perceived barriers making it difficult to use the FCS. Nearly half (44%) of participants thought there were no barriers to using the Scheme, while 36% believed that there were barriers, and 18% were unsure.

Among those who opted to briefly explain why they were unsure, or why they did or did not perceive barriers, various reasons were cited. Most frequently, being ineligible due to age was cited, while other recurring barriers included not having a GP or having difficulties making an appointment. More infrequently, distrust in using selected forms of prescribed contraceptives (<5), and other medical barriers linked to existing conditions or treatments (<5) were reported. The age range, GP access and ease (or otherwise) of making appointments are structural or administrative barriers that could be addressed practically, while distrust could be addressed with better information supports. Clinical barriers may be less amenable to resolution.

Consideration of Free Contraception Scheme

Participants were then asked reasons for using or thinking about using the FCS. Among the 214 participants who opted to include reasons they use or are thinking about using the Scheme, many stated the external cost of contraceptives and the benefit of it being free, others cited a desire to get a IUD through the Scheme, that they do not wish to have children, and that the belief that free contraception is a right.

Accessibility of Free Contraception Scheme

Participants were then asked, how accessible or easy to use they found the FCS. While 20% of participants were unsure, 28% found the Scheme to be accessible or easy to use, 24% found the Scheme fairly easy to access or use. Fewer participants (4%) found the Scheme not easy to access, while 7% found the Scheme difficult to access.

Among those who opted to explain their choice, being ineligible as a result of age was the most common response. Others (<5) cited difficulty accessing GP services or that their GP was not signed up to provide the Scheme. Less frequently, some (<5) stated not having sufficient knowledge of the Scheme and not having a PPSN (<5).

Participants who identified as trans or who had a trans history provided unique insight. Among these participants, they were less likely (8% versus 26%) to find the Free Contraception Scheme very easy to use, while being more likely to find the Scheme difficult to access (25% versus 6%).

Across racial backgrounds, there was minor statistical significance, with White participants being most likely to find the FCS very easy to access or use. No Asian or Asian Irish participants noted the ease or difficulty in access the Scheme, which may reflect the need for further research in this area.

Notably, among white ethnicity subgroups, Irish Travellers were more likely (38%) to be unsure of the Scheme's accessibility or ease of use. Further analysis of these data is rendered difficult due to the small number of Traveller participants in this study. It should also be noted that many Travellers would have been accessing contraception free, or at very low cost, through medical and/or GP Visit cards, for which most would be eligible.

The most significant factor affecting participants identification of accessibility and ease of use was age. For those within the age parameters of the FCS, there were greater shares of positive feedback; 42% of participants found the Scheme very easy to access and use and 32% found access and usage fairly easy.

Challenges or difficulties of the Free Contraception Scheme

Elaborating on previous questions, participants were asked to identify if they experienced any challenges or difficulties in accessing the FCS. Overall, 69% participants cited no challenges or difficulties accessing the FCS, while 31% participants attested to experiencing challenges or difficulties.

Participants were again given the opportunity to elaborate on their reasoning for their response. For those who faced challenges or difficulties accessing the FCS, being outside the eligible age range was again noted, accessing a GP was again mentioned, being previously charged or being informed of a charge to see a GP regarding the Scheme (<5), and difficulties for those who travel frequently for work (<5).

Among the identified ethnic groups in this study, and as demonstrated in Table 35, those identified as 'Other', particularly Arabic and Mixed participants, were most likely to cite challenges or difficulties in accessing the FCS. Due to the small sample size, these findings may not be statistically significant but nonetheless indicate the need for further investigation into ethnic minorities' experiences of the FCS.

Returning to age, similarly to responses to survey question 20, age was statistically significant among participants' responses to question 21. The greatest rate of experiencing difficulties accessing the FCS was noted by participants aged 35-40 (58%), followed by those 41 and above (39%). Notably, the significant concern amongst participants aged 35 and above should not be ignored.

In Ireland, as reported by the HSE, the average age of menopause is 51 (HSE, 2022). Likewise, while men do not experience menopause, their fertility may begin to reduce in their mid-40s (HSE, 2023). Many couples therefore continue to be at significant risk of unintended pregnancy beyond the current upper age limit of 35;

moreover, prescription contraception is often prescribed to treat perimenopausal symptoms such as irregular and heavy periods, which increase in incidence above the age of 35. For those experiencing such symptoms, or who do not wish to become pregnant, access to contraception could be improved above the age of 35.

Free Contraception Scheme: Impact on health and well-being

Participants were then asked to identify the change or impact that the FCS has had on their health and well-being. The greatest share of participants (41%) found the FCS to have a positive impact on their health and well-being. Nearly half of participants either found no noticeable impact (28%) or were unsure (20%) of the impact on their health and well-being. Few participants cited a negative impact (6%,) or a mixed impact (5%) on their health and well-being.

For participants who identified positive experiences, saving money was frequently cited (n=10); particularly for those who opted for, or were considering, an IUD. Additionally, other participants cited the agency, support, and empowerment (<5) that the FCS provided, while further participants cited the ease of use (<5), and positive impacts on other medical conditions (<5).

Among those who cited negative experiences, age was again frequently cited, poor reactions to contraceptives were s also cited (<5), the limited scope of offering such as not including dental dams (<5), and the lack of broader resources on contraceptive use impacts on female fertility (<5) were noted.*

Similar to prior analysis of survey questions 20 and 21, women above the age of 35 were less likely (30%; 15%) to cite a positive impact of the FCS. Overall, the greatest level of positive impacts on health and well-being occurred among 25–34-year-olds (62%), followed by 18–24-year-olds (50%).

Moreover, analysing the impact of the FCS by ethnicity, minor statistical significance may be noted, in the negative impact cited by 33% of Asian or Asian Irish participants. As a result of the small sample size of Asian or Asian Irish participants in this study, further research may be advisable in order to look at this in more depth.

Free Contraception Scheme: Experiences and perspectives

Finally, participants were asked to share their experiences and perspectives on the FCS, particularly if they could suggest improvements and accessibility concerns for marginalised groups. Among participants, 50% opted to elaborate on their experiences and perspectives.

The most cited experiences and perspectives again identified barriers resulting from the current age limits. Other notable responses suggested greater accessibility of information about the programme, by outreach, advertisement, and education, further promotion among ethnic minorities, streamlined access to providers and clinics, greater rural accessibility to health services, and free contraceptive related

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[*] Research has well recognised possible delays in fertility return in injectable contraceptives, particularly Depo-Provera (Damtie et al, 2023).

appointments with GPs. Particularly among those who mentioned GP and clinic services, follow-up appointments were emphasised, and some identified reactions to existing or previous contraceptives.

Conclusions from the survey

In conclusion, the FCS digital survey provides valuable insights on women's experiences of the FCS. For participants between the ages of 18 to 34 who are using or thinking of using the FCS, their feedback was frequently positive, and many cited the positive impacts that the FCS has had on their health and well-being. The freedom of choice and the financial relief were greatly noted by these participants and may be testaments to the benefits of the Scheme.

Of the limitations and constraints of the FCS, the age limit most frequently arose as a barrier for utilisation and satisfaction. As previously stated, the concern among participants 36 and over should not be ignored. In Ireland, and as reported by the HSE (2023), most men and women are typically fertile beyond the age of 35, and broader scientific knowledge informs us that there is not a set age on fertility, although prescription contraception is not typically prescribed above the age of 55, beyond which age, natural pregnancy is very rare.

For example, Garcia et al. (2018) argue that age-related fertility decline research regarding women has been largely insufficient and cites the need for greater research in the area, while Almeida et al. (2017) made similar note arguing contributing factors beyond decreasing testosterone production with age not being well evaluated. As a result, one may confidently argue that the age limit of the FCS should increase, as unplanned pregnancy remains a risk beyond the age of 35.

Contraception also supports family planning such as spacing of pregnancies, while denying certain age groups access to the FCS may conflict with Ireland's commitments under domestic and international law and policy with respect to age discrimination. Finally, women's medical needs which may be ameliorated through some forms of prescription contraception may continue and, in some cases, increase after 35, with the increase in incidence of peri-menopausal symptoms.

Accessing a GP or clinic was regularly mentioned as a barrier to utilising the FCS, and greater analysis of how doctors and health professionals engage with women regarding the FCS could be reviewed. Rural participants were more likely to not be using the FCS, and rural accessibility was cited as an additional barrier to engagement.

The most notable limitation of the survey was the low levels of engagement by participants who may be considered ethnic minorities in Ireland. As previously noted, usage of the FCS among those who identified as White or White Irish, Black or Black Irish, and 'Other', occurred at comparable rates (37%, 36%, and 35%), while Asian or Asian Irish usage was lower (13%). Likewise, no Asian or Asian Irish participants noted ease or difficulty in accessing the Scheme, and 33% of Asian or Asian Irish participants cited a negative impact on their health and well-being. While statistically insignificant as a result of low sample sizes in this study, such indicators may warrant additional research into Scheme accessibility for those of Asian or Asian Irish ethnicity. Overall, the percentage (2%) of participants in this study that were Asian or Asian Irish was slightly higher than that for the Irish population as a whole as identified in the 2022 Census (CSO, 2022).

The overall low engagement among ethnic minorities and BIPOC women may further highlight that such groups are often relatively inaccessible to sexual and reproductive health research, which, in turn, emphasises the need for further community-based engagement and qualitative research using creative or participatory methodologies.

6.2 Focus groups findings

In this section, the findings of four focus groups with participants who identified as Traveller women, disabled women, migrant women and LGBTIQ+ individuals are included to explore their awareness and experiences of the Free Contraception Scheme and contraception more broadly. Names used in the report are not the real names of the participants to protect their identity.

The focus group themes are:
(1) Awareness of the Free Contraception Scheme
(2) Accessing the Free Contraception Scheme
(3) Barriers to contraception use
(4) Areas for improvement.

Traveller women

The focus group consisted of nine Traveller women sharing their knowledge and awareness of the Free Contraception Scheme and their experiences of accessing contraception.

(1) Awareness of the Free Contraception Scheme

Traveller women who participated in the focus group had access to the medical card scheme (GMS). Based on their understanding of how the medical card system operated, they believed that relevant healthcare costs, including contraception, were already covered. As a result, they were not specifically aware of the Free Contraception Scheme: *'The medical card, I thought because we had medical cards, we were aware it was already free'* (Maggie). However, the participants acknowledged and agreed that the FCS is important for all women across Ireland, but despite access being 'free' Traveller women believed that accessing contraception remains challenging and the participants discussed how Traveller women could have difficulty accessing the FCS and contraception more broadly.

Traveller women discussed their awareness of contraception and how they become informed about contraception and contraception options in their community. Rather than discussing with allied healthcare providers, Traveller women preferred to discuss contraception with sisters, female family members and close friends: *'My sisters, my sisters, if you have sisters, we would talk, like for example, I have the coil, what do you think? Do you ever know anybody who could recommend a contraception?* (Sarah). Within the community they would share their experiences, and this information and advice would inform their choice and method: *'I had a bad experience after giving birth and the doctors wanted to discuss other things with me so I did have a discussion with my sisters... and they said try this, try that, me and you have been on the patch together, it was you who told me about the patch...'* (Paula).

For example, if their sister, or someone they knew in their community was using LARCs, this would encourage them to decide on this type of method of contraception. Moreover, if their sister or friend in the community experienced a negative outcome with a particular contraception method, it would likely discourage them from using this type of contraception. Sharing stories and experiences with each other was both useful and empowering but also led to incorrect information or misconceptions about methods: *'I wouldn't recommend contraception because it affected me having children, but it affects everybody differently,'* (Claire) and *'I know someone who had the exact same story as you…'* (Patricia).

Despite some concerns with using LARCs, Traveller women discussed poor adherence to the contraceptive pill and discussed their preference for LARCs overall: *'I don't like the pill because it's an everyday taking, cause I have 11 months between two children because I forgot to take the pill'* (Sarah). For these reasons, it was important for Traveller women participating to have access to LARCs as their preferred choice of contraception.

Traveller women shared their cultural values and beliefs which also significantly impacted their access to contraception:

> *'It's individually personal to say to a Traveller girl, you shouldn't have any more children, we are not God, God only blesses you with the children he thinks you should have, it's against our religion you know', some women might be on it, but pretend that they are not on it. Most of us Travellers, peoples got different beliefs and different ways of doing things, so why I might recommend, we are all different, even though we all come from one culture, we are all different'* (Maggie).

(2) Accessing the Free Contraception Scheme

Traveller women described experiencing stigma and prejudice from healthcare providers in the past which continues to impact their experiences of contraception more broadly. Traveller women had experienced comments like *'see you next year… you will be back again next year'* (Linda). From healthcare providers after childbirth and they felt comments like these excluded them from discussing contraception with healthcare providers.

These experiences impacted Traveller women from accessing contraception and would impact on them accessing the Free Contraception Scheme too if they needed to: *'I says to the nurse I am from the Traveller community, and I just want checked…. I said, this is my second baby, and the nurse said to me, oh my God you're not like the rest of them, at least you have got yourself on contraception… Because I said it was my second baby, they were shocked….'* (Patricia).

Often Traveller women experienced judgement following multiple births and in situations where they had just given birth: *'Get yourself on contraception, there's a letter for your GP, she said to another Traveller girl… The nurse was very cheeky, and I think it was because I was a member of the Traveller community'* (Claire). These experiences only confirm Traveller women's preference to discuss contraception with their sisters, family members and within their community.

Traveller women spoke about accessing contraception after the age of 36. They explained that many Traveller women may prefer to use contraception at this stage of life to avoid further pregnancies, as their bodies are older, they may have already had multiple births, and health considerations often become the key factor in deciding to use contraception:

> *'I think when you come to a certain age, you know when you have had enough, your body knows when it has had enough, it individually depends on the person. My mother had 12 children, and I don't think my mother would have been on contraception, just understand what I am saying to you, she had her last child at 37 years of age, but if you asked me, or God, no I am sorry, I've enough!'* (Sarah).

In keeping with cultural values and norms within the Traveller community, contraception was often discussed only after a young women married and for family planning reasons only: *'I was on the pill when I was younger, but I kept that to myself, for health, for balancing hormones'* (Mary). In some incidents, contraception discussions only occurred after the birth of their first child: *'Sometimes they [nurse] do, like I only had a wain nine months ago and they said, 'Do you want to start the contraception once more?'* (Paula). Or after the birth of multiple children: *'They [nurse] had a talk with me, because I had six babies, and they were all caesareans'* (Patricia).

(3) Barriers to contraception

Traveller women participants spoke of preferring not to access contraception from a male GP and were less likely to discuss contraception with a male GP: *'I wouldn't go to a man doctor, if it's a man doctor, I would wait, I would just leave...'* (Mary). The participants in the focus group were all accessing a women's health centre, which allowed them access to a female GP and nurse. However, not all women across the country have access to a women's health centre or the options of female GPs. Traveller women expressed a preference for accessing the out-of-hours GP instead of a male GP in the community. The out-of-hours GPs were often less familiar to them, and the practice waiting rooms were quiet with less people.

Traveller women discussed contraception in the context of their general health and discussed how Traveller women do not prioritise their health in general. They have busy, full days in their role as mother, family support and extended family support. Time was a concern, and also Traveller women reported being less likely to prioritise their own needs: *'To get a Traveller woman to go to the doctor, Traveller women is hard to get to go to the doctor, for myself, I wouldn't go to the doctor, ah I will be grand in a couple of days, my limbs could be falling off and I am still grand, I haven't the time, it's not laziness, I haven't the time, to go talk about contraception'* (Sarah).

(4) Areas for improvement

Traveller women discussed areas for improvement to support their community accessing contraception and supporting contraceptive needs more broadly. They believed young girls should be provided with information in schools with an emphasis on culturally appropriate and age-appropriate information. The participants recognised that contraception education should be provided by a female nurse who could go into schools. These considerations may also be relevant to other minority groups who face similar cultural or access-related barriers:

> *'I think talking to young girls when they go into secondary school to make them understand that there is contraception out there, not every girl is gonna get married at 18, there's different norms for different Travellers... Young girls need to understand you can go to your GP; you can access [contraception] it...The minute they go into high school, that's*

> *appropriate, like, once a month for the nurse to go in and talk to all the young women, or you can walk into the nurse and say… Can you explain this to me and how do I go about it, discreetly, and if she wants to and if she doesn't want to, she doesn't have to… That there someone there to talk to as it opens up a lot for young girls, and they don't find that at home.'* (Joan).

Traveller women discussed how young boys need to be informed also and included in conversations because they are often excluded from conversations related to women's health: as the Traveller women say their men are excluded: *'Young boys too, and if the young girl fears going to the doctor, or the stigma, then the boyfriend can… Encourage more open, get them to learn about it in school'* (Mary).

Traveller women discussed DSGBV and coercive control as a factor inhibiting women from accessing contraception. They noted that DSGBV crosses all groups of women in society and that it was not unique to Traveller women, but does exist within their communities also: *'Domestic violence is in every part of our community regardless of background, it doesn't discriminate, and I do think there are men that try to control women, and young girls from an early age need to know about contraception'* (Sarah). Traveller women discussed solutions and ideas for meeting the contraception needs of women experiencing DSGBV and coercive control:

> *'A lot of women don't have access to phones because of power and control and stuff, when they are going into their GP, like that, it wouldn't be any harm, if a woman in the GP, and for, a nurse to call her aside five minutes after her appointment, well now, I haven't seen this woman in a month, and I will check in, I will check in with that woman and let that nurse just take five minutes to, away from the man, just five minutes, to say 'How are you, do you need anything, can we help you, do you know this is available?', because some women don't have access to phones, …" If your happy for me to do it, then I can set it up for you and we can send the prescription to the chemist and you just go and pick it up", Sometimes you can't take leaflets home with you, because you mightn't want the husband to know, But not everybody can use a phone, not every man allows the woman access to a phone'* (Claire).

Traveller women don't believe that posters and leaflets about contraception, and the Free Contraception Scheme reach everyone equally because of literacy concerns: *'Posters doesn't work for everybody, 70 per cent of our community has literacy problems, and can't read or write'* (Mary). Moreover, Traveller women discussed how posters and leaflets were not culturally inclusive or easy to understand: *'We can make it our culture friendly so that our culture will understand it and then we can share that information cause, always kept it followed up…'* (Cora).

They called for their input into the Free Contraception Scheme by being involved in the discussions and design of information for the wider Traveller community: *'Leaflets left here and we can provide that information, and we can change the posters to make them easier to understand'* (Claire).

The focus group participants provided solutions to accessing contraception information using technology for young women:

> *'Short videos on TikTok, videos on YouTube, all places where you're getting young people to be using the phone, they are always on the phone, so do short videos, Snapchat, put up like a QR code that they can scan, and they can do it privately, no one has to know, you know like, they don't like talking about it in front of the parents and the minute you mention the*

> *parents, no-body knows your business, you would get a lot more people coming forward than you think, especially younger ones as well…'* (Mary).

Traveller women have access to Traveller Primary Healthcare Projects, which are pivotal in sharing and communicating information: *'If we did a video that was understandable, then we would be able to put in our website, and we as workers can share it, because we are friends with everybody in the community'* (Sarah). Traveller women discussed further opportunities to provide contraception information in the community.

They talked about events and gatherings where Traveller women and families attend. For example, Primary Health Care Traveller Projects (PHCTPs) operate as partnership initiatives between the HSE and Traveller organisations and provide ongoing, community-based support to Traveller families. Functioning as an interface between mainstream health services and the Traveller community. Moreover, they are a peer-led model that train Travellers to work as Primary Health Care Workers, and this allows Primary Healthcare to be developed based on the Traveller community's own values and perceptions. and enables primary healthcare to be shaped by the community's own values, priorities, and perceptions.

> *'Where there are high traffic of women passing through, [Women's health talks] at Traveller family days, the whole community comes, that's men, women and children, teenagers and we do everything, and we get big numbers, so it would be great, services come that day to deliver to us'* (Cora).

> *'Free information clinic once a month, in the middle of the town, in the shopping centre, and a woman passing by that never thought about it, and might think, that's a good idea, At least then you don't have to say you're going into the clinic, you can say you are going into the butchers, or the shop'* (Nora).

Disabled women

There were eleven disabled women in the focus group. It was conducted online to promote accessibility. Both a facilitator and a researcher were present. Participants were not asked to share details of their impairments but could do so if they wanted to.

(1) Awareness of the Free Contraception Scheme

Barriers to awareness of the Free Contraception Scheme occurred on practical and perceptual bases. Practically speaking, disabled women indicated that they may not encounter information on the Free Contraception Scheme in a format that is accessible to them. Alice, for instance, who has a significant visual impairment stated: *'…. I couldn't read the leaflets.'*

Combined with practical impediments were perceptual and attitudinal barriers, such as the view that the Free Contraception Scheme may not be available to or intended for disabled women: *'there's a lot of disabled women… would like to avail of the free contraceptive scheme, and they know what's available, but they're, they're being shut out or you know that they don't know what's available. They don't know what's available or they're being told this isn't for you'* (Laura). Kate added: *'I want to know how does the contraception scheme work? And is it accessible for me to apply like can I just apply but then do I need to be disabled to be able to apply?'*

There were different ways that disabled women might become aware of the Free Contraception Scheme, according to participants. Some participants had not previously heard of the Scheme, others heard about it from the media, healthcare providers and from friends. Laura highlights how disabled women might be pointed to the Scheme when receiving medical treatment that relates to their impairment(s) or regulation of their cycle:

> *'People don't have regular periods... sometimes contraception is kind of thrown at you or seen as a solution to regulate your cycle and when actually all the information is not given to you. Because obviously with contraception, uh, like, like the pill, there's a lot of side effects, I think there needs to be more kind of awareness and education around the, the effects of it and just obviously around you're taking this because you know you are fully aware of you know the side effects and that you're taking it because you want to take it or not because you feel. ...oh, sure it will be grand or because my doctor said so'* (Laura).

Barriers to full labour-market participation are significant for many people living with disabilities; labour market participation is proportionally lower. As a result, many disabled women are entitled to means-tested payments and hold medical or GP Visit cards. As was also the case with the Traveller participants, there was potential for confusion about the Free Contraception Scheme being universally free regardless of medical card status, for those within the eligible age range: *'medical card... because it's means tested... You get a full-time job where you go over the threshold, sorry, and you then don't qualify for that card, but you could qualify, you will qualify for the Free Contraception Scheme'* (Laura).

Finally, the accessibility of information on the Free Contraception Scheme and role of disabled person's organisations (DPOs) in supporting women to gather information was highlighted: *'But there needs to be readily available accessible information and there needs to be training and collaboration with DPOs in my opinion to.'* (Emma) and Participant 1 added: '*None of that was explained to me. I had to find that out on my own'* Overall, participants alluded to a need for better awareness and education around the Free Contraception Scheme: *'I think it definitely there does need to be more awareness and education around it, because that's an issue that there's a lot of incentives and things that are available but people aren't aware'* (Laura).

(2) Accessing the Free Contraception Scheme

Participants explained how access to the FCS is limited for disabled women in the same ways that wider access to healthcare services at large can be limited due to impairment related inaccessibility factors. Kate shares the view that different kinds of impairments can mean different degrees of experiencing inequality and points to barriers to using her guide dog to access medical services as a visually impaired woman: *'as somebody who's totally blind, who has been fighting the healthcare system...on every level, for years, I've had negative experiences with my own Disabled Persons Organisation (DPO). The focus there is autism. And wheelchair. The blind are way out of the kitchen. And we're way down the food chain for a lot of things within the healthcare setting... like a hospital that I can use my dog, they need a rabies injection just to enter the hospital'.* Jessica highlights similar experiences of barriers to accessing healthcare services for mobility impairment:

> *'I was speaking to a woman and she told me that she couldn't get access to a smear test because she was in a wheelchair and the doctor's office that she was attending didn't have a hoist in the office to allow her onto the bed... You know people who will go and have sedation, so that they don't have to go through it, so it doesn't happen in your local GP, you have to go to a different place altogether... so I imagine... For women who can't, who need that extra help with getting onto the beds and things like that as well.'* (Jessica).

Information on accessing the service also needs to be given in different formats for women: *'with visuals for people that are able to learn'* (Emma).

Additionally, fear grounded in past medical traumas related to disabled women's impairments was raised as preventing disabled women from wanting to engage with the Free Contraception Scheme: *'women are not taken seriously with that pain. If a man goes in to have something done with his testicles, he will have some kind of numbing agent put on for a, for an ultrasound. But a woman will be told grin and bear it and take some ibuprofen beforehand'* (Jessica), Participant 10 added: '*trauma, like trauma stories...man was in the meeting [a meeting on women's health] and I was saying it's a very personal stuff, women stuff really, and I'm very sensitive about that sort of stuff when there's a man I've had negative experiences. And I was unaware that he was in the room [due to visual impairment] ... Everybody else could see he was there'* (Kate).

Laura explained how the responsibility to make accessible routes to the Free Contraception Scheme should lie with disabled women themselves in line with a social model of disability:

> *'Social model of disability, which basically means that we operate, and we see the disability as it is not a person's impairment or clinical label, it's actually an interaction, I mean, a person's perceived impairment label and the external environment, or people's ableist attitudes or inaccessible policies. So basically, we don't see disability as something that is wrong with us or something that a person has, but it's actually done to people that have impairments basically, so it's external. So, it's not us that need to change ...it's not our bodies, our minds that need to change. It's actually society that needs to change and, and that's how we, we see society.'* (Laura).

Finally, participants highlighted the value in accessing the Free Contraception Scheme for empowering disabled women to take control of their own healthcare: *'it gives me some sort of sense of control for myself. And I could actually work on my health as well.'* (Jenny)

(3) Barriers to contraception

Participants highlighted prejudicial views about disabled women that could act as barriers to the Free Contraception Scheme: *'I'm obviously a disabled woman myself. I was born with my impairment. But I think for other disabled women, the assumption is that well, because of their impairment or their clinical label, well, you're not going to need to use the free contraception scheme'* (Laura). In addition, practical barriers relating to impairments also made contraception use difficult:

> *'I'm totally blind. My story is long and varied, but back when I was 19, I wanted to get sterilized, and I was told that I had no right to choose. I'm blind, I have neurofibromatosis, I have scoliosis. I would die if I carried a child. I never wanted children. No children. Sorry for parents and here, but so I wasn't. Like that. So... was put on the pill. And I nearly had*

> *a freak out whenever my sister said you're taking the pill wrong. I was like. What do you mean? She said, it's got the days on it. Monday, Tuesday, Wednesday, Thursday. And I thought then that that meant that each day was a different meaning, and I was like there I was like, oh, sweet Jesus. The very thing I don't want. I can end up having. But then I didn't realize that there were days of the week written on them. I just took them randomly'* (Alice).

Barriers to contraception also arose from traumatic past experiences: *'had it in [the Coil] for three years and throughout those three years I had two periods every month. But I feel every month and ended up having to take the pill with this to regulate. There was no doctor that said, let's take it out.'* (Jessica).

Finally, existing treatments that disabled women are receiving due to their impairment(s) could act as barriers to the effectiveness of contraception: *'I was put on to the contraceptive pill, and then I have... I also have bipolar disorder, so I was taking medication for that. And it turns out the pill does not work with antidepressants and things like that... It can be... It can be, counterintuitive. It can stop either the pain from working, which leads to you becoming pregnant, or it can stop your medication working. And so, you get sicker. And nobody wants to be that sick and pregnant'* (Jessica).

(4) Areas for improvement

The last theme for the focus group of disabled women is focused on areas for improvement. Participants had ideas of how the Free Contraception Scheme could be improved. Alice felt the Scheme was interpreted by some as promoting promiscuity and thus information sharing about the Scheme could be improved: *'And I think the kind of the negative way around it, obvious when they promote stuff, promiscuity and all that in the media'* (Alice).

Participants suggested information would be provided in ways that support the particular needs of disabled women such as having more in-person services that disabled women can access where it would be explained to them face-to-face that there is a Scheme: *'I do think anyone with really high level of traumatic medical experiences... If I'm allowed to say that... I should be able to go up and talk in person'* (Kate). Better collaboration and coordination of work between healthcare providers and DPOs was recommended:

> *'They need to understand, have an understanding around the importance of DPOs and what their role are, nd they need to have an understanding of what ableism is and how prevalent it is in society and that it is particularly prevalent, you know, within the medical profession. And there's a lot of disabled people and disabled women in this case that do have a lot of medical trauma... You know that needs to be taken into account and also, they need to get appropriate training around... there needs to be disability equality training, not disability awareness, because that's focused on impairment and medical conditions and, but this will be equality training as well'* (Laura).

A disability-inclusive and rights-based approach to administration and delivery of the Free Contraception Scheme was suggested: *'when we're engaging with the healthcare services that we don't feel that we have to kind of tell people our traumatic experiences and as a way to bring about social change'* (Alice), with Laura adding: *'But I think in general there does need to be a piece of work around our attitudes towards disabled women, because there is this hierarchy of impairment where you know, if you're perceived to be, you know not capable* *unquote on quote to disabled, you know, will then the likes of this initiative... They're not... They're not for you. And I think that needs to be challenged'* (Laura).

Better medical expertise around the intersection of disability and contraceptives is needed to avoid disabled women having to experience painful and traumatizing experiences:

> *'And I live with fibromyalgia. So, it's chronic pain disorder and... After a month, you're supposed to go back in and have it (the coil) checked so when I went back in, I was told they could not find it. I was going to have to go for a scan to make sure that it was still in place and that in the meantime, now I have to go back on the pill to make sure that I am covered. And so, I went and had to scan down a couple of months later because you have to wait months before you can have that done. And to find out that everything was OK, within the next two years I was admitted to hospital because they suspected septicemia for chronic pain. All different types of things going on. And it turned out that the coil was not placed properly and left me in horrendous pain to the point where I couldn't lie down on that side that was affected'* (Alice).

Finally, participants argued that attitudes towards disabled women's reproductive health need to change: *'this issue is quite a nuanced issue and especially when it comes to disabled women because you know what health it's, it's not taken seriously or reproductive health. You know people are still being... forcibly sterilised, and things like that... And you know, around autonomy and things like that. But for the likes of the Free, the Free Contraceptive Scheme, that can really help with disabled women's autonomy and, and you know the overall well-being'* (Laura).

Migrant women

The focus group consisted of seven migrant women from various backgrounds now living in Ireland. Migrant women living in International Protection Accommodation Service did not participate in the study focus group. However, qualitative research on asylum seekers' experiences of sexual health services in Ireland has identified multiple systemic, socioeconomic and informational barriers to accessing sexual and reproductive healthcare, including contraceptive services, for women living in International Protection Accommodation (Chakraborty et al, 2024), The participants shared their knowledge and awareness of the Free Contraception Scheme and discussed their experiences of accessing contraception more broadly in Ireland. The findings consider the participants age range between 18-35, and two participants who were over the age of 35.

(1) Awareness of the Free Contraception Scheme

The majority of the participants stated that they were not aware of the Free Contraception Scheme and believed many migrant women, including those living in International Protection Accommodation Service, whom they know are also not aware of the Free Contraception Scheme. Della outlined the following reasons: *'I didn't know anything about it and until I spoke to you... I have had four children in Ireland, and I never heard of this Scheme'.*

The experiences of migrant women who worked directly in sexual and reproductive healthcare demonstrated awareness of the FCS because of their roles; however, they concurred with the general findings that women from migrant communities across Ireland do not always know about the Free Contraception Scheme.

This suggests that a significant proportion of migrant women may have been obtaining free contraception through their medical cards, indicating that limited awareness is unlikely to be the sole barrier to access. *'I know about the Scheme, because I work in that space, I work as a health officer, and that is how I know, but I came here as a student and when I was a student and of course the Scheme was in pass, but I still didn't know anything about it... Part of my job is to know [about the Scheme], otherwise if I was working in some other sector, I might not know'* (Sophie). Sophie continues: *'In a professional and in a personal capacity, I feel a lot of migrant women do not know about the Scheme'.*

The women in the focus group confirmed that they were not currently accessing the Free Contraception Scheme. Migrant women in Ireland depend on other migrant women for information about contraception and they tend to discuss contraception within their unique migrant groups rather than with healthcare providers: *'For me I have the coil, for me I just asked my sisters, and they said the coil, so I just used the coil, for me I never actually asked a healthcare provider, I asked my sisters and their experiences... and that's what I went for'* (Marie).

(2) Accessing the Free Contraception Scheme

Migrant women expressed interest in accessing the Free Contraception Scheme but felt they continue to be excluded from accessing the FCS for many reasons. Migrant women in the group discussed exclusion from the FCS because they may not have a PPSN number which is a requirement to access: *'To access it, you need the PPS number, and when you enter the country for the first time, I knew, I was told I needed it to work part-time and so, but they never told me I needed a PPS number to access for health reasons, like health related services like abortion or contraception for free if you have a PPS number'* (Nessa). Migrant women may hold temporary or short-term visas for many different reasons. Accessing a PPSN can take time and may be provided (or not) based on their legal status to remain in the country, whether permission to work is included in the visa and the time interval allowed for legal residence, as stipulated in the visa.

From a practical perspective, not all migrant women have access to a GP, and this was particularly prevalent for women living in cities where GP with whom practices are at capacity and are not taking on new patients: *'The reason why, [I] didn't get a chance to use it here, is because I don't have a GP, eh, it's been three years [In Ireland], I still don't have GP and just to have, or use the Scheme for the first time you need to go through the GP'* (Marie). Marie continued: *'They are full, there are no GPs available, I would just say they are over worked, I am not saying that they are not willing to take me, in that sense, they just don't have the capacity to take me in'.*

This is further exacerbated by the lack of options where migrant women may only have had access to a male GP, with whom they were not comfortable discussing contraception. Migrant women living in International Protection Accommodation Service are assigned a GP and may require additional transport support to attend the GP clinic. As a consequence of these issues, it is not uncommon for migrant women to continue accessing healthcare in their countries of origin by either visiting 'home' throughout the year or accessing their doctors at home using an app:

> *'You just go back home, get your tests done, get your medicines in bulk and hope that they don't expire before the next visit home, that's it! …There is an online app which we can get, which we can ask or consult, but then again, there are some things you need immediate answers to, like if you have a reaction to a medicine or a contraception, then the online consultation is not really going to help you'* (Cassie).

Moreover, migrant women expressed a preference for a female GP or healthcare provider and not having access to a female healthcare provider impacted on their choice of contraception and access: *'For me, I prefer a female, and I feel more comfortable than the male, especially you know when it comes to the coil, and contraceptives, so'* (Tina).

Migrant women discussed the complexities of navigating the Irish healthcare system in general which they found challenging: *'Just knowing the way around the Irish system, navigating the healthcare system is not easy, for migrant women… not knowing where to go exactly, who to ask… the service is there, but the information is not there to use it'* (Nessa).

(3) Barriers to accessing contraception

Barriers to accessing the Free Contraception Scheme and contraception more broadly included English literacy skills because the participants believe that information about the Free Contraception Scheme is not always accessible to them: *'Better communication, especially the language barriers, like for some women in the migrant community, who might not necessarily know how to read or write, even to try and find a better way of doing visuals that can explain things… sometimes these women may be accessing the GP, or the hospital and there is a flyer, but because they can't read in the language or they can't read it at all, is also a barrier – you know, you think the message is getting across but maybe for many migrants it is not'* (Lisa).

Migrant women discussed waiting lists and appointment as a barrier for accessing contraception: *'Contraception is urgent, especially if someone is sexually active and waiting for access is a barrier, we need to ensure they get an appointment, and through advocacy, the different advocates in the sector'* (Tina). This concern extended across all their reproductive healthcare needs:

> *'I came to this country in 2022 and I had a gynae issue and I was put on a waiting list up until last year in 2024, I got a call asking if I still wanted to be on the waiting list, so for me, I think I lost any faith in the healthcare system in terms of like having to deal with issues like that, so if I have a problem like that, anytime, I will try and fly back to (country of origin) and have everything sorted… Issues like women's health need to be taken seriously'* (Dora).

Cultural barriers remain a concern for migrant women in Ireland when accessing contraception more broadly: *'It's not surprising for a lot of women choose not to access contraception for cultural reasons'* (Lisa). Participants discussed their religious and cultural values which do not always translate to medical practitioners and called for cultural competency approach to their reproductive needs. Like when they may access contraception, and not: *'Talking about the Scheme, I think you know, different culture, different behaviour, I think the big gap needs to be bridged because, if there is a service there, it needs to reach out to all beneficiaries, healthcare workers don't know it is not reaching out to everyone, there is a gap, they will need to communicate'* (Della).

Migrant women discussed the impact of female genital mutilation (FGM)[19] and how certain internal long-acting contraceptive devices cannot be used. Moreover, they believe that the numbers of women experiencing FGM in Ireland is increasing and healthcare providers need to be culturally sensitive when discussing contraception with migrant women and from a trauma informed perspective:

> *'For those who are circumcised, you know, FGM, they cannot use some, ehm, will not be able to use some contraception, because of the circumcision, or the female genital mutilation, it would be impossible to use because of the FGM itself, and the damage to the female genitalia, so like the coil, or anything that has to go through the female genitalia, or implanted would not be an option… Even in Ireland now and the numbers are increasing with a number of migrant women came to Ireland with experience of FGM'* (Cassie).

The migrant women discussed the stigma and trauma experienced from FGM: *'These women have lots of stigma to carry… Accessing contraception, and traumatic and re traumatic experiences of contraception for survivors of the women living with FGM (Cassie). This was exacerbated by healthcare providers knowledge and experience of FGM: 'Not all healthcare providers are familiar with FGM, so we need to train them, you know to give them this idea and the cultural issues, regarding the FGM, so that, they can help their patients who have experienced that'* (Cassie).

Female Genital Mutilation (FGM) – Care in Ireland

Aspect	Details
What is FGM?	Harmful procedures on female genitalia for non-medical reasons. No health benefits. Serious physical and psychological impact.
Legal Status	Illegal in Ireland, including travelling abroad for FGM.
Specialist Care	IFPA FGM Treatment Service (HSE-funded) – free, confidential, no GP referral.
Services Provided	Medical assessment, deinfibulation, pregnancy & sexual health care, counselling, interpretation.
Locations	Dublin City Centre & Tallaght (accessible nationwide).
Other Supports	GPs, maternity & community health services, HSE mental health services.
Community & Advocacy	AkiDwA – culturally sensitive support & advocacy.
Child Protection & Safeguarding	Report at-risk children to Tusla; criminal matters to An Garda Síochána.
Care Principles	Trauma-informed, culturally sensitive, confidential.

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[19] Female genital mutilation is a human rights violation, and practice that involves intentional changes or injuries for non-medical reasons to the female genital organs. Information and supports are available through the Health Service Executive such as through the Free FGM Treatment Service (ifpa.ie).

Previous negative experiences of contraception use also impact on migrant women accessing the Free Contraception Scheme and contraception more broadly. They discussed how women's health in general and their experiences are not taken seriously: *'You know sometimes when you experience something not good, you wouldn't want this to happen to the next person… it's not like the system is broken, broken, we just like, need to have a little more push, for this and the more, we can do better and try to help other people'* (Lisa).

4) Areas for improvement

The participants discussed areas for improvement which include extending the age bracket for older women who still require contraception: *'To expand on the Free Contraception Scheme to women of all reproductive age category that is definitely something that is needed because there are women who cross the age category, or didn't know about it until now, that is definitely needed. That should definitely be the push from this report, something that I expect'* (Lisa). Participants also discussed information that included different languages, visuals:

> *'Adverts that also tackle language barriers with the majority of the languages, even using, I don't know, something like imagery, that can also work for people, let's say, like are hearing impaired. Migrant women also may be blind, hard of hearing, so making sure we have in Braille, making sure we have visuals for those who are hearing impaired. Lots of cartoons [graphics] are mainly white so also making sure we have inclusive language, and inclusive imagery'* (Dora).

Migrant women advocated for women and healthcare providers to be informed by cultural competency and/or have similar or shared cultural backgrounds. This should include information in multiple languages on how to register with a GP and access the FCS; *'Someone in the sector that has similar cultural backgrounds so they can educate and make them [other healthcare providers] aware of what are the barriers [for migrant women]'* (Tina).

LGBTIQ+ people

The focus group consisted of four LGBTIQ+ individuals. The participants shared their knowledge and awareness of the Free Contraception Scheme and discussed their experiences of accessing contraception more broadly. In this context, we acknowledge LGBTIQ+ individuals as a hard-to-reach population, and our recruitment drive allowed for a small sample only. Based on the findings from the focus group, we understand how this group can be experiencing significant barriers accessing contraception, health and reproductive health more broadly.

(1) Awareness of the Free Contraception Scheme

The focus group participants were mainly aware of the FCS. They mainly credited their awareness to being in university or third level education, where student unions and health services actively promoted the FCS: *'I always found it very easy to access information about it because like I said at the time when I was accessing it, I was in my undergrad. I was in [university named] and the student union and the student health services were very vocal about it.'* (Jade).

LQBTIQ+ members highlighted the importance of digital literacy and institutional support for visibility across campus networks and social media, combined with accessible online information, helped to promote the Free Contraception Scheme: *'I always found it very easy to Google it when I was going and making my appointment with [a specialist family planning and women's health clinic] to access the scheme. It was fairly easy to find on their website'* (Mia).

Some participants suggested they didn't fully understand what the Free Contraception Scheme was. For example, Jo believed it was intended for people *'under the age of 25 or within a certain age bracket'.* The participant discussed being able to access some forms of contraception over the counter for free. Their knowledge of the Scheme came from university sources, such as *'leaflets distributed by the student union'.* Another participant thought it was *'free for anyone 18 to 30, maybe 25'* (Alex). This suggests that the FCS's initial rollout had a lasting impact on participants' overall awareness and understanding. However, subsequent changes to the age bracket continue to cause confusion and uncertainty about eligibility.

> *'Yeah, I would have... I suppose it's linked to when the Free Contraception Scheme came out and they did all the information campaigns. I think I was just about to turn 26, so all the initial information about what's available wasn't relevant to me. They did later extend the age bracket, but they had already done the information campaigns that said it wasn't relevant to me. I think I probably missed the boat a little bit in terms of knowing what's on the scheme'* (Mia).

(2) Accessing the Free Contraception Scheme

One non-binary participant expressed a deeper knowledge of the FCS. They reported using the FCS to access contraception for the second time. At the time they identified as bisexual, and they were dating a trans woman: *'I find it pretty good. I know all you need to actually access it is a PPS number and, obviously, to be in the age bracket. And you can get anything from the pill to the bar, to em... the patch on it. I think it's like really good for anyone'* (Jade). The participant described their overall experience with the Free Contraception Scheme as positive. While they initially used the pill for contraceptive purposes, they now take it to manage heavy periods and alleviate symptoms. They highlighted several key benefits, including reduced stress around scheduling appointments and the financial relief of not having to pay out-of-pocket for contraception.

> *'Em... I ...At the time, I identified as bisexual. Em and I was dating a trans woman. So, I needed the pill, like for contraception reasons. But since then, I actually stayed on the pill and stayed using the Scheme because I get quite bad and heavy periods. So, it's been a life changer for me, because it means I don't have to be paying... I think it was' not expensive, 'I think for a box of three, of the progesterone only pill. Like you know, I don't even have to worry about paying for a doctor's appointment or for going to the chemist. It's been brilliant. Because even that would only be 50 euros for a doctor's appointment and then maybe 20 for the pill itself. It means I am saving that bit of money, and I can put it towards rent or groceries, or fuel for the car, you know?'*

(3) Barriers to contraception

The focus group participants discussed the barriers faced by individuals outside of university, third level or an educational context. They focused on individuals for whom English is not their first language For example, a non-binary lesbian participant illustrated this by stating: *'While I never had any issue with it, but I can imagine maybe if English is not your first language, or you don't have access to the internet or if you don't have access to third level education it would probably be harder to find the information on it'* (Jade). Another participant, a lesbian woman, agreed with this *'I was just going to say if you weren't in university, you are not coming across it [information about the contraceptive scheme] as frequently'* (Alex).

> *'However, I will also add that I work for [participant names organisation], and a lot of the girls [who didn't attend college] didn't even know about the Scheme. But then again, I was thinking through my degree course, everybody knew about the Scheme. There's almost a lack of education on it. I think, like, understanding what it entails it doesn't have to be complicated. I think it's more of a thing that it wasn't as dispersed as a lot of other schemes are intended to be... I never really saw this out in public'* (Mia).

Further barriers included living in a rural location. A participant from a rural location experienced an instance of professional bias, with staff expressing personal opinions and asking intrusive questions related to their sexuality. Participants reported feeling as though they had to justify their decisions regarding contraception, which added to the sense of frustration and exclusion: *'well my experience, because I am originally from rural [location named]... the experience I have had let's say from moving to the city and trying to access it has been completely different to rural [location named]. Up in the city whenever I go to a GP there's no question about why do you need the pill, it's just the general questions of high blood pressure, blood tests and all that you know? It's like 'ok you're under 35 you have a PPS number, ok grand'* (Mia).

Participants described a stark contrast between their experience accessing the Free Contraception Scheme in a city compared to a rural area. They recounted their first attempt to use the FCS, highlighting how location significantly influenced the quality and ease of access to services:

> *'But then when I had moved home between my undergrad and my post grad, I had gone to our local GP. [Participant expresses anger, in their voice] I had to pay for the appointment even though I knew I could get it for free because the receptionist said 'oh we don't do that Scheme' and I was like 'Ok but it's a national scheme, it's not opt in or opt out', but I still had to pay for the appointment... and then when I went to the chemist, despite me saying 'hey I have a PPS number, I'm under whatever the age was at the time. They still made me pay for the pill'* (Mia).

The rural participant continued: *'And then I later... when I was talking about it a friend who had a friend who had to access... like an at home abortion, where you pick up the prescription. That chemist refused to fill the at home abortion for my friend's friend... I guess you could say personal opinion concerning reproduction'.*

Participants shared experiences of healthcare providers asking intrusive questions regarding their sexuality, leading them to feel they had to justify their contraceptive choices based on what they believed were homophobic and heteronormative assumptions about their sexual orientation. This presented an additional layer of gatekeeping not typically encountered by heterosexual individuals combined with feelings of exclusion to accessing the Free Contraception Scheme: *'But when I went home [to rural location], because my GP knew I was queer, it was a question of, well, 'Why do you need this?' It wasn't, you know, 'Why do you need this—are you having safe sex?' It was a question of, 'Sure you're gay, why would you need it?'* (Mia).

The participant expanded: *'And you know, the pill isn't just obviously for contraception. It can be for things like heavy periods, or even someone just not wanting to get their period. It was... it felt like at home—or at least in rural [location named] I was fighting an uphill battle'.*

A non-binary lesbian participant shared a friend's similar experience, highlighting the stark contrast between urban and rural areas in accessing the Free Contraception Scheme.

> *'I think another big part is the discrepancy in information about it. I know my friend's experiences. Like, I have a friend who lives in [redacted], and her trying to access that for herself and her boyfriend, it was like an uphill battle. She actually ended up having to go to Cork City, to, I think it was a women's clinic or a sexual health clinic. It was easy. Whereas when she was trying to access it down home, in the very west part of rural Cork, it was quite hard'* (Jade).

Similar themes emerged in the narratives for trans man *'I was in with my friend; we had a sleepover; this was about a year or two ago. Anyway, I needed to go to the doctor [in a rural area], and the questions I was asked over there were a lot more..., I felt that there were personal biases coming in... I don't think it's ethically acceptable to ask someone those really, really personal questions'* (Jo).

A trans man also recounted an experience of transphobia when attempting to access information on contraception, indicating how gender identity can complicate access to sexual and reproductive healthcare. Their account underscores the additional barriers trans individuals may face, not just in receiving appropriate care, but even in being acknowledged and treated with basic respect when seeking essential information regarding contraceptive choices:

> *'I think I was about 16 or 17 and, my mum took me to the GP. So, I had to see a different doctor who... I kind of knew was a bit more traditional, a lot more conservative, very religious, all that kind of, you know, jazz... And we were talking about pills and contraceptives and stuff (in relation to sexual health). And the words he said to me were you are almost 16; we will not be entertaining this nonsense for much longer.' Those were his words.'* (Jo).

The participants were asked if previous experiences impacted on them accessing the Free Contraception Scheme and contraception more broadly: *'Absolutely, it's not just a doctor thing but also with pharmacies, where you ultimately have to get the medication from and if you feel like you know them or there's going to be that personal bias you can be almost like well I don't want to go in there because I know I am going to put myself in an uncomfortable situation'* (Jade).

The LGBTIQ+ participants talked about the LGBTIQ+ community and their unique barriers to accessing the Free Contraceptive Scheme. Their discussion reflects the complex interplay between sexual identity, stigma, and access to contraception for queer individuals, who must justify their use of contraception: *'I suppose for a young queer person em... who maybe is bisexual or engaging in activity where they would actually have to be worried about contraception use, that is something then that kinda like... yeah I suppose it's the frustration or even embarrassment whatever around it where they kinda have to go 'No, I need this for X, Y Z reason or whatever'* (Jade). This finding was also echoed by a bisexual woman in the focus group:

The assumptions of heterosexuality and gender normativity can make contraceptive consultations uncomfortable for bisexual women and other members of the LGBTIQ+ community. The participant describes the emotional impact of healthcare professionals defaulting to male pronouns, which disrupts the flow of conversation and creates a sense of erasure. A lack of sensitivity or flexibility around language adds to the discomfort, leaving the participant feeling that the interaction was strained:

> *'It's not so much about being believed, but that if you're like 'I have a partner and I'm looking for contraception, they [health care professional] will go quite quickly to 'he, he, he… it's going to be he… It's a man that you're dating and that's really uncomfortable if you're like 'that's not even true… But if you're someone [the health care professional] who is not fluid in swapping pronouns, it just makes the conversation pretty clunky if someone is like getting it wrong and not caring or getting it wrong…'* (Jo).

Participants who were ineligible for the Free Contraception Scheme due to age, highlighted their indirect involvement by collecting emergency contraception on behalf of others, often because those individuals feared being recognised or judged. This act underscores how deeply stigma surrounding sexual health persists in rural or close-knit areas in Ireland: *'But I have been the person who has been sent to pick up the morning after pill for other people, where there has been a case of like I don't want them to know I am coming back again, or I just don't want them to see me going in… you kinda stick out a little bit anyway, particularly in the hometown whatever'* (Alex).

LGBTIQ+ participants talked about *'sticking out'* and were frequently tasked with collecting contraception or emergency contraception on behalf of others. The participant's willingness to help suggests a sense of solidarity but also highlights how queer individuals may be perceived as *'already different'* or *'hyper-visible'* in these settings. Their comment about 'sticking out' and acting as a 'defence' implies that her visibility as a queer woman may, paradoxically, offer others a form of cover while also reinforcing her own marginalised position: *'The other side of it is, being visibly gay that I have been the person who has been kind like punted into going to pick up contraception because nobody is going to ask any questions'* (Jade).

The quote below reflects mixed feelings about the Free Contraception Scheme among LGBTIQ+ women nearing 36, who age out of eligibility. The participant highlights a shared sense of frustration; particularly among their straight friends about being excluded, despite having faced limited reproductive options in the past, including travelling to England for abortion. While the Scheme is seen as a positive step, there is also a sense of being left behind by a system that now offers support they previously missed out on.

> *'I know the chat that I had with a lot of my friends who would be in the same age group as me. We are all heading into our forties quite unhappily. There has been a number of women who would have had to access abortion in England, different things like that at various points. So, it has been kinda like 'oh this is brilliant that nobody will have to be, or at least the likelihood of people accessing abortion will be reduced and people have more control over it and everything. But the main thing is like 'oh god it's a bit annoying that that bracket skips some of us. I do know it is quite fraught. It is predominantly my straight friend's that I suppose would be kind of disappointed perhaps that it would have been nice to be able to get access'* (Jo).

The participants reflected on how attitudes toward contraception are changing between generations in Ireland. The participant talked about the idea that free contraception should make it easier to talk openly about sexual health. But they say that even if contraception is easier to get, people don't always feel comfortable discussing it. They see younger people as more confident talking about these topics, which is a positive change compared to their own experience when even saying the word 'condom' was something people whispered. This reflects the long history of silence and stigma around sexual health in Ireland, especially because of the strong influence of Catholic values: *'Because of the assumption that it's free, that it would be more accessible, that it would be easier to have those conversations, it doesn't necessarily ring true'* (Mia).

Participants' experiences with contraception reveal a deep mistrust in contraceptive care. This includes a lack of personalised, informed care. A non-binary lesbian participant's account highlights how contraception was misused when their GP tried to prescribe the Pill at age 14 to 'fix' a diagnosis of gender dysphoria rather than for reproductive health. It shows how contraception can be wrongly used to control identity instead of supporting choice: *'My GP had tried to put me on it when I was 14 because I had gone to CAMHS [Child and Adolescent Mental Health Services] and they had diagnosed me with gender incongruence and my GP had said 'well the pill will fix that' which is not true, there is no research behind that and I don't know in what world putting a 14 year old on the pill is going to fix homosexuality, but that's a whole different conversation' (*Mia).

The story reflects how LGBTIQ+ young people may face homophobic or misinformed care, which can damage trust in healthcare. LGBTIQ+ people may have a history of negative experiences with health professionals, and this may impact how they use the Free Contraception Scheme. A nonbinary lesbian participant disclosed the following:

> *'Like I was saying, when I was 14, my GP was quite homophobic, transphobic, and is explicit in that, like, doesn't hide it. You know, it medicalises the queer and trans experience. So that was when I was about 13 or 14, like, every time I went in, it was treated as a symptom of being queer. Like, 'you're depressed because you're gay.' And it's like, no, I can be gay and depressed. They're not mutually... one doesn't come free with the other, like, and I felt like every time I had gone in, it didn't matter if I saw my GP or another GP working in the clinic. It felt like I was being, I was working, an uphill battle. I was having to prove every single little thing: that it wasn't just because I was gay, that it wasn't just because, at the time, I was experiencing gender dysphoria. Em... you know... let's say, take the depression and anxiety thing. I was depressed and anxious because I was a teenager, or for different reasons, not because I was gay. I was totally comfortable in that'* (Jade).

This quote shows how LGBT1Q+ young people can face bias and discrimination in healthcare. The participant describes how their GP treated all their health issues as being caused by their sexuality or gender identity. They had to constantly prove their health concerns were real and not just *'because they were gay'.* This made them feel invalidated and dismissed.

Participants discussed the ongoing and evolving journey individuals often experience in meeting their reproductive needs, emphasising that contraception choices can change over time, dependent on the personal circumstances, health considerations, and informed decision-making of the individual. In other words, *'our bodies are always* *changing, and the Free Conception Scheme will be needed to help people navigate these changes on a more regular basis'.* This participant's story reveals how the quality of contraceptive care can vary depending on the provider and location.

At college and a private clinic, they were offered clear information, choice, and support to find a method that suited their needs and medical history. In contrast, their local GP was less helpful, requiring them to know and request the correct Pill themselves, even when it posed health risks. They felt more confident and respected when doctors took the time to explain all options.

This shows that appropriate contraceptive care isn't just about access, but depends on how providers communicate, listen, and support individual needs: *'I actually had to go in knowing the brand I was on the type of pill I was on. I had to specify, 'I do not want the oestrogen pill because I actually get migraines with aura, so that made mine worse. I physically can't be on it.'* And my GP begrudgingly kind of prescribed me what the Well Woman Clinic had originally prescribed' (Alex).

Jade shared an opposite experience which was positive, and they felt heard and validated: *'I went to the GP in my college, and the doctor was brilliant. Like, not only did he say, 'There are these two types of... eh, you know... pill you take every day,' but he also talked me through the implant, the patch, the coil, the IUD. He gave me so much information on it that it actually felt like it was a level playing ground'.*

Findings also point to the need for inclusive, individualised sexual and reproductive healthcare that respects and understands trans experiences, rather than assuming universal contraceptive needs: *'Just as a trans person, I would never use it. But em... I suppose secondly to that... with the medication I am already on. My libido is completely down on the floor. So, I would never use it for contraceptive reasons. I also just wouldn't have any cramps or pains or any need for that'* (Alex).

The participant notes that while many people around them use contraception for both pain and pregnancy prevention, it's often only seen as socially acceptable for trans men when used for managing pain. The example is given of their friend who is a trans man, who had to justify his use to his father by citing pain relief. This highlights how people assigned female at birth may feel pressure to mask or reframe their reproductive choices to align with socially acceptable narratives.

This insight reveals how gender norms and expectations shape not just access to contraception, but also the freedom to use it without judgement, reinforcing the need for public education that challenges such stigma:

> *'A lot of the people I am surrounded by do use it. Some people were using it for intense pain and for contraceptive reasons. Emm... I also kinda know that in terms of social attitudes towards it that a lot of the time it is only really acceptable if it's only for pain management and if it's anything but that it's frowned upon... I remember I had a friend who said it to her dad and he kind of went on a bit of a tangent. She did end up saying to him it was because of pain management, and it was like 'oh well then that is perfectly fine. I feel like on the flip side. If this was something that cis men could like employ. I don't think those standards would apply to them. Em... I think it is just social attitudes to how women and men are expected to act and behave and hold themselves'* (Mia).

LQBTIQ+ participants discussed how heteronormativity (the assumption that heterosexuality is the default or normative sexual orientation) shapes access to and experiences within reproductive healthcare settings. The participant (non-binary lesbian) initially recounts a rare, affirming encounter at a clinic, where her disclosure of having a trans woman partner was met without judgement. However, this experience stands in stark contrast to her subsequent interactions within more traditional medical contexts, where she felt compelled to conceal her partner's trans identity and adopt heteronormative language to navigate the system safely. Their decision to use 'he/him' pronouns and to present her relationship as heterosexual reflects an internalised understanding that deviation from heteronormative expectations could lead to misunderstanding, judgement, or even denial of care.

Additionally, their reluctance to disclose her lesbian identity when seeking the pill for menstrual issues underscores the invisibility of queer women's reproductive health needs within a system that often ties contraception solely to heterosexual sex. This enforced conformity silences non-normative sexualities and gender identities, placing the burden on LGBTIQ+ individuals to self-edit and endure erasure in order to receive basic reproductive healthcare:

> *'I knew when I went home to access the Scheme a couple of months later, I couldn't even say that my partner was trans. I knew not to mention it. I knew just to say 'right ok let's just use he - him pronouns, because if I had even brought up the idea of having a girlfriend at the time who was trans, my doctor wouldn't be able to wrap his head around it. It would be like 'oh well like, you know, if it's a woman... you know I just knew... he would not understand it. If I had brought up the idea that being on hormones for the first couple of months can affect fertility, but it's still not something you want to play around with when your 19 or 20. That wasn't even an option. So, I had to say my partner was a cis man'* (Jo).

Heteronormativity and assumptions about sexual identity influence experiences in reproductive healthcare. The participant's (non-binary lesbian) choice to list 'lesbian' as their usual method of contraception caused confusion and suspicion from pharmacy staff, showing that healthcare settings often fail to recognise or accommodate non-heterosexual identities. The question *'Why is a fella with you?'* reflects the expectation that sexual activity follows heterosexual norms and that anything different needs explanation.

Instead of explaining her sexual fluidity or uncertainty, the participant gave a simple, self-discrediting excuse ('I got drunk'), revealing how queer people often feel pressured to hide or change their identities to avoid judgment or discomfort: *'I didn't want to get into the semantics of 'Well, you know, I'm experimenting, I'm in college, I'm not really sure,' so I just had to be like, 'Oh, I got drunk'; which is ridiculous'* (Jade).

(4) Areas for improvement

LGBTIQ+ participants highlighted the crucial distinction between the medical and social dimensions of contraception access, emphasising how current language and frameworks are exclusionary. 'She' critiques the prevalent use of gendered and binary terminology such as framing contraception as a service for 'women aged 17 to 35' which overlooks and invalidates the experiences of non-binary people, trans individuals, and those with trans partners. By calling for more inclusive language like *'people who require contraception',* they point to the need for healthcare communications, health literacy and policies to move beyond rigid, heteronormative, and cisnormativity assumptions.

It should be noted, however, that the Health Service Executive language utilised in official information is in fact referring to women, transgender and non-binary people for whom prescription contraception is deemed suitable by their doctors and thus is more inclusive than the term 'women' alone[20].

'Her' emphasises how current discourse is *'narrow', 'black-and-white'*, and *'linear'* underscores how binary thinking fails to capture the diversity of gender identities and reproductive needs. This reflects broader issues of heteronormativity and cis-normativity in healthcare, where systems often erase or marginalise those who do not conform to traditional gender and sexual norms. The participant's call to challenge these norms through inclusive language is a vital step toward making contraception access affirming and equitable for all individuals:

> *'I think that's something that could be challenged. For people who are non-binary, trans, or have trans partners, that's almost invalidating that person's experience or identity. I think it could also be, like, even just saying 'persons who require contraception, like, I'm sure there are other ways to word it. But, you know, there's a more… I say like, I would love the report such as this to call for more inclusive language. For any report looking at contraceptive resources, I would love to see more inclusive language because it's very gendered and very binary'* (Jo).

On this subject a participant who identifies as lesbian nonbinary agrees: *'It's seen through a very heteronormative lens, of this is a boy and a girl having sex or a man and a woman. Whereas I at some point in the past was someone having sex with a trans woman but there was still a risk of pregnancy'* (Jade). The participant (non-binary lesbian) further recommended enhancing the visibility of the Scheme by expanding advertising efforts, particularly in rural areas: '*Like advertisements for the Scheme… but I don't even think my GP down home has a poster up for it in his office, never mind seeing it on a billboard, side of a bus or a taxi station, you know? It's almost very hush-hush anywhere outside the big areas'* (Jade).

Participants recommended a more sensitive approach to how reproductive healthcare is addressed by GPs. Their account underscores how assumptions about gender and sexuality, can lead to uncomfortable and exclusionary interactions. Moreover, the key roles of prescription hormonal contraception in controlling menstrual and peri-menopausal symptoms that may affect people, regardless of orientation, need to be acknowledged. The quote suggests that more inclusive training for healthcare professionals, particularly around LGBTIQ+ issues, could help create a more respectful and supportive environment for discussing contraception: *'I think generally just more sensitivity when it comes to the whole… I guess you could say, doctor's appointment discussing contraception'* (Jo).

In the focus group discussion, one participant concurred with the importance of training. The participant emphasised the need for enhanced GP training, particularly in women's health and LGBTIQ+-inclusive care. The participant described negative experiences with cis-male GPs who failed to ask essential questions, resulting in inappropriate prescriptions.

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[20] See, for instance, Health Service Executive information at: https://www.gov.ie/en/department-of-health/campaigns/free-contraception-scheme/

Conversely, they reported more positive outcomes with GPs and services specialising in women's health and highlighted the need for clearer visible indicators, such as website statements of LGBTIQ+ inclusivity, to facilitate open and informed communication between healthcare providers and LGBTIQ+ patients: *'I definitely think the training piece is important, because after I had all those experiences of male GPs... I changed to going to GPs who specialised in women's health, and that's kind of a thing you see on people's websites. But you don't really see many GPs who are like, 'I'm queer-inclusive' or 'I did this LGBTIQ+ course... My pronouns or my partners are this, that, or the other.' It's just to know that they [GPs] know what they're talking about'.*

One participant (non-binary lesbian) expresses gratitude towards the focus group underscoring the aim and focus of this research project. This statement expresses gratitude for the inclusion of LGBTIQ+ voices in discussions about the Free Contraception Scheme, highlighting a previous sense of being overlooked. The participant critiques the Scheme's design as primarily oriented toward heterosexual, cisgender couples, thereby marginalising non-heteronormative experiences. Overall, their statement underscores the importance of representation and inclusivity in healthcare policy and research:

> *'I just want to say thank you for interviewing LGBTIQ+ people regarding the contraception scheme, because I know, at least for me, I have constantly felt overlooked. The experience of the contraceptive scheme is designed for a heterosexual man and a heterosexual woman having heterosexual, cis-normative sex. It's really refreshing to see that our experiences, whether as a trans woman, a lesbian, or someone who has gone in to get the pill for someone else are being included. It's very heartwarming, I guess. I just wanted to say that and to say thank you'* (Jade).

A participant who identified as a trans woman agrees with the previous participant. They expressed gratitude for including LGBTIQ+ voices in contraception research, as an underrepresented group in this area: *'Thank you for conducting research and reports on a very under-researched minority group within contraception research. I just want to say thank you for that. And thank you for having an enjoyable space to talk about our shared experiences'.*

07. **Discussion**

7. Discussion

This research has fulfilled the aim of investigating, through mixed methods, women's awareness and experiences in the Republic of Ireland of the Free Contraception Scheme. Through a survey method and focus groups, we have gathered critical insight into women's attitudes in Ireland towards the Scheme, and toward contraception more broadly.

Findings illustrate significant challenges for some marginalised women in engaging with the FCS as well as with the wider health care system that provides the infrastructure underpinning it. These challenges are linked to women's marginalised status, supporting observations made in the *Women's Health Action Plan 2024-2025* (Department of Health, 2022). Findings of 505 participants show, for instance, that 36% of participants believed there were barriers to them accessing the Scheme and a further 18% were unsure of whether barriers existed.

Whilst this is an important finding, survey results also show a high rate of accessing contraception in general among participants. In the Healthy Ireland Survey, 45% of heterosexual women aged 18-55 were not currently using any form of contraception (Department of Health, 2025), whilst comparatively, findings of the survey in this study showed a potentially higher use of contraception by participants in this study as well as a higher awareness of the Free Contraception Scheme. This is a very positive finding, which indicates that the FCS is reaching a significant proportion of those who may need its support the most.

It has been over half a decade since the Report of the Working Group on Access to Contraception identified the presence of significant challenges affecting equitable access to contraception in Ireland, laying the groundwork for the Free Contraception Scheme (Department of Health, 2019). Yet, to date, findings of this report show the perseverance of significant barriers to accessing contraception for marginalised women, even with the FCS now rolled out at a national level. Moreover, the survey included in the research was not exclusive to marginalised women and contributes to the evidence that extended barriers remain for many women in Ireland.

Focus group findings from this report offer a detailed picture of the multi-dimensional spectrum of diverse barriers faced by marginalised women in accessing the Free Contraception Scheme. This spectrum spans from practical impediments such as having no PPSN (reflective of some migrant women in Ireland), to socio-cultural and attitudinal barriers such as healthcare providers potentially assuming some disabled women, Traveller women or LGBTIQ+ individuals do not need contraception, to socio-emotional barriers such as past medical trauma like FGM linked to women's marginalised status.

This reflects a reality of social exclusion, shaped by discrimination or lack of awareness among healthcare professionals, limited access to information for marginalised women, unmet specialist needs, missing translation support, and, at times, patients being unaware that clinicians must ask certain questions for clinical reasons such as BMI, smoking, or combined hormonal contraception. In this context, more guidance is also needed for healthcare providers. One example of this would be further development of the Transgender Model of Care to inform healthcare providers whose transgender patients may seek contraceptive products that may be deemed anatomically and/or hormonally unsuitable for them.

Marginalised women's intersecting identities were found to hold significant importance for their awareness and experiences of the Free Contraception Scheme. Survey findings indicate that the most common factors in participants' self-reported marginalisation were mental health related, and thereafter, linked to not having enough money or resources. Thus, the removal of some financial barriers to contraception through the Free Contraception Scheme is to be welcomed, however financial reprieve from the cost of contraception will be far from sufficient on its own, to ensure equality of access for marginalised groups. The complex interplay of limited resources with social, economic, health and health literacy disadvantages that create marginalisation (Cruwys et al., 2013), warrants a multi-faceted approach to reducing barriers to accessing the Scheme for marginalised groups.

Focus group findings also demonstrate the importance of marginalised women's experiences of health care services at large, including attitudes they hold and have encountered around reproductive health, and this came across strongly throughout all focus groups which can have a significant bearing on their view of the Free Contraception Scheme. Women's marginalisation has been socio-culturally constructed in the context of accessing reproductive healthcare, such as holding culturally alternative practices and perspectives on reproductive health than the prevailing culture of healthcare provision. This circumstance has interacted with a strong material reality of marginalisation surrounding the Free Contraception Scheme such as disabled women being physically unable to access a healthcare provider to acquire contraception or review information in accessible formats.

Thus, the commitments to rethink how marginalised women can better access healthcare in the *Women's Health Action Plan 2024-2025* must translate into a sufficiently detailed and evidence-informed picture of marginality in line with findings of this research (Department of Health, 2022). Central to building this picture are the views, wishes and experiences of marginalised women themselves as experts on their own lives and reproductive healthcare needs.

The findings confirm that marginalised women often encounter layered barriers to getting appropriate GP and contraception care. This includes access to a woman GP which is often compromised by geographic location and socio-economic status (Sweeney et al, 2015). For migrant women, practical obstacles were discussed, such as language barriers, limited interpreting options, and unfamiliarity with the complexities of our health care system. While HSE policy recognises the need for standardised interpreting and translated materials, provision remains uneven, and navigation is difficult. Traveller women addressed the compounded stigma and discrimination in mainstream services and broader Irish society, which undermines trust, deters attendance, and calls for wider access to community-led interventions, such as the PHCTPs.

In support of the findings, work led by Pavee Point shows the value of culturally appropriate information but also the persistence of structural racism (Pavee Point, 2025). Disabled women reported inaccessible buildings and equipment, a lack of accessible information and contraceptive options, and paternalistic attitudes that question their capacity or their right to be a parent which impact and limit choice (National Disability Authority, 2025). LGBTIQ+ women (including trans and non-binary people, who are explicitly eligible for the Free Contraception Scheme) shared experiences of heteronormative assumptions, confidentiality worries, particularly in rural settings, and gaps in provider competence, and reduced uptake of preventive sexual health care.

Across the focus groups, GP gatekeeping, patchy rural provision, and conscientious objection in related reproductive services illustrate how points of entry to care can be restrictive in practice, especially when combined with feelings of stigma and insecure status as outlined by migrant women. In effect, confirming delayed consultations, limited method of choice and interrupted care pathways.

In addition, the survey provides valuable insights to women's experiences of the Free Contraception Scheme. For participants between the ages of 17 to 35 who are using the FCS, their responses were positive. The freedom of choice removed by financial constraints is evident and a successful outcome of the FCS. Despite this significant finding, barriers persisted.

Women over the age of 35 years remain excluded despite women of this age still being fertile and having capacity to bear children. Issues with exclusion may include unplanned pregnancy in addition to insufficient control of peri-menopausal symptoms such as menorrhagia (heavy bleeding), for which hormonal coils and implants are very effective treatments. The survey reiterates that access to GPs (and to women GPs in particular) remains a significant barrier. Low levels of engagement with the Free Contraception Scheme persist amongst ethnic minorities in Ireland. Findings of this research support the view that contraception is about much more than physical health and prevention of unplanned pregnancy but includes mental and social well-being.

Further illustrated by findings is the critical importance of healthcare providers understanding the unique needs of marginalised women and making changes to provide services that meet those needs in an inclusive, effective and supportive way. With most survey participants reporting that awareness of the Scheme came from social media, the internet or their healthcare provider, these will be key avenues to disseminate any future messages and information geared at overcoming existing barriers which have been communicated by marginalised women in this study.

When compared with results from the Healthy Ireland Survey (2025, p.46), it is notable that 45% of heterosexual women aged 18 to 55 do not report using contraception versus 44% of marginalised women who were surveyed for this study. In the Healthy Ireland study, 61% of the general population reported being aware of the Free Contraception Scheme whilst 85% of marginalised women in this study reported awareness. In the Healthy Ireland (2025) survey, 9% of women in the general population relied on barrier methods of contraception like the condom and 25% relied on prescription contraception. There appeared to be higher uptake of contraception use in these categories for marginalised women in this study with 39% using oral contraceptive pill and 14% relying on male condoms.

Overall, the social construction perspective views health as much more than the absence of disease or infirmity (Schramme, 2016) and acknowledges that broader social factors have a significant role to play in health (World Health Organisation, 2025). Findings of this research show that whilst marginalised women overall welcome the Free Contraception Scheme, there is significant scope for improvement in making the Free Contraception Scheme accessible to them whilst accounting for the broader social factors that impact their lives. To realise a more equitable standard of access to the FCS, evidenced-based recommendations that align with Ireland's current legislative and policy commitments will be made.

The intention is to furnish a set of recommendations that arise specifically from the raw qualitative and quantitative data collected and analysed. From these recommendations, change can be made that is grounded in the expertise of marginalised women themselves, building better capacity for fairness and inclusion in Irish healthcare.

08. Conclusions and Recommendations

8. Conclusion and recommendations

The overall contribution of this research is significant in filling a gap in understanding marginalised women's access to the Free Contraception Scheme in the Republic of Ireland.

Prior to publication of the 2025 Healthy Ireland Survey and the completion of this research, the work of estimating key factors around marginalised women's awareness and experiences of the Free Contraception Scheme was largely based on anecdotal guesswork and speculation.

Now, utilising a new body of evidence, recommendations are presented in drawing this report to its conclusion. Recommendations are drawn from the participants findings who provided important and valued solutions to address the needs of their respective marginalised groups in society. The study is participant-led and inclusive. Twenty-two recommendations are presented next, clustered around target stakeholders.

8.1 Recommendations

1. Policy and funding

- **Expand the FCS** beyond the current age limit of 35 to include eligibility to all women of reproductive age (17-55).
- **Implement the Evidence and Learning Strategy (2024) to ensure long-term funding** for contraception services so access is not vulnerable to political or budgetary changes (Department of Health, 2024).
- Further integrate sexual and reproductive health services and equity into broader health policy and service delivery, in line with recommendations in the Programme for Government, National Sexual Health Strategy, Sláintecare and the Women's Health Action Plans.

2. Service accessibility

- **Expansion of specialised GP services, women's and sexual health clinics and centres in communities:** Provide greater reach of contraception services through additional specialist facilities and services, as also recommended in the Programme for Government. This could also include the provision of mobile or ambulatory clinics, supporting greater access to women living rurally, Traveller women, and those in the international protection system.
- **Extended Women's/Sexual Health Clinic hours** to accommodate women with precarious work schedules or caregiving responsibilities.
- **GP- based provisions:** Expand the provision of culturally appropriate and inclusive consultations free from racism and discrimination with access to interpreters and women practitioners when preferred.

- **Pharmacy-based provision:** Expand pharmacist prescribing rights for short-acting forms of contraception including oral contraceptives, the patch and ring.
- **Accessible information:** Widen provision of accessible information and services in multiple languages and formats to meet diverse needs.

3. Information and education

- Widen provision of **culturally sensitive education materials** in multiple languages and/or audio-visual materials (including plain English, Irish, Arabic, Polish, Urdu, etc.) to address the needs of migrant, Roma women, women seeking asylum and those living with literacy challenges. Widen provision of sexual health education tailored for marginalised groups (e.g., minority ethnic groups (including Traveller women and Roma communities) disabled women and survivors /victims of gender-based violence).
- Further develop **community partnerships** with NGOs and grassroots organisations to build trust in communities and among individuals with known structural health inequalities to better disseminate accurate information.

4. Equity and inclusion

- Fully provide contraceptive and reproductive health services in line with the HSE and Department of Health's statutory duty, outlined in the Irish Human Rights and Equality Commission Act 2014
- Expand the **co-design of reproductive health strategies** with community leaders and marginalised populations.
- **Traveller and Roma women:** Develop targeted reproductive health strategies co-designed with community representatives, to be delivered through PHCTP and equivalent outreach in the Roma community.
- **Disabled women:** Widen provision of accessible information formats (Braille, Easy Read, Sign language interpretation) and provider training on disability rights.
- **Migrant and undocumented women:** Guarantee confidential, stigma-free access regardless of immigration status.

5. Healthcare provider training

- Implement further anti-bias and cultural competence training for GPs, pharmacists, and nurses to reduce discrimination against marginalised women.
- Implement further trauma-informed care and training in FGM approaches, particularly for survivors/victims of domestic or sexual, or gender-based violence
- Enhance awareness of social barriers and determinants of health (poverty, literacy, legal status) to inform more empathetic and inclusive service provision.

6. Monitoring, accountability, and evaluation

- Widen data collection and research on contraception access disaggregated by gender, age, ethnicity, migration status, disability, and socioeconomic background.
- Independent oversight body to track progress and publish annual reports on equity in sexual and reproductive health.
- Meaningful consultation with marginalised women in designing, implementing, and evaluating services.

Study limitations

The study has several important limitations. The sample was confined to Traveller women, migrant women, women with disabilities and LGBTIQ+ people. Although these groups represent key marginalised populations, other eligible groups were excluded due to time constraints and the limited scope of the study.

Therefore, the findings cannot be generalised to all marginalised women accessing the Free Contraception Scheme, including women experiencing homelessness, those in IPAS centres, women in rural isolation, or those not engaged with community services. The relatively small sample size further limits generalisability and may not reflect the full diversity of experiences within each group.

The study did not include key stakeholders or healthcare professionals, meaning provider perspectives and system-level implementation challenges were not examined. This limits opportunities for triangulation and a comprehensive understanding of structural facilitators and barriers.

Time restraints reduced the depth of engagement and prevented longitudinal follow-up, restricting insight into sustained use and longer-term impacts.

Despite these constraints, the study offers valuable, community-informed insight into how the FCS is experienced by underrepresented women. It provides important evidence to inform policymakers, service planners, and advocacy organisations seeking to strengthen equitable access and guide future development of the scheme.

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