Universal, free access to contraception in Ireland

FRAMEWORK REPORT

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Contents

BAYER

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1.0 Key principles underpinning universal free access to contraception

Contraception is critical to good health, wellbeing and gender equality. According to the World Health Organisation, access to contraceptive information and services enables individuals and couples to live healthy sexual lives, reduce their risk of unintended pregnancies and plan the number and spacing of their children, if any.[1]

The following are the key principles, arising from a consultation process[2], that should underpin any policy or legislation to provide universal free access to contraception for women in Ireland who require it.

1. Any scheme to provide free access to contraception should be truly universal and apply to all individuals who require contraception. Any phased-in approach, such as an initial roll-out to all under-25s (as provided for under the Programme for Government), should be part of a clear plan with a timeframe for its extension to all those requiring it.
2. The scheme should cover the full range of female contraceptive methods, including all forms of Long Acting Reversible Contraception (LARCs) and emergency contraception (see 'Appendix 1' for a full description of female contraception, including LARCs).
3. The scheme should ensure ample choice of provider and be available through general practice clinics, family planning clinics, health centres, third-level campus health facilities and other locations staffed by suitably qualified and trained healthcare practitioners. In addition to being delivered by trained GPs, suitable trained nurse practitioners should also be engaged in the delivery of the scheme.
4. The scheme should be wholly inclusive and non-discriminatory, and consider the needs, priorities and perspectives of disadvantaged groups including young women and girls, migrant women, women with learning or physical disabilities, Traveller women, LGBTI+ people[3], and persons who are non-binary.
5. Informed decision-making is fundamental to the right to health. The scheme should be supported by accurate information to enable individuals to choose the method that is most appropriate for them, that is comprehensive, evidence-based, accessible and age-appropriate.
6. The scheme should be adequately resourced to ensure it is viable for GPs and other providers to deliver it; and to ensure it is inclusive of all female contraception options available on the market.

1 *Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations*. World Health Organisation (2014)

2 See 'Section 3.0' of this report.

3 This report uses LGBTI+ people to be broadly inclusive of people who can get pregnant regardless of their sex assigned at birth, their gender identity, their gender expression or their sex characteristics.

2.0 About this report

This framework report has been developed to support policy formation in relation to the provision of universal free access to contraception for individuals who require it in Ireland.

This framework report builds on the commitment in the Programme for Government to provide free contraception over a phased period, starting with women aged 17-25,[4] emphasising that the time for the delivery of this commitment is now. It makes the case for an expeditious, phased introduction of free contraception starting with those aged 25 and under, and progressing as soon as possible to all those who require access to the scheme.

The report is informed by a review of existing literature and analysis of current legal frameworks pertaining to contraception. In addition, a series of focus group consultations comprising stakeholders concerned with contraception in Ireland were conducted to inform this document. Among those consulted were medical professionals, legal professionals, academics, sexual health and reproductive health professionals, student and youth leaders, representatives of the LGBTI+ community, the Traveller Community, as well as TDs and Senators.[5]

The report has been commissioned by the life-sciences company Bayer. Its development has been supported by the Irish Family Planning Association.

The consultation and research underpinning this report was conducted by DHR Communications and Dr Fergus Ryan, Associate Professor, Department of Law, Maynooth University.

All of those who contributed to the development of this framework document support the principle of universal free access to contraception. While pregnancy is a much-desired outcome for many, the ability to control fertility and to determine the timing and context of pregnancy is crucial for the meaningful realisation of several human rights and to the achievement of gender equality. Access to contraception is vitally important in securing the rights to autonomy, bodily integrity and self-determination. Access to effective and appropriate contraception allows people, particularly women, to explore and express their sexuality and develop relationships in a context where contraception and the timing of any contraception is a matter of choice.

The cost of contraception is a burden which primarily and disproportionately falls on women. For some, this cost is prohibitive and results in limited contraceptive choice and over-reliance on less effective, user-dependent methods that have a higher risk of contraceptive failure.[6] The gender inequality in cost and burden can only be resolved by state funding to remove the cost barrier of access to, and choice of, contraceptives.

This framework report contains, at its heart, a set of key principles (see: 'Section 1.0') that should – in the view of the groups consulted – be included in any policy or legislation to underpin the introduction of universal free access to contraception in Ireland. Additional consideration in any policy and supporting legislation are further outlined in this report (see: 'Section 4.0').

4 *Programme for Government: Our Shared Future* (Government of Ireland 2020).
5 See 'Appendix 2' of this report for details of consultees.
6 *The Contraception Conversation*, Dublin Well Woman (2020)

3.0 Why now for universal free access to contraception?

It is a key principle of human rights that all countries should provide universal access to a full range of modern contraceptive methods to enable all couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice.[7]

In Ireland, the case for the provision of universal free access to contraception for individuals who require it is an issue which has strong public support. In a recent national survey on the attitudes of adults towards the provision of free, universal access to contraception in Ireland, 78% favoured the implementation of the measure.[8]

The provision of such universal free access to contraception was a key recommendation in the Report of the Joint Committee on the Eighth Amendment of the Constitution when it reported in 2017. Specifically, alongside measures to repeal the Eight Amendment and provide for access to abortion services, that committee called for "the introduction of a scheme for the provision of the most effective method of contraception, free of charge and having regard to personal circumstances, to all people who wish to avail of them within the State".[9] It flagged concerns about the cost of contraception, noting "that, while it is free for those with a medical card, for those on the cusp of qualifying for a medical card, the costs can be prohibitive."[10]

A working group on access to contraceptives was established within the Department of Health in 2019, following a public consultation, and reported on the barriers to access and the mechanisms to address them.

Notably, the Programme for Government (June 2020) firmly commits to providing free contraception over a phased period, starting with women aged 17-25.[11] However, no provision was made for the introduction of this measure in budget 2021. In December 2020, Seanad Éireann passed a motion, calling on the Government "to roll out free access to contraception to women and girls aged 17 to 25, as a matter of priority" and "to set out a timeline for the development of a scheme for contraception in the lifetime of this Government, in consultation with stakeholders."[12] In July 2021, a Contraception Implementation Group was established at the Department of Health to initiate implementation of the Programme for Government commitment.

7 *International Conference on Population and Development Programme of Action (UNFPA)*.

8 The survey was carried out by Ámarach Research across a national sample group of over 1,800 Irish adults. Field work was conducted in December 2020. Quotas were set on gender, age, social class and region and data was weighted to achieve a sample aligned with the national population.

9 *Report of the Joint Committee on the Eighth Amendment of the Constitution* (House of the Oireachtas 2017) 3.16 (p.14)

10 Ibid. 3.15 (p.14)

11 Programme for Government: Our Shared Future (Government of Ireland 2020), 47

12 "Access to Contraception: Motion" Vol. 273 No. 9 *Seanad Éireann Debates* 15 December 2020.

June 2021 saw the passing of a resolution by the European Parliament on sexual and reproductive health and rights in the EU. Specifically, Paragraph 30, calls on member states:

> "to ensure universal access to a range of high-quality and accessible modern contraceptive methods and supplies, family planning counselling and information on contraception for all, to address all barriers impeding access to contraception, such as financial and social barriers, and to ensure that medical advice and consultations with healthcare professionals are available, allowing all persons to choose the contraception method that best suits them, and thereby safeguarding the fundamental right to health and the right to choice".[13]

Against this backdrop of clear public and policy support for the provision of a scheme to introduce free universal access to contraception for all women in Ireland who require it, budgetary measures to implement the 2020 Programme for Government commitment have not yet been forthcoming.

Many of those who need access to contraception are denied meaningful choice because they can't afford their preferred method, even though long-acting reversible "fit and forget" methods are both the most effective means of controlling fertility and cost less in the long term. Those who don't have medical cards may find the upfront cost beyond their means.[14]

Dr Áine Murphy, who operates as a GP in Mayfield Cork and supports the Youth Health Service, reported[15] that she, and colleagues across the Southern region who were delivering termination of pregnancy services were witnessing how the cost of contraception, especially Long Acting Reversible Contraception (LARCs), was prohibitive for women attending for post-termination consultations. While the cost of termination was covered by the State, the cost of contraception was not.

13 Sexual and reproductive health and rights in the EU, in the frame of women's health European Parliament resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the frame of women's health (2020/2215(INI)).

14 IFPA (2019) *Annual report: access, choice, and advocacy*, pg. 13

15 Interview, Today with Claire Byrne, RTE Radio 1 (20 July 2021).

The issue of prohibitive costs of contraception has been further highlighted by data from four recent studies. These provide a body of evidence that underscores the urgency of allocating funding to establish a contraceptive scheme:

- A Dublin Well Woman Centre report on contraceptive use in Ireland found that the majority of women involved in the study were using less effective user-dependent forms of contraception and were experiencing high levels of contraceptive failure, with under 25s particularly reliant on the pill or condoms.[16]
- Analysis of IFPA client data in 2019 found that 68% of women who accessed abortion care services were not using contraception; 20% were using condoms; 8% were using short-acting methods, such as the pill; 2% were using high-risk strategies such as withdrawal.[17]
- A 2021 audit by the Southern Task Group on Abortion and Reproductive Topics (START) of 475 women accessing abortion care found a virtually identical pattern.[18]
- A 2021 study carried out by UCC on contraceptive choices among university students concluded that cost heavily influences contraceptive choice: 40% of women rely on the pill and 55% rely on condoms and they overwhelmingly choose these methods due to the high cost of other methods like LARCs.[19] More than half of women surveyed said that they would definitely change, or consider changing, their contraceptive method if the cost barrier was removed, with the majority indicating they would move to the more-effective LARC methods.

As the Covid-19 vaccination programme concludes and Irish society more fully reopens, demand for sexual and reproductive health services will likely increase. In the main, young women will have little option but to choose a contraceptive method based on its cost and not its effectiveness, leaving them exposed to increased risk of unintended pregnancy.

For women, LGBTI+ people and non-binary people, access to contraception is fundamental to their overall health and wellbeing. Yet the high cost of the most effective methods makes them inaccessible to many in practice. The evidence is clear on the importance of providing individuals with access to reliable methods of contraception without adverse cost implications. Now, leading into Budget 2022, it is the critical time to act on longstanding commitments to provide universal free access to contraception to individuals in Ireland who require it.

16 The Contraception Conversation, Dublin Well Woman (2020)
17 IFPA (2019). *Annual report: access, choice, and advocacy.*
18 Horgan, P., Thompson, M., Harte, K., Gee, R. (2021). Termination of pregnancy services in Irish general practice from January 2019 to June 2019. *Contraception.*
19 McConnell, R., Meaney, S., and O'Donoghue, K. (2021). Influence of cost on contraceptive choices amongst University students in Ireland. *Irish Medical Journal*, 114(6), p.376

4.0 What should inform a policy of universal free access to contraception in Ireland?

The scheme for universal free access to contraception should be designed to systematically and comprehensively provide rights-based information and services in line with international frameworks, standards, and best practice. The State should ensure that female contraceptives, as a fundamental component of sexual and reproductive health information and services, are available to all, accessible to all, acceptable to all, and of high quality.

Based on the WHO framework for contraception provision, an extensive literature review and a comprehensive series of consultations with key stakeholders, this document – in addition to the key principles that should underpin universal free access to contraception – also establishes a number of issues that should be considered in constructing policy and legislation to support the delivery of a universal scheme.

1. Non-discrimination

A universal free contraception scheme should be accessible across the State, to women in rural, suburban and urban areas alike; to women in direct provision, women who are homeless, women with irregular immigration status, as well as Traveller women and LGBTI+ people, with the means of access being appropriate to the particular situation of each person and cohort. Particular efforts should be made to ensure that sex workers have access to appropriate contraception without judgment or fear of penalty. Such a scheme should also be disability-proofed to ensure full, appropriate access for people with disabilities.

Provision for free contraception should be inclusive, both in terms of coverage and in terms of the language used. In many cases, the decision to use contraception is a collective decision of a couple. In that regard, while contraception is important for most women, speaking of contraception solely in terms of access for women may be too narrow. LGBTI+ people and persons who are non-binary, may also require or wish to access female contraception methods.

2. Availability

Contraceptives are part of a continuum of sexual and reproductive health services that should be considered as part of an overall sexual and reproductive health strategy, encompassing:

- Comprehensive sexuality education;
- Counselling and services for the full range of modern contraceptives, including emergency contraception;
- Antenatal, childbirth and postnatal care, including emergency obstetric and new-born care;
- Safe abortion services;
- Prevention and treatment of HIV and other sexually transmitted infections;
- Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence;
- Prevention, detection and management of reproductive cancers, especially cervical cancer;

- Information, counselling and services for subfertility and infertility;
- Information, counselling and services for sexual health and well-being throughout the life cycle.

The scheme for universal free access to contraceptives should ensure availability of a full range of female contraceptive methods, including short and long-acting reversible contraception, and emergency contraception.

3. Accessibility

Contraceptive information and services should be accessible to all who need them, free of all barriers to access, including information, location and cost.

Up-to-date targeted education on sexual and reproductive health – including on all contraceptive options – is vital, not only for younger persons, but for all age groups. Education and outreach must be tailored to the particular needs of diverse communities and be mindful of the effects of marginalisation. A sex-positive approach should be placed at the centre of such information and education. The provision of information and education needs to be properly resourced, and available from a variety of sources and outlets.

If the scheme is to ensure equitable access to all available methods of female contraception, and promote good reproductive health, each phase of its roll-out must remove the cost barrier for all in the relevant age-group.

The scheme should be accessible through general practice and also family planning clinics, health centres, third-level campus health facilities and other locations staffed by suitably-qualified and trained healthcare practitioners. Nurse practitioners should have a central role in service delivery. Where a provider does not offer the full range of methods, clear signposting and referral to other providers must be available.

The reproductive healthcare needs of adolescents must be addressed through clear, national guidelines about how to approach both sexuality education and the delivery of sexual healthcare, such as providing contraception, to those under the age of 17 must be addressed.[20] Furthermore, the legal discrepancy between the ages of medical consent (16) and sexual consent (17) must be resolved.

Even with comprehensive free, universal access to contraception, for a complexity of reasons, women will still experience crisis pregnancies and will require support in that context, including access to emergency contraception, counselling, and abortion care. Women seeking emergency contraception in particular may still be subject to provider bias and judgement.

The individual right to access contraception and contraceptive choice must be free from coercion and the bias of others.

20 SE/Tusla (2016) *Sexual Health and Sexuality Education Needs Assessment of Young People in Care in Ireland (SENYPIC) Composite Report of Findings.*

4. Acceptability

The scheme to provide universal free access to contraceptives should be respectful of personal choice and values. It should facilitate each person to access the method that best suits their wishes, needs, and their individual situation and circumstances. Not every contraceptive will work for everyone and the same contraception will not suit every woman throughout her life course. For example, the commonly prescribed combined oral contraceptive pill ("the pill") is not recommended for women who are obese, smokers over the age of 35, or those who take certain medications, due to the risk of blood clots. Some individuals may prefer the "fit and forget" model of LARCs, while others may prefer a shorter-term option like the pill, patch, or ring. Furthermore, an individual's contraception needs and preferences vary throughout their reproductive life cycle.

5. High quality

Providing quality healthcare in the context of contraception will require proper and full funding of all medical options in the field of contraception, with full financial support for medical-led counselling and advice, as well as funding for prescribing, insertion, and fitting of the most appropriate contraception by medical professionals who are properly trained to counsel, prescribe, insert or fit such contraception. This will entail funding for access to appropriately trained medical practitioners, nurses, and family planning practitioners. The scheme for universal access to free contraceptives should be properly costed and resourced, with access to appropriate professional expertise.

6. Informed decision-making

The scheme for universal free access to contraceptives should be designed to respect the dignity and bodily integrity of each person by giving them the opportunity to make autonomous reproductive choices. In order for a person to make informed decisions, they need access to comprehensive information, counselling and support. Government policy on the availability of free contraception should support the principle of free and informed choice and access, while respecting personal preferences and providing supports for all pathways.

7. Privacy and Confidentiality

The scheme to provide universal free access to contraceptives should be designed to provide confidential and private information and services, in particular to ensure that groups such as adolescents, LGBTI+ people, sex workers, migrants, and Travellers are comfortable with accessing services. It may well be that the closest available provider will not be favoured by the individual seeking contraception. While medical practitioners are, of course, required to respect the confidentiality of a patient,[21] those seeking contraception should not be compelled to access it through one location to the exclusion of other options that the individual perceives as more acceptable.

21 On the responsibility of states to protect patient confidentiality, see *Panteleyenko v. Ukraine* (ECtHR, 29 June 2006), *L.L. v. France* (no. 7508/02) (ECtHR, 10 October 2006), *Armonas v. Lithuania* and *Biriuk v. Lithuania* (ECtHR, 25 November 2008), *L.H. v. Latvia* (no. 52019/07) (ECtHR, 29 April 2014), *Radu v. the Republic of Moldova,* (ECtHR, 15 April 2014), *Y.Y. v. Russia* (no. 40378/06) (ECtHR, 23 February 2016), *Konovalova v. Russia* (ECtHR, 9 October 2014) and *P.T. v. the Republic of Moldova* (no. 1122/12) (ECtHR, 26 May 2020).

8. Participation

The scheme to provide universal free access to contraceptives should be designed with the needs and perspectives of service users in mind. The scheme should therefore be designed in close consultation with women, adolescents, LGBTI+ people, migrants, sex workers, Travellers, and other relevant groups.

9. Accountability

The scheme for universal free access to contraceptives should incorporate effective accountability mechanisms to ensure that the agency and choices of all service users are respected and fulfilled. Effective accountability means that all women, LGBTI+ people, and non-binary people are aware of their entitlements to sexual and reproductive health, and processes are in place for them to seek remedies and redress if their rights are not respected.

Systems to collect disaggregated data on contraceptive use should be developed to determine where investments should be focused and to determine where progress is being made.

5.0 Next steps

The time for action on the provision of universal free access to contraception is now. The case has already been established, a commitment was made in the Programme for Government, and recent research highlights the urgency of this issue.

Policy, budget and enabling legislation are now required to establish universal free access to contraception for those requiring it in Ireland. Until universal free access to contraception is provided for, it will remain an unacceptable contradiction that women can avail of abortion care without a cost burden, but may be exposed to risk of further unintended pregnancy because they are unable to afford their choice of the most reliable contraception and have to continue with the method that let them down in the first place.

The Minister for Health, Stephen Donnelly, TD, noted that, to provide for universal free access to contraception for women in Ireland "a sizeable body of work would need to be addressed in order to develop and finalise the policy approach, bring forward the necessary legislative proposal and ensure the implementation of service delivery arrangements".[22] This framework report, and ancillary work, has been developed to support the Government in delivering on its commitment to provide universal free access to contraception.

Building on the key principles and informants identified in this report, draft legislation is required to provide a comprehensive legal framework upon which the scheme can be built. This framework proposes new legislation, rather than amending existing legislation, so that it can, unequivocally, support the implementation of all the key principles set out herein.

Bayer, the life sciences company, has built a Budget Impact Model from the perspective of the HSE, accounting for direct costs of funding the scheme, i.e. drug costs and GP service fees. It has been developed in line with HIQA guidelines for Budget Impact Analysis of Health Technologies in Ireland 2018. It is costed over a five-year time horizon (2022 to 2026) with the intrauterine system (IUS), implant, injection, ring, patch and the oral contraceptive pill (OCP) methods included.

Based on the current IMO contract which lists payments to GPs for counselling and insertion of Long Acting Reversible Contraception (LARC) at €70[23] and removal of a LARC at €50, the full year additional cost of providing a scheme for 17-25 year olds would be €7.8m in 2022 rising to €8.4m by 2026. The increase is driven by population changes. It is based on the current situation whereby GMS patients have GP and drug costs covered, and GP visit card patients have GP costs covered.

22 PQ 178 10 December 2020.

23 In the Budget Impact Model, Bayer included an additional €20 fee to cover the cost of the sterile pack used in LARC insertion.

However, given that LARC counselling and insertion requires the equivalent of four standard 15-minute GP appointments, it is likely that an increased fee may be sought reflecting the time required and service costs in the private market. To determine the impact of an increase in GP fees for LARC services, Bayer conducted a scenario analysis based on a range of prices charged to private patients for LARC services in various locations across the country. They also factored in a higher rate for a Short Acting Contraception (SAC) consultation, increasing it from €11.87 per the GMS GP consultation cost to €25 per visit in this scenario analysis.[24] In this scenario, taking a mid-point of rates charged in the private market for LARC counselling, insertion and removal; and a fee of €25 per consultation for SACs; the additional costs for a scheme for 17-25 year olds would be €10m in 2022, rising to €10.8m in 2026.

The cost burden of contraception falls on women significantly more than on men, and the impact of an unintended pregnancy, whether it is continued or not, is also significantly harder on women. The gender inequality in cost and burden can only be resolved by state funding to remove the cost barrier of access to and choice of contraceptives.

With broad public and political support for the introduction of a scheme to provide universal free contraception to women who need it in Ireland, the time is now opportune to address the gender cost and provide women with the support they need to exercise choice and autonomy in their relationships, their work and their families, and to determine their own futures. The first step in achieving this self-determination for women will be the provision of an allocation in the 2022 budget which would facilitate the rollout of a scheme, starting with those under the age of 25, and subsequently expanding to all those who require access to the scheme.

24 See: https://www.hse.ie/eng/staff/pcrs/pcrs-publications/annual-report-2019.pdf

Appendix 1

Female contraceptive methods—cost and effectiveness

The following information has been prepared by the Irish Family Planning Association (IFPA) and reflects the methods of contraception available on the Irish market as of August 2021.

Fit and forget methods

- Long-acting, reversible contraceptives (LARCs) last from three months to ten years. They include intrauterine systems (IUS) also known as hormonal coils which lasts up to six years; hormone-free intrauterine copper devices (IUDs), or copper coils which can last up to ten years; implants (small rods under the skin in the arm that release hormones over up to three years); and injections of hormones that are effective for up to three months.

User dependent methods

- Barrier methods include diaphragms and condoms.
- Short-acting, hormonal contraceptives, such as the combined pill, vaginal ring and patch, and mini pill, work by preventing the ovaries from producing eggs and/or preventing sperm passing the cervix.

Emergency contraception

- The hormone-based emergency contraceptive pill and the copper coil prevent pregnancy when regular contraception has failed or wasn't used. Emergency contraception is effective for up to five days after unprotected sex.

Permanent methods

- Vasectomy and tubal occlusion—are ideal for those whose family is complete or who don't want to have children.

LARCs, such as the IUD, IUS and the implant, LARC methods are around 20 times more effective than any other form of reversible contraception excluding the injection - depot-medroxyprogesterone acetate (DMPA).[25]

LARCs have proven to be a highly effective form of contraception. LARC offers women full contraceptive compliance (i.e. you cannot forget to take it). This is important, as other methods are susceptible to human error. LARCs offer much higher protection from pregnancy in typical use with 0.2 per cent failure rate for levonorgestrel intrauterine systems (LNG IUS), 0.8 per cent for copper intrauterine device (IUD), and 0.05 per cent for subdermal implants.[26] In contrast, with typical use of the pill (which reflects the reality that women forget to take it) the failure rate is 9%. With typical use, male condoms have a failure rate of 18% when used alone.[27] However, condoms have an important role to place in reducing transmission of Sexually Transmitted Diseases (STDs).[28]

The availability of a wide variety of contraceptive options is critical. Each woman's medical history and risk factors are unique, so not every contraceptive will work for everyone and the same contraception won't suit every woman throughout her life course. For example, the commonly prescribed combined oral contraceptive pill ("the pill") is not recommended for women who are obese, smokers over the age of 35, or those who take certain medications, due to the risk of blood clots. Some individuals may prefer the "fit and forget" model of LARCs, while others may prefer a shorter-term option like the pill, patch, or ring. Furthermore, an individual's needs and preferences with respect to contraception often varies across their reproductive life cycle.

While LARCs represent the most effective form of contraception, and can last years before needing to be replaced, the initial cost outlay for an IUD, IUS or an implant is particularly onerous. Combined with the fee for the initial consultation with a doctor and the subsequent appointment to insert the device, a woman may be faced with an outlay of several hundred euro if she does not have a medical card. However, over three to five years, the average annual cost can be significantly lower than less reliable user-dependent methods, such as daily pills, patches, diaphragms or condoms.

Other barriers to contraceptive access and LARC uptake can include lack of awareness of contraceptive options, regional disparities in the quality and availability of services, stigma and lack of confidentiality, and lack of provider training in LARC insertion methods.

Proposed reforms to contraception policy should promote good health by removing cost barriers for all those covered and from all methods. If, for example, long-acting methods are not included, the scheme will incentivise uptake of contraceptives that are less effective at preventing unintended pregnancy.

25 Shoupe D. Contraception and Reproductive Medicine. LARC methods: entering a new age of contraception and reproductive health. Accessed Sept 2021.
26 J. Trussell, Contraceptive Failure in the United States. Elsevier. Contraception 83 (2011)397-404. Accessed Sept 2021.
27 J. Trussell, Contraceptive Failure in the United States. Elsevier. Contraception 83 (2011)397-404. Accessed May 2021.
28 Centers for Disease Control and Prevention. Accessed May 2021.

Appendix 2

Consultation underpinning this report

Feeding into the considerations in this document are the views harvested through a consultation process. This consultation process was conducted in June 2021 and took the form of a series of focus groups run over a one-hour period, using a virtual meeting space.

Participants were drawn from the medical profession (including: GPs; family planning specialists; nurses; consultants); members of the Oireachtas (recruitment was undertaken by the IFPA through the informal All-Party Group on Sexual and Reproductive Health); advocacy groups with an interest in women's health. In addition, a number of individuals with a track record in legal and academic work, specialising in sexual and reproductive health, participated in the consultation.

Consultation Attendees

Name	Organisation
Senator Aisling Dolan	Seanad Eireann
Senator Fintan Warfield	Sinn Féin
Senator Pauline O'Reilly	Seanad Eireann
David Cullinane, TD	TD Sinn Féin spokesperson on Health
Dr Liz Barry	GP and member of START
Dr Éadaoin Lysaght	Student Health Service ,University College Dublin
Dr Catriona Henchion	Medical Director, IFPA
Dr Mary Short	ICGP
Dr Aine Murphy	GP and member of Start Doctors Group
Dr Aoife O'Sullivan	UCC Student Health Dept, Irish Student Health Association (ISHA)
Nurse Lisa Cryan	UCC Student Health
Maeve Taylor	Director of Advocacy and Communications, IFPA
Mairead Enright	Reader in Law, University of Birmingham
Catherine Forde	Barrister and reproductive rights activists (former member IFPA and IPPF boards)
Dr Catherine Conlon	Asst Prof Social Policy, School of Social Work and Social Policy, Trinity College Dublin
Noeline Blackwell	Director, Dublin Rape Crisis Centre

Name	Organisation
Dr Caroline Munyi	Migrant Women's Health Coordinator, AkiDwA
Lorna Fitzpatrick	USI President 2019 - 2021
Clare Austick	USI President
Dr Mary Favier	MICGP FRCGP Past President Irish College of General Practitioners.
Dr Shirley McQuade	Medical Director, Dublin Well Woman Centre
Dr Deirdre Lundy	Women's Health Specialist and LARC inserter / trainer ICGP
Dr Nicola Cochrane	GP at Carrig Clinic, Mirena Clinic at the National Maternity Hospital, Holles St, Dublin, SATU at the Rotunda Hospital
Mary Brigid Collins	Assistant Coordinator of Pavee Point's Primary Health Care for Travellers Project, Pavee Point
Moninne Griffith	CEO BeLonG To Youth Services
Sean Frayne	Sexual Health Youth Worker BeLonG To Youth Services
Leah Palleschi	Former IFPA staff member
Gillian Richardson	Macra na Feirme
Debbie Donnelly	Macra na Feirme
Dr Ann Nolan	Course Director, MSc in Global Health and Assistant Professor in Global Health, Trinity College Dublin

Note: not all of those who participated in the consultation were available, at the time of this report's publication, to provide consent to having their name included. As such, the above list only represents those who provided consent.