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Between stigma and solidarity: Experiences of sexual and reproductive health among young women in the Republic of Ireland

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ABSTRACT

This study explores how a sample of Generation *Z* women ($M_{age} = 22$ years) in the Republic of Ireland negotiate empowerment and disempowerment in their experiences of sexual and reproductive health. Five semi-structured focus groups ($N = 30$) were conducted with undergraduate women at an Irish university between December 2024 and January 2025. Using reflexive thematic analysis, three themes were developed: *(1) Stigma surrounding sexual and reproductive health in families and medical spaces, (2) Empowerment through peers and social media,* and *(3) Navigating stigma and empowerment simultaneously*. Family and clinical encounters often reproduced silence, dismissal, and discomfort, while peer and digital platforms fostered collective knowledge-sharing and resistance. Anticipated judgement from healthcare providers contributed to hesitancy and withdrawal from care. Notably, stigma and empowerment were not experienced as opposites but as coexisting and relational, shaping how participants made sense of their bodies and health needs. These findings highlight the need for health and medical practitioners to move beyond procedural care, fostering relational, sensitive, and culturally responsive dialogue. By centring the voices of Generation Z women (typically defined as those born between the late 1990s and early 2010s), this study offers insights into avenues for empowerment, informed decision-making, and equitable access to sexual and reproductive health services.

In recent years, the Republic of Ireland (RoI) has witnessed significant progress in women's healthcare, including the rollout of the human papillomavirus (HPV) vaccine, the free contraception and hormone replacement therapy (HRT) schemes, and the historic repeal of the Eighth Amendment, which enabled legal abortion services (Londras and Enright, 2018). However, legal and structural reforms do not automatically translate into lived empowerment and women continue to face barriers rooted in stigma, cultural silences, and unequal access. For example, national survey data in Ireland show high knowledge of condom use but limited understanding of women's fertility, alongside inconsistent contraceptive practices (Nolan and Smyth, 2025). Moreover, the RoI Department of Health's Working Group on Access to Contraception in Ireland has identified embarrassment and confidentiality concerns as persistent deterrents to seeking care and accessing contraception (Department of Health, 2019). Recent research conducted in Ireland has highlighted stigma associated with cervical cancer (Kinsella and Kavanagh, 2025) and abortion (Broussard, 2020) as barriers to equitable healthcare.

Intersectional perspectives also underscore that women's experiences vary by class, geography, and minority identity, as seen in research with young Muslim women navigating post-repeal Ireland (Agha and Gaynor, 2024). These findings mirror global patterns, where young women's sexual and reproductive health remains constrained not only by medical or procedural barriers but also by enduring cultural norms, generational silence, religious legacies, and gendered power dynamics (Morris and Rushwan, 2015; Baigry et al., 2023; Oerther and Oerther, 2021). Without further empirical inquiry into these dynamics, interventions risk being policy-driven rather than responsive to the complex realities shaping women's health. Ireland's trajectory—from restrictive Catholic influence to progressive reproductive rights—offers a critical case for understanding how empowerment and disempowerment coexist both locally and globally.

Sexual and reproductive health encompasses a wide range of conditions and topics, including contraception, fertility, pregnancy, endometriosis, menopause, screening (such as cervical smear tests) and sexual wellbeing. Women's experiences of *disempowerment* in relation

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sexual and reproductive health are driven by laws, policies or social norms that restrict access to care or treatment (see United Nations Population Fund [UNFPA], 2021) or due to lack of knowledge or health literacy (e.g. Sen and Östlin, 2008). However, disempowerment may also relate to structural barriers that limit access to services, healthcare system interactions, and stigma (e.g., Starrs et al., 2018). Indeed, research highlights stigma — a social process that discredits individuals by associating their identities with deviance or moral failure (Carnevale, 2007) — as a key factor influencing women's engagement with sexual and reproductive health care (e.g., Bohren et al., 2022). In the present research, stigma is conceptualised not as synonymous with disempowerment, but as a social and structural mechanism through which disempowerment is produced and reproduced across healthcare, familial, and peer contexts. To fully understand these dynamics, however, it is necessary to also consider the ways in which women exercise agency and experience empowerment, which the next section explores.

Empowerment in relation to sexual and reproductive health may involve gaining voice, agency, and control over health-related decisions, encompassing psychological, social, and structural dimensions (Peterson, 2014; Rodwell, 1996). Key dimensions of empowerment in women's health could include autonomy and decision-making (e.g., Alfian et al., 2025; Idris et al., 2023), health literacy (e.g., Tavananezhad et al., 2022), access to supportive healthcare (e.g., Golestani et al., 2025) and overcoming (or not experiencing) structural and social barriers.

While these global discussions highlight ongoing stigma, even in high-income contexts such as Ireland—despite advances in women's health and its strong economic and democratic status—stigma surrounding sexual and reproductive health persist. Recognising stigma as a mechanism of disempowerment, while also attending to the ways young women resist, navigate, or mitigate its effects, allows for a more nuanced examination of how disempowerment and empowerment may coexist. This creates a foundation for examining how young women negotiate constraint and agency across their life contexts.

The present research seeks to explore experiences of empowerment and disempowerment among Generation *Z* women ('Gen Z'), typically defined as those born between the late 1990s and early 2010s, in the RoI. Gen Z women occupy a unique position in this landscape as the first generation to grow up entirely in the digital age, with unprecedented opportunities to engage with health information, peer networks, and advocacy online (Martínez-Estrella et al., 2023). While digital spaces can challenge traditional medical, familial, and societal silences around sexual and reproductive health (Martínez-Estrella et al., 2023; Ray, 2023), they are also marked by contradictions: enabling support and collective knowledge-sharing while simultaneously exposing young women to misinformation, commercialisation, and uneven access to reliable resources (Jiao et al., 2023; McCashin and Murphy, 2022; Lupton, 2012).

The present study is situated within the Irish context, where young women have come of age during a period of rapid sociopolitical change, including the repeal of the Eighth Amendment in 2018 and subsequent reforms in sexual and reproductive health policy. Despite these shifts, scholarship has primarily focused on stigma related to abortion (Broussard, 2020; O'Donnell et al., 2018) and cervical cancer (Kinsella and Kavanagh, 2025), with limited qualitative research centring the everyday perspectives of Irish Gen Z women themselves. In particular, the intersection of digital engagement with family and clinical contexts in shaping empowerment and disempowerment remains under-examined.

Accordingly, this study asks: *What are Gen Z women's experiences of empowerment and disempowerment relating to sexual and reproductive health in the Republic of Ireland?* By focusing on the voices of young women, the study seeks to illuminate how empowerment is fostered or constrained across familial, clinical, and digital contexts, and how stigma and empowerment coexist as relational processes rather than opposites. The analysis draws on stigma as a social process (Goffman, 1963; Herek, 2009) and on multidimensional understandings of empowerment (Peterson, 2014; Rodwell, 1996) as concepts to guide interpretation. In doing so, the research contributes to ongoing debates about youth, digital health cultures, and reproductive justice, offering (a) the first qualitative account of Gen Z women's reproductive health experiences in post-repeal Ireland, (b) a theoretical contribution by demonstrating how stigma and empowerment operate relationally rather than dichotomously, and (c) practical insights for health practitioners, educators, and policymakers striving toward more equitable and youth-responsive sexual and reproductive healthcare.

1. Method

1.1. Design and participants

A qualitative approach was adopted, using focus group discussions to explore participants' experiences. A purposive sampling strategy was used to recruit 30 participants who met the following inclusion criteria: (1) have a cisgender female identity, (2) member of Gen Z (defined as those born between the late 1990s and early 2010s), 3) have lived in Ireland for the past five years and (4) fluent in English. This age cohort was selected to capture the perspectives of cisgendered women who have come of age during key sociopolitical and digital transformations in Ireland. The final sample had a mean age of 22.5 years (range 18-25 years), with all participants residing in Ireland.

Participants were recruited through university networks via email. Each was provided with a participant information sheet. Eligibility was confirmed by verifying participants' age, gender, and language fluency. Eligible individuals were then contacted via email and provided with a comprehensive study information sheet and an informed consent form, which they signed prior to focus group allocation (based on availability). This study adheres to Level 1 of the Transparency and Openness Promotion (TOP) Guidelines for transparency in data and methods (Nosek et al., 2015).

1.2. Data collection

Ethical approval for the study was granted by the Education and Health Sciences Research Ethics Committee (2024_10_03_EHS). Five semi-structured focus groups were conducted online via Microsoft Teams, each comprising 4–6 participants. All focus groups were conducted online to support participation from across the Republic of Ireland and to reflect the digital environments in which many participants already engage with sexual and reproductive health information, support, and care. Participants self-selected into focus groups based on availability.

Focus group methodology was used to encourage interaction between participants, allowing experiences to be co-constructed through discussion rather than elicited solely at the individual level. This format enabled participants to respond to, affirm, or challenge one another's accounts, supporting collective meaning-making across familial, medical, peer, and digital contexts. Prior methodological research suggests that three to six focus groups can capture over 90% of thematic content in qualitative studies (Guest et al., 2016).

The semi-structured interview guide (Appendix 1) comprised five

Table 1
Sociodemographic characteristics of study participants.

Characteristic	Category	Frequency (*n*)	Percentage (%)
Gender	Female	30	100
Age Group	18-19	2	6.7
	20-21	9	30
	22-23	15	50
	24-25	4	13.3
Ethnicity	Caucasian	30	100
Education Level	University Student	30	100

Table 1. Sociodemographic characteristics of study participants ($N = 30$).

core questions exploring: (1) experiences of empowerment and disempowerment in sexual and reproductive health; (2) factors contributing to these experiences; (3) comfort and discomfort discussing sexual and reproductive health with healthcare professionals; (4) perceived barriers to agency and informed decision-making; and (5) the influence of healthcare interactions on participants' sense of empowerment. While these questions did not explicitly name specific contexts (e.g. healthcare, familial, peer, or digital), facilitators used consistent follow-up prompts across all focus groups to encourage participants to situate their experiences within these domains where relevant.

With participant consent, all sessions were audio recorded and transcribed verbatim. Video recordings were used solely to support transcription accuracy and were permanently deleted two weeks after the final focus group. All data were pseudonymised. Participants were informed that, due to the group-based nature of focus groups, it may not be possible to fully remove individual contributions once shared within the group; however, they were offered a two-week period following participation to request withdrawal of their data. No withdrawal requests were made. NVivo (version 15.1.3) was used to support data management and analysis.

1.3. Data analysis

Reflexive thematic analysis (Braun & Clarke, 2006, 2022), an approach suited to exploring how participants make meaning of their experiences, was adopted — recognising the active role of the researcher in co-constructing knowledge and was selected for its capacity to capture nuance, complexity, and contextual subjectivity. Data were analysed using Braun and Clarke's (2006) six-phase reflexive thematic analysis framework.

1. **Familiarisation with the data.** All focus group recordings were transcribed verbatim. One researcher (ZD) repeatedly read and listened to the data, noting initial ideas, patterns, and striking quotations, while reflecting on their own positionality and assumptions.
2. **Generating initial codes.** Data segments relevant to stigma and empowerment were systematically coded using NVivo (ZD, EK). Codes were descriptive and interpretive, capturing both semantic content and underlying meanings (such as "taboo around sexual/reproductive health" and "dismissive medical encounters"). Initial codes were generated iteratively through constant comparison across transcripts and focus groups. For example, early codes such as *"awkward GP," "fear of being recognised,"* and *"not wanting parents to know"* were initially coded separately but were later merged as they consistently reflected participants' experiences of anticipating judgement in interconnected family and clinical contexts.
3. **Searching for themes.** Codes were examined for patterns and collated into potential themes. The researchers (ZD, EK) considered how codes related to each other and the research question, grouping them into preliminary thematic structures (such as "Familial silence and internalised stigma").
4. **Reviewing themes.** Preliminary themes were reviewed against the full dataset to ensure they accurately reflected participants' experiences and captured the richness of the data. Themes were refined, merged, or split as necessary over several weeks with input from all researchers.
5. **Defining and naming themes.** Each theme was clearly defined and discussed by the researchers, with attention to its scope, central concept, and relation to other themes. Subthemes were identified where needed to highlight nuance. Reflexive notes were maintained throughout to document interpretive decisions.
6. **Producing the report.** Themes were woven into a coherent narrative, supported with illustrative quotations, and contextualised within existing literature. The write-up aimed to balance participants' voices with analytic interpretation, highlighting both patterns and contradictions in experiences.

1.4. Reflexivity

One member of the research team identifies as a member of Gen Z and shares a similar university background with the participants. This positionality as both an insider and observer facilitated rapport during focus group discussions. Continuous reflexivity was enacted through multiple strategies: the team held regular discussions during coding to critically examine how individual positionalities might influence interpretation; reflective notes were maintained to document analytic decisions and potential biases; and coding decisions were revisited iteratively to ensure interpretations remained grounded in participants' accounts rather than researchers' assumptions.

In contrast, the other team members are older and did not grow up in digitally saturated environments. This diversity in generational and technological experience provided a broader interpretive lens, enabling reflexive dialogue and critical comparison of experiences. It enriched the analysis by supporting the interpretation of stigma and empowerment across generational and digital contexts, ensuring multiple perspectives informed theme development.

2. Results

Data analysis resulted in the development of three overarching themes: (1) *Stigma surrounding sexual and reproductive health in families and medical spaces*, (2) *Empowerment through peers and social media*, and (3) *Navigating stigma and empowerment simultaneously*. These themes address the core aim of the study to explore young women's experiences of both stigma and empowerment in sexual and reproductive healthcare contexts. The following sections present each theme, supported by illustrative extracts and broader patterns observed across participants.

2.1. Theme 1: Stigma surrounding sexual and reproductive health in families and medical spaces

Participants across all focus groups described how stigma shaped their ability to address their sexual and reproductive healthcare needs. Several participants recalled growing up in a Catholic household where reproductive and sexual health discussions were considered taboo. In such cases stigma was communicated implicitly—through the recollections of discomfort, silence, and perceived shame. Participants also recalled more explicit stigma through recollections of dismissive medical encounters or overtly judgemental language making it difficult to speak openly or advocate for their healthcare needs.

In Extract 1, Alice described her experience of a Catholic upbringing and its part in creating a context of silence around sexual and reproductive matters in her home:

Extract 1, (Alice, 21 years old) *" I had a very Catholic upbringing in my home. So, like that kind of stuff was very taboo and like we did not talk about it at all. I did not have any sort of talks with my parents. I did not seek help from them when I got like my first period or whatever, that was all that I had to deal with on my own … … I never felt comfortable discussing this in any kind of shape or manner with my parents or my doctor, because in my head it was kind of like they're an extension of like that. Like, if I told my doctor, therefore, he'd have to explain that to my parents or if I explained it to my parents."*

Alice describes her family's religious status as *"very Catholic"* and that certain topics relating to women's reproductive health were *"very taboo"* foregrounding a culture that governs silence. Alice's repetition of negation, *"did not talk"* and *"did not seek help",* conveys how bodily knowledge was seen as private in her household. The phrase *"on my own"* underscores the isolating effects of this privacy and silence. This internalisation extends beyond the home; with Alice articulating how the boundaries between family and medical spaces are blurred as she conceptualises the doctor as an *"extension"* of her parents. This imagined

breach of confidentiality indicates a feared lack of trust in the medical space. Participants' experiences of sexual and reproductive silence within the family echo Foucault's (1978) concept of power/knowledge, where institutional forces (e.g., religion, medicine) regulate bodies and sexuality by rendering certain topics unspeakable. In this case, Catholic moral norms have produced discursive silences, where even basic sexual and reproductive issues are framed as morally suspect. Bartky's (1990) notion of internalised oppression is also visible: young women have absorbed these norms to the extent that they censor their own needs. Alice's reluctance to speak even to doctors (*"I never felt comfortable discussing this in any kind of shape or manner")* illustrates how stigma becomes self-regulating, shaping behaviour perhaps through the need to protect herself or because of experiencing shame.

In Extract 2, Emily shared a similar experience to Alice, regarding the difficulty of disclosing her decision to use birth control in a household where such topics were rarely discussed.

Extract 2, (Emily, 21 years old). *"I feel like because my family, like my parents, really find it awkward about, like, talking about health and stuff like that, or like anything to do with … Like, again, like birth control or anything. Like when I told my mom, I was going on birth control. She's like, 'why did you need that?' …. Like … like she's really like … I don't know, she's very kind of … And then that kind of means that I think me and my siblings don't like, not that we'd be talking about like birth control, but like, you know, like we just don't talk about any like sort of touchy like health topic then really at all, like the thoughts of that."*

Emily describes some topics were avoided due to the awkwardness experienced by her parents; her words *"like birth control or anything"* positions sexual and reproductive health as just one example within a wider category of taboo topics. Emily recounts her mother's reaction to her choice to go on birth control: *"why did you need that?"*. This question implies shock and perhaps an underlying judgment, suggesting using contraception must be justified and alludes to disapproval over the primary reason of preventing pregnancy. This moment shows how perceived stigma can become experienced stigma, as a parent's reaction reinforces the idea that certain health behaviours must be defended. Similarly, Emily expresses that because of her mother, she and her siblings would avoid "*touchy like health topics"*, reinforcing how stigma can be internalised. Her use of the word *"touchy"* indicates that subjects like these are sensitive and to be avoided. Across participants, these experiences were common: over a third described avoiding discussions about menstruation, contraception, or sexual activity due to fear of judgment, showing that familial stigma was pervasive.

While family discomfort shaped both Emily and Alice's experiences, clinical settings also emerged as significant sites of stigma. Participants described encounters with both male and female clinicians in which their autonomy or knowledge was disregarded. In Extract 3, Stacy described an encounter with a medical professional when seeking to have her Nexplanon implant ("the bar") removed, highlighting how healthcare interactions can mirror the same silencing and presumptive attitudes found within the family context.

Extract 3, (Stacy, 21 years old). *"I had the bar for three years and I needed to go get it changed a couple of months ago. So, I went back to him as a male doctor, and he did it for me the first time. But just when I was talking to him about like options and stuff. He kind of just dismissed any of my questions that I had, and I remember he, like, I was talking about like how I felt when I had it for the three years before. And I was telling him how I kind of wanted to get the bar out and just not be on anything. […] He just turned around to me and he was like, 'well, do you have a boyfriend?' And I was like, yes. And he was like, 'So what are you going to do then if you don't have anything?' And I was like, that's not really like what I came here to talk about. […] And then he was talking to me about, like, getting the coil instead. And when I went in, I said that I didn't want to get the coil or the pill because I just know I'm not going to take the pill. I'll forget. […] he just kept trying to push it on me and show me it and, like, explain how fine it was. And I was like, look. I'm just not comfortable with this, but like he just kind of just ignored any questions that I had and just told me what he wanted me to do. Basically, rather than like what I actually needed."*

Stacy specifies her doctor as male, which subtly indicates that it influenced her experience and her perception of how he approached her concerns. Stacy describes a lack of engagement, and feeling *"dismissed"* suggesting her preferences were not acknowledged. The doctor asking about her relationship status and subsequently asking about her plans to continue without birth control suggests a moralising stance. While distinct from the parental judgment in Extract 2 in that sex is not denied but rather assumed, this nevertheless reflects gendered contraceptive assumptions falling to the women's responsibility and the contrasting ways of disempowering women through silencing and judging. Stacy appears to express frustration by stating, *"not really what I came here to talk about"*. This interaction suggests that Stacy found the doctor's questions irrelevant, highlighting a clear incongruence between her preferences and the doctor's agenda. Despite Stacy expressing a clear and informed decision, the doctor persisted in recommending the coil. This moment reflects experienced discrimination, and possibly stigma, as her autonomy and choice were disregarded in favour of a medically imposed preference. Her use of the phrase, *"he kept trying to push me"* suggests a coercive tone rather than giving her an opportunity for informed decision-making. Stacy reported feeling *"ignored"* by the doctor. This choice of word indicates the perceived stigma and underscores patient disempowerment. Her choice of phrase, *"told me what he wanted"*, further reinforces this dynamic, suggesting a lack of patient-centred care.

Fricker's (2007) notion of epistemic injustice is relevant to the analysis here, where young women's health knowledge is discredited due to age, gender, or perceived sexual activity. Stacy's experience shows how medical authority can override patient autonomy — an example of medical paternalism. The doctor assumes heterosexual activity, presumes contraception is mandatory, and dismisses Stacy's preferences. This aligns with feminist critiques of medicalisation, where women's bodies are often treated as sites of risk and objects of control, rather than as autonomous (e.g., Martin, 1987; Lupton, 2012). The assumption that women must justify opting in or out of contraception underscores a gendered double standard in healthcare.

Similar accounts were reported by other participants regarding female clinicians who emphasised prescriptive guidance over listening to patients' preferences. Across the sample, over half of participants explicitly reported feeling dismissed or not taken seriously during medical consultations, suggesting that epistemic injustice was a common experience.

2.2. Theme 2: Empowerment through peers and social media

A consistent theme across all focus groups was that participants described their peers as trusted sources of emotional support and health information. Peer relationships—often shaped by shared gender and age—offered non-judgmental spaces for reassurance, validation, and knowledge exchange. These interactions were characterised by mutual understanding and accessible communication, which fostered a sense of empowerment and encouraged self-advocacy.

Social media and digital platforms also emerged as important tools for accessing health knowledge. Participants highlighted how these spaces offered opportunities for learning and connecting, particularly when formal healthcare interactions felt dismissive or inaccessible. Overall, this theme illustrates how peer and online interactions created alternative, affirming spaces for informed decision-making and sexual and reproductive health empowerment. Niamh's reflection on discussing sexual and reproductive health with her peers highlights the value of mutual understanding in these exchanges.

Extract 4, (Niamh, 20 years old). *"I think when it's peers and it's the same age and you're like female as well, it is easier because I feel like family barriers like talking to parents and like older members. There is more of a generational gap, and they see things different and it's more like a why are you doing something rather than like their experience as well? And like with my friends you don't have to explain everything from the beginning, like, they just get it."*

In Extract 4, Niamh explains that talking to peers is *"easier"* because they *"just get it"*. The shared gender and age dynamic are central to this ease, indicating that these conversations are framed by a sense of shared understanding, which is often absent in family interactions. Niamh contrasts this with her experience of *"family barriers"* and a *"generational gap"* where older family members view such topics through a lens of judgment rather than support. The phrase *"you don't have to explain everything from the beginning"* emphasises how peers' lived experiences foster a deeper sense of comfort, affirming the importance of shared knowledge in promoting health empowerment.

Like Niamh, Everly's account in Extract 5 illustrates how peer relationships offer both emotional support and vital health guidance consistent with previous work that highlights peer support as offering potential to promote health behaviours, self-efficacy and confidence in decision-making (Dennis, 2003). Her experience underscores the role of shared peer spaces in facilitating reassurance, trust, and informed decision-making—especially in the absence of supportive clinical or familial conversations.

Extract 5, (Everly, 24 years old). *"If you're having like if you had a really bad period and you're like, Oh my God. Like I've such bad cramps. Like your friend might be like. Oh, like I get them as well. And, you know, you're kind of like, it's like, reassuring that other people go through the same thing that you go through. Like maybe it's just me but I would never say them sort of things to my mam, I'm pretty sure majority of my friends would be the same, no, maybe one of my friends is super close to her mam and would but that's just like not the norm, you know. For one time, I had my period for, like, three weeks straight, and I wouldn't have dared say that to my mam, but I probably told my friends in school every day about it until one of them was like, that's not normal you should mention that to your doctor"*

Everly describes it as *"reassuring"* when others experience the same health concerns as her, potentially indicating a mutual understanding fosters relief over perceived normality. The contrast with her family is striking, where she notes, *"I wouldn't have dared say that to my mam"*, suggesting that maternal figures do not occupy the same position that peers do. She states, *"is just not the norm"* to discuss these issues with your mother, to underscore how silence within the family is perceived as standard. Everly could confide in her peers *"every day"*, indicating her high level of comfort in talking to them about these issues. Everly expresses how her friends were able to be honest and say, *"that's not normal you should mention that to your doctor"*, indicating peer relationships not only provide emotional reassurance and validation but also encourage of help-seeking behaviours.

The role of digital platforms in health empowerment is emphasised in Clare's account in Extract 6, where she reflects on the growing role of digital platforms in promoting health practices such as breast self-checks and smears among women. Social media was identified as a tool to access information on one's sexual and reproductive health and listen to others' experiences without having to speak to someone face to face.

Extract 6, (Clare, 23 years old)*"I know there's a good few influencers that have been involved in breast check campaigns and obviously with everything surrounding the smear tests and the ages and stuff like that. It's been talked about a lot more and it's good that it's coming from these people that you watch every day and if they recommended a makeup product, you'd buy it. So, if they are recommending that you do these things that you do your breast check that you check in with your smear tests and I know. So, I don't know if anyone follows Annlivia, probably everybody. She recently talked about going to get her smear test and she said she was telling these women that were going, that it didn't hurt that she had no problem with the doctors, that she had been worried before, like, just sharing your experience with someone like it might encourage somebody else to do it."*

Clare's reference to *"these people that you watch every day"* points to the everyday visibility of influencers in young women's lives. When asking who knows the content creator Annlivia, her casual assumption, *"probably everybody"*, suggests young women have a collective recognition of different influencers. Clare recalls Annlivia telling her TikTok audience the smear test *"didn't hurt"* and that she *"had no problem with the doctor"*, suggesting that sharing her experience informed other women. Clare expresses that sharing an experience like this *"might encourage somebody else to do it"*, indicating that shared experiences may reduce a person's fear of the smear test. Clare's example illustrates how social media can make health information accessible (consistent with Maslen and Lupton, 2018), shifting away from traditional medical gatekeepers and fostering a broader sense of collective health responsibility. Participants across the focus groups reflected on potential risks of misinformation, commercialisation, and performativity on social media, indicating awareness of both benefits and limitations.

These accounts demonstrate how peer relationships and digital platforms serve as critical alternatives to traditional sources of health information and support. In contrast to clinical or familial spaces that may be shaped by stigma or silence, peers and social media offer accessible, empathetic environments where shared experiences foster reassurance, validation, and practical guidance. Across focus groups, nearly all participants noted at least one digital source or peer group that contributed to their health knowledge and confidence. This theme highlights the importance of collective knowledge and community in empowering young women to understand, manage, and advocate for their sexual and reproductive health.

2.3. Theme 3: Navigating stigma and empowerment simultaneously

Participants described a complex tension between the empowerment gained through peer support and social media, and the persistent stigma surrounding sexual and reproductive health in familial and clinical spaces. This theme explores how young women inhabit dual realities: while they increasingly access affirming, informative communities online and among peers, they also remain acutely aware of the social and cultural stigmas inherited from older generations and reinforced in medical encounters. This simultaneous experience of stigma and empowerment reflects an ongoing generational shift—one in which younger women are not only negotiating inherited silences but actively reshaping the narrative around sexual and reproductive health and autonomy.

Clare's narrative in Extract 7 exemplifies the tension between internalised silence around sexual and reproductive health and the gradual emergence of empowerment through peer dialogue.

Extract 7 (Clare, 23 years old). *"I think one of the harder parts of growing up here is knowing when to keep quiet. Like, I remember having dinner one night and my parents were talking about one of our cousins, well she's like a second or third cousin, I actually can't remember. Anyways, she got pregnant and the way my family spoke about her, like she had thrown her life away. Or as if she had done something disgraceful, it was made pretty clear to me that having sex young or I suppose even conversations about contraception were not things I could or I suppose were supposed to talk about. So, when I started having like, I know this is probably too much info, haha, but when I started having like discharge, I didn't say a word. I kind of just dealt with it in silence, because I was convinced if I told my mom she would assume I was doing something I shouldn't have been. It was only until a couple years later that I was sat with a group of friends and someone made a joke about discharge, not in a*

bad way, just in a funny way, and I kind of realised then how much I had been conditioned to hide something that was completely normal."

Clare's reflection on *"knowing when to keep quiet"* signals her awareness of the societal stigma surrounding women's health and can be deemed inappropriate around different settings. Her parents' condemnation of her young relative's unexpected pregnancy as, *"had thrown her life away"* and *"disgraceful"* illustrates how unplanned pregnancies were deemed shameful and met with moral judgement. The phrase, *"it was made pretty clear to me"* indicates how the reactions of her parents were strong enough to elicit self-censorship from Clare. The line, *"I was convinced if I told my mom she would assume I was doing something I shouldn't have been"*, poignantly reflects how internalised stigma can lead to self-censorship, preventing open discussions of normal bodily experiences like discharge. Clare shared that she realised she *"had been conditioned to hide something that was completely normal*" which indicates a potential pivotal moment where her peer discussions act as corrective spaces to challenge her internalised beliefs.

Bella's experience in Extract 8 further underscores the shift from passivity to self-advocacy. Clare and Bella both reflect on moments of reorientation: while Clare's shift emerges through peer humour, Bella's stems from witnessing her younger sister challenge the doctor.

Extract 8 (Bella, 22 years old). *"I only realised how much I had been quiet on my own concerns and my own health when I spoke to my sister after she was at the doctors. She suffers from really bad period cramps, like really really bad, and whenever she told our GP, he was always like telling her it was normal. But my sister didn't accept that, and my sister is really confident already and told the doctor that she wanted to be tested for PCOS and endometriosis because she seen some TikToks of girls who had it and she had a funny feeling she might have had too. When she came home and told me how she basically told the doctor his answer wasn't good enough and she wanted further testing, I realised that all I ever do is nod along to the answer the doctor gives me, even if I know deep down something's wrong. I suppose it's kind of bittersweet seeing my little sister stand up for herself and realising I just suffer if I have an issue, so I don't cause a fuss. Like, I really admire my sister for it, and after that, I suppose even though I would be less confrontational, it just goes to show that you are allowed to do the same and like stand up for yourself."*

Bella's observation, *"I only realised I had been quiet on my own concerns"*, reflects an emerging awareness of her passivity in the doctor's office. Bella contrasts her approach with her younger sister, who, *"basically told the doctor his answer wasn't good enough"*, while Bella is just compliant and submissive when speaking to the GP and agreeing without questioning them by her *"nod along"*. The repetition of the words for *"really really bad"* signifies the pain she was enduring along with the frustration by the persistent doctor dismissing them as *"normal"*. Bella's admiration, *"I really admire my sister for it"* suggesting that by witnessing advocacy a person's self-perception might shift on their own advocacy perhaps empowered though observations of other girls on social media raising awareness about reproductive health. Lastly, the phrase *"you are allowed to do the same and stand up for yourself"* indicates a moment of reorientation that you can feel empowered and be self-asserted in healthcare and not internalised complaints.

Kelly's narrative in Extract 9 represents a direct confrontation with outdated attitudes regarding birth control.

Extract 9 (Kelly, 21 years old). *"Oh my god, there was this one time at like my grandads 80th birthday dinner, my uncle was like, 'teens just want to go on birth control, so they have a free pass to have sex'. This made me so mad, and I shut him down so fast. I was like, challenging him that [birth control] fix acne and help with period pain and irregular cycles and yeah, I guess some teenagers want to go on birth control for sex reasons, but for a majority of the time it's nothing close to that reason and he shouldn't say stuff like that cause it damaging to women. He kind of scoffed at first but once I laid out my facts by the end of the conversation, he finally admitted he didn't think of it that way. Maybe he just agreed because it got awkward, and he wanted to move the conversation on, but either way, it was a small win. I felt so good after calling him out because, like, it's actually such an outdated belief"*

Kelly outlines her uncle's perception that contraception is used as a tool for adolescents to "*have a free pass to have sex"*, interpreting this as undermining legitimacy as a healthcare item. Kelly's response *"I shut him down so fast"* suggests her feeling passionate about the opposing side of the argument. By stating she *"laid out my facts"*, she presents her defence as not just emotional but as she sees it, informed and evidence-based. Her reflection *"it felt good"* and labelling his belief *"outdated"* could indicate that she felt empowered for speaking up for women. When Kelly mentions that the conversation "*got awkward*", she is acknowledging that the societal stigma surrounding women's health can make such conversations uncomfortable. Likewise, when she mentions "*it was a small win*" this could be referring to aiming to break the stigma surrounding women's health and challenge different beliefs. Her ability to assert herself in this context perhaps represents a growing shift towards the normalisation of sexual and reproductive health conversations. It is interesting here that Kelly feels the need to defend young people and legitimise contraceptive use for health-related matters in addition to allowing young people to be sexually active without fear of pregnancy (also a legitimate reason for contraceptive use).

Across participants, these narratives showed that empowerment was often incremental and context-dependent. For example, many reported feeling confident discussing sexual health with peers but hesitant with parents or clinicians. Several participants described moments where online or peer support enabled them to overcome previously internalised stigma, indicating a dynamic interplay between social, digital, and medical contexts in shaping empowerment.

3. General discussion

This study set out to explore how a sample of Gen Z women in RoI navigate sexual and reproductive health with particular focus on experiences of empowerment and disempowerment. Participants recalled early exposure to silence, shame, and dismissal regarding menstruation, contraception, and sexual activity—most often within the family context. These experiences were frequently linked to conservative gender norms and Catholic values. These patterns echo Brangan's (2024) analysis of the enduring ideological legacy of the Magdalene Laundry Institutes, which historically framed women's bodies and sexual and reproductive anatomy as sites of secrecy and social control (see also Foran et al., 2025; Moroney et al., 2025).

Crucially, participants did not experience home and clinical settings as distinct. Rather, these spaces often blurred: GPs—especially in rural areas—were seen as extensions of the family, reinforcing discomfort in disclosing sexual and reproductive health concerns. This reinforces Bommaraju et al.'s (2016) discussion of stratified stigma, where both interpersonal and structural hierarchies influence access to and comfort with sexual and reproductive services. Participants described a sense of mistrust and emotional withdrawal from clinicians, rooted in experiences of being dismissed or disbelieved—even when seeking care for routine concerns like contraceptive side effects or irregular bleeding. These interactions reflected not only interpersonal barriers but also internalised stigma. As Holland et al. (2020) argues, internalised body stigma can delay care-seeking by conditioning women to expect judgement or trivialisation. Notably, mistrust was not limited to male practitioners. Several participants described dismissive dynamics with both male and female clinicians, challenging assumptions that gender concordance inherently improves patient trust or rapport in domains of sexual and reproductive health. Taken together, these findings extend theoretical understandings of stigma and empowerment by highlighting their relational and context-dependent nature. The coexistence of disempowerment and empowerment challenges linear models that assume

a unidirectional movement from oppression to liberation (Rodwell, 1996; Rissel, 1994).

These findings are not unique to the RoI. Bittleston et al. (2024) found similar patterns among Australian youth, who wanted open and respectful dialogue with doctors concerning their sexual and reproductive health but often avoid sharing their concerns due to fear of judgement. In the present research, our participants noted their hesitancy to use services such as the free contraceptive scheme because of uncomfortable experiences in family and medical settings, underscoring that policy and access alone are insufficient without relational and cultural reform. This situates findings within Ireland's post-repeal policy landscape, demonstrating that legal change interacts with but does not fully resolve the lived realities of stigma and disempowerment.

In contrast to the constraining effects of family and clinical spaces, participants framed peer and digital spaces as sources of empowerment. Female friends were framed as trusted confidants who *understood* but also acted as sources of knowledge, reassurance, and encouragement. Participants described how conversations with female friends normalised sexual and reproductive health issues, which were previously seen as embarrassing or abnormal. This aligns with Burke et al.'s (2018) findings that peer support reduces internalised stigma and fosters health-seeking behaviours.

Digital platforms also emerged as powerful spaces for sexual and reproductive health education and sharing experiences, consistent with Heslin et al.'s (2024) finding regarding the power of online storytelling around abortion experiences in RoI's referendum campaign. In the present study, influencers and content creators were often described as accessible and relatable sources of knowledge, offering solidarity through vulnerability and humour. Chamakiotis et al. (2020) conceptualise these online spaces as not just informational networks but communities where meaning, identity, and support are co-constructed. However, participants also acknowledged risks of misinformation, commercialisation, and performativity in these spaces, highlighting that digital empowerment is conditional and sometimes precarious.

In this study, participants did not passively consume health content—they actively shared, discussed, and emotionally processed it, both online and offline. This reflects Pretorius et al.'s (2022) argument that digital influencers often act as informal educators, shaping how young people understand and discuss health. The mechanism through which empowerment emerges appears relational: shared storytelling, humour, and collective negotiation of norms allow participants to counteract internalised stigma and construct more confident self-narratives.

These findings resonate with Haslam et al.'s (2018) social identity approach to health, which argues that health is shaped not only by individual behaviour but by the social groups with which individuals identify. In this study, peer and digital spaces served as identity-affirming environments where participants could share experiences, access validation, and construct more empowered narratives of their sexual and reproductive health. By explicitly connecting empowerment to social identity processes, the study demonstrates that belonging to supportive groups can buffer against stigma, foster resilience, and facilitate positive health engagement.

Perhaps the most conceptually distinctive finding is that stigma and empowerment were not experienced as opposites. Instead, participants frequently described holding both at once—feeling confident in one setting and ashamed in another: empowered by peers but shamed by parents and intimidated by clinicians. This challenges traditional empowerment frameworks that suggest a linear movement from oppression to liberation (Rodwell, 1996; Rissel, 1994). Rather, the findings align with Fischer's (2019) framing of post-repeal RoI as a landscape of affective contradiction: a society undergoing rapid legal change while still negotiating the cultural and emotional legacies of silence (Heslin et al., 2024). Participants seemed to unlearn internalised sexism/stigma via peer and digital empowerment and normalising what were previously perceived as shameful experiences. This illustrates a relational, context-dependent form of empowerment where agency emerges alongside, rather than in opposition to, stigma.

This was particularly evident in accounts of *anticipated stigma*—where participants delayed or avoided seeking care based on not direct shaming but on the expectation of it (Herek, 2009; O'Donnell et al., 2018). Such responses reflect Carnevale's (2007) framing of stigma as a socially enacted, relational phenomenon. Empowerment too was relational, emerging not only from individual resilience but through connection, humour, shared stories and witnessing others speak up. These women were not simply overcoming stigma; they were learning to live with and work around it, often creatively and communally. These findings suggest that empowerment in sexual and reproductive health is co-constructed within peer and digital networks, highlighting the need for health frameworks that account for relational and community-based processes.

3.1. Strengths and limitations

The study offers a timely contribution to research by capturing the lived experiences and emotional and social complexity of sexual and reproductive health in a post-repeal RoI. By centring the voices of Gen Z women and employing reflexive thematic analysis within focus groups, the study captured both the shared and contested ways that stigma and empowerment are felt, navigated, and negotiated. The group setting fostered collective meaning-making and emotional resonance, revealing how participants co-constructed knowledge and validation in real time. Unlike more individualistic methods, this allowed for a deeper engagement with the relational and affective dimensions of sexual and reproductive health discourse.

However, the sample was drawn from university networks, which likely skewed toward more educated and urban participants, limiting the socioeconomic, ethnic, and geographic diversity of the data. The absence of rural, working-class, and ethnic minority voices is notable, as experiences of stigma, empowerment, and healthcare access are likely to vary along these intersecting axes. Furthermore, the online format may have excluded those with limited digital access or differing communication preferences. While virtual environments arguably increased participants' comfort and privacy, they also constrained non-verbal cues and may have encouraged socially desirable responses, particularly around empowerment, which was not predefined by the research team. Lastly, the focus group structure may have inhibited more vulnerable disclosures that might arise in one-on-one interviews. Future research could benefit from mixed method approaches to capture both the communal and deeply personal dimensions of sexual and reproductive health navigation.

3.2. Theoretical and practical implications for future research

This study deepens understandings of how stigma and empowerment operate not as binary states but as coexisting, fluid experiences that unfold relationally and contextually. The findings challenge prevailing empowerment models that assume a linear journey toward confidence or autonomy. Instead, participants described moving in and out of empowered states depending on context, support, and institutional trust—highlighting the need for feminist health frameworks that embrace ambiguity, contradiction, and emotional nuance.

From a clinical standpoint, the findings from this study underscore the need for relational competence, not just procedural skill. Sexual and reproductive health education for healthcare providers must address tone, empathy, and the subtle cues that shape whether patients feel heard and believed. Chinn et al. (2021) argue that health promotion must be centred around women's lived experiences, not just their risk profiles —a shift which would address some of the key challenges raised by women in the present research. Initiatives such as RoI's free contraception scheme are important, but without accompanying cultural and relational reform—through clinician training, institutional policy

change, and improved patient engagement—the impact of such programs may be limited.

Policy makers should also invest in peer-led education, participatory media campaigns, and digital literacy initiatives tailored to Gen Z. These interventions should not only provide information but also actively address the relational and emotional dimensions of stigma, fostering solidarity and collective empowerment—particularly when co-designed with young women themselves. As Maguire and Murphy (2023) argue, meaningful change in sexual and reproductive health must go beyond expanding access; it must transform how services feel and function in people's everyday lives.

Further research should adopt intersectional and longitudinal approaches, exploring how stigma and empowerment interact with race, class, gender identity, and rurality, and how these dynamics evolve over time. There is also a growing need to examine how digital actors—including influencers—are reshaping public understandings of sexual and reproductive health, and whether these informal health educators are filling, reproducing, or challenging institutional gaps. Such research should also critically examine both the empowering and potentially disempowering effects of digital platforms to fully understand their role in shaping young women's sexual and reproductive health.

4. Conclusion

This study shows that stigma and empowerment in sexual and reproductive health are not oppositional but coexisting, context-dependent, and relational experiences. Gen Z women in Ireland navigate a complex landscape of familial, clinical, and digital influences, finding support and agency in peer and online networks even while encountering persistent cultural and institutional barriers. These findings underscore the importance of relationally informed healthcare, peer-led interventions, and digital literacy initiatives that acknowledge both the empowering and potentially constraining aspects of online spaces. Future research should explore these dynamics across diverse social locations and life stages to inform policies and practices that move beyond access alone, fostering truly equitable and responsive sexual and reproductive health care. Ultimately, centring young women's voices reveals that empowerment is an ongoing, negotiated process, deeply intertwined with social, cultural, and digital contexts.

Ethical approval and informed consent statements

Ethical approval for the study was granted by the Education and Health Sciences Research Ethics Committee (2024_10_03_EHS). Informed consent was obtained from all individual participants included in the study.

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Elaine L. Kinsella: Conceptualization, Formal analysis, Investigation, Methodology, Project administration, Supervision, Writing – original draft. **Zélie Dunne:** Conceptualization, Data curation, Formal analysis, Writing – original draft. **Sarah Jay:** Writing – review & editing. **Aisling T. O'Donnell:** Writing – review & editing.

Declaration of conflicting interest

The authors declare that there are no conflicts of interest regarding the publication of this paper.

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Appendix

Appendix 1: Interview Guide

1. Can you describe a time when you felt empowered in your sexual and reproductive health experiences? What factors contributed to that feeling?
2. Can you describe a time when you felt disempowered in your sexual and reproductive health experiences? What factors contributed to that feeling?
3. In which areas of your health or body do you feel most confident discussing with healthcare professionals? Are there any areas where you feel less comfortable or hesitant? Why?
4. What are some of the challenges or barriers you face when trying to take control of your own sexual and reproductive health or make informed healthcare decisions?
5. How do your interactions with healthcare providers affect your sense of empowerment in managing your sexual and reproductive health? What changes would help you feel more empowered?

Data availability

Data will be made available on request.

References

Agha, Y., Gaynor, K., 2024. A qualitative exploration of young female Muslims' perspectives of abortion and belonging following the 2018 Irish abortion referendum. Sex. Res. Soc. Pol. 21, 657–666. https://doi.org/10.1007/s13178-023-00932-x.

Alfian, S.D., Griselda, M., Pratama, M.A.A., et al., 2025. Factors associated with decision-making autonomy in healthcare utilization among married women from the Indonesia demographic health survey 2017. Sci. Rep. 15, 9770. https://doi.org/10.1038/s41598-025-94057-3.

Baigry, M.I., Ray, R., Lindsay, D., Kelly-Hanku, A., Redman-MacLaren, M., 2023. Barriers and enablers to young people accessing sexual and reproductive health services in Pacific island countries and territories: a scoping review. PLoS One 18 (1), e0280667. https://doi.org/10.1371/journal.pone.0280667.

Bartky, S.L., 1990. Foucault, femininity, and the modernization of patriarchal power. In: Femininity and Domination: Studies in the Phenomenology of Oppression. Routledge, pp. 63–82.

Bittleston, H., Hocking, J., Temple-Smith, M., Sanci, L., Goller, J., Coombe, J., 2024. What sexual and reproductive health issues do young people want to discuss with a doctor, and why haven't they done so? Findings from an online survey. Sex. Sex. Reprod. Healthc. 40, 100966. https://doi.org/10.1016/j.srhc.2024.100966.

Bohren, M.A., Vazquez Corona, M., Odiase, O.J., Wilson, A.N., Sudhinaraset, M., Diamond-Smith, N., et al., 2022. Strategies to reduce stigma and discrimination in sexual and reproductive healthcare settings: a mixed-methods systematic review. PLOS Glob. Publ. Health 2 (6), e0000582. https://doi.org/10.1371/journal.pgph.0000582.

Bommaraju, A., Kavanaugh, M.L., Hou, M.Y., Bessett, D., 2016. Situating stigma in stratified reproduction: abortion stigma and miscarriage stigma as barriers to sexual and reproductive healthcare. Sex. Sex. Reprod. Healthc. 10, 62–69. https://doi.org/10.1016/j.srhc.2016.10.008.

Brangan, L., 2024. States of denial: Magdalene Laundries in twentieth-century Ireland. Punishm. Soc. 26 (2), 394–413. https://doi.org/10.1177/14624745231218470.

Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. Qual. Res. Psychol. 3 (2), 77–101. https://doi.org/10.1191/1478088706qp063oa.

Braun, V., Clarke, V., 2022. Toward good practice in thematic analysis: avoiding common problems and be(com)ing a knowing researcher. Int. J. Transgender Health 24 (1), 1–6. https://doi.org/10.1080/26895269.2022.2129597.

Broussard, K., 2020. The changing landscape of abortion care: embodied experiences of structural stigma in the Republic of Ireland and Northern Ireland. Soc. Sci. Med. 245, 112686. https://doi.org/10.1016/j.socscimed.2019.112686.

Burke, E., Pyle, M., Machin, K., Varese, F., Morrison, A.P., 2018. The effects of peer support on empowerment, self-efficacy, and internalised stigma: a narrative synthesis and meta-analysis. Stigma Health 4 (3), 337–356. https://doi.org/10.1037/sah0000148.

Carnevale, F.A., 2007. Revisiting Goffman'sStigma: the social experience of families with children requiring mechanical ventilation at home. J. Child Health Care 11 (1), 7–18. https://doi.org/10.1177/1367493507073057.
Chamakiotis, P., Petrakaki, D., Panteli, N., 2020. Social value creation through digital activism in an online health community. Inf. Syst. J. 31 (1), 94–119. https://doi.org/10.1111/isj.12302.
Chinn, V., Neely, E., Shultz, S., Kruger, R., Hughes, R., Thunders, M., 2021. Empowering women in the face of body ideals: a scoping review of health promotion programs. Health Educ. Behav. 49 (3), 534–547. https://doi.org/10.1177/10901981211050571.
Dennis, C.-L., 2003. Peer support within a health care context: a concept analysis. Int. J. Nurs. Stud. 40 (3), 321–332. https://doi.org/10.1016/S0020-7489(02)00092-5.
Fischer, C., 2019. Abortion and reproduction in Ireland: shame, nation-building and the affective politics of place. Fem. Rev. 122, 32–48. https://doi.org/10.1177/0141778919850003.
Foran, A.M., O'Donnell, A.T., Moroney, D., Muldoon, O.T., 2025. When saying sorry is not enough: the paradox of a political apology offered to Irish mother and baby home survivors. Polit. Psychol. 46 (2), 397–413. https://doi.org/10.1111/pops.13012.
Foucault, M., 1978. The History of Sexuality: an Introduction. Hammonsworth: Penguin.
Fricker, M., 2007. Epistemic Injustice: Power and the Ethics of Knowing. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198237907.001.0001.
Goffman, E., 1963. Stigma: Notes on the management of spoiled identity. Simon & Schuster, Inc.: New York, US. Department of Health. (2019, October 29). Report of the Working Group on Access to Contraception. Government of Ireland.
Golestani, R., Farahani, F.K., Peters, P., 2025. Exploring barriers to accessing health care services by young women in rural settings: a qualitative study in Australia, Canada, and Sweden. BMC Public Health 25, 213. https://doi.org/10.1186/s12889-025-21387-2.
Guest, G., Namey, E., McKenna, K., 2016. How many focus groups are enough? Building an evidence base for nonprobability sample sizes. Field Methods 29 (1), 3–22. https://doi.org/10.1177/1525822x16639015.
Haslam, S.A., Jetten, J., Cruwys, T., Dingle, G.A., Haslam, C., 2018. The New Psychology of Health: Unlocking the Social Cure. Routledge.
Herek, G.M., 2009. Sexual stigma and sexual prejudice in the United States: a conceptual framework. In: Contemporary Perspectives on Lesbian, Gay, and Bisexual Identities. Springer, New York, pp. 65–111.
Heslin, R.A., O'Higgins, S., O'Donnell, A.T., 2024. “We were cast aside”: an interpretative phenomenological analysis of abortion journeys from Ireland. Fem. Psychol. 34 (4), 555–575. https://doi.org/10.1177/09593535241265899.
Holland, K.J., Silver, K.E., Cipriano, A.E., Brock, R.L., 2020. Internalised body stigma as a barrier to accessing preventative healthcare for young women. Body Image 35, 217–224. https://doi.org/10.1016/j.bodyim.2020.09.005.
Idris, I.B., Hamis, A.A., Bukhori, A.B.M., Hoong, D.C.C., Yusop, H., Shaharuddin, M.A., Fauzi, N.A.F.A., Kandayah, T., 2023. Women's autonomy in healthcare decision making: a systematic review. BMC Womens Health 23 (1), 643. https://doi.org/10.1186/s12905-023-02792-4.
Jiao, W., Chang, A., Ho, M., Lu, Q., Liu, M.T., Schulz, P.J., 2023. Predicting and empowering health for generation Z by comparing health information seeking and digital health literacy: cross-sectional questionnaire study. J. Med. Internet Res. 25, e47595. https://doi.org/10.2196/47595.
Kinsella, E.L., Kavanagh, E., 2025. Evaluating the impact of a patient-representative model of support for women affected by cervical cancer. Women's Health 21, 17455057251351415. https://doi.org/10.1177/17455057251351415. https://journals.sagepub.com/doi/10.1177/17455057251351415. (Accessed 18 July 2025).
Londras, F. de, Enright, M., 2018. Repealing the 8th: reforming Irish abortion law. https://doi.org/10.1332/9781447347545.
Lupton, D., 2012. Medicine as Culture: Illness, Disease and the Body, third ed. SAGE Publications.
Maguire, L., Murphy, F., 2023. Putting abortion in the frame: the success of the campaign to repeal the 8th amendment in Ireland. Soc. Sci. 12 (9), 475. https://doi.org/10.3390/socsci12090475.
Martin, E., 1987. The Woman in the Body: a Cultural Analysis of Reproduction. Beacon Press.
Martínez-Estrella, E., Samacá-Salamanca, E., García-Rivero, A., Cifuentes-Ambra, C., 2023. Generation Z in Chile, Colombia, México, and Panama: interests and new digital consumption habits. Their use of Instagram and TikTok. El Prof. Inf. https://doi.org/10.3145/epi.2023.mar.18.
Maslen, S., Lupton, D., 2018. "You can explore it more online": a qualitative study on Australian women's use of online health and medical information. BMC Health Serv. Res. 18 (1). https://doi.org/10.1186/s12913-018-3749-7.
McCashin, D., Murphy, C.M., 2022. Using TikTok for public and youth mental health – a systematic review and content analysis. Clin. Child Psychol. Psychiatr. 28 (1), 279–306. https://doi.org/10.1177/13591045221106608.
Moroney, D., O'Donnell, A., O'Connor, M., Muldoon, O.T., 2025. Adoption and social identity loss: insights from adults adopted through Ireland's mother and baby homes. Br. J. Soc. Psychol. 64 (2), e12869. https://doi.org/10.1111/bjso.12869.
Morris, J.L., Rushwan, H., 2015. Adolescent sexual and reproductive health: the global challenges. Int. J. Gynecol. Obstet. 131 (Suppl. 1), S40–S42. https://doi.org/10.1016/j.ijgo.2015.02.006.
Nolan, A., Smyth, E., 2025. Sexual health literacy and sexual health behaviours among young adults in Ireland. In: ESRI Research Series, 200. ESRI, Dublin. https://doi.org/10.26504/rs200.
Nosek, B.A., Alter, G., Banks, G.C., Borsboom, D., Bowman, S.D., Breckler, S.J., et al., 2015. Promoting an open research culture: transparency and openness promotion (TOP) guidelines. Science 348 (6242), 1422–1425. https://doi.org/10.1126/science.aab2374.
O'Donnell, A.T., O'Carroll, T., Toole, N., 2018. Internalized stigma and stigma-related isolation predict women's psychological distress and physical health symptoms post-abortion. Psychol. Women Q. 42 (2), 220–234. https://doi.org/10.1177/0361684317748937.
Oerther, S., Oerther, D.B., 2021. Review of recent research about parenting generation Z pre-teen children. West. J. Nurs. Res. 43 (11), 1073–1086. https://doi.org/10.1177/0193945920988782.
Peterson, N.A., 2014. Empowerment theory: clarifying the nature of higher-order multidimensional constructs. Am. J. Community Psychol. 53 (1–2), 96–108. https://doi.org/10.1007/s10464-013-9624-0.
Pretorius, C., McCashin, D., Coyle, D., 2022. Mental health professionals as influencers on TikTok and Instagram: what role do they play in mental health literacy and help-seeking? Internet Interventions 30, 100591. https://doi.org/10.1016/j.invent.2022.100591.
Ray, G., 2023. Feminine knowledge in the digital age. UF J. Undergraduate Res. 25. https://doi.org/10.32473/ufjur.25.133131.
Rissel, C., 1994. Empowerment: the holy grail of health promotion? Health Promot. Int. 9 (1), 39–47. https://doi.org/10.1093/heapro/9.1.39.
Rodwell, C.M., 1996. An analysis of the concept of empowerment. J. Adv. Nurs. 23 (2), 305–313. https://doi.org/10.1111/j.1365-2648.1996.tb02672.x.
Sen, G., Östlin, P., 2008. Gender inequity in health: why it exists and how we can change it. Glob. Public Health 3, 1–12. https://doi.org/10.1080/17441690801900795.
Starrs, A.M., Ezeh, A.C., Barker, G., Basu, A., Bertrand, J.T., Blum, R., et al., 2018. Accelerate progress—sexual and reproductive health and rights for all: report of the guttmacher–lancet commission. Lancet 391 (10140), 2642–2692. https://doi.org/10.1016/S0140-6736(18)30293-9.
Tavananezhad, N., Bolbanabad, A.M., Ghelichkhani, F., Effati-Daryani, F., Mirghafourvand, M., 2022. The relationship between health literacy and # empowerment in pregnant women: a cross-sectional study. BMC Pregnancy Childbirth 22 (1), 351. https://doi.org/10.1186/s12884-022-04686-z.
United Nations Population Fund, 2021. My Body is my Own: Claiming the Right to Autonomy and self-determination. UNFPA. https://www.unfpa.org/sites/default/files/pub-pdf/SoWP2021_Report_-_EN_web.3.21_0.pdf.