Gender Matters

A user friendly guide to providing health services responsive to the needs of women and men

HEALTH SERVICE EXECUTIVE / NATIONAL WOMEN'S COUNCIL OF IRELAND

National Women's Council of Ireland
Comhairle Náisiúnta na mBan in Éirinn

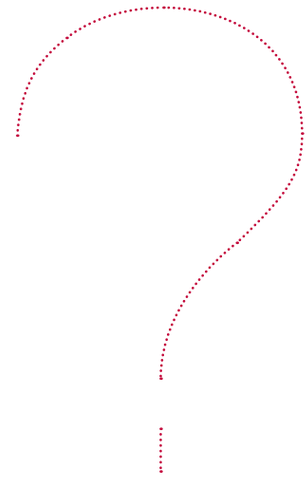
Gender Mainstreaming in Health

GENDER MAINSTREAMING IN HEALTH IS A METHOD OF INTEGRATING A GENDER PERSPECTIVE INTO POLICY AND SERVICE DELIVERY, IN ORDER TO PROVIDE EQUALITY OF ACCESS TO SERVICES, EQUALITY OF PARTICIPATION AND EQUALITY OF OUTCOMES IN HEALTH FOR WOMEN, MEN AND TRANSGENDER PERSONS.

It involves a process of incremental change that enables women, men and transgender persons to benefit equally from health care policies and the delivery of health services. In other words, gender comes into the mainstream of health care.

"The factors that determine health and ill health are not the same for women and men. Gender interacts with biological differences and social factors. Women and men play different roles in different social contexts. These roles are valued differently, and those associated with men are usually valued more highly. This affects the degree to which women and men have access to, and control over, the resources and decision-making needed to protect their health. This results in inequitable patterns of health risk, use of health services and health outcomes."

Source: WHO Mainstreaming Gender Equity in Health, Madrid Statement



EQUAL BUT DIFFERENT: A FRAMEWORK FOR INTEGRATING GENDER EQUALITY IN HEALTH SERVICE POLICY, PLANNING AND SERVICE DELIVERY (2012)

In 2012 the Health Services Executive (HSE) and National Women's Council of Ireland (NWCI) published '*Equal but Different: A framework for integrating gender equality in health service policy, planning and service delivery*'. The Framework was informed by research and consultations within the HSE, with community organisations and experts in the field. The Framework sets out recommendations for the HSE in developing gender-sensitive policy making, planning and service delivery.

GENDER MAINSTREAMING PROJECT (2013)

NWCI received funding from the HSE to support the implementation of gender mainstreaming. This work has been overseen by a Gender Mainstreaming Advisory Group (with representatives from the HSE, NWCI, Men's Development Network, Men's Health Forum, Institute of Public Health, Irish Cancer Society, the IMNO, Equality Authority, Cairde and Pavee Point Traveller and Roma Centre). The project involved pilot projects in mental health and primary care, developing training materials on gender mainstreaming and producing awareness-raising materials.

THIS DOCUMENT HAS BEEN PRODUCED BY THE NWCI AS PART OF THE HSE/NWCI PROJECT ON GENDER MAINSTREAMING IN HEALTH, WRITTEN BY DR JANE PILLINGER, A GENDER EXPERT WORKING WITH THE NWCI ON THE PROJECT.

It seeks to provide HSE personnel with a clear overview of the rationale for gender mainstreaming and the steps needed to implement it. Other resources which have been produced are:

1 **'GENDER MATTERS'** – *A Toolkit on Gender Mainstreaming in Health*

2 **'EQUAL BUT DIFFERENT'** – *A framework for integrating gender equality in Health Service Executive Policy, Planning and Service Delivery.*

3 **'GENDER MATTERS'** – *A Training the Trainers Handbook on Gender in Health*

ACKNOWLEDGEMENTS

National Women's Council of Ireland wish to acknowledge the work of Dr Jane Pillinger, the main author of this user guide. We acknowledge and appreciate the work of Rachel Doyle and Trish Brennan who edited and prepared it for final publication, and Jacqueline Healy for her work on coordinating the Gender Mainstreaming project.

We also acknowledge the members of the Gender Mainstreaming Steering Group who supported this work.

Finally, we are grateful to the Health Services Executive for providing the necessary funding.

March, 2014

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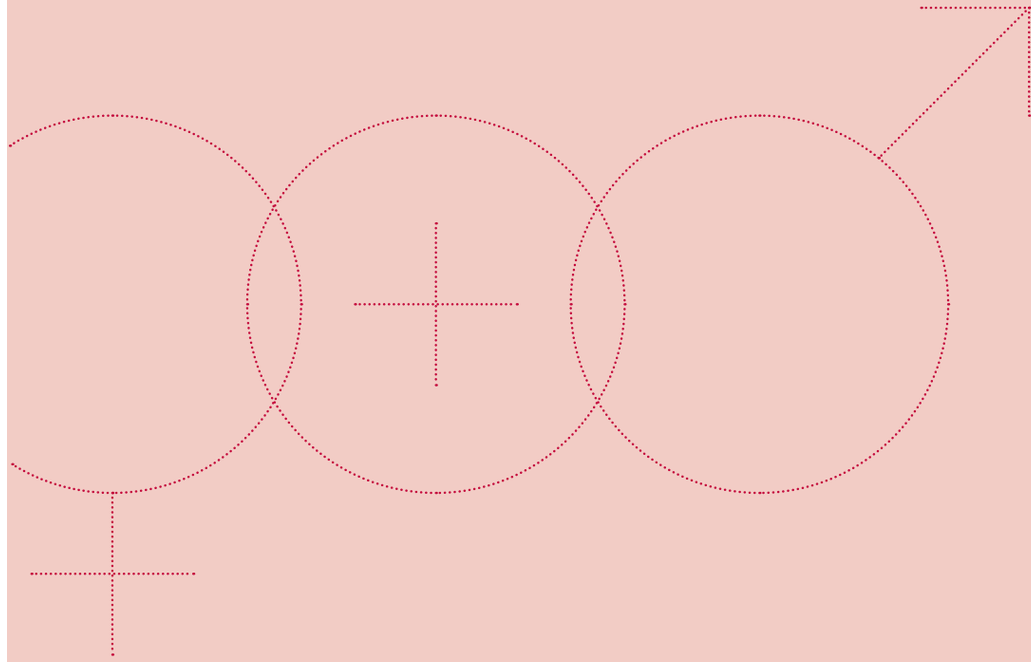


SECTION 1: INTRODUCTION

WHY IS GENDER EQUALITY IMPORTANT IN HEALTH?

Gender inequalities have a significant impact on the health status of women and men and are one of the key social determinants of health as defined by the World Health Organisation. Gender inequalities cut across other forms of inequality, for example, poverty, economic disadvantage, disability, age, ethnicity or sexual orientation. Gender inequalities also affect how health service providers respond to women's and men's health, and can influence assumptions made about the roles of men and women in society.

GENDER IS ONE OF THE NINE EQUALITY GROUNDS PROTECTED UNDER THE EQUAL STATUS ACT 2000–2011 AND THE EMPLOYMENT EQUALITY ACT 1998–2011, WHICH OUTLAW DISCRIMINATION AGAINST WOMEN AND MEN IN SERVICE DELIVERY AND EMPLOYMENT. THE GENDER GROUND REFERS TO A MAN, A WOMAN AND A TRANSSEXUAL PERSON.[1] IN A HEALTH CARE SETTING, THIS MEANS PROVIDING SERVICES THAT DO NOT DISCRIMINATE AND THAT PROMOTE EQUALITY OF OPPORTUNITY.

WHAT IS GENDER MAINSTREAMING?

Gender mainstreaming is concerned with the health needs of women and men. It means acknowledging gender differences and taking them into account when health services are provided and planned.

Gender mainstreaming provides tools that can be used by policy makers, health planners and health service providers to address gender inequalities and thereby contribute to better health for women and men. Gender mainstreaming is a process which enables health personnel to identify and act upon gender inequalities in the area of health.

In implementing gender mainstreaming, health professionals have knowledge and awareness of gender inequalities and how this affects men's and women's health. They take responsibility for integrating gender in their work and take action to address gender so that it is no longer a barrier to good health.

THIS USER-FRIENDLY GUIDE COVERS INFORMATION ON:

Ill-health, how it relates to gender, and the impact that this has on women's and men's health status and access to services **(Section 2)**.

The process of gender mainstreaming in health in uncovering the gender-related health risks experienced by women and men **(Section 3)**.

Methods for implementing gender mainstreaming and providing gender-sensitive services **(Section 4)**.

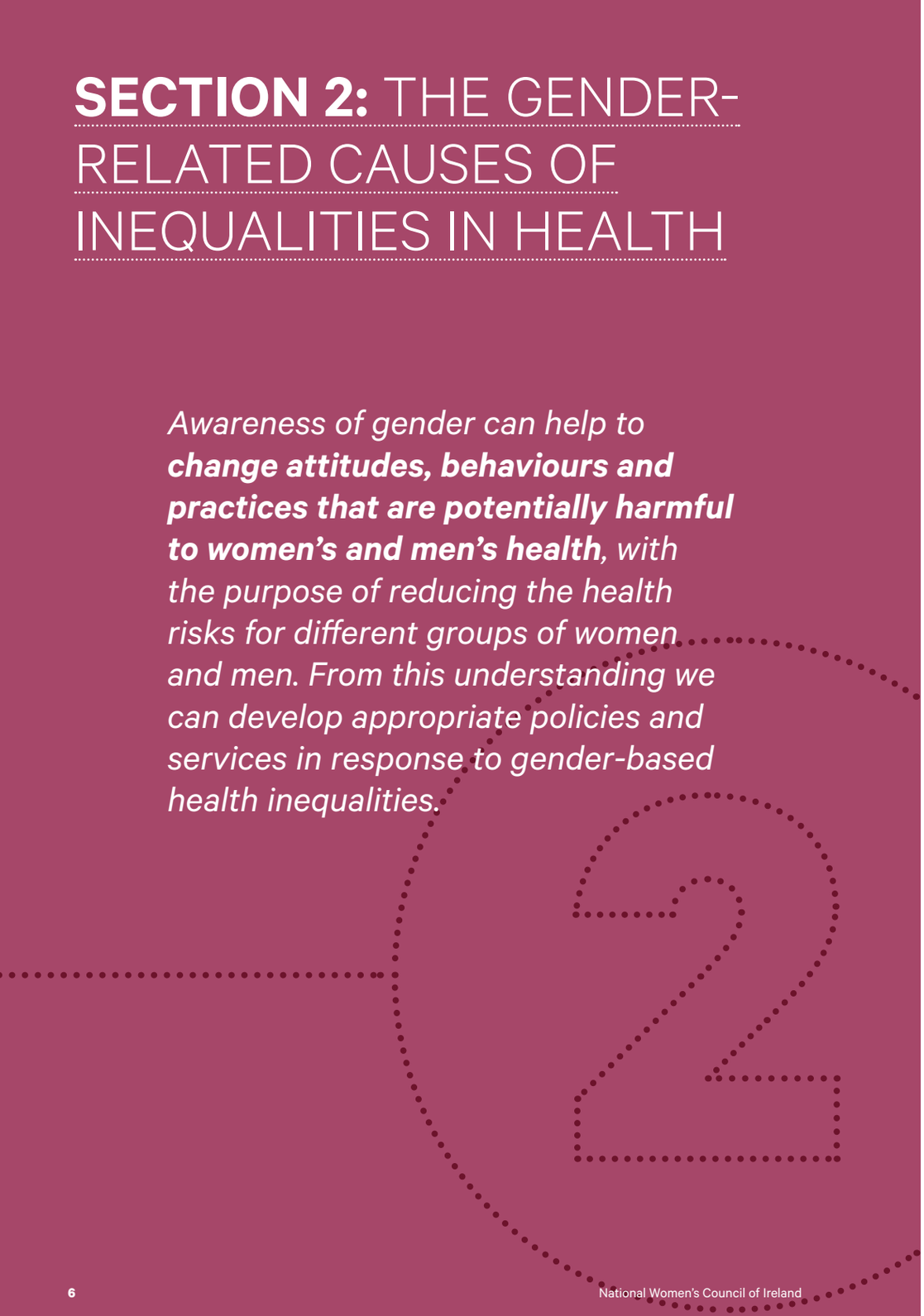
Suggestions on how health services providers and community organisations can begin to implement gender mainstreaming in partnership **(Section 5)**.

WHO IS THE GUIDE FOR?

This guide is for health professionals, planners, service providers at all levels, and community-based women's and men's groups. It is hoped that people and organisations working in the area of health will use the guide in a practical way so they can be more aware and responsive to the effects of ignoring gender inequality in the provision of health services.

SECTION 2: THE GENDER-RELATED CAUSES OF INEQUALITIES IN HEALTH

Awareness of gender can help to ***change attitudes, behaviours and practices that are potentially harmful to women's and men's health****, with the purpose of reducing the health risks for different groups of women and men. From this understanding we can develop appropriate policies and services in response to gender-based health inequalities.*



Improving the health of women and men means that we need to be aware of the social and cultural factors that lead to gender inequalities. By becoming aware of how **gender creates different roles for women and men**, and by taking account of **unequal power relations** between women and men, health service providers will be able to address different health risks and vulnerabilities experienced by different groups of women and men. This is also relevant when examining health seeking behaviour patterns and the ways in which women and men use health services.

> *"The factors that determine health and ill health are not the same for women and men. Gender interacts with biological differences and social factors. Women and men play different roles in different social contexts. These roles are valued differently, and those associated with men are usually valued more highly. This affects the degree to which women and men have access to, and control over, the resources and decision-making needed to protect their health. This results in inequitable patterns of health risk, use of health services and health outcomes."*
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> **Source: WHO Mainstreaming Gender Equity in Health, Madrid Statement**

DEFINING 'SEX' (BIOLOGY) AND GENDER (SOCIAL)

Sex and gender are not the same, but they interact in many different ways. Defining 'sex ' and 'gender' can sometimes be confusing. 'Male' and 'female' are sex categories. 'Masculine' and 'feminine' are gender categories.

Sex refers to biological and physiological differences that define women and men. These exist because of hormones or chromosomes. In most cases we are born either male or female, but some people choose to change their biological sex through surgery in order to adopt a gender identity more appropriate to them.

Gender refers to women's and men's social roles, behaviour and attributes that are constructed socially, culturally and historically. Gender differences and gender inequalities can affect men's and women's health status and their access to health care. Gender is not fixed and can be changed over time through better awareness and strategies that address inequalities between women and men.

EXAMPLES OF SEX FEATURES

1. Women menstruate while men do not
2. Men and women have different reproductive organs
3. Women have developed breasts that are usually capable of lactating, while men have not
4. Men generally have higher bone density than women

EXAMPLES OF GENDER FEATURES

1. Women carry out more housework and have greater care responsibilities than men
2. Women earn 16% less than men for work that is similar or of an equal value
3. Traditionally men were seen as the breadwinner, earning a 'family wage', with economic responsibility for providing for their families

GENDER NORMS, ROLES AND RELATIONS

GENDER INEQUALITIES ARE AFFECTED BY THE NORMS, VALUES AND EXPECTATIONS OF A SOCIETY AT A PARTICULAR POINT IN TIME. THEY ARE PERPETUATED BY WHAT IS CONSIDERED APPROPRIATE 'MALE' AND 'FEMALE' ROLES AND BEHAVIOUR.

There are many different forms of 'masculinity' and 'femininity'. They are not fixed categories and can change over time, and can vary within and between cultures.

Gender norms, roles and relations affect the health of women and men across their lives, and across all ages and social groups – they are socially constructed and result in unequal power relations between men and women, which affect health and well being for different groups of women and men .

Gender norms: A gender norm is a behavior or attribute that society accords to a particular sex. Gender norms change from culture to culture and over time since they are expectations of societies that are constantly evolving. Things as simple as the colours boys and girls typically wear 'pink is for girls, blue is for boys' are gender norms. Accepted norms can lead to unhelpful stereotypes, which are widely held judgements or biases which oversimplify and exaggerate gender differences and can cause unequal treatment of women and men. These exaggerated gender stereotypes can cause conflict when pressure is put on them to conform. Gender norms prescribe that women hold most responsibility for caring for children, elderly, sick or disabled relatives.

Norms that value male authority, power and privilege increase health risks for women. Heterosexual norms can also lead to discrimination that affects the health of lesbian, gay, bisexual and transgender people.

Gender roles adhere to these norms, and are the socially constructed definition of the roles considered appropriate for either a man or a woman. Women's lower levels of access to power and resources can result in negative health consequences because of inequality and poverty, and because women have to take on 'dual roles' in paid work and care roles in the family. Assumptions about men's roles as being the 'breadwinner' can also have damaging health consequences, for example, men are more likely to work long hours that prevent them from taking on care roles in the family. Other assumptions about masculine emotional strength may make it difficult for them to talk out their feelings during times of stress or pressure.

Changes in gender roles over time can be seen from women's participation in the labour market (which rose from 26% in 1961 to 56% in 2011). However, women make up 35% of part-time workers (compared to 12% of men), and many women work part-time in order to balance work and family/care responsibilities. Certain male gender roles and socially ascribed notions of 'masculinity' can constrain men and lead to behaviour and attitudes that are health damaging. For example, for some men this is manifested through 'acceptable' male outlets, such as alcohol abuse and aggressive behaviour. Health damaging or risky behaviours can be closely associated with 'proving' one's masculinity, while health-seeking behaviour can be associated with 'femininity'.

Gender relations are power relations since the status of women and men and the values attached to their respective roles in society are not on an equal level. Gender relations define how women and men interact with each other and the rights and responsibilities they have in relation to one another. The relations of power and dominance structure the life chances of women and men. For example, women's care roles are under valued and restrict women's broader participation in work and society. This results in unequal relationships within the family, in relation to care and in access to employment, education and training, and in wider society.

HOW DOES GENDER IMPACT ON WOMEN'S HEALTH? EXAMPLE: WOMEN AND SMOKING

ALMOST ONE IN THREE IRISH WOMEN, AND ONE IN TWO YOUNGER WOMEN SURVEYED (18 – 29 YEARS) FROM LOWER SOCIO-ECONOMIC BACKGROUNDS ARE ADDICTED TO TOBACCO.

Today more women die of lung cancer than breast cancer and it is the main cause of death from cancer for women in Ireland. Lung cancer is nearly twice as high amongst women from disadvantaged communities. (ICS 2013).

NWCI and the Irish Cancer Society published a report[2] in 2013, which provides evidence of the rise in smoking amongst women, and the way the tobacco industry targets women with specific marketing tactics designed to make cigarettes appear attractive and less dangerous than they are. It also addresses the social and psychological reasons which make it hard for women to quit smoking. Women are more likely to be poor, to parent alone, to be the main provider of unpaid care work, to earn low wages, to be at risk of domestic or sexual violence, and to be in poorly protected employment. Women are less likely to engage in sport from an early age. These factors have significant consequences for the effectiveness of health promotion strategies, and in particular, in how to prevent women starting to smoke and how to support women to take the steps to stop.

The report makes the strong link between the reasons women start and continue smoking and the current and persistent gender inequalities in our society. It states that gender inequalities between women and men need to be addressed in community-based smoking cessation services. For example, according to HSE figures at end of 2012 smoking rates for men have declined over the previous two years to 22.58% but increased for women to 20.87% **(www.hse.ie/eng/about/Who/TobaccoControl/Research)**. For many women, smoking is a coping mechanism. Smoking can be used to relieve stress, and many women smoke out of boredom, particularly women who work long hours in the home. These issues need to be factored into strategies designed to help women quit and find alternatives in their lives.

HOW DOES GENDER IMPACT ON MEN'S HEALTH?

Socially ascribed roles for men may make it difficult to acknowledge and discuss health problems. Men's gender roles often mean that they are less likely than women to seek health advice, discuss their health problems, visit a GP, have contact with services through a primary care team or to participate in activities that promote their health. This is particularly the case for young men and Traveller men.

Men are more likely to be at risk of occupational ill health or injury because they carry out occupations, for example, in construction, where there is a higher risk

of injury or death. The death rate due to accidents for men was more than twice that of women in 2009. Men's longer working hours impact on their health and reinforce gender divisions in families.

Societal and peer pressure mean that men are more likely to engage in risky behaviour. Two-thirds of treated alcohol cases are male, with the highest rate in men aged 65 – 74 years. Men represent nearly three quarters of discharges from hospital which are related to 'mental and behavioural disorders due to alcohol'.

Gender-related factors can have an impact on early death. For men, death rates arising from suicide, drug related poisonings, accidents at work and are higher than amongst women. There may also be biological differences in exposure to risk, for example some studies are showing that women who smoke the same number of cigarettes as men are 20% more likely to develop lung cancer. **(www.mskcc.org/blog/study-suggests-women-are-more-susceptible-smoking-related-lung)**

HOW DO SEX AND GENDER INTERACT?

GENDER INTERACTS WITH SEX RELATED ILLNESSES OR DISEASES EXPERIENCED BY MEN AND WOMEN . IN SOME CASES WOMEN'S AND MEN'S ANATOMICAL AND PHYSIOLOGICAL DIFFERENCES CAN AFFECT DRUG TREATMENTS AND REACTIONS TO DRUG TREATMENTS, FOR EXAMPLE, IN CARDIAC CARE.

However, the absence of a gender perspective will affect how health professionals act upon these problems. Biological differences can be the basis upon which assumptions are made about men's and women's health. However, gendered assumptions are common in the health care system and may impact on prevention, diagnosis and treatment, for example, of heart disease or mental ill health. Having a gender perspective can go a long way to preventing the causes of early death and ill health. Lifestyle, social roles or poor health-seeking behaviour are all important in the analysis of life expectancy, and gender differences pertaining to these should be a consideration in strategies to increase life expectancy.

Having a gender perspective is important in responding to the higher death rate of the 15 – 24 year age group, where the male rate is more than three times that of the female rate. It is also important in responding to the fact that although women have a longer life expectancy, they live with disability and ill health in their later years, (WHO Factsheet No. 334). Traveller men have a life expectancy 15 years less than the general population and Traveller women have a life expectancy of nearly 10 years less than the non-traveller – population.[3]

GENDER AND VIOLENCE

Sex and gender interact in complex ways when we look at **gender and violence**. Gender roles and relations have a powerful impact on gender-based violence (physical, sexual or emotional). Male conditioning can create expectations about 'masculine' behaviour, based on social roles that are strong, dominant and powerful.

GENDER INEQUALITIES AND UNEQUAL GENDER POWER RELATIONS MEAN THAT WOMEN ARE OFTEN THE VICTIMS OF VIOLENCE, RAPE, CONTROL AND COERCION FROM INTIMATE PARTNERS.

Women experience a disproportionately higher rate of physical or sexual violence than men.[4] The majority of sexual violence and violent assaults are perpetrated by men.[5]

Gender conditioning also means that men do not report or seek support if they have experienced sexual abuse or violence. Men who are victims of abuse often find it hard to report abuse because this runs counter to gender norms that expect men to be powerful and dominant. Men's violence against men and women is affected by gender norms whereby some men have been taught to express masculinity through aggression. Addressing men's social roles and conditioning is therefore important in changing violent or abusive behaviour.

GENDER AND THE SOCIAL DETERMINANTS OF HEALTH

Women's and men's health and their access to health care are affected by a wide range of determinants of health that impact on women and men in different ways. Gender intersects with other population groups, for example, in relation to age, disability, ethnicity, and sexual orientation. Other determinants of health include poverty, socio-economic status, education, employment status and income, culture, household position and geographic location.

Looking at women's and men's health within the broader context of the social determinants of health enables us to identify key life experiences that impact on women and men who experience poverty and/or multiple inequalities. This can improve access to health services for different groups of women and men, such as socially isolated older men, lone parents, women living in poverty, Traveller women and men or lesbian, gay, bisexual and transgender (LGBT) people.

HOW DO GENDER INEQUALITIES INTERACT WITH OTHER DETERMINANTS OF HEALTH?

1 Women and men from minority ethnic groups experience multiple forms of discrimination because of gender discrimination and racism. Racism and discrimination impact on their health and their access to health care. Account needs to be taken of a woman's culture and religion, for example, in enabling Muslim women to have access to female GPs, if requested. Traveller women's experiences of gender inequalities and racism impact hugely on their health status and access to health services.

2 Women with disabilities have reported difficulties in accessing reproductive health care and screening. For example, if women with intellectual difficulties are assumed to not be sexually active, they may not be offered cervical screening or sexual health services. Negative assumptions sometimes exist towards mothers with intellectual disabilities and those with mental health difficulties – in some cases there are unfounded perceptions that they pose a risk to their child. Further barriers faced by women with mental health difficulties arise because they may be reluctant to disclose because of a perceived stigmatisation that they are not capable of being good mothers.[6]

GENDER, MENTAL HEALTH AND WELL BEING

GENDER INEQUALITIES HAVE A POWERFUL IMPACT ON MENTAL HEALTH AND WELL BEING. HAVING A GENDER PERSPECTIVE WILL AFFECT HOW SUPPORT IS PROVIDED, AND HOW HEALTH PROMOTION MATERIALS OR TREATMENT PROGRAMMES ADDRESS MENTAL HEALTH CONCERNS.

Although biology may play a part in understanding some mental health conditions, women's and men's social roles are linked to many causes of mental ill health. For example, family carers, the majority of whom are women, may experience depression because of isolation, lack of support and stress. Risk factors that impact on mental ill health in women include poverty, inequality in the home and in work, domestic violence, sexual violence and rape. Anxiety, depression and eating disorders are more common in women. Depression and anxiety are three times more prevalent amongst women.[7] A significant number of women experience post-natal depression (around 15% of new mothers in Ireland experience postnatal depression),[8] and more women than men attempt suicide and self-harm.[9]

Men may experience mental ill health because their social roles expect 'masculine' behaviour that isolates them and makes it difficult for them to express themselves.[10]

Substance misuse and anti-social personality disorders are more common amongst men. Men's depression and other mental health problems often go undetected and are under-treated. Male depression is often manifested through more 'acceptable' male outlets, such as alcohol abuse and aggressive behaviour. Although depression is linked to over half of all suicides, men are less likely to be diagnosed with depression than women and are three times more likely to die by suicide than women. Death from suicide is five times higher among men than in women, and the rate among young men in Ireland is amongst the highest in the EU.[11] The economic crisis and higher unemployment can be attributed to an increased rate of suicide amongst men.[12]

EXAMPLES OF HOW A GENDER PERSPECTIVE CAN LEAD TO IMPROVED HEALTH

THE FOLLOWING TWO EXAMPLES SHOW HOW A GENDER PERSPECTIVE CAN HIGHLIGHT SPECIFIC AND DIFFERENT HEALTH ISSUES FOR WOMEN AND MEN. THEY BOTH SHOW HOW A GENDER PERSPECTIVE CAN POSITIVELY IMPACT ON MEN'S AND WOMEN'S HEALTH.

Women and Coronary Heart Disease

Women and men have different experiences of cardiovascular health, in diagnosis, treatment and health outcomes. However, the 'normal' heart disease patient is perceived as being male, where detection and treatment are based on typical male symptoms. Gender stereotyping and a lack of awareness of female symptoms may explain why women have significantly higher rate of death following a heart attack. (Data from the World Health Organization shows that 54% of deaths from cardiovascular disease are women and 43% are men).[13]

WOMEN'S SYMPTOMS RELATE TO SHOULDER OR ABDOMINAL PAIN, DYSPNEA, FATIGUE AND NAUSEA, WHEREAS MEN'S SYMPTOMS ARE TYPICALLY RELATED TO SEVERE CHEST PAIN.

Women are more likely to be misdiagnosed than men, while men are more likely to be referred for further tests. Rates of hospitalisation for men with heart disease and heart attack are nearly double that of women, while only slightly fewer men die from cardiovascular disease than women each year. Today about 5,000 women die of heart disease annually in Ireland – 7 times more than from breast cancer.[14]

An assessment tool to improve the awareness of women's symptoms of heart disease in emergency departments was drawn up by the Women's Health Council and the Irish Association for Emergency Medicine.[15] It highlights the fact that heart disease is the most common cause of death for women in Ireland and a woman is 10 times more likely to develop heart disease than breast cancer. It aims to counter the gender bias in the assessment, investigation and treatment of heart disease through improved awareness of symptoms.

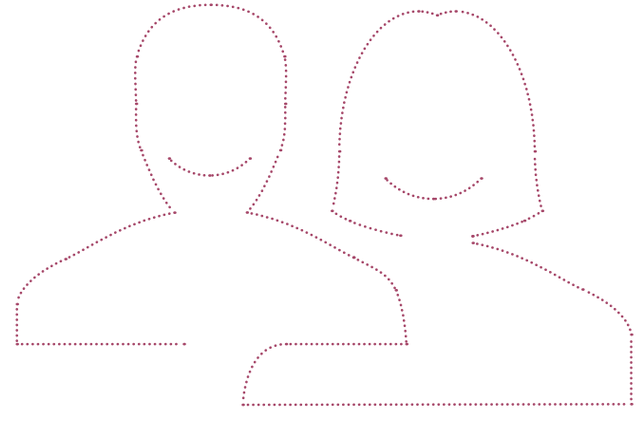
Working with obese men in a primary care setting

A study of obese men who attended Community Nutrition and Dietician Services[16] (CNDS) in HSE South in 2008 led to the development of a resource book on best practice approaches for health-care professionals working with obese men in a primary care setting.

Male obesity rates have tripled since 1990, resulting in 44% of men being overweight and 26% obese. Obesity is more prevalent among men than women and poses a risk of hypertension, diabetes and metabolic syndrome. Men's diets are less healthy than women's diets and men who are overweight or obese often do not see their weight as a cause of concern. Men's dietary habits are mostly influenced by long working hours, an approach to food that is more pleasure orientated and an association of size with masculinity.

The study found that men are less likely than women to observe advice about healthy eating and to consider dieting to lose weight. It was found that men are less likely to be referred to lifestyle counselling for obesity and that obesity is largely ignored in primary care settings.

The study further found that interventions tailored to men's dietary and lifestyle behaviours can have a positive impact in raising men's awareness and changing men's dietary habits, in promoting higher levels of physical activity and reducing alcohol consumption. The importance of a patient-centred approach was highlighted where men were given personal choice and took responsibility for their own health.



SECTION 3: WHAT IS GENDER MAINSTREAMING?

Gender mainstreaming is a tool for bringing gender equality into health-care policy, planning and service delivery. The goal is to improve delivery of services so health-care providers respond to the health needs of different groups of women and men. The benefits of gender mainstreaming are that it can result in:

- **Improved health for women and men, improved quality of services provided and better delivery of patient-centred care.**
- **Appropriate and equitable health services able to respond to the barriers and risk factors experienced by women and men.**
- **Services that are informed, evidence-based and targeted to address gender-related health inequalities.**

GENDER MAINSTREAMING IS A COMMITMENT UNDER THE IRISH **NATIONAL WOMEN'S STRATEGY 2007 – 2016**. THE NATIONAL WOMEN'S STRATEGY MAKES A SPECIFIC COMMITMENT TO INCORPORATE A GENDER PERSPECTIVE IN HEALTH POLICY AND TO INTRODUCE POSITIVE-ACTION MEASURES TO ENSURE WOMEN'S HEALTH IS PROMOTED AND PROTECTED.

The **Men's Health Policy 2008 – 2013** makes a wide range of recommendations to tackle men's health issues, which include implementation of a gender mainstreaming approach to men's health. The document states that "targeting men's health can impact not just on men's lives, but can have positive spin-offs on the lives of women and children."

GENDER MAINSTREAMING MEANS THAT HEALTH-CARE PROVIDERS HAVE A RESPONSIBILITY TO:

Raise awareness, learn about and develop steps in relation to gender mainstreaming.
Give time, commitment and resources to implement gender mainstreaming and to monitor outcomes.
Change behaviour, attitudes and practices that impact negatively on women's and men's health status.
Carry out activities that empower women and men to promote their health and well being.
Change policies so they do not reinforce gender inequality in staffing or governance.
Encourage participation from women and men from all backgrounds in influencing health priorities.
Deploy resources proportionate to the needs identified.

Examples of how a gender perspective in health care can reduce ill health, provide more effective services and make better use of resources:

Increase in the use of GP, primary care and preventative services by men.
Remove gender bias in the identification and treatment of women with cardiovascular disease.
Improve responses to gender-based violence by front-line service providers, appropriate to women and men.
Facilitate access to clinicians who are of the same sex as their patients, on request.
Enhance access to sexual health services that are targeted to different groups of young women and young men.
Address the different social and health-care needs of women and men in a way which takes account and is sensitive to cultural diversity.
Address the different social and health-care needs of older women and men living in residential care or who require care support to enable them to live in their own homes.
Respond to the gender-related causes of women's and men's mental ill health, and to provide appropriate prevention, treatment and recovery.
Identify areas of women's and men's health that receive a low priority in service delivery, for example, to improve services to women experiencing perinatal suicide and first year post-natal suicide, where data is not collected.
Enhance support and responses to the health-care needs of family carers.
Respond to the increasing smoking rates amongst young women from a gender perspective.

Address the health risks, needs and discrimination faced by lesbian, gay, bisexual and transgender people.

Prioritise the gender-related health risks experienced by women and men living in poverty and social isolation.

CARRYING OUT GENDER IMPACT ASSESSMENT (GIA)

GENDER IMPACT ASSESSMENT IS A TOOL THAT IS USED IN GENDER MAINSTREAMING. IT IDENTIFIES, ASSESSES AND INFORMS ACTIONS TO ADDRESS GENDER INEQUALITY AND UNEQUAL POWER RELATIONS BETWEEN AND AMONG WOMEN AND MEN.

It also addresses other factors that impact on gender inequalities, such as ethnicity, education, employment or care roles. Gender impact assessment can be applied to:

- Planning and provision of front line services
- Development of health legislation and policies
- Budgetary considerations
- Design of health research
- Implementation of strategies
- Services on specific health problems

Gender impact assessment is a tool that should be built into all levels of the HSE and the Department of Health's activities and functions where there is gender relevance. Gender impact assessment will enable health-policy makers, planners and managers to address the consequences of inequalities in health and the differences between specific groups of women and men. This can include assessment of:

- Risk factors and vulnerabilities experienced by women and men
- Gender-related factors that relate to different patterns of disease, illness and mortality
- Gender-related health effects of legislation, policies or programmes
- Gender differences in access to health services, including preventative services, health promotion and information

THERE ARE TWO STAGES TO CARRYING OUT A GENDER IMPACT ASSESSMENT (GIA)

Stage 1: Is the policy or service area gender relevant?
The first stage in carrying out gender impact assessment is to check whether the policy or service is gender relevant. Data is needed to check this (in the form of statistics of service usage or consultations with service users). If there is no data available it will be important to consult with service users and examine other methods of additional data collection. If there is gender relevance to the policy or service, the next stage is to carry out a gender impact assessment.

Stage 2: Gender Impact Assessment (GIA)
Gender impact assessment is one of the tools used in gender proofing. It involves an assessment of policies and practices to see whether they will affect women and men differently, with a view to adapting these policies/practices to make sure that they have equality of outcome. In carrying out a GIA, account should be taken of:

- Risk factors related to gender inequality, such as poverty or geographic location, that affect women's and men's health.
- Different levels of access to resources and how this impacts on women's and men's capacity to take up services (and whether there are specific groups of women and men that are not taking up services).
- Health-seeking behaviour and access to health services. Consideration should be given as to whether specific services should to be developed for particular groups.
- Gender inequalities which may play a part in determining treatment options and whether women and men are receiving the same quality of diagnosis and treatment for their health problems.
- How services can promote a positive health experience in accessing health care that takes account of women's and men's health care needs and experiences.
- How gender inequality impacts on health and social outcomes and consequences for an individual or family.
- Whether the specific or different needs of women and men have been taken into account in the planning of services and whether there are any policies or plans that unintentionally perpetuate gender inequalities or gender stereotypes, or unintentionally disadvantage specific groups of women and men.

SECTION 4: EIGHT STEPS TO GENDER MAINSTREAMING

In the framework for gender mainstreaming – 'Equal but Different: A Framework for Integrating Gender Equality in Health Service Policy, Planning and Service Delivery' – the National Women's Council of Ireland and the Health Services Executive recommend that:

- **Policy makers, planners, managers and front-line service providers take account of the interaction between of sex (biology) and gender (social roles).**
- **The framework be implemented through a whole organisational approach and with the involvement of women and men from different population groups.**
- **There is a commitment to collecting data and asking women and men about their experiences of services, and to ensure that evidence of inequalities in health is acted upon at all levels of policy making, planning and service delivery.**
- **Health-care planners, managers and service providers plan and deliver services that are responsive to women's and men's health care needs.**

THE FOLLOWING EIGHT STEPS SET OUT THE KEY ACTIONS THAT NEED TO BE TAKEN TO PUT IN PLACE A GENDER MAINSTREAMING PROCESS. ALL STEPS WILL NEED TO BE IMPLEMENTED TO IMPROVE ACCESS TO QUALITY HEALTH CARE AND REDUCE GENDER RELATED HEALTH INEQUALITIES.

1 **Senior level commitment and leadership in health care services**
There must be full commitment to gender mainstreaming at the senior levels of the Department of Health and current and future structures of the HSE. This commitment needs to be visible and championed.

2 **Improve awareness about gender differences in health**
All health-care staff and managers need to be aware of gender differences in health and implement a gender-sensitive approach in the planning and delivery of services.

3 **Collate and analyse gender and sex-disaggregated data**
There is a need for improved data and indicators on gender inequalities in health and how they relate to social determinants of health. Improved data will provide the evidence upon which services can be assessed for any gender differences in health.

4 **Consultations with service users, health care professionals and staff**
The HSE must consult and involve women and men from different population groups when creating a gender-sensitive health system. With this participation, services can be more responsive to the actual experiences of women and men from all communities.

5 **Assessing gender relevance and carrying out Gender Impact Assessments**
As a first step it will be important to assess whether gender is relevant to a policy or service. This will be informed by collected data and consultations. Once gender is relevant, the next step is to carry out a full gender equality impact assessment on all new policies and at the beginning or during the planning cycle for services.

6 **Develop priorities for service planning and delivery that address identified gender differences**
Once a Gender Impact Assessment has been completed priorities will need to be set to address existing inequalities and resources allocated to meet these priorities.

7 **Gender mainstreaming projects in specific services**
Demonstration projects are the best way to develop the expertise, awareness and application of this framework. It is recommended to conduct gender mainstreaming projects in primary care, mental health, cancer care, cardiovascular care, emergency services, older people's services, health promotion and social inclusion.

8 **Monitoring, reviewing and reporting**
Gender mainstreaming is not a one-off activity. All policies, procedures and service delivery need to be monitored and reviewed through the development of performance indicators in the planning process.

SECTION 5: GENDER MAINSTREAMING IN HEALTH: WHAT YOU CAN DO

Gender mainstreaming is a shared responsibility and should be carried out in partnership between health-care providers and organisations, and groups outside of the health care system.

HEALTH-CARE PROVIDERS

HEALTH-CARE PROVIDERS, PLANNERS, POLICY MAKERS AND MANAGERS NEED TO EXAMINE HOW THEY CAN BRING A GENDER PERSPECTIVE INTO THEIR EVERYDAY WORK:

- Plan to carry out a gender impact assessment of your service or programme. See NWCI / HSE Gender Mainstreaming Toolkit, available on **www.nwci.ie**
- Gather gender disaggregated data and consult with women and men in the community.
- Work in partnerships with other organisations in the community sector and with agencies.
- Inform colleagues and raise awareness within your team or department, for example by organising a team training day or half day. See NWCI/HSE Training the Trainers Guide to Gender Mainstreaming in Health, available on **www.nwci.ie**

Avail of the resources available giving more information to help you provide gender-sensitive services. For example, 'GENDER MATTERS': Training the Trainers Manual and 'GENDER MATTERS': Toolkit for Mainstreaming Gender in Health Service Policy, Planning and Delivery. Both available from the NWCI and on website **www.nwci.ie/learn/publications**

National Women's Council of Ireland (NWCI) and its member organisations have played an important role in countering gender-based discrimination and in promoting women's health. This is on the basis that women experience social, economic and political inequalities that affect their physical and mental health, and which in turn can be a barrier to accessing health care. NWCI's 'Y' Project has a specific focus on young women, including young women's health.

Men's groups in Ireland and the **Men's Development Network (www.mensdevelopmentnetwork.ie)** have played an important role in improving men's access to health care, and in challenging negative 'masculine' gender norms that can impact on men delaying seeking help. The Men's Development Network provides resources and information about men's health as well as training for community groups and health service providers.

COMMUNITY-BASED ORGANISATIONS AND HEALTH-CARE TRADE UNIONS

TO IMPLEMENT THE GENDER MAINSTREAMING FRAMEWORK IT WILL BE IMPORTANT FOR COMMUNITY-BASED WOMEN'S AND MEN'S HEALTH GROUPS, LOCAL COMMUNITY ORGANISATIONS AND HEALTH-CARE TRADE UNIONS TO BE AWARE OF THE VALUE OF GENDER MAINSTREAMING IN HEALTH.

- Disseminate information about the benefits of gender mainstreaming.
- Encourage and highlight, to health-care managers and service providers the importance of implementing the gender mainstreaming framework at a strategic and practical level.
- Work in partnership with health-care providers to provide the evidence base to address the gender-related health experiences, risks and needs of different groups of women and men.

FURTHER RESOURCES

- Health Services Executive / National Women's Council of Ireland (2012) 'Equal but Different: A Framework for Integrating Gender Equality in Health Service Policy, Planning and Service Delivery'. Available from: **www.nwci.ie/download/pdf/equal but_different_final_report.pdf**

- Health Services Executive (2009) Health Inequalities Framework 2010 – 2012. Available from: **www.hsenet.hse.ie/HSE_Central/IntegratedServices/PerformanceandFinancialManagement/AcutePrimaryandCommunityCare/HealthPromotion/HSEHealthInequalitiesFramework20102012.pdf**

- Department of Health and Children (DOHC) (2008) 'National Men's Health Policy', DOHC: Dublin. Available from: **www.dohc.ie/publications/national_mens_health_policy.html**

- Department of Justice, Equality and law Reform (2007) 'National Women's Strategy 2007–2016'. Available from: **www.justice.ie/en/JELR/NWS2007-2016en.pdf/Files/NWS2007-2016en.pdf**

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- European Institute for Gender Equality, (2013) 'Good Practices in Gender Mainstreaming'. **www.eige.europa.eu/content/document/good-practices-in-gender-mainstreaming**

- World Health Organisation, (2009) 'Gender Mainstreaming Strategy' **www.who.int/gender/mainstreaming/strategy/en**

- 'Strategy for integrating gender analysis and actions into the work of WHO'. **www.whqlibdoc.who.int/publications/2009/9789241597708_eng_Text.pdf?ua=1**

- 'GENDER MATTERS' - Training for Trainers handbook available from NWCI, **www.nwci.ie/learn/publications**

- 'GENDER MATTERS' - Toolkit for Mainstreaming Gender in Health Service Policy, Planning and Delivery, available from NWCI, **www.nwci.ie/learn/publications**

USEFUL CONTACTS

- National Women's Council of Ireland **www.nwci.ie**

- Health Service Executive **www.hse.ie**

- Men's Development Network **www.mensdevelopmentnetwork.ie**

- Men's Health Forum in Ireland **www.mhfi.org**

- 'Manup' campaign **www.manup.ie**

- Equality Authority **www.equality.ie**

- Institute for Public Health **www.publichealth.ie**

- Cairde **www.cairde.ie**

- Pavee Point Travellers Centre **www.pavee.ie**

- Department of Health **www.dohc.ie**

- Irish Cancer Society **www.cancer.ie**

- Irish Heart Foundation **www.irishheart.ie**

- Gay and Lesbian Equality Network **www.glen.ie**

- Transgender Equality Network Ireland **www.teni.ie**

- National Advocacy Unit, HSE **www.hse.ie**

ENDNOTES

1 Gender in this guide refers to a man, woman and transgender person. The European Court of Justice in P v S (C-13/94) held that discrimination against a transsexual person constituted discrimination on grounds of sex.

2 Irish Cancer Society and NWCI Women and Smoking: Time to Face the Crisis **www.nwci.ie/download/pdf/womenandsmoking_finalreport2013.pdf**

3 School of Public Health, Physiotherapy and Population Science, University College Dublin (DOHC) (2010) *All Ireland Traveller Health Study 2007–2010: Summary of Findings*, Dublin, UCD.

4 Research carried out by the National Crime Council and the ESRI indicates a lifetime prevalence of physical, sexual or emotional violence by an intimate partner of 15% for women (1 in 7 women) and 6% for men (1 in 17 men). Violence against partners increases significantly (7 times for women and 2.5 times for men) where the partner controls decisions about money. See: Parsons, D., and Watson, S., (2005), *Domestic Abuse of Women and Men in Ireland*, National Crime Council and ESRI. Recent data from Safe Ireland show that nearly 8,000 women and nearly 3,000 children received domestic violence support services in 2010. See: *Safe Ireland: Domestic Violence Statistics* 2010. See: **www.d1288522-32838.cp.blacknight.com/safeireland.ie/wp-content/uploads/si-factsheet-2010.pdf**

5 McGee, H. R., Garavan, R., de Barra, G. M., Byrne J. and Conroy, R., (2002), *The SAVI Report: A National Study of Irish Experiences, Beliefs and Attitudes Concerning Sexual Violence*. Dublin: The Liffey Press.

6 Begley, C., et. al. (2009) *Women with Disabilities: Barriers and Facilitators to Accessing Services during Pregnancy, Childbirth, and Early Motherhood*. Dublin: National Disability Authority.

7 Research evidence from epidemiological studies from the UK, US, Europe, Australia and New Zealand shows that women are up to 40% more likely than men to develop mental ill health; women are around 75% more likely than men to report having recently suffered from depression, and around 60% more likely to report an anxiety disorder. Men are more likely to report substance misuse disorders – around 2½ times more frequently than women. Conditions such as ADHD and schizophrenia do not show significant gender differences. See Freeman, D., and Freeman J. (2013), *The Stressed Sex: Uncovering the Truth about Men, Women and Mental Health*. Oxford: Oxford University Press.

8 HSE *Guide to Post Natal Depression* Available at **www.hse.ie/eng/services/Publications/services/Children/Postnatal_Depression_A_Guide_for_Mothers,_Family_and_Friends.pdf**

9 Freeman, D., and Freeman, J. (2013), at endnote 7 above.

10 Richardson, N., Clarke, N., and Fowler, C. (2013), *Report on the All-Ireland Young Men and Suicide Project*. Available at: www.mhfi.org/ymspfullreport.pdf

11 Richardson et al. (2013), ibid.

12 Chang, S., Stuckler, D., Yip, D., and Gunnell P., (2013), *Impact of 2008 Global Economic Crisis on Suicide: Time Trend Study in 54 Countries*. BMJ 2013; p. 347: f. 5239. **www.dx.doi.org/10.1136/bmj.f5239**

13 Irish Heart Foundation (2009) *Red Alert for Women's Hearts Women and Cardiovascular Research in Europe* **www.irishheart.ie/media/pub/red_alert_on_womens_hearts__final_report_nov_09.pdf**; and the Irish Heart Foundation campaign to raise awareness on women and heart disease. **www.irishheart.ie/media/pub/go_red_for_women_info_leaflet.pdf**

14 Ibid

15 Women's Health Council (2009), *The Emergency Department Assessment of Women with Acute Coronary Syndrome*. Dublin: Women's Health.

16 McCarthy, M., and Richardson, N. (2011), *Report on Best Practice Approaches to Tailoring Lifestyle Interventions for Obese Men in the Primary Care Setting. A Resource Booklet for Health-Care Professionals Working with Obese Men in the Primary Care Setting*. Centre for Men's Health, Institute of Technology Carlow.

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Registered Charity No. CHY11760
Published March 2014 by
National Women's Council of Ireland

Funded and supported by the Health Service Executive

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive