

Equal but Different

A framework for integrating gender equality in Health Service Executive
Policy, Planning and Service Delivery



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Orla O'Connor

National Women's Council of Ireland

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FOREWORD



The purpose of *Equal but Different: A Framework for Integrating Gender Equality in Health Service Executive Policy, Planning and Service Delivery* is to support the Health Service Executive (HSE) in developing a policy which will outline how the different health care needs of men and women can be addressed in a more fair, just way.

We know, for example, that there are differences between men and women in both mortality and sickness patterns, and health systems that take account of these gender differences are more likely to be successful (Payne, 2009). Women and men also use health care differently, and their experiences of the health care system are shaped by gender differences in many factors such as employment and family responsibilities.

This framework adopts a globally recognised gender mainstreaming approach that has already been successfully implemented into national policy in countries including Sweden, Canada, England, Scotland, Wales and Northern Ireland. The approach seeks to achieve gender equality through an assessment of gender inequalities and by integrating a gender sensitive approach into health care policy planning and service delivery. The framework builds on existing policy and developments in the HSE on women's and men's health. Gender mainstreaming is a commitment under the National Women's Strategy and the Men's Health Policy, and is a policy goal of the Gender Equality Division in the Department of Justice and Equality. The framework will also complement existing HSE and Department of Health policies and commitments to reduce inequalities in health under the National Health Strategy, Quality and Fairness - A Health Service for You (DOHC 2001) and the HSE Health Inequalities Framework 2010-2012 (HSE 2010).

The framework has been developed under the aegis of an inter-agency Gender Mainstreaming Steering Group led by the HSE (Population Health/Health Promotion) and the National Women's Council of Ireland and including men's organisations, the Equality Authority, the Irish Cancer Society and the Institute of Public Health. It identifies eight key steps required to achieve gender equality within the HSE. These are: (1) senior level commitment and leadership (2) awareness raising about gender differences in health (3) collating and analysing gender and sex disaggregated data (4) consultations with service users, health care unions and staff (5) gender proofing – assessing gender relevance and carrying out gender impact assessments (6) developing priorities for service planning and delivery that address identified gender differences (7) gender mainstreaming demonstration projects in specific services for example primary care and mental health (8) monitoring, review and reporting.

The framework presents a strong and compelling rationale for embedding gender mainstreaming into the policy, planning and service delivery functions of the HSE. It builds on the social determinants of health approach currently being progressed under the HSE Health Inequalities Framework 2010-2012 (HSE 2010). It will assist the organisation meet its strategic objectives and targets to reduce inequalities in health and in making a difference to the lives of women and men by improving the quality of services provided in relation to the prevention, diagnosis and treatment of illness and improve patient outcomes. This will enable the organisation in a better targeting of resources in order to plan and deliver services that are evidence-based and informed, that are tailored to the specific needs of women and men. The implementation of this framework can be achieved within existing resources. Targeting resources will ensure that they are used in the most cost effective way and focused on areas of greatest need. This will result in a more effective service delivery, a better allocation of resources to address needs, long term cost savings and better health outcomes for women and for men.

I am pleased to note that the implementation of *Equal but Different: A Framework for integrating Gender Equality in Health Service Executive Policy, Planning and Service Delivery* has already begun. This process of implementation will be fully aligned with the corporate function of the HSE to ensure that the gender mainstreaming approach will be embedded within the HSE. The implementation process will also feed into the forthcoming Public Health Policy which presents an ideal opportunity to place gender mainstreaming as a core approach to health service planning and delivery across all civil and public service bodies and organisations in Ireland. In addition, there will be scope within an All-Ireland context, for better cooperation on gender mainstreaming on a cross-border basis and in progressing activities under the remit in health held by the North-South ministerial Council.

I would like to thank the HSE staff and the representatives of the National Women's Council of Ireland, Men's organisations, the Equality Authority, the Irish Cancer Society and the Institute of Public Health and all others who contributed their time and expertise in the development of this valuable framework.

Dr. Kevin Kelleher,
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Executive Summary



EXECUTIVE SUMMARY

Section 1: Introduction to the Gender Mainstreaming Framework and gender inequalities in health

1.1 Introduction and background

- Gender inequalities result in unequal access to health care and inequality of health outcomes for women, men and transgender persons, and amongst specific population sub-groups of women, men and transgender persons. Persistent gender inequalities and gender gaps continue despite the implementation of equality legislation and national international and European commitments to gender equality.
- Gender mainstreaming is a strategic and operational approach to giving visibility to gender inequalities and to addressing the problems entrenched in gender inequalities and unequal social relations.
- The core purpose of the Health Service Executive (HSE) Gender Mainstreaming Framework is to recommend actions that better enable the HSE to deliver its services for women, men and transgender persons and ensure more equal health outcomes for women, men and transgender persons. The aim is to help the HSE to improve the quality of the services provided in relation to the prevention, diagnosis and treatment of illness by improving the utilisation of services and service user satisfaction.
- This will contribute to fairness, social justice and equality and a better understanding of the integration of gender with the social determinants of health. These will consequently result in better health and improved quality in health care for women, men and transgender persons.
- This Gender Mainstreaming Framework is addressed to senior decision makers in the HSE and has relevance for HSE policy, planning and service delivery. It recommends actions to be taken across government, by the Department of Health and Children (DOHC) and other non-HSE bodies developing policy and delivering health services. It concerns women, men and transgender persons and specific populations such as lesbian, gay, bisexual and transgender people (LGBT).
- Gender mainstreaming has to be seen as an incremental and long-term activity, rather than a once-off strategy. Using a gender mainstreaming approach will have a transformative impact on decision-making processes, policy, planning and

service delivery by taking a systematic and evidenced based approach.

- Central to the framework is that gender mainstreaming addresses the complex interaction between gender and other social determinants of health, for example, socio-economic status, poverty, ethnicity, sexual orientation, disability and age.
- Similarly, actively promoting an equal gender balance in the HSE workforce and addressing the under-representation of women in senior decision-making positions are crucial factors to be addressed if the HSE is to effectively integrate gender equality into all of its policies, plans and operations.

1.2 Achieving gender equality in health

- Gender equality means equal visibility, power and participation between women, men and transgender persons in all spheres of public life and in the delivery of services. It concerns economic equality, political equality, cultural equality and caring equality.
- Gender is one of the nine equality grounds protected under the Equal Status Acts 2000-2011 and the Employment Equality Acts 1998-2011. The gender ground refers to a man, a woman and a transsexual person. In a health care setting this means providing for equality of opportunity, equality of participation and equality of outcome, regardless of gender.
- The Gender Mainstreaming Framework takes an organisational and informational approach, although it does acknowledge the need for a strong regulatory approach to underpin gender equality, including positive duties on public authorities to actively promote equality. This is part of the dual approach to equality that encompasses gender mainstreaming and positive action that targets resources to support equality objectives through specific projects or initiatives.

1.3 Evidence of gender inequalities in health: sex, gender and the social determinants of health

- This report presents evidence of inequalities in health and the factors that impact on women's and men's health status and access to services.
- It shows how sex and gender overlap and how many social factors that shape and determine women's and men's health occur across the lifecycle. For example, evidence from

research and consultations suggests that women, men and transgender persons who live on low incomes or in poverty, have higher rates of death, higher levels of ill-health and fewer resources to adopt healthier lifestyles.

- This takes account of the complex and different ways in which gender impacts on health, as well as the different health risks and different health outcomes that are related to women's and men's social roles, access to power, resources and decision-making, and their access to health services. Poverty, care responsibilities, education, access to employment and participation in decision-making, are all factors that have a differential impact on the health status of women, men and transgender persons, and within different groups of women, men and transgender persons.

1.4 Gender mainstreaming as an international obligation

- Gender Mainstreaming is a globally recognised strategy and approach for achieving gender equality. International human rights frameworks and policies of the European Union and the Council of Europe place obligations on the Irish government to integrate a gender perspective into the planning, delivery, implementation and monitoring of health care.
- The Irish government's commitment to equality in health and gender mainstreaming is embedded in a wide range of international obligations, first established in the United Nations, Beijing Platform for Action, 1995. Gender mainstreaming has since then been developed through policy and guidance under the United Nation's Convention on the Elimination of Discrimination Against Women (CEDAW), the World Health Organisation, the Council of Europe and is a core goal of the European Commission's Strategy on Gender Equality 2010-2014.

1.5 Gender mainstreaming: Irish policy context

- The HSE, the Department of Health and Children, the former Women's Health Council, the Department of Justice and Equality and the Equality Authority have, to date, developed a range of policies, tools and initiatives that impact on equality in health and in the development of gender mainstreaming of the policy making process.
- Gender mainstreaming is a commitment under the government's National Women's Strategy 2007-2016 and the HSE's National Men's Policy 2008-2013, and is a policy goal of the Gender Equality Division in the Department of Justice and Equality (formerly Department of Justice Equality and Law Reform). The National Women's Strategy makes a specific commitment to gender mainstreaming in health

and to strategic objectives in health, which aim to improve the health status of women through gender focussed policies.

- Gender mainstreaming can also complement existing HSE and DOHC policies and commitments to reduce inequalities in health under the National Health Strategy, Quality and Fairness - A Health Service for You (DOHC 2001) and the HSE Health Inequalities Framework 2010-2012 (HSE 2010). The National Men's Health Policy sets out a range of activities to address men's health through a relational and social determinants approach and argues for gender to be taken into account in understanding how men's experiences of health and access to health care is shaped by ascribed gender roles (DOHC 2008).
- Aside from the HSE Health Inequalities Framework 2010-2012, gender is not systematically integrated into HSE and DOHC health policies, strategies and plans.

Section 2: Gender mainstreaming and its application to health care

2.1 What is gender mainstreaming?

- Gender mainstreaming integrates gender into the mainstream of policy planning and service delivery. An important aspect of gender mainstreaming is that gender equality is integrated into all policies, plans and services through equality proofing and *gender impact assessment*.
- Embodied in this is the need to collect data, question basic assumptions and show how gendered social, economic, political, cultural and caring inequalities can adversely impact on in this case HSE policy and the development, planning and delivery of health services. Building gender awareness is central to uncovering problems and in developing strategic and concrete solutions through the delivery of gender sensitive services.
- Gender mainstreaming has the benefit of shifting the emphasis away from the personal characteristics of women, men and transgender persons towards a more systematic approach to analysing gender differences in organisational and institutional processes, structures and social norms.
- Gender mainstreaming in health is transformative because it requires a root and branch challenge to the organisation and delivery of health care, alongside an understanding of the direct and indirect ways in which gender impacts on social relations and access to power. As a result gender mainstreaming has the potential to transform gender relations and to address differences and diversity in women's and men's health.

- Gender mainstreaming has its origins in feminist critiques of patriarchy and has been promoted by the women's movement as a method for transforming gender relations, with the goal of achieving gender equality and women's human rights.

2.2 Gender mainstreaming and the social determinants of health

- Gender inequalities cannot be separated from other areas of inequality and the broader social determinants of health. The Gender Mainstreaming Framework builds on the social determinants of health approach currently being progressed under the HSE Health Inequalities Framework 2010-2012 (HSE 2010).
- The sharp class gradient in mortality and morbidity in all major causes of ill-health are in part a result of higher rates of health-damaging behaviour, societal risks impacting on mental ill health and poor access to health services, such as screening and preventative services and the identification and treatment of chronic disease. The Gender Mainstreaming Framework shows that by addressing the complex interaction of biological differences and social factors, improved health outcomes can be attained.
- Shifting the approach to addressing the underlying causes of women's and men's health will benefit women, men and transgender persons alike. It can have the effect of transforming gender relations, for example, by enabling men to be more aware that belonging to a gender is shaped by male norms and values, and by addressing gender stereotypes and prejudices that reinforce expectations and values about women's and men's societal roles across the lifecycle.
- Addressing the health risks of women, men and transgender persons, including LGBT people, and improving health outcomes is an important task for health service providers. In some cases this means addressing invisible health issues. For example, providing health services for women who experience domestic violence and abuse is a major challenge for the HSE, particularly because of the high level of under-reporting. Implementing the HSE Policy on Gender Based, Domestic and Sexual Violence will be vitally important in this regard and for services and resources to be provided that are proportionate to the needs of both women, men and transgender persons experiencing gender based violence. In other cases, for example, gender mainstreaming may require the provision of targeted services to address men's low take up of preventative, GP and primary care services; while in others this may require a better awareness of the identification and treatment of cardiovascular disease in women.

2.3 Case studies on gender mainstreaming in health in Ireland

- Two case studies are presented to exemplify the benefits of gender mainstreaming in addressing the specific health care needs of women, men and transgender persons. The first is an example of gender mainstreaming in cardiovascular health carried out by the Women's Health Council, the second is an example of a specific initiative for health care professionals working with obese men in a primary care setting carried out by the HSE and the Centre for Men's Health.
- Both case studies show how a gender mainstreaming approach can not only raise awareness of specific health risks faced by women, men and transgender persons, enhance health outcomes for women, men and transgender persons, but in the long-run provide more cost-effective services that are tailored to the specific needs of women, men and transgender persons.

2.4 The lessons from implementing gender mainstreaming in other countries

There is some very useful learning from other countries that have experience of implementing gender mainstreaming in health. This has been taken into account in drawing up the framework and ensuring that previous difficulties in implementing gender mainstreaming in health can be avoided.

- Gender mainstreaming is an important and complex area of government policy to implement. A review of the implementation of gender mainstreaming in health in a selection of countries was carried out in order to draw out the lessons on how gender mainstreaming in health can be applied in Ireland.
- Examples of gender mainstreaming from Sweden, Canada, England, Scotland, Wales and Northern Ireland are highlighted. These show the importance of having a legal framework that places a positive duty on public authorities to implement gender mainstreaming, political leadership and resources to implement gender mainstreaming.
- Examples are also given of how gender mainstreaming has been successfully implemented in public health policies in Sweden and Canada, and of the implementation of gender impact assessment in health in England, Scotland, Wales and Northern Ireland. In a Northern Ireland context, there is scope for better cooperation on gender mainstreaming on a cross-border basis and in progressing activities under the remit in health held by the North-South Ministerial Council.
- Specific lessons from these examples and from recent global evaluations of gender mainstreaming in health show that there is often a gap between a policy objective

on gender mainstreaming and the practice of applying gender mainstreaming. This variously results from resistance from; key decision-makers, lack of accountability, lack of awareness, absence of user-friendly tools and expertise to implement gender mainstreaming at an operational level and a lack of integration of gender into the design, implementation and monitoring of policies and programmes.

- A key lesson is that gender mainstreaming needs to focus on women, men and transgender persons in order to have a lasting impact on key areas of health such as cardiovascular health, cancer, and mental health.
- Many commentators argue that it is important to define gender mainstreaming as a human rights issue of equality, rights and justice and to address underlying resistance to gender mainstreaming.

2.5 Implementing gender mainstreaming in health

- Implementing gender mainstreaming in health requires an integrated and comprehensive approach to women's and men's health, rather than a separate focus on women's health, men's health and the health of transgender persons. Differences between and within population sub-groups of women, men and transgender persons need to be identified, recognised and acted upon through gender sensitive approaches in policy making, data collection, planning and service delivery.
- As a result health outcomes should be related to the social processes that influence gender equality and health and well-being, and the resources deployed proportionate to the need identified. On this basis equality can benefit everyone and has wider societal benefits. For example, if men's mental health improves or if risk-taking behaviour is reduced, this will benefit the health and well-being of women and children in their families and their participation in family life. If women's poverty is reduced, for example, through participation in good quality employment, this benefits men in their families and in the local community.
- Gender mainstreaming requires that there are changes in organisational structures and thinking, including the equal representation of women, men and transgender persons in decision-making positions. Although gender mainstreaming can be complex and time consuming, it is possible to develop some simple gender mainstreaming techniques in the HSE.
- Tools and a template for assessing the gender impact of frontline service delivery are key mechanisms for progressing gender mainstreaming. This means that all actions across the workforce, in policy making, planning and service provision can be assessed for their gender relevance and gender impact.

- This is particularly important in the current economic and financial climate because gender mainstreaming can help to more effectively identify health needs and also address widening inequalities and more complex health problems that exist in the community. As a result consideration should be given to the role that gender budgeting and gender impact analysis can play in monitoring the gendered impact of budgetary cuts on service delivery and access to health services.

Section 3: A framework for gender mainstreaming in health

3.1 Introduction

- The HSE Gender Mainstreaming Framework recommends a strategy for integrating gender into policy, planning and service delivery for endorsement by senior decision-makers and managers in the HSE. It shows why gender mainstreaming should be implemented and makes recommendations for how this can be done through senior level commitment and practical steps in policy, planning and service delivery.
- Underpinning the Gender Mainstreaming Framework is the core recommendation to take into account evidence of sex (biology) and gender (social roles) in the context of the broader social determinants of health. It is recommended that this be done through top down and bottom up approaches through a whole organisational approach that is strategic, systematic and planned. This includes a commitment to ensuring that evidence of inequalities in health is acted upon at all levels of policy making, planning and service delivery.
- The implementation of policy based on an analysis of gender will enable health care planners, managers and service providers to plan and deliver services that are responsive to women's and men's health care needs. This will enable them to have a better understanding of how gendered roles and choices impact on health outcomes and in the delivery of patient-centred services.

3.2 The business case for integrating gender into health care policy, planning and delivery

- There is a strong rationale and business case for gender mainstreaming and through this the integration of a gender perspective in the policy, planning and service delivery functions of the HSE. Addressing women's and

men's health and the differential barriers in access to health services can help health service providers to effectively and equitably respond to the different needs of women, men and transgender persons.

- Integrating an analysis of gender into the planning and delivery of health care makes good business sense because it enables the HSE to:
 - Improve access to health care services for everyone, through a change in culture and by providing services that respond to differences between women, men and transgender persons in health status, in relation to their expressed needs and in the utilisation of services.
 - Plan and deliver services that are evidence-based and informed, by allocating and targeting resources in the most effective way and to areas of greatest need, and thereby achieve better value for money.
 - Meet its strategic objectives and targets to reduce inequalities in health making a difference to the lives of women, men and transgender persons.
 - Promote gender mainstreaming as a tool for driving social inclusion and equality in health and to empowering women, men and transgender persons in the promotion of health and well-being.

3.3 The Gender Mainstreaming Framework

The main elements of the Gender Mainstreaming Framework contain eight key steps, which cover the strategic and operational tasks to be put in place in order to implement the framework, as follows:

1. Senior level commitment and leadership

- Senior level commitment and leadership is essential if gender mainstreaming is to have a transformative effect on the delivery of services to women, men and transgender persons. It is essential to ensuring lasting and equal health outcomes between women, men and transgender persons, and to ensuring gender equality within the HSE workforce.
- It is recommended that the HSE visibly champions equality. Gender mainstreaming should be built into all corporate goals and actions, including a commitment to redeploy resources and personnel to implement the framework.
- The actions that are recommended in this report are suggested actions based on the experience and expertise of the inter agency Gender Mainstreaming Steering Committee as convened by the HSE. The actions require agreement by the CEO, the HSE Management Team and the HSE Board, all of which have a key role to play in ensuring that gender mainstreaming is implemented in a comprehensive way across all policy, planning and

service delivery functions. There is a wealth of information, guidance and support available in Ireland to support the HSE in the furtherance of this objective.

2. Awareness raising about gender differences in health

- Gender mainstreaming requires that staff are fully aware of gender differences in health, and develop gender sensitivity and a 'gender lens' to their core work. Without this awareness the framework will be difficult to implement in practice.
- It is the responsibility of all health care staff and managers to promote equality as part of their core business and service, from the senior decision-makers to the front-line service providers. This is crucial to enable and empower staff to act on gender differences and take ownership of this in their work.

3. Collate and analyse gender and sex-disaggregated data

- Gender mainstreaming in health should be based on robust data and indicators. This will be critical to the systematic evaluation of how gender interacts with the factors that lead to social inequalities in health that are influenced by gender (age, social class, poverty, education, etc.) and the application of a 'gender lens' to the findings.
- The HSE has a corporate responsibility for generating internal sex and gender disaggregated data. It is recommended that the HSE work closely with the DOHC, the CSO, the ERSI and the HRB to develop indicators for sex and gender based data and for inclusion in national databases and published reports.

4. Consultations with service users, health care unions and staff

- Consultation and involvement is a core objective of the service user's strategy and the provision of advocacy services in the HSE. The integration of a gender perspective into service user involvement will enhance the participation of women, men and transgender persons and of representative organisations in framing gender equality focused policies and services.
- It is recommended that the HSE consults with staff and health care unions regarding changes in service delivery, in drawing up plans and data collection in order to implement gender mainstreaming and in promoting equality in the workforce.

5. Gender proofing: assessing gender relevance and carrying out gender impact assessments

- A core part of the Gender Mainstreaming Framework is the gender proofing of policies, planning and service delivery. As a first step it will be important to assess the gender relevance of a particular policy or service, which is informed by data and consultations.
- Where gender relevance has been identified, the second 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 it is recommended that the findings are acted upon and implemented. Depending on the findings, priorities will need to be established to redress existing inequalities and a reconfiguration of resources and services to meet these priorities.

7. Gender mainstreaming projects in specific services

- Gender mainstreaming demonstration projects are the best way to develop the expertise, awareness and application of this framework. Specific recommendations are made for gender mainstreaming projects in primary care, mental health, cancer care, cardiovascular care, emergency services, older people's services, health promotion and social inclusion.
- The HSE's women's and men's health officers, along with the NWCI and the Men's Development Network, have a crucial role to play in supporting the learning and awareness raising of staff involved in projects and in assisting these projects in drawing up schemes for gender impact assessment, data collection and the drafting of health indicators.

8. Monitoring, review and reporting

- Gender mainstreaming is not a one-off event or activity. It is recommended that this be systematically built into the monitoring and reviewing of all policies, procedures and service delivery, and through the development of Key Performance Indicators (KPIs).

Section 1: Introduction to the Gender Mainstreaming Framework and gender inequalities in health



SECTION 1: Introduction to the Gender Mainstreaming Framework and gender inequalities in health

1.1 Introduction, aims and objectives

Gender mainstreaming in health is a method for 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.¹ 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.

An important aspect of gender mainstreaming is that it requires that all policies, plans and service delivery are gender proofed and that *gender impact assessment* be carried out. This means that it is necessary to collect data, question basic assumptions and show how gendered social, economic, political and cultural inequalities can adversely impact on HSE policy and the development, planning and delivery of health services. Collecting information and building gender awareness is central to uncovering problems and in developing strategic and concrete solutions through the delivery of gender sensitive services.

Gender inequalities exist because of unequal economic and social roles in the workplace, in the home, in public life, in politics and at a societal level. They are sustained by historical and patriarchal systems of power that impact on gender roles and access to power and resources. In a health context, this results in unequal access to health care and inequality of health outcomes for women, men and transgender persons and amongst specific population sub-groups of women, men and transgender persons. Persistent gender inequalities and gender gaps continue despite the implementation of equality legislation and international and European commitments to gender equality. Addressing the problem of gender inequality and unequal social relations requires a strategic commitment and a more sustained approach to addressing inequality than currently exists. This can be achieved through gender mainstreaming.

Gender mainstreaming is a globally recognised approach for achieving gender equality, which can be implemented through an assessment of gender inequalities and by integrating a gender-sensitive approach into health care policy, planning and service delivery. This Gender Mainstreaming Framework provides a strategic and operational plan for uncovering and tackling entrenched gender inequalities and gender differences in health. This concerns women, men and transgender persons and specific sub-groups of women, men and transgender persons, including lesbian, gay, bisexual and transgender people (LGBT).

It seeks to give visibility to gender inequalities in health and to ensure that there is a commitment to addressing these inequalities. It connects with and builds on existing policy and work in the HSE on women's and men's health. It is addressed to senior decision-makers in the HSE and has relevance for HSE policy, planning and for the delivery of front line services. It has implications for how resources are allocated, including dedicated staff that have expertise in and can support the strategic and operational implementation of gender mainstreaming across the HSE. Although it is specifically targeted at the HSE the Gender Mainstreaming Framework is relevant to all health care policies, including those of the Department of Health and Children (DOHC) and non-HSE provided services.

Gender mainstreaming is an incremental and long-term activity, rather than a once-off activity. In the long term it can have a transformative impact on the delivery of health care and health outcomes. By taking a systematic, evidenced based approach to promoting gender equality the HSE can address gender inequalities and monitor the impact of its work so that it has a lasting impact in achieving gender equality in health. This also means transforming decision-making processes so that a gender perspective is included at all stages of policy, planning and service delivery and addressing barriers arising from vested interests and male-dominated structures of decision-making.

The core focus of this Gender Mainstreaming Framework is the achievement of gender equality in health. It sets out a plan to do this by addressing the complex interaction between gender and other social determinants of health, for example, socio-economic status, poverty, ethnicity, disability and age. This is important because a separate focus on women's and men's health will not take into account the underlying causes of gender inequalities related to the ideological, political and social factors that influence health (Payne and Doyal 2010, WHRA 2010, Richardson

¹ The terms 'equality' and 'equity' are often used interchangeably in international research and policy literature. However, 'Equality' is the term used in the context of Irish policy & legislation and EU directives. Both terms refer to the unfair and unjust health outcomes for different social groups. In this Framework, "equality" refers to equal chances or opportunities for different groups to access and control social, economic & political resources such as health services. "Equity" refers to fairness, and is based on the different needs of different social groups (e.g. men, women, transgender persons). Both terms emphasise that different but not less favourable treatment may be required to ensure equality of opportunity. Under Irish Equality legislation this type of action may be defined as 'positive action.' Farrell *et al*, 2008

et al 2011). Women's and men's organisations in Ireland also consistently highlight the importance of the social determinants of health in influencing gender differences and health outcomes (WHRA 2010, Men's Health Forum 2004, DOHC 2008).

1.2 Aims and objectives of the Gender Mainstreaming Framework

The aims and objectives of this HSE Gender Mainstreaming Framework are:

Aims

- To present a framework that can integrate gender at a strategic and operational level in HSE policy, planning and service delivery.
- To raise awareness in the HSE about why a gender equality perspective should be a core goal for the delivery of high quality, patient-centred services.
- To show how changes in awareness and capacity of all staff needs to be implemented so that gender mainstreaming becomes part of the core work of the HSE.

Objectives

- To improve health care for everyone, by linking a gender perspective to the broader social determinants of health.
- To enhance the efficiency and effectiveness of health policies, planning and the delivery of health services for women, men and transgender persons.
- To achieve leadership and senior-level commitment to implementing the framework.
- To provide a model for gender mainstreaming that can be applied to other areas of government policy and service delivery.

1.3 How has the Gender Mainstreaming Framework been drawn up?

The Gender Mainstreaming Framework has been developed through an inter-agency process under the auspices of the HSE Gender Mainstreaming Steering Group, led by the HSE (Population Health) and the National Women's Council of Ireland, with involvement of men's organisations.

The Gender Mainstreaming Steering Group is made up of the following agencies:

- Health Services Executive
- National Women's Council of Ireland
- Men's Development Network
- Men's Health Forum in Ireland
- Equality Authority

- Institute of Public Health Ireland
- Irish Cancer Society
- Experts on women's and men's health

Appendix 1 lists the full list of names and organisations of the members of the inter-agency group.

The content of the framework has been drawn up using the following methodology:

- Discussions in the Gender Mainstreaming Steering Group.
- A review of the literature and different approaches to gender mainstreaming in health in Ireland and in other countries where this has been implemented.
- Collation of the findings of consultations that have been carried out with women, men and transgender persons in Ireland in relation to their health and experience of health services.
- A review of existing health policies and data sources for their relevance to gender mainstreaming.
- Consultations with key decision-makers in the HSE, the DOHC, Department of Justice and Equality, and representatives of women's and men's health organisations. A summary of key points from the consultations can be found in **Appendix 2**.

1.4 Achieving gender equality in health

Gender equality is a fundamental principle of equality, social inclusion, social justice and social progress and empowers both women, men and transgender persons. Gender equality means giving equal visibility, empowerment and participation to women, men and transgender persons in all spheres of public life and in the delivery of services. Gender is one of the nine equality grounds protected under the Equal Status Acts 2000-2011 and the Employment Equality Acts 1998-2011, which outlaw discrimination against women or men in service delivery and employment. The nine equality grounds are gender, civil status, family status, sexual orientation, religion, race, age, disability, and membership of the Traveller community. The gender ground refers to a man, a woman and a transsexual person.² In a health care setting, this means providing for equality of opportunity, equality of participation and equality of outcome.

In an Irish context a multi-dimensional approach to equality (Baker *et al* 2004) provides a very useful framework for equality, which has helped to inform the work of the Equality Authority, the NWCI and the Equality and Rights Alliance. It encompasses four specific areas that are relevant to the health care sector:

² The European Court of Justice in *P v S* (C-13/94) held that discrimination against a transsexual person constituted discrimination on the ground of sex.

- *Economic equality*, covering employment, income and economic development and linked to access to social goods such as health services, education and housing.
- *Political equality*, access to and participation in decision making in public and private spheres of society and political representation
- *Cultural equality* based on the recognition, acknowledgement and valuing of diversity on the basis of a person's identity
- *Affective / caring equality* based on the creation of social relations of solidarity, trust and respect between social groups and the recognition of care work.

Gender equality can be approached in a number of ways in a health setting. As a starting point this should always be looked at through a 'dual approach' that encompasses gender mainstreaming and positive action targeting resources to support equality objectives through specific projects or initiatives (Equality Authority 2008, Payne 2009, Ravindran and Kelkar-Khambete 2010, Sen and Östlin 2010, European Commission 2010). Broadly this encompasses three main approaches:

- *Regulatory approaches* provided through equality legislation and legal duties on organisations and public authorities to promote equality;
- *Organisational approaches* that require organisations to actively promote gender equality in their strategies and operational functions, to integrate a gender perspective through gender mainstreaming, to carry out equality impact assessments and develop gender-sensitive health indicators and targets;
- *Informational approaches* to raise awareness of gender equality and provide the tools for implementing gender equality.

This Gender Mainstreaming Framework takes an organisational and informational approach. However, implementation would be greatly assisted by a regulatory approach across government, whereby positive duties on public authorities to carry out gender mainstreaming would be embedded in equality legislation. Successful models of gender mainstreaming in other countries (discussed in Section 2) have shown that gender mainstreaming is more likely to succeed if it is grounded in strong gender equality legislation that is designed to address the structural causes of inequality. This is why the Equality and Rights Alliance, for example, has called for a public equality duty to be implemented in Ireland, in line with developments in Northern Ireland, Scotland, England and Wales (Equality and Rights Alliance 2010).

1.5 Evidence on gender inequalities in health: sex, gender and the social determinants of health

There is a wide range of factors that impact on women's and men's health status. There are certain elements of women's and men's health that are biologically determined. For example, women have a longer life expectancy than men, women experience higher rates of auto-immune disease such as diabetes, men typically develop heart disease earlier than women, and women, men and transgender persons have a susceptibility to different cancers and mental health difficulties. These overlap with the many social factors that shape and determine women's and men's health that occur across the lifecycle. For example, evidence from research and consultations suggests that women, men and transgender persons who live on low incomes or in poverty, have higher rates of death, higher levels of ill-health and fewer resources to adopt healthier lifestyles.

As a result women's and men's health has to be seen as part of the broader tapestry of the social determinants of health. Consultations with women, men and transgender persons consistently point to the complex and different ways in which gender impacts on health. Women, men and transgender persons experience different health risks and different health outcomes that are related to their social roles, access to power and decision-making, and their access to health services. These include social factors such as social capital, social connectedness, powerlessness, access to resources and constraints in male and female roles, for example, in the family. Poverty, care responsibilities, education, access to employment and participation in decision-making, are all factors that have a differential impact on the health status of women, men and transgender persons, and within different groups of women, men and transgender persons. Social factors play an important role in determining health risks. For example, in relation to mental health, women are more likely to suffer from anxiety or depression, whereas men are more likely than women to commit suicide and less likely to seek help when experiencing mental distress. Although more men than women smoke today, there has been a sharp increase in the numbers of young women smoking. The 2007 Slan survey found that 31% of men and 27% of women smoked; with 56% of young women aged 18-29 smoking.

In relation to the gender breakdown of employees in the Irish health service, in 2010, four out of five employees in the Irish health service were women (CSO 2010). Women (excluding home helps) were in the majority in most grades within the health service, accounting for 91.8% of nurses, 85.2% of managers and administrators, and 83.5% of health and social care professionals. However, in the Medical/Dental category women were in the minority, accounting for just over a third of medical and dental consultants (CSO 2010).

Appendix 3 provides a list of key selected available health data on women's and men's health covering: life expectancy and death rates, health status, mental health and well-being, disability, hospital in-patient and discharge data, differences in diagnosis and health conditions, self-reported health and well-being, consultations with a GP, medical card and health insurance and carers in Ireland.

a) Inequalities in health experienced by women

Research and consultations with women across Ireland carried out by the Women's Human Rights Alliance (2010), the National Women's Council of Ireland (2006 and 2010) and the Women's Health Council (WHC 2004, 2005, 2006, 2007 and 2009), as well as European and international data (Thümmeler *et al* 2009, WHO 2009) highlight persistent gender inequalities in health status and the impact of gender inequalities on women's access to health care. Consultations carried out with women across Ireland by the Women's Human Rights Alliance (2010) on the 'right to health' found that poverty, isolation, a heavy burden of care work, low levels of participation in public life and domestic violence all impact negatively on women's mental health and well-being. In some cases the low visibility given to and an absence of services affects key areas of women's health experience, for example, in relation to a fully integrated domestic violence services.

The following are some selected data on women's health inequalities:

- Women from lower socio-economic groups experience the greatest disadvantage in health, are at a greater risk of poor health, experience a higher burden of ill-health and live shorter lives. Women that live in poverty and isolation, particularly lone parents and older women, report on the impact of low incomes on their health.
- Factors such as income, wealth, educational achievement and opportunities, housing and employment status, experience of violence and harassment, access to recreation and transport and environmental factors all impact on women's health (Luddy 2007, WHC 2007, WHRA 2010, NWCI 2008).
- Although women have a longer life expectancy than men, they carry a disproportionately larger burden of ill health later in their lives. When life expectancy is expressed as years lived in good health (i.e. healthy life years), the difference between women, men and transgender persons is much less significant, indicating that women live longer but with more health problems (CSO 2010).
- When it comes to energy/vitality, 16% of women reported feeling worn out or tired all or most of the time compared with 10% of men. 65% of men reported having felt full of life compared with 59% of women. (CSO, QNHS 2011).
- Women are less likely to report very good or good health status, compared to men, with 14.3% of men and 16.8% of women reporting fair, bad or very bad health (SILC 2008). A higher proportion of women (44%) reported at least one health condition when compared with men (40%) (CSO, QNHS 2011).
- Women are more likely to experience domestic violence and there is substantial evidence to show that this largely goes unreported. Around 83% of domestic violence is experienced by women and often women are forced to leave their homes with their children in order to be safe.
- Women are less likely than men to be diagnosed with a Coronary Heart Disease than men. Women present with different symptoms than men, which are often not fully understood by health practitioners.
- There are differences in health and in the experiences of health services amongst certain groups of women.
- The life expectancy of women from the Traveller community is 70.1 years for females (compared to 81.6 years for women in the general population) (All Ireland Traveller Health Study 2010).
- Female Travellers experience significantly higher rates of heart disease and stroke than male Travellers (337 males to every 100 in the general population, compared to 489 females to every 100 in the general population).
- Women with disabilities experience particular difficulties in accessing services such as reproductive health care and screening, and in receiving maternity care services that accommodate their disabilities (Begley *et al* 2009 and 2010).
- Minority ethnic women and migrant women experience specific inequalities in accessing health care, in some cases in having legal entitlements to HSE services and in countering negative societal attitudes and racism (HSE 2007, WHRA 2010).
- Women may have better access to their GP than men because of their children or may be more aware of their health than men. However, many women report on difficulties in accessing health services, discriminatory or stereotypical views held by doctors and health care practitioners and poor diagnosis and treatment for the causes of mental ill health or heart disease.
- Women are often not included in clinical trials or clinical data is often not subject to a specific gender data analysis. Even if women are included in clinical trials it is not always the case that the results are analysed by gender (Ramasubbu and Gurum 2001).
- Women are more likely to have caring responsibilities, which has a major impact on their access to health services and results in a high burden of ill-health (Cullen *et al* 2004). Four-fifths of recipients of the Carer's Allowance or Carer's Benefit were women in 2009. Women Carers were more likely to be in full-time care roles and have a lower participation in the

labour market than men (representing 73.2% labour force participation for men and 52.8% for women (CSO, QNHS 3rd Quarter 2010).

- Women are less likely than men to receive treatment in a private hospital and to have health insurance and are more likely to have a medical card. The proportions of both men and women with medical cards have increased from 2007 to 2010 (24% to 31% for males and 34% to 41% for females) (QNHS, 3rd Quarter, 2010).

b) Inequalities in health experienced by men

Evidence of inequalities in men's health has been widely documented in recent years (European Commission 2011, White *et al* (2011), Richardson and Carroll 2009a, Richardson and Carroll 2009b, Carroll 2009, White and Whitty 2009). Research and consultations with men across Ireland carried out for the National Men's Health Policy 2008-2013 show evidence of men's health status and the specific ways in which male gendered behaviour has a negative impact on men's health status. This points to the impact of gendered lifestyles and behaviours in accounting for many premature deaths, and the need for change through school education programmes, in the workplace and by targeting marginalised groups of men, such as homeless men, minority ethnic men, sexual minorities, isolated rural men, disabled men and men in prisons. This points to the need to develop positive health promotion, constructive dialogue with men, the creation of health enhancing environments, community development and an approach that is holistic and focused on the physical and mental health of younger men (DOHC 2008).

The following are some key selected data on men's health inequalities:

- Male life expectancy is almost five years lower than women's (81.6 years for men, 76.8 for women). Data for 2005-2007 shows male life expectancy at 65 years to be 18.7 years for men and 19.8 for women (CSO 2010).
- Men in the lower socio-economic groups have higher rates of death and poorer outcomes than men in higher socio-economic groups. Mortality rates arising from suicide, drug related poisonings, accidents at work, lung cancer and heart disease are higher amongst men than women.
- Men in disadvantaged communities experience significant health inequalities, are less likely to participate in local community health projects than women or engage in activities that promote health, gender equality and health equity (White *et al* 2011, WHO 2012).
- The mortality rate due to accidents for men was more than twice that of women in 2009 (at 33 per 1,000 population) (CSO 2010).
- Men from the Traveller community have a life expectancy 15 years less than the general population, and 10 years less than Traveller women. Life expectancy is 61.7 years for men

(compared to 76.8 in the general population) (All Ireland Traveller Health Study 2010).

- The death rate is higher for men than women in all age groups. The biggest difference is in the 15-24 year age group where the male rate was more than three times that of the female rate (CSO 2010). Young men (18-35 years) are four times more likely to die than young women, and they have the second highest suicide rate across 30 OECD countries.
- Men's depression and other mental health problems are under-detected and under-treated (DOHC 2008). 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 two to three times more likely to commit suicide than women.
- The rate of admission of men to psychiatric units for non-alcohol related drug disorders was nearly three times the rate for women in 2008. The male rate of admission for schizophrenia was nearly two-thirds higher than the female rate while the female rate of admission for depressive disorders was over one third higher than the male rate (CSO 2010).
- Two-thirds of treated alcohol cases are male. The proportion has decreased from 68.6% in 2005 to 64.8% in 2010. Overall 1.8% of older Irish adults report a diagnosed history of alcohol or substance abuse. The rate is highest in men aged 65-74 years (3.9%) (Trinity College Dublin, TILDA database 2011). Male principal discharges from hospital were 72.4% of those related to 'mental and behavioural disorders due to alcohol'.
- Men predominate in occupations that have high levels of occupational injury and death. Men's longer working hours also impact on health and this reinforces gender divisions in the family.
- Men are less likely than women to seek health advice, discuss their health problems and to access medical services. For example, men are less likely to visit a GP, have contact with services through a primary care team or take up preventative services, than women. This is particularly the case for young men and Traveller men. Data shows that 34% of men having no GP consultation in the previous twelve months, compared with 19% for women. The average number of consultations by men was 2.5, while for women this was 3.8 consultations (CSO, QNHS 2011).
- Certain male gender roles and notions of masculinity can constrain men and tie them into behaviour and attitudes that are health damaging. Health damaging or risk behaviours are closely associated with 'proving' one's masculinity, while health-seeking behaviour can be associated with femininity.

- Socially ascribed roles for men make it difficult to acknowledge health problems, they are more likely to be at risk of occupational ill-health or injury, while societal and peer pressure mean that men are more likely to engage in risky behaviour.

c) Inequalities in health experienced by the LGBT community

It is estimated that approximately 5-7% of the population are lesbian, gay or bisexual (LGB), while the numbers who are transsexual and transgender are not known. Research shows that significant challenges exist with regards to access to services for older LGBT people (Higgins *et al* 2011) and the mental health and well-being of LGBT people (Mayock *et al* 2009). Up to 35,000 LGBT parents are living in Ireland.

Research on LGBT parenthood in Ireland has highlighted specific health-related issues for LGBT parents, including having access to affordable and accessible Assisted Human Reproduction, legal rights to adoption and fostering, recognition of LGBT parental roles, particularly when their children access health care, and attitudes of staff (Fagan & Pillinger 2012, Centre for Gender & Women Studies 2008, Walsh & Ryan 2006, Working Group on Domestic Partnership 2006, Ombudsman for Children 2009, Elliot 2010, Ryan-flood, 2009). Despite improvements and awareness of LGBT health care needs, research does show that the attitudes of staff may result in discrimination and negative attitudes for LGBT parents and their children (Elliot 2010, CGWS 2008, Ryan-Flood 2009). Furthermore, transgender/ transsexual people experience specific barriers in accessing health care that is responsive to their needs, resulting from gaps in knowledge and awareness of staff and a lack of specialist services (HSE 2009, Collins and Sheehan 2004, Whittle *et al* 2008, Equality Authority 2010).

The HSE has begun to raise awareness of LGBT health through their guidelines: *Working with Lesbian, Gay, Bisexual and Transgender People- Good Practice Guidelines for Health Service Providers*. The HSE's 2009 report *LGBT Health: Towards meeting the health care needs of Lesbian, Gay, Bisexual and Transgender People* documents existing health-related services, supports and gaps in services and makes recommendations for further action by the HSE. Specific gaps in resources were identified in LGBT mental health, lesbian health and transgender/transsexual health and recommendations are made for; the development of a National HSE Strategy and Action Plan for LGBT people, the naming of LGBT people as a target group in HSE policy and planning and an HSE policy governing the funding and allocation of LGBT health-related work. Some of these actions are currently being implemented through the HSE's 2012 Service Plan. The 2009 report provides a comprehensive picture of the health issues facing LGBT people including the intersection of gender with sexual orientation, age, ethnicity and disability:

- Health impacts of higher levels of smoking, alcohol consumption, recreational drug use, and a higher incidence of obesity and eating disorders.
- LGBT young people experience isolation, fear, stigma, bullying and family rejection contributing to depression, anxiety, self-harm, suicide, and substance misuse.
- Lesbian and bisexual women have higher incidence of cardio-vascular disease, polycystic ovarian syndrome, ovarian cancer and possibly breast cancer; a lower use of gynaecological services; low awareness of STIs and barriers to accessing assisted human reproduction (AHR) services.
- Gay and bisexual men experience homophobic abuse and violence, stress, substance misuse, and sexual health risks (including HIV and syphilis).
- Transgender/Transsexual people experience a lack of essential health services and a designated gender specialist. Isolation, fear, stigma, physical violence and family rejection contribute to depression, anxiety, self-harm, suicide and substance misuse.
- Older LGBT people experience invisibility, isolation and loneliness; lack of recognition of partners and difficulties expressing bereavement.
- Ethnic and cultural minorities experience health problems resulting from discrimination/persecution in their country of origin, and discrimination within their communities in Ireland.
- Disabled LGBT people experience mental and physical health consequences of 'double discrimination', lack of recognition of the disabled as sexual beings, access problems in relation to health services and participation in the LGBT community.
- Parenting, fostering and adoption is constrained by a lack of social and legal recognition of their family unit. Psychological distress is associated with systemic stigmatisation of their families, and related risk of isolation and bullying of children with LGBT parents in schools.

1.6 Why gender mainstreaming? Rationale for integrating gender in health policy, planning and delivery

The core purpose of the HSE Gender Mainstreaming Framework is to recommend actions that better enable the HSE deliver its services to women, men and transgender persons so that these services can more effectively uncover and address gender inequalities in access to services and ensure that health outcomes are equitable for women, men and transgender persons. Actively promoting gender equality will avoid potentially discriminatory situations from arising. It will help the HSE to improve the quality of the services provided in relation to the prevention, diagnosis and treatment of illness by improving the utilisation of services and service user satisfaction. This will

contribute to fairness, social justice and equality and a better understanding of the integration of gender with the social determinants of health. Both are outcomes that will result in better health and improved quality in health care for women, men and transgender persons.

Outcome 1: Fairness, social justice and equality in health

- Bringing a gender perspective into patient-centred care will result in outcomes that are fair, socially just and equal. For example, integrating a gender perspective into cancer care, cardiovascular health, mental health or health promotion will help to improve patient outcomes, enable a better targeting of resources where they are needed, with the result services meet the different needs of women, men and transgender persons. This is particularly important because of the differences in which women, men and transgender persons experience and manage ill-health and use services.

Outcome 2: A better understanding of gender and the social determinants of health

- Taking account of the social determinants of health alongside the specific identities and health needs of different groups of women, men and transgender persons, will help to improve access to health care and uncover the health care needs of women, men and transgender persons who are disadvantaged. A better understanding of the complexities of women's and men's health needs, within the broader context of the social determinants of health, will help to identify key life experiences and issues impacting on women, men and transgender persons who experience multiple inequalities, such as; socially isolated older men, single parents, women living in poverty or access to services that take account of the needs of lesbian, gay, bisexual and transsexual/transgender people.

1.7 Gender mainstreaming as an international obligation

Gender Mainstreaming is now a globally recognised strategy and approach for achieving gender equality. International human rights frameworks and policies of the European Union and the Council of Europe place obligations on the Irish government to integrating a gender perspective into the planning, delivery, implementation and monitoring of health care.

The Irish government's commitment to equality in health and gender mainstreaming is embedded in a wide range of international obligations. Human rights treaties guarantee specific rights to individuals and place obligations on the State in relation to these rights. In the area of gender mainstreaming

the United Nations, *Beijing Platform for Action*, 1995 agreed at the Fourth World Conference on Women in Beijing that governments would introduce gender mainstreaming by analysing the impact of their policy decisions on women, men and transgender persons (United Nations 1995). This recognised that a strategy of gender mainstreaming is an essential component of gender equality requiring governments to carry out an analysis of policies and programmes for their effects on women, men and transgender persons and mainstream gender into all policies and programmes. Gender mainstreaming has since then been developed through policy and guidance under the United Nation's Convention on the Elimination of Discrimination Against Women (CEDAW), the World Health Organisation, the Council of Europe and is a core goal of the European Commission's *Strategy on Gender Equality 2010-2014*.

Appendix 4 provides a more detailed discussion of international obligations and their application in an Irish policy context.

1.8 Gender mainstreaming: Irish policy context

Integrating equality into policy, planning and service delivery can contribute to the best quality health care (HSE 2008). The HSE, the Department of Health and Children, the former Women's Health Council, the Department of Justice and Equality and the Equality Authority have, to date, developed a range of policies, tools and initiatives that impact on equality in health and in the development of gender mainstreaming of the policy making process (DEJLR 2000, McGauran 2005, Equality Authority 2005, Women's Health Council 2007, DOHC 2008).

Government policy and activity on gender mainstreaming

Gender mainstreaming is a commitment under the Irish National Women's Strategy 2007-2016 and the HSE's National Men's Policy 2008-2013, and is a policy goal of the Gender Equality Division in the Department of Justice and Equality (formerly Department of Justice Equality and Law Reform).

The National Women's Strategy makes a specific commitment to gender mainstreaming in health:

In line with policy development generally, at international and national level, the emphasis today is on the incorporation of a gender perspective into mainstream health policy and the implementation of positive action measures to ensure that the health of women in this country is promoted and protected. (National Women's Strategy 2007-2016)

The following are the strategic objectives on health contained in the National Women's Strategy (Objective 8–A) 'To improve the health status of women in Ireland through gender focused policies':

- Incorporate a gender dimension into health policy planning at the earliest possible stage of development, e.g. the Cardiovascular Strategy
- Ensure that the ongoing redevelopment of the health services structures includes representation of women at all decision-making levels
- Update women's health structures in light of recent health reform in collaboration with the Health Service Executive and the Women's Health Council target
- Put in place health policies and services that allow women full access (e.g. transport, childcare/eldercare, privacy)
- Put in place health policies and services to support carers (respite, counselling, information, financial security)

The experience to date of gender mainstreaming, under Ireland's National Development Plan 2000-2006, shows the need for a comprehensive approach, with resources, expertise and government commitment (McGauran 2005). In a health context the work of the Women's Health Council has highlighted the need for a systematic approach to addressing fundamental inequalities between women, men and transgender persons, and for this to be integrated into all areas of health policy (Women's Health Council 2007).

Appendix 5 gives a more detailed account of the existing legislation and policy frameworks that provide an important context for gender mainstreaming in health.

Gender mainstreaming and Irish health care policy

A core goal is for gender mainstreaming to be integral to all DOHC and HSE health policies. For example, it should enable there to be a transparent gender perspective to complement the HSE's mission "to enable people to live healthier and more fulfilled lives" (HSE Transformation Programme 2008). The National Health Strategy, *Quality and Fairness - A Health Service for You* (DOHC 2001) acknowledges the need to reduce health inequalities that arise because of gender, age and ethnicity and socio-economic status. Equity is one of the four underpinning principles on the basis that services are provided that are fair and result in equality of outcomes.

Specific commitments to reducing inequalities in health across different population groups and sub-groups are contained in the HSE Health Inequalities Framework 2010-2012 (HSE 2010), the HSE Population Health Strategy (HSE 2008) and the HSE Corporate Plan 2008-2011 (HSE 2008). It is embedded in the HIQA draft standards on health care (2010), the National Strategy for Service User Involvement (2008), the framework for mental health under Vision for Change (DOHC 2006), the consultation framework for the development of a new Public Health Policy 2012-2020 (DOHC 2011) and the Primary Care Strategy (2001).

Targeted work carried out by the HSE Social Inclusion Care group with groups such as asylum seekers, minority ethnic groups, Travellers, LGBT people and homeless people, includes reference to the National Traveller Health Strategy 2002-2005 and the National Intercultural Strategy in Health 2007-2012. Similarly, the National Men's Health Policy sets out a range of activities to address men's health through a relational and social determinants approach and argues for gender to be taken into account in understanding how men's experiences of health and access to health care is shaped by ascribed gender roles (DOHC 2008).

Appendix 5 gives a more detailed overview of DOHC and HSE policy that has relevance for gender mainstreaming.

A brief review of a selection of health policies shows that a gender analysis is largely absent from existing health policies, strategies and plans. For example, there is no reference to gender in the HSE *Population Health Strategy* (2008) and the HSE *Chronic Illness Framework* (2008), the latter of which does cite evidence from SLÁN of high risk factors in the lower socio-economic groups, which will lead to a widening of health inequalities. HSE Service Plans for 2010 and 2011 make only limited reference to gender.³ The HSE Health Inequalities Framework 2010, in contrast, states that "Being male or female can influence your life expectancy, mental health, risk of different chronic diseases, experience of abuse and risk of suicide" (HSE 2010: 4), on the basis that the causes of health inequalities are social, economic, cultural and political.

Although a *National Men's Health Policy 2008-2013* (DOHC 2008) was agreed in 2008, the HSE does not have a policy on gender equality and dedicated funding on women's and men's health is limited to three designated women's health officers and one men's health officer. There is no dedicated HSE funding for LGBT health, although specific funding is allocated to LGBT NGOs, and some of the biggest deficits exist in the area of transgender health (HSE 2009).

A Plan for Women's Health 1997-1999 was published by the DOHC in 1997. It had four main objectives: (1) To maximise the health and social gain of Irish women, (2) To create a woman-friendly health service, (3) To increase consultation and representation of women in the health services, and (4) To enhance the contribution of the health services to promoting women's health in the developing world. This led to the establishment of the Women's Health Council, regional Women's Health Advisory Committees and a Women's Health Policy Unit in the DOHC to monitor the implementation of the plan. These structures no longer exist and the plan has not been updated. Currently there is no specific focus given to women's health in DOHC policy.

³ For example, the 2010 Service Plan refers to actions in primary care on women's and men's health promotion and in relation to the framework to address the health related actions of Ireland's national action plan against female genital mutilation, under ethnic minority services; the 2012 Service Plan refers to cervical and breast screening for women.

The government sponsored consultation exercise that led to DOHC's *Plan for Women's Health 1997-99* (DOHC 1997) and the consultation exercise that was carried out for the DOHC's *National Men's Health Policy* (DOHC 2008) are good examples of specific measures to address gaps in understanding and evidence of the impact of gender on health.

1.9 The key elements of the Gender Mainstreaming Framework

The HSE Gender Mainstreaming Framework presents a strategy for integrating gender into policy, planning and service delivery for endorsement by senior decision-makers and managers in the HSE. The main elements of the Gender Mainstreaming Framework can be found in Section 3. This sets out eight key steps, which cover the strategic and operational tasks required to implement the framework, as follows:

- Senior level commitment and leadership to gender equality and gender mainstreaming
- Awareness raising about gender inequalities in health
- Collation of gender and sex-disaggregated data
- Consultations with women's and men's organisations, service users, health care unions and staff
- Gender proofing: assessing gender relevance and carrying out gender impact assessments
- Priorities for service planning and delivery that address identified gender differences
- Gender mainstreaming demonstration projects in specific services
- Monitoring, review and reporting on gender mainstreaming

Before presenting the Gender Mainstreaming Framework, the next section provides a more detailed overview of what is gender mainstreaming, the policy context on gender mainstreaming in relation to health policy, how gender mainstreaming relates to health inequalities and the social determinants of health and the lessons from gender mainstreaming in health in other countries.

Section 2: Gender mainstreaming and its application to health care



SECTION 2: Gender mainstreaming and its application to health care

2.1 What is gender mainstreaming?

Gender mainstreaming is defined by the United Nations as a process for achieving gender equality:

Mainstreaming a gender perspective is the process of assessing the implications for women, men and transgender persons of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres so that women, men and transgender persons benefit equally and inequality is not perpetuated. The ultimate aim is gender equality. (United Nations Economic and Social Council 1997)

It is defined by the Council of Europe as a process to ensure that a gender equality perspective is integrated at all levels of policy making:

The (re)organisation, improvement, development and evaluation of policy processes, so that a gender equality perspective is incorporated in all policies at all levels and at all stages, by the actors normally involved in policy making (Council of Europe 1998)

This HSE Gender Mainstreaming Framework is grounded in the theory and practice of gender mainstreaming and applies this to a health setting. Gender mainstreaming has its origins in global feminist struggles for gender equality, the first commitment to which was made at the Beijing World Women's Conference in 1995.

Gender mainstreaming is an all-encompassing approach to address the unequal distribution of power and resources between women, men and transgender persons and is a method to address the fundamental and structural causes of women's inequality (Women's Health Council 2007, McGauran 2005, Walby 2005a and 2005b, Daly 2005, Mazey 2002, Beveridge and Shaw 2002, United Nations 2002, Rees 2009). Applying gender mainstreaming in a health setting, however, is complex and multi-multidimensional, and has not been without its contentions and difficulties (Tolhurst *et al* 2011), particularly taking into account the interaction of biological and social factors, as well as the gendered nature of medicine and health care.

Central to this Gender Mainstreaming Framework is the need to address inequalities in women's and men's health,

including the health of transsexual/transgender people. Gender mainstreaming has the benefit of shifting the emphasis away from the personal characteristics of women, men and transgender persons towards a more systematic approach to analysing gender differences in organisational and institutional processes, structures and social norms. Gender mainstreaming in health is transformative because it requires a root and branch approach to the organisation and delivery of health services, alongside an understanding of the direct and indirect ways in which gender impacts on social relations and access to power.

Gender mainstreaming has the potential to transform gender relations in assessing differences and diversity in women's, men's and transgender peoples' health. Gender mainstreaming in health requires policy makers and health care providers to assess all actions and policy functions for the impact they have on gender equality. An important aspect of gender mainstreaming is that it requires a *gender based assessment* which means that it is necessary to collect data, question basic assumptions and understand how social, economic, political and cultural factors impact on policy and the provision of health services.

2.2 Gender mainstreaming and gender discourse

Gender mainstreaming has its origins in feminist critiques of patriarchy and has been promoted by the women's movement as a method for transforming gender relations with the goal of achieving gender equality and women's human rights. Feminist critiques of gender mainstreaming have shown that policy processes need to take account of the root causes of gender inequality and unequal power relations between women, men and transgender persons, and transform the vested patriarchal interests of the 'mainstream' (Walby 2005, Moser 2005, Rees 1992, Marshall 1998, Verloo 2001 and 2005, Shaw 2002, Doherty 2010). For example, Rees' (1998) analysis of three models of gender equality in relation to gender mainstreaming shows that gender mainstreaming can only achieve effective equality if this is incorporated into policy making and political institutions. In an Irish context, the National Women's Council of Ireland and feminist activists have for many years anticipated that gender mainstreaming would lead in the long-term to a transformation of gender relations, by making public decision makers accountable in achieving gender equality in service planning, resource allocation and delivery. (See 2.7 below for a more detailed discussion of how gender mainstreaming has been implemented in other countries and some of the lessons learnt for Ireland).

2.3 Gender mainstreaming and the social determinants of health

Gender inequalities cannot be separated from areas of inequality and the broader social determinants of health. Gender is now widely recognised as a key social determinant of health (WHO 2001, Government of Ireland 2007, Department of Justice, Equality and Law Reform 2008, DOHC 2008, HSE 2010). The social determinants of health such as poverty and low-incomes, employment, education, living and working conditions, occupational hazards and lifestyles are highly gendered factors, which are crucially linked to inequalities and differences between women, men and transgender persons.

The Gender Mainstreaming Framework builds on the social determinants of health approach currently being progressed under the HSE Health Inequalities Framework 2010-2012 (HSE 2010). The sharp class gradient in mortality and morbidity in all major causes of ill-health are in part a result of higher rates of health-damaging behaviour, societal risks impacting on mental ill health and poor access to health services, such as screening and preventative services (IPH 2001, DOHC 2008, HSE 2010). For example, an analysis by gender and socio-economic status is very important to identifying how social class and gender interact in different ways in relation to the identification and treatment of chronic disease.

In doing this, the Gender Mainstreaming Framework shows that by addressing the complex interaction of biological differences and social factors improved health outcomes can be attained. According to the World Health Organisation:

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. (WHO *Mainstreaming Gender Equity in Health*, Madrid Statement)

There is a wealth of evidence of gender-based inequalities in mental and physical health. This ranges from structural, behavioural and psychosocial determinants of health, that relate to the lives of women, men and transgender persons (socio-economic, age, social support structures, family arrangement) and differences in lifestyle (smoking, drinking, exercise, diet) and psychosocial (critical life events, stress, psychological resources). For example the EU State of Men's Health Report documents the impact on men's health of social and structural inequalities (European Commission 2011). The report of the Women and Gender Equity Knowledge Network to the WHO Commission on the Social Determinants of Health (Sen and Östlin 2007)

identifies four factors that determine inequitable health outcomes, which in turn have "serious economic and social consequences" for girls and boys, and women and men. These include discriminatory values, norms, practices and behaviours that exist in health, within households and in communities. These result from gender norms and stereotypes; differences in exposure and vulnerability to disease, disability and injury; gender bias in health care systems; and gender bias in health research.

2.4 The overlap of biological and gender differences in health

Biological and social factors overlap in their impact on health, on the basis that:

Sex relates to biology, the dimorphic division of male and female, gender in contrast refers to the cultural meanings that are attributed to those biological differences -gender in other words is socially constructed. (Stakelum and Boland 2001)

While women's and men's biological, genetic and hormonal make-up are biologically determined, gender reflects the norms, values and expectations of a society at a particular point in time. For example, at a population level, women's lower levels of access to power and resources, and over their bodies and their lives, result in negative health consequences. However, even though men benefit from higher levels of power and resources than women their higher mortality rates for all leading causes of death and lower life expectancies can be explained by both biological and social factors. For example, the association of male gender roles with risk taking behaviour around drinking and driving accounts for significantly higher mortality rates in younger age groups. When this is looked at by socio-economic status, access to employment or education it is possible to see how marginalised men experience specific and wider health inequalities.

Gender refers to differences between women, men and transgender persons, that are socially constructed and that influence health behaviour and health outcomes. This is related to differences in the social roles, gender identity, social contexts and power relations between women, men and transgender persons, which are affected by access to resources and decision-making. Gender relations and roles are not universally prescribed; rather they change over time. For example, men are often constrained by societal notions of masculinity, as much as women are constrained by prescribed gender roles. Women are expected to provide care for children, elderly or disabled family members, which impacts on their health and well-being. Men's roles are often influenced by pressures to be 'masculine', which may result in health risks associated with risk-seeking behaviour or reluctance to seek health care:

Gender relations of power constitute the root causes of gender inequality and are among the most influential social determinants of health. They operate across many dimensions of life affecting how people live, work and relate to each other. They determine whether people's needs are acknowledged, whether they have voice or a modicum of control over their lives and health, whether they can realize their rights (Sen and Östlin 2010: 12)

Biological (sex) differences, on the other hand, relate to characteristics that are biologically determined and that result in different illnesses and symptoms that are universal and are the result of biological differences. There are obvious differences related to reproduction and cancer risks, and the fact that men have higher rates of mortality than women. However, some of these biological differences are masked or invisible.

Sex and gender have overlapping effects. For example, the higher level of alcohol consumption among men can be related to societal culture. However, there are biological differences between women and men that influence alcohol consumption. Changes are also apparent over time, for example, seen in relation to the rising numbers of young women who drink and smoke. Rates of breast or cervical cancer amongst women and of testicular or prostate cancer among men are biologically determined. However, gender affects health seeking behaviour and the take up of health services for different reasons. Men, particularly in lower socio-economic groups, are less likely to visit the GP and talk about their health concerns. Women, particularly those living in poverty, may have difficulties in accessing health care because of an absence of childcare, a lack of time because of multiple work, family and caring responsibilities, or because of lack of access to transport.

2.5 The benefits of addressing gender mainstreaming through a social determinants of health approach

Shifting the approach to addressing the underlying causes of women's and men's health will benefit women, men and transgender persons alike. It can have the effect of transforming gender relations, for example, by enabling men to be more aware of that belonging to a gender is shaped by male norms and values (DOHC 2008). Gender mainstreaming can also help to break down gender stereotypes and prejudices, which are collectively internalised and are reinforced by deeply rooted expectations and values about women's and men's societal roles. Stereotypes can negatively impact on women's and men's roles and participation in health across the lifecycle. This may be particularly relevant to men who may be less aware of their gender roles since their 'masculine' roles are often considered to be the norm, whereas women may be more aware of their gender

because of the experience of poverty, gender based violence, caring roles or low participation in work or decision-making.

Addressing the health risks of women and men, including LGBT people, and improving health outcomes is an important task for health service providers. In some cases this means addressing invisible health issues. For example, providing health services for women who experience domestic violence and abuse is a major challenge for the HSE, particularly because of the high level of under-reporting. Implementing the HSE Policy on Gender Based, Domestic and Sexual Violence will be vitally important in this regard and for services and resources to be provided that are proportionate to the needs of both women, men and transgender persons who experience gender based violence.

In some cases this will require a redesign of services currently provided to make services accessible and acceptable to women, men and transgender persons. Redesigning services so that they take account of men's working patterns benefits women, men and transgender persons. This can be achieved by extending opening hours to evenings or early mornings, for example, in GP services or cancer screening services. An experiment by the Rotunda Maternity Hospital in providing outreach clinics for pre-natal care for pregnant women in the evenings enabled women to attend the clinics with their partners. Other examples are the design of specific women's and men's clinics for sexual health services or for cervical screening to increase the take-up of services.

Designing specific health clinics and services for men may be one way to improve men's health seeking behaviour. Men may feel uncomfortable attending a GP surgery or health care centres because they have to wait in a waiting room with women and children. Waiting rooms in GP surgeries and health care centres often create environments that are more conducive to women. Examples of this are 'pink walls' or 'only magazines for women', or posters on the walls that are targeted to women rather than men. A way forward is to have more publicity targeted to men in GP surgeries and health centres and through the media, health checks in the workplace for blood pressure, cholesterol, body mass index etc., and special outreach clinics for young men engaged in risk taking behaviour, such as drug or alcohol. Other examples include the provision of separate counselling services for women, men and transgender persons in order to provide support for women, men and transgender persons who have experienced child sexual abuse or violence.

Examples of how a gender perspective in health care can result in more effective service delivery, a better allocation of resources to address need, long-term costs savings and a lower burden of ill-health:

- Increase the utilisation of GP, primary care and preventative services by men.
- Improve the identification and treatment of women with cardiovascular disease.
- Improve and coordinate more effective responses to gender based violence by front line service providers.
- Improve access to clinicians who are of the same sex as their patients, if this is requested.
- Improve access to sexual health services for young men and young women.
- Address the different social and health care needs of older women, men and transgender persons living in residential care.
- Respond to the different mental health needs of women, men and transgender persons, for example, of young men involved in risk taking behaviour, of LGBT people, of women with a heavy burden of care responsibilities, of women, men and transgender persons living in disadvantaged communities.
- Identify areas of women's and men's health that receive a low priority in service delivery, for example, perinatal suicide and first year post-natal suicide, where data is not collected and which is a low priority in service provision.
- Identify how women's and men's anatomical and physiological differences can affect drug treatments and reactions to drug treatments, for example in cardiac care; or how these differences increase exposure to risk, for example, women who smoke the same number of cigarettes as men are 20% more likely to experience lung cancer than men.
- Enhance the support and respond to the health care needs of family carers.
- Respond to the increasing smoking rates amongst young women.
- Address the health risks experienced by older women, men and transgender persons living in poverty and social isolation.
- Respond to the different social and health care and social needs of women, men and transgender persons living in residential care.

2.6 Case studies on gender mainstreaming in health in Ireland

Two case studies are presented below to exemplify the benefits of gender mainstreaming in addressing the specific health care

needs of women and men. The first is an example of gender mainstreaming in cardiovascular health carried out by the Women's Health Council, the second is an example of a specific initiative for health care professionals working with obese men in a primary care setting carried out by the HSE and the Centre for Men's Health. Both case studies show how a gender mainstreaming approach can not only raise awareness of specific health risks faced by women and men, enhance health outcomes for women and men, but in the long-run provide more cost-effective services that are tailored to the specific needs of women and men.

Case study 1: Gender mainstreaming in cardiovascular health

An analysis of the content of the DOHC's *Building Healthier Hearts Strategy* by the Women's Health Council found that there was a very limited perspective given to gender in the Strategy. No recommendations were made in the Strategy in relation to gender issues, including the need for sex and gender disaggregated data and research on cardiovascular disease. In particular, there was no reference in the document to gender differences in the presentation of symptoms of cardiovascular disease, despite the evidence base for this. The Women's Health Council highlighted the need for gender specific and gender disaggregated data on cardiovascular disease, differences in its progression, symptoms and of the experiences of women and men.

Despite this, the cardiovascular strategy, *Changing Cardiovascular Health: National Cardiovascular Health Policy 2010 – 2019*, fails to implement a gender perspective throughout all actions. It does make reference to gender differences in smoking, salt consumption, exercise and physical activity amongst women and men and young people, and in relation to rates of obesity, inequitable prescribing by gender, age and geographic variation. However, only one recommendation is made with reference to gender, age, education, distance from specialist services and transport, in relation to equity of access to services and models of care for equitable cardiac rehabilitation programmes.⁴

Gender mainstreaming as an approach can help to uncover some of the biological and social factors that impact on cardiovascular disease. Women and men have different experiences of cardiovascular health, in diagnosis, treatment and health outcomes. However, gender bias exists in that the norm of the heart disease patient has been male, based on male symptoms.

Myocardial infarcts are a leading cause of death for both men and women; male risk of coronary artery disease is at a younger age while women are more likely to develop heart disease at a later stage than men and experience different symptoms for a longer period of time than men. Women's symptoms relate to shoulder or abdominal pain, dyspnea, fatigue and nausea,

⁴ Recommendation 6.4 "Equity of access to services and models of care: A menu-driven system of delivering rehabilitation should be established to support equitable access for groups vulnerable from traditional programmes"

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 ischaemic heart disease or acute myocardial infarction are nearly double that of women, while only slightly fewer men die from cardiovascular disease than women each year. Men are more likely to die prematurely from heart disease than women. Gender stereotyping may go some way to explaining why women have a significantly higher post MI mortality than men (Phillips 2005).

A good example of an Irish initiative on gender mainstreaming, carried out by the Women's Health Council and the Irish Association for Emergency Medicine, led to an assessment of how Emergency Departments assess women with Acute Coronary Syndrome (WHC & IAEM 2007). The research found gender bias in current policy and practice on cardiovascular health, and a lack of knowledge of appropriate ways to provide services and treatment for women. The initiative sought to raise awareness among Emergency Medicine health care professionals in identifying, diagnosing and treating women with Acute Coronary Syndrome who present in Emergency Departments. Box 1 reproduces the postcard produced for health care professionals. The postcard recommends that the spectrum of ACS symptoms are considered in women, which include chest pain, fatigue, shoulder and neck pain, nausea, abdominal discomfort and syncope. A list of further resources are provided including departmental guidelines on suspected ACS.

Box 1: The Emergency Department Assessment of Women with Acute Coronary Syndrome (text of the postcard developed by the Women's Health Council and the Irish Association for Emergency Medicine).

Are you aware that...?

- Heart disease is the most common cause of death for women in Ireland
- In her lifetime, a woman is ten times more likely to develop coronary heart disease than she is breast cancer.
- Women tend to present for the first time with ACS at an older age than men.
- Women are more likely than men to present with symptoms labelled as 'atypical'.
- Studies have demonstrated gender bias in the assessment and investigation of ACS.
- Women experience more treatment delays during all stages of care. They wait longer for aspirin and are less likely to receive beta-blockers or fibrinolytic therapy. They undergo fewer cardiac procedures including angiography, PCI and GABG.
- Research has shown higher mortality in women with ACS even when adjusted for age and co-morbidities.
- Historically women have been under-represented in clinical trials.

Case study 2: Best practice approaches in working with obese men in a primary care setting

A study of obese men who had attended Community Nutrition and Dietitian Services (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 (McCarthy & Richardson 2011). In addition, the National Men's Policy highlighted the significant rate of increase in obesity in men in Ireland and the need for a gender-specific approach in tackling male obesity through targeted action and specific lifestyle interventions (DOHC 2008).

The best practice resource book points to the need for a gender lens to male obesity on the basis that male obesity rates have tripled since 1990, resulting in the fact that 43.8% of men are overweight and 25.8% are obese. In particular, visceral obesity is more prevalent among men than women and poses a risk of hypertension, diabetes and metabolic syndrome. This also showed evidence that men's diets are less healthy than women's diets, that men who are overweight or obese do not see their weight as a cause of concern and that men lack control over their diets and are less knowledgeable about healthy eating. Moreover, men's dietary habits are influenced by long working hours, an approach to food that is more pleasure orientated and an association of size with masculinity. Similarly, men are less likely than women to observe advice about healthy eating and 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. However, it is evident that men are more likely to be open to changes in their diet and weight loss when promoted to do so by their GP.

As a result of the specific work carried out by the CNDS it was found that lifestyle interventions that are 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. In particular, the approach showed the importance of a patient-centred approach whereby men were given personal choice and took responsibility for their health in a process described as shared decision-making:

It is well established that the most effective interventions at a population level are those that (i) adopt an integrated, multidisciplinary, and comprehensive approach; (ii) involve a complementary range of actions; and (iii) work at an individual, community, environmental and policy level (McCarthy & Richardson 2011: 9)

Box 2 sets out the best practice approaches for health care professionals working with obese men in a primary care setting.

Box 2: Best practices approaches for health care professionals working with obese men in a primary care setting:

- Don't ignore the problem (of male obesity)
- Adopt a 'shared investment' approach to lifestyle change
- Increase the breadth and capacity of primary care teams to deal with obesity
- Consider the impact of key 'transitional' periods in men's lives
- Account for and anticipate likely problems and barriers to weight-loss
- Place a strong focus on physical activity as a means to weight loss for men
- Use practical approaches when working with men
- Provide long term follow up with men to enable them to sustain lifestyle changes
- Tailor interventions to the individual – not all men are the same
- Provide training for primary care teams on how to work effectively with men

2.7 The lessons from implementing gender mainstreaming in other countries

Gender mainstreaming in health is widely regarded as one of the most important and complex areas of government policy to implement. As a result a brief review of the implementation of gender mainstreaming in other countries has been carried out in order to draw out the lessons for the implementation of gender mainstreaming in health in Ireland. These lessons have been taken into account in drawing up this Gender Mainstreaming Framework and to ensure that previous difficulties in implementing gender mainstreaming in health can be avoided.

Examples of gender mainstreaming that have lessons for Ireland are provided in **Appendix 7**, covering Sweden, Canada, England, Scotland, Wales and Northern Ireland. These show the importance of having a legal framework that provides a positive duty on public authorities to implement gender mainstreaming, political leadership and resources to implement gender mainstreaming. In summary:

- In Sweden, gender mainstreaming is part of a political objective to remove structural inequalities and unequal power relations between women and men through a systematic approach across all government policies, implemented with dedicated resources and wide engagement with women's and men's organisations in the process. One example is the application of gender

mainstreaming to the Swedish public health policy (2003) where gender is integrated into the objective of reducing inequalities across indicators on socio-economic status, ethnicity and geography (Östlin and Diderichsen 2010).

- In Canada gender mainstreaming has been implemented through the 2000 *Gender Based Analysis Policy*, which includes a commitment to reducing gender health inequalities. The strategy for *Sex and Gender-based Analysis* incorporates the assessment and analysis of health research, policies and programmes to uncover the biological and gender based differences across the social determinants of health. An example is the gender analysis carried out by the Canadian Federal Mental Health and Addictions Policy with regards to mental health and substance abuse (Salmon *et al* 2006).
- In England, Scotland and Wales, gender mainstreaming as a proactive approach to gender equality was first introduced in 2007 through the Gender Equality Duty and is now included as part of the broader equalities framework under the Equality duty (introduced under the Equality Act 2010). This requires a gender perspective to be integrated into the development of policy, planning and service delivery of all public authorities, including health.
- Separate provisions exist for Northern Ireland, under Section 75 of the 1998 Northern Ireland Act, which place similar equality duties on public bodies, including the requirement for all public authorities, including health and social care providers, to carry out an equality impact assessment and integrate an equality perspective into their strategies, plans and service delivery functions.

Specific lessons are drawn from this review and from recent global evaluations of gender mainstreaming in health (Eyben 2010, United Nations 2010, Tolhurst *et al* 2011, Payne 2011, Walby 2005, Rees 2005, Sen and Östlin 2010, Sen and Östlin 2002, Ravindran and Kelkar-Khambete 2007 and Ravindran and Kelkar-Khambete 2010).

- One of the key lessons from gender mainstreaming in health in other countries is that there is often a gap between a policy objective and the practice of applying gender mainstreaming. This results from resistance by policy makers, a lack of accountability, a lack of awareness and confusion on how to implement gender mainstreaming and an absence of user-friendly gender mainstreaming frameworks.
- Specific initiatives on gender mainstreaming in health have not always systematically integrated gender and there is sometimes a gap between the intention set out in the policy and the practice of implementing gender mainstreaming. One key problem is the absence of gender-disaggregated data and where data does exist it is not analysed and applied to health care policy, planning and service delivery. Another is that gender mainstreaming is not embedded in

the design, implementation, monitoring and evaluation of policies and programmes.

- Despite progress on gender equality in many countries, gender mainstreaming has often resulted in a separate focus on women's and men's health (Payne 2011, Bates *et al* 2009). Many gender mainstreaming strategies have focussed on women, rather than women, men and transgender persons, the result of which is that there has been a limited impact on key areas of women's and men's health, for example, cardiovascular health, cancer, and mental health.
- Barriers in implementing gender mainstreaming include a lack of robust gender statistics and sex-disaggregated data and where sex disaggregated data is collected this is not analysed, a lack of financial resources, a lack of expertise to implement gender mainstreaming, a misunderstanding of what gender mainstreaming is and a lack of engagement of men in the process.
- Gender mainstreaming has tended to be reduced to a set of tools and activities, and predominantly training, rather than a systematic approach to transform gender relations in health and the structures that reinforce inequality.
- Commentators argue that it is important to define gender mainstreaming as a human rights issue of equality, rights and justice and to address underlying resistance to gender mainstreaming. Gender mainstreaming in health care needs to be closely linked to social justice objectives, while also challenging established male value systems that dominate power structures of decision-making in organisations and in challenging gender relations of power which constitute the root cause of gender inequality.
- If gender mainstreaming is to achieve gender equality, it requires gender power relations to be addressed and tackled. This has proved very difficult to achieve in practice. Organisational and institutional structures of health care are inextricably linked to historical and structural gender inequalities that exist at societal, economic and political levels and to deeply embedded structures of patriarchy.
- Further challenges exist because of the predominance of the bio-medical approach to health, which often presents a 'gender neutral' approach to treating individual patients.
- Gender mainstreaming needs to be based on robust data and indicators. This will be critical to the systematic evaluation of how gender interacts with the factors that lead to social inequalities in health, for example, socio-economic status, age and race/ethnicity.

the basis that to treat people equally sometimes means treating people differently. It also highlights the need for an integrated and comprehensive approach to women's and men's health, rather than a separate focus on women's health and men's health (Bates *et al* 2009).

One of the positive outcomes of the process of drawing up the Gender Mainstreaming Framework was that women's and men's organisations in Ireland were jointly involved in discussions and learning about gender inequalities in health Through the Gender Mainstreaming Steering Group. This resulted in a collaborative approach and a shared understanding of how gender inequalities and women's and men's unequal social roles impact on women's and men's health. Both the Men's Development Network and the Centre for Men's Health have approached men's health through an analysis of the social context of gender inequalities on men's lives and health, which is underpinned by a feminist theory. This has been important in ensuring that women's and men's health are not viewed as separate or competing entities, rather that gender inequalities can be explained through complex and interacting inequalities and social and economic roles held by both women and men. This approach is reflected in the NWCI's work in promoting women's equality in health and the National Men's Health Policy (DOHC 2008) through the social determinants of health approach.

The Gender Mainstreaming Framework starts from a position that inequalities in women's and men's health, and differences within different sub-groups of women, men and transgender persons, should be identified, recognised and acted upon. It does this by integrating women's and men's health needs within a single framework, so that their differences and concerns are reflected in gender sensitive health care policies, plans and service delivery. It does not take a position that women, men and transgender persons inhabit separate spheres of life, that gender equality pitches women against men or that there is a competition for resources between women, men and transgender persons. Rather it focuses on the need for health outcomes to be related to the social processes that influence gender equality and health and well-being, and that the resources deployed are proportionate to the need identified.

Gender sensitivity and awareness in the delivery of health care should be viewed, therefore, as a way of ensuring that health care is delivered in the most appropriate ways, for example, in addressing the health needs of the most vulnerable or disadvantaged women, men and transgender persons. Moreover, equality benefits everyone and has wider societal benefits. For example, if men's mental health improves or if risk-taking behaviour is reduced, this will benefit the health and well-being of women and children in their families and their participation in community and family life. If women's poverty is reduced, for example, through participation in good quality employment, this benefits men in their families and in the local community.

2.8 Implementing gender mainstreaming in health

A gender perspective in health requires new ways of thinking and a commitment to take action on gender inequalities in health. The objective is to give visibility to gender inequalities on

Gender Mainstreaming will require the HSE to change organisational structures and thinking. This also means that it is important that women, men and transgender persons are equally represented in decision-making positions and that they are included in the process of implementing gender mainstreaming.

An important outcome of the gender mainstreaming process is that there is a rethinking of the policy-making and planning framework in the HSE, by identifying new methods and strategies to meet gender equality goals, and, where necessary introducing positive action policies.

Although gender mainstreaming can be complex and time consuming, it is possible to develop some simple gender mainstreaming techniques in the HSE. Having tools and a template for assessing the gender impact of front line service delivery, can progress gender mainstreaming throughout the HSE in very concrete ways. This means that every service provided, every report or proposed policy is assessed for its gender impact.

Gender mainstreaming is also a mechanism and tool for addressing workforce inequalities, such as pay inequalities and occupational segregation. Along with changes required in service delivery this requires political, institutional and structural changes that get at the root causes of gender inequality. Despite some progress in tackling institutional and legislative obstacles in Ireland, there remain a large number of attitudinal, ideological, structural and political barriers that have yet to be addressed. This is complex and difficult to resolve, not least because of the impact of cuts on women, men and transgender persons, but also because this requires the involvement of all stakeholders, employers and trade unions, government departments, local authorities, local development bodies, community organisations, and women's and men's organisations through an inter-sectoral approach to improving health outcomes and gender equality in both the workplace and in relation to access to and the provision of services.

Gender mainstreaming is of great importance in the current economic and financial climate. First, in the context of stretched resources, gender mainstreaming can assist in identifying where health needs lie and how they can be prevented and addressed. Second, the growing burden of ill-health amongst the population and widening inequalities mean that the HSE will need to be responding to a wider and more complex set of health problems in the community. The reality and potential of higher levels of gender-based discrimination, for example, discrimination against pregnant women in the workplace, a widening gender pay gap and rising levels of domestic violence pose challenges that the HSE needs to respond to (NWC 2011). As a result consideration should be given to the role that gender budgeting and gender impact analysis can play in monitoring the gendered impact of budgetary cuts on service delivery and access to health services.

2.9 Conclusion

Gender mainstreaming in health is a multi-faceted and complex process to implement. It has to take into account multiple factors and analyses related to women's and men's biological and gender differences in relation to health and their access to health care, and to interweave these into broader social determinants of health.

In Ireland current health policies tend not to have a gender perspective integrated into their main activities, and the experiments and initiatives on gender mainstreaming and equality proofing have not been systematically applied across the health sector. One barrier to implementing gender mainstreaming has been the absence of robust sex and gender-disaggregated data needed for the evidence base for the multiple factors influencing women's and men's health. Where disaggregated data is available it is very important that this is analysed by gender, acted upon and then fed into subsequent plans for the service delivery. The evidence from the two case studies on women and cardiovascular health, and men and obesity shows how awareness of women's and men's health needs can have a positive and lasting impact on women's and men's health. The lessons from gender mainstreaming in health in other countries does also point to some learning for the implementation of gender mainstreaming in health in Ireland, the need for a strong regulatory framework and leadership to implement gender mainstreaming.

Gender mainstreaming needs to take account of the fact that gender inequalities in health are socially constructed and related to gender power relationships, which are also influenced by biological factors. Gender mainstreaming can help to identify the social factors that lead to vulnerability to ill-health, health behaviour that is risk prone and whether health needs are identified and acknowledged, thereby challenging the bio-medical model of disease and illness. In contrast, consultations with women, men and transgender persons tend to focus on the broader impact of gender relations and the social determinants of health in shaping health and well-being. Improving the visibility of sex and gender-disaggregated data, and the interaction with the social determinants of health, will be essential in progressing gender mainstreaming in health.

The next section sets out the framework for gender mainstreaming in health. If endorsed and implemented it will enable the HSE to achieve the goal of equality and equity in health in a systematic and planned way.

SECTION 3: A framework for gender mainstreaming in health



SECTION 3: A framework for gender mainstreaming in health

3.1 Introduction

This section sets out the framework for gender mainstreaming, the recommended steps to be taken and what is proposed at each level. It will show **why** gender mainstreaming should be implemented, **what can** be done and suggests recommendations for **how** this can be implemented through senior level commitment and practical steps in policy, planning and service delivery.

The Gender Mainstreaming Framework has been written in anticipation of the introduction of a new organisational structure for health in 2012. Although suggested recommendations are made within the framework of the current organisational structure in the HSE, it may be important to factor the Gender Mainstreaming Framework into the new organisational structure once it has been agreed. Crucial to this will be the development of a mechanism to integrate the recommendations from the Gender Mainstreaming Framework into the proposed new Integration Agency, which is signalled to come into effect in 2013. It is also proposed that once the new organisational structure has been agreed and implemented that the Gender Mainstreaming Framework be updated to take account of the reorganisation of services so that it is managed in an integrated way across all services.

Underpinning the Gender Mainstreaming Framework is the need to take into account:

- Evidence and data that addresses both sex (biology) and gender (social roles), and the broader determinants of health that impact on women's, men's and transgender persons health status.
- Top down and bottom up approaches to ensure that a gender perspective in health results in the provision of gender sensitive health services.
- A whole-organisation and inter-sectoral approach to removing gender bias and promoting gender visibility in policy, the provision of health care, as well as in medical research and training.
- A strategic approach to gender equality that addresses underlying structural barriers that result in unequal access to services, unequal outcomes in health and the promotion of good quality patient-centred health care services.
- A lens on the different and complex ways in which women, men and transgender persons are affected by gender roles and the impact that this has on their health.

- A shift in focus from the bio-medical model of health to one that encapsulates women's and men's social roles and the social determinants of health.
- A commitment to ensuring that evidence of inequalities in health is acted upon at all levels of policy making, planning and service delivery.
- The participation and involvement of women, men and transgender persons, particularly those that are the most disadvantaged.

Gender mainstreaming requires that health care providers and planners move away from an ad-hoc response to addressing gender inequality and implement a whole organisational approach that is strategic, systematic and planned. This requires that specific tools, targets and plans be put in place, including sex and gender disaggregated data and staff training on gender equality.

The Gender Mainstreaming Framework has a specific focus on gender equality in access to services and equality of health outcomes. Promoting and implementing a gender perspective in the delivery of health care is the basis for achieving equal health care outcomes for women, men and transgender persons and between different sub-groups of women, men and transgender persons. The implementation of an analysis of gender will enable health care planners, managers and service providers to plan and deliver services that are responsive to women's, men's and transgender persons' health care needs. This will enable them to have a better understanding of how gendered roles and choices impact on health outcomes and in the delivery of patient-centred services. A key objective is to show how gender roles interact with the social determinants of health and how gender intersects with other equality grounds.

Allied to this is the fact that the promotion of gender equality in the workforce is crucial to the implementation of gender equality in service provision. Although the main focus of the framework is on service delivery, it is recommended that gender equality be systematically built into all relevant policies and procedures affecting the workforce. An organisational culture and working environment that promote gender equality will not only help to deliver equality outcomes, they will also ensure that the HSE promotes best practice approaches with regard to work-life balance and supporting staff with care responsibilities; addressing the gender pay gap, occupational segregation, anti-discrimination and harassment, age management and diversity; gender representation in senior and decision-making positions and gender based data.

This Gender Mainstreaming Framework also integrates the needs of and access to health care for the Lesbian, Gay, Bisexual and Transgender (LGBT) community. As a result the framework takes a position that sexual orientation and gender identity are an important element of gender mainstreaming. It is recommended that this also be factored into HSE policy and strategic development.

3.2 The business case for integrating gender into health care policy, planning and delivery

There is a strong rationale and business case for gender mainstreaming and through this the integration of a gender perspective in the policy, planning and service delivery functions of the HSE and into the new organisational structure that will be implemented in 2012. Addressing women's and men's health and the differential barriers in access to health services can help health service providers to effectively and equitably respond to the different needs of women, men and transgender persons.

Integrating an analysis of gender into the planning and delivery of health care makes good business sense because it enables the HSE to:

- Improve access to health care services for everyone, through a change in culture and by providing services that respond to differences between women, men and transgender persons in health status, in relation to their expressed needs and in the utilisation of services.
- Plan and deliver services that are evidence-based and informed, by allocating and targeting resources in the most effective way and to areas of greatest need, and thereby achieve better 'value for money'.
- Assist the HSE in meeting its strategic objectives and targets to reduce inequalities in health and in making a difference to the lives of women, men and transgender persons.
- Have access to a tool for driving social inclusion and equality in health and to empowering women, men and transgender persons in the promotion of health and well-being.

3.3 The Gender Mainstreaming Framework: 8 Steps to Success

The Gender Mainstreaming Framework has a focus on gender mainstreaming in HSE policy developments, in the planning of services and the delivery of services. In addition, it is also relevant to policies of the DOHC and the delivery of services in non-HSE settings, such as private residential care homes for older people.

A specific process has been drawn up, based on best practice approaches from other countries and in Ireland. The framework is based on the fact that gender mainstreaming should be complemented with specific and targeted initiatives for women, men and transgender persons alongside gender mainstreaming initiatives in specific services and in the workforce. The main elements of the Gender Mainstreaming Framework are illustrated in Figure 1.

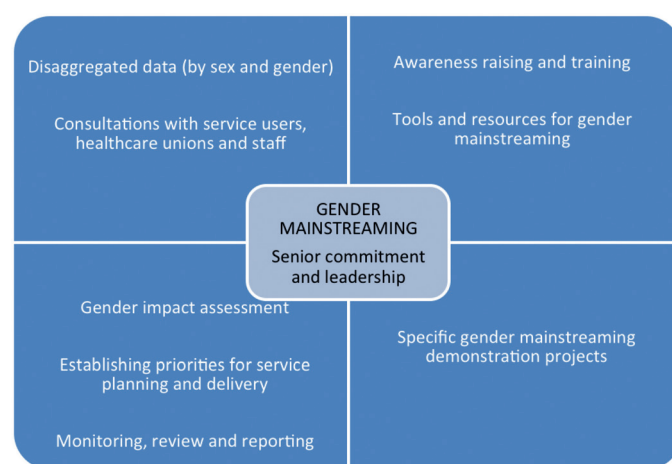


Figure 1: Gender Mainstreaming Framework

Step 1 Senior level commitment and leadership

Senior level commitment and leadership is essential if gender mainstreaming is to have a transformative effect on the delivery of services to women, men and transgender persons, and if there are to be lasting and equal health outcomes between women, men and transgender persons, and gender equality within the HSE workforce.

It is recommended that the HSE visibly champion equality. Gender mainstreaming should be built into all corporate goals and actions, including a commitment to redeploy resources and personnel to implement the framework.

The actions that are recommended require agreement by the CEO, the HSE Management Team and the HSE Board, all of which have a key role to play in ensuring that gender mainstreaming is implemented in a comprehensive way across all policy, planning and service delivery functions.

Recommendations:

- Gender to be integrated into all key health reforms and future restructuring in the HSE. This should include the development of key performance indicators (KPIs) on gender equality using the WHO's Gender Sensitive Indicators along with KPIs to implement the strategic objectives contained in the National Women's Strategy on gender mainstreaming; and targets on women's health, on gender representation in senior and decision-making positions in the HSE and on the HSE Board. KPIs should also be put in place to implement the recommendations and the further development and roll-out of the National Men's Health Policy. It is further suggested that the KPIs contained in the current 2012 HSE Service Plan on LGBT health should be fully implemented.
- A HSE gender equality policy statement should be drawn up that sets out the organisation's commitment to gender equality in employment and service provision, to the prevention of discrimination and to a pro-active approach to promoting equality, including positive action. This should outline the objectives of gender mainstreaming and the process by which endorsement of activities to progress the framework can take place.
- All future policies and service plans should be gender proofed. There is an ideal opportunity to gender proof the HSE Corporate Plan due for publication in 2012 and to ensure that all future National Service Plans are gender proofed at the drafting stage. This means building a gender perspective into the business planning in each service and across the HSE. This should include policy development, resource allocation, planning, implementation and monitoring of actions. As part of the planning cycle it is recommended that the HSE sets goals and clear priorities for meeting gender mainstreaming goals.
- The DOHC should also gender proof all future policies initiated by the DOHC and in the first instance gender proof the new Public Health Policy.
- A separate toolkit on gender proofing of policies and service plans should be drawn up to assist those producing the policies and plans.
- An assessment of the budget – using gender budgeting methodology – should be put in place to ensure that spending priorities match the different and proportionate needs of women, men and transgender persons.
- The planning of services should take account of gender considerations, and this should be part of the integrated planning mechanisms recommended under the Health Inequalities Framework, so that gender intersects with the actions identified to address inequalities in health.
- A senior level commitment should be given to carrying out a gender relevance test and gender impact assessments of service provision and in employment (as part of the HSE corporate plan and annual service plan). This senior level commitment should also specify actions to raise awareness through training, gender disaggregated data gathering, the participation of women, men and transgender persons as service users in formulating services and monitoring access to and the utilization of services. A commitment should be made to achieve change in service delivery and to achieving equal health outcomes for women, men and transgender persons.
- Responsibility for gender equality and implementing the Gender Mainstreaming Framework should be assigned to a senior manager in health promotion (for services) and in human resources (for the workforce), with ultimate responsibility resting with the CEO of the HSE.
- It is recommended that a network of gender specialists and gender mainstreaming champions be created across the HSE who can take responsibility to implement the framework at a local level. This network could provide a vital role in supporting learning, the implementation of the framework, building capacity and exchanging good practices across the HSE.
- It is recommended to redeploy resources for gender mainstreaming demonstration projects (see (7) below).

- Consideration should also be given to adopting an all-Ireland approach to gender mainstreaming and through this to draw on the experiences of gender mainstreaming implemented in Northern Ireland. This is particularly relevant to the development of cross-border approaches to health, such as Co-operation and Working Together (CAWT) the cross border health and social care partnership

and through the remit in health held by the North-South ministerial Council. Gender mainstreaming could be one area where cooperation could be fostered and where the lessons from the implementation of the statutory equality duty in health in Northern Ireland could be applied in the Republic of Ireland.

Specific actions for the HSE:

Action	Responsibility	Date
1.1 Integrate gender into all key health reforms and the restructuring of the HSE. This should include the development of KPIs on gender equality and the implementation of the strategic objectives on women's health contained in the National Women's strategy, in the National Men's Health Policy and commitments to LGBT health in the 2012 HSE Service Plan. It is suggested that specific attention should be given to gender mainstreaming, targets on women's health, men's health and transgender health and gender representation in senior and decision-making positions in the HSE and on the HSE Board.	HSE Management Team / HSE Board	2012 onwards
1.2 Draw up an HSE gender equality statement that sets out the goals of gender equality and senior level commitment to implement the Gender Mainstreaming Framework.	CEO, HSE Management Team and HSE Board	2012
1.3 Gender proof all future service plans and corporate plans by integrating a gender perspective into the business planning in each service and across the HSE (covering policy, planning, resource allocation, implementation and monitoring).	All Directorates and CPCP	Annually starting with the 2013 Service Plan / 2012 Corporate Plan
1.4 Carry out a gender assessment of the annual budget by adopting an annual gender budgeting exercise.	FD / HSE Management Team	Annually starting in 2013
1.5 Ensure that gender mainstreaming is part of the integrated planning mechanisms set out in the HSE Inequalities in Health Framework, including the roll-out of the health equality audits/ reviews in primary care and hospital settings	HP	2012 onwards
1.6 Assign responsibility for gender mainstreaming to a senior manager in the HSE (covering health service delivery and employment)	CPCP / HSE Management Team	2012
1.7 Create a network of gender equality specialists and champions across the HSE (led by the HSE's Women's Health Offices and the Men's Health Officer)	HSE's Women's Health Officers and the Men's Health Officer, to be endorsed by the HSE Management Team	2013
1.8 Redeploy resources for gender mainstreaming demonstration projects in specific services – see (7) below	HSE Management Team	Two projects each year starting in 2013
1.9 Put in place a HSE communications strategy for dissemination of the Gender Mainstreaming Framework to staff and other relevant government departments and agencies.	HSE Management Team	2012

Step 2 Awareness raising about gender differences in health

Gender mainstreaming requires that staff are fully aware of gender differences in health, and develop gender sensitivity and a 'gender lens' to their core work. Without this awareness the framework will be difficult to implement in practice.

Managers, health professionals, front-line service providers, primary care teams, community mental health teams and health promotion teams are amongst those that need to be gender aware. For example, avoiding unintentional gender bias in the treatment of women, men and transgender persons requires that practitioners should not assume 'sameness' or 'gender neutrality', but that they make visible differences in biology, social experiences and roles. This applies to clinical work, medical education and research programmes, as it does to health care policies.

It is the responsibility of all clinicians, health care staff and managers to promote equality as part of their core business and service. It is recommended that this be promoted at all levels of the organisation, from the senior decision-makers to the front-line service providers. This is crucial for staff awareness on gender so that they are empowered to act on gender differences and take ownership of this in their work.

Raising awareness about gender differences and inequalities can be promoted through a wide range of activities. This requires a commitment to implement gender equality, by building the capacity and awareness of staff, to enable the HSE to implement its gender mainstreaming commitments in practice. Training on gender equality should be integral to staff development and should include a focus on customer service, implementing equality and managing diversity. The objective should be to create a learning organisation approach to gender awareness, across all HSE services and functions

The responsibility for building awareness of gender mainstreaming should be first and foremost with the HSE Management Team and established through a HSE-wide approach to integrating gender into all education and training programmes. This should be progressed through the Leadership and Management Development Unit (LMDU), the SKILL Programme for support staff and support service managers, Health and Social Care Professions Education & Development Unit (HSCPEDU) and Centres for Nurse and Midwifery Education (CNME). The HSE's Women's Health Officers and the Men's Health Officer will have a key role to play in raising awareness of gender equality and gender mainstreaming across the HSE.

Recommendations:

- Gender should be integrated into all workforce training and development programmes.
- Service managers should be given the responsibility for progressing gender mainstreaming awareness across all services and all functions.
- Visibility should be given to gender issues in publications circulated to staff, through regular gender mainstreaming e-bulletins, news features in staff newsletters and on the staff intranet.
- Specific learning modules on gender equality in health and gender mainstreaming should be drawn up for use in the HSE's staff learning hub, HSELand.
- Gender awareness to be built into performance appraisal systems, which should measure gender awareness and capacity.
- Specific staff teams, for example, primary care teams, community mental health teams, health promotion teams and hospital-based teams, should ensure that gender awareness is incorporated into team discussions and activities.
- Professional health care bodies should be encouraged to build gender awareness into their own training and development programmes, and to assess professional medical ethics, clinical guidelines and practice standards for their gender relevance.
- The HSE should take an active role in producing guidelines to integrate gender into the health care curricula, for example, in the medical and nursing curricula, for dissemination through relevant university departments and training providers. Gender awareness should also be incorporated into the DOHC's review of the undergraduate nursing and midwifery degree programmes, which is examining the efficiency and effectiveness of these programmes in preparing nurses and midwives to practice in the Irish healthcare system (DOHC 2012).
- Women's and men's health officers should have a key role to play in raising awareness, developing and disseminating training tools and in creating an organisational approach to learning on equality across the HSE.

Specific actions for the HSE:

Action	Responsibility	Date
2.1 Integrate gender into all workforce training and development.	LMDU / SKILL programme / HSCPEDU / CNME	2012 onwards
2.2 Raise awareness about gender mainstreaming across all services.	Service managers (supported by Women's and men's health officers)	2012 onwards
2.3 Give visibility to gender mainstreaming through HSE staff publications, through gender mainstreaming e-bulletins and on the staff intranet.	CD and all Directorates	2012 onwards
2.4 Draw up learning modules on gender equality in health and gender mainstreaming on the staff learning hub.	HSELandD	2013
2.5 Integrate gender awareness in the performance appraisal/ competency and skills systems for staff.	All Directorates	2012 onwards
2.6 Incorporate gender awareness into team meetings, discussions and activities in all relevant services.	All relevant teams (priority on primary care, community mental health, health promotion, hospitals)	2012 onwards
2.7 Encourage professional health bodies to integrate gender into their accredited education/training programmes, in practice standards and in clinical guidelines (IMO, ICGP, An Bord Altranais etc.). Ensure that gender awareness is incorporated into the DOHC's (2012) <i>Review of Undergraduate Nursing and Midwifery Degree Programmes</i> .	HSE Management Team with professional health bodies	2012 onwards

Step 3 Collate and analyse gender and sex-disaggregated data

Gender mainstreaming in health needs to be based on robust data and indicators. This will be critical to the systematic evaluation of how gender interacts with the factors that lead to social inequalities in health, for example, socio-economic status, age and race/ethnicity. This should be developed in line with White and Richardson's (2011) 'gendered epidemiological approach' which includes the analysis of sex differences in conjunction with other factors that are influenced by gender (age, social class, education, civil status etc.) and the application of a 'gender lens' to the findings.

Disaggregated data is essential if senior managers, service planners and front-line staff are to respond to the different health needs of women, men and transgender persons. Data on sex and gender differences is essential for the evidence base against which gender inequalities can be addressed. Limitations in data currently impede an effective development of gender sensitive health services and where data does exist the implications of the findings from data need to be acted upon. Data is needed to identify employment patterns in the HSE, current service use, gaps in service provision and outcomes from service provision. This will build also on the commitment to collect and analyse socio-economic data on service users as part of the implementation of the HSE Health Inequalities Framework 2010-2012.

To start with it will be important to evaluate what is currently taking place with regards to women's, men's and transgender persons' health status and access to health care. Data should be collected and disaggregated by sex and gender on who uses the service, what services are taken up, what outcomes are recorded, as well as feedback from consultations with services providers, customer satisfaction surveys and complaints.

Data should be disaggregated by gender in relation to the social determinants that impact on gender, such as socio-economic status, low income, poverty levels, labour force participation, education, housing, access to power, resources and decision making etc.; as well the intersection of gender by disability, age, race and ethnicity, Traveller status, civil status, family status and sexual orientation (including transgender/transsexual status).

Data should reflect both internal data and national data sources:

- Internal HSE data that is currently collected for each service area, including the identification of areas where there are data gaps in internal data.
- National statistics and data collected by the DOHC, CSO, HRB and ESRI (for data sources see Appendix 3). Data from research is of great importance to the assessment of gender relevance and in overall health trends. It will also be important for national statistics and data to be cross-

tabulated and presented by gender, and other indices such as age or socio-economic status.

Ideally, disaggregated data should cover access to and utilisation of services, prevalence of all health conditions and illness, treatments, health outcomes and service outcomes, such as referrals to other services, discharge rates or readmission rates. The following are an indication of the main areas where disaggregated data can be drawn up and published in relation to service delivery:

- Life expectancy and premature mortality
- Mental health
- Cancer
- Coronary heart disease
- Stroke
- Diabetes
- Asthma
- Dental health
- Obesity
- Long standing illness
- Physical and sensory disability
- Intellectual disability
- Carers
- Lifestyle (smoking, alcohol, drugs, physical activity, sexual health)
- Hospital activity and community based services
- Access to and utilisation of services
- Levels of satisfaction and type of complaints

The following are the main areas where disaggregated gender can be drawn up and published in relation to the workforce:

- The gender profile of staff in the workforce, by each profession, grade and type of employment
- The representation of women in senior level / managerial positions
- Training and career development
- Work-life balance and flexible working
- Gender pay differences and the gender pay gap

Recommendations:

- HSE data should be disaggregated on health care services and on the workforce, as described above.
- Clear direction should be given about the type of data and information that will need to be gathered, how the data will be monitored over time, the responsibilities for front line managers, the tools that will be developed and used

and how service users, staff and health care unions are to be consulted. It will be crucial that the data collected is critically analysed and that the findings are used to inform service delivery and/or policy developments.

- A gender analysis should be integrated into the provision of performance information through Healthstat.
- National health data collected by the HSE, CSO, DOHC HRB and ERSI should be collated in an annual gender health report in order to raise awareness and provide an evidence base for the health sector.
- Gender-sensitive indicators should be developed for data collection. These indicators should help clarify whether the differences in health, either between women, men and transgender persons and between different sub-groups of women, men and transgender persons, are a result of gender inequality/unequal gender roles or inequitable health care provision.
- Guidelines should be developed to ensure that all health research and data collection includes a gender perspective.
- All HSE patient/service user satisfaction surveys, complaints, and service evaluations to automatically integrate gender and that a question is inserted about whether a person is male or female. These surveys should be conducted annually to ensure capture of patient experience of healthcare service with a gender breakdown to reflect any statistical significance in relation to the male or female experience to inform policy, practice and service delivery.
- A review should be carried out of existing data sources in order to identify any gender gaps. This should include the

Intellectual and Physical and Sensory Disability databases, SLÁN, HBSC, Cancer Registry, Local Health and Social Well-Being Indicators & Health Poverty Index, data generated from Ireland and Northern Ireland's Population Health Observatory, the Children's Longitudinal Study, and the TILDA Longitudinal Study on Older People.

- Following from this review a data strategy should be carried by the HSE and the DOHC to ensure that all relevant health data is disaggregated by gender and that there is an integrated and systematic approach to data gathering. In the case of national data, some of this data is already disaggregated by gender, but not always presented by gender in published reports or analysed to inform service developments.
- An examination should be conducted on how data on women's and men's health can be expanded through existing data sets and national surveys. Creating gender indicators or a composite of variables, as a measurement of gender needs to be further progressed in national research and health databases. This requires agreement on which measurable variables could form a gender co-efficient to enable a more routine analyses of the multifaceted social factors that impact on women's and men's health.

The HSE has a corporate responsibility for generating internal sex and gender disaggregated data. It is recommended to work closely with the DOHC, the CSO, the ERSI and the HRB to develop indicators for sex and gender based data and for inclusion in national databases and published reports.

Specific actions for the HSE:

Action	Responsibility	Date
3.1 Disaggregate all relevant HSE data by gender a) in relation to the intersection of gender on the social determinants of health and across the equality grounds, and b) in relation to the HSE workforce and representation of women in senior and management positions. The HSE should report annually on gender representation in the workforce and progress in achieving balanced representation of women, men and transgender persons in senior and decision-making positions.	HSE Management Team	2012 onwards
3.2 Draw up a framework and guidance for all directorates and services in drawing up gender-disaggregated data, including how data will be monitored over time and how service users are to be consulted.	HSE Management Team	2012 onwards
3.3 Integrate a gender analysis into the provision of performance information through Healthstat.	Healthstat	2013 onwards
3.4 Collate all national health data collected by the HSE, CSO, DOHC HRB and ERSI in an annual gender health report.	HSE and DOHC	2012 onwards
3.5 Develop gender-sensitive indicators for data collection.	All Directorates	2012 onwards
3.6 Carry out a review of all existing HSE and other national data sources and identify where there are gender gaps.	HSE and DOHC	2012
3.7 Draw up a data strategy to ensure that all relevant health data is disaggregated by gender and that there is an integrated and systematic approach to data gathering.	HSE and DOHC	2013
3.8 Examine how the scope of data for analysing women's and men's health can be expanded through data collected in national surveys.	HSE and DOHC	2012

Step 4 Consultations with service users, health care unions and staff

Consultation and involvement is a core objective of the service user's strategy and the provision of advocacy services in the HSE. The integration of a gender perspective into service user involvement under the Service User's Strategy (DOHC and HSE 2008) should enhance the participation of women, men and transgender persons and of representative organisations in framing gender equality focused policies and services. This participation can be organised by including women, men and transgender persons who experience inequality and their representative organisations in existing consultative fora, and by developing a specific dialogue with women, men and transgender persons and the organisations that represent them. It is recommended that the HSE consults with staff and health care unions regarding changes in service delivery, in drawing up plans and data collection in order to implement gender mainstreaming and promote equality in the workplace.

Recommendations:

- Linked to the gathering of data, every service should also be involved in consultations with service users, health care unions and staff involved in delivering services. Different methods of consultation can be put in place for this, with reference to the methods of service user involvement and participation being developed within the HSE Advocacy Service.
- Where relevant, all consultations held by HSE services should include a question on and a specific focus on gender differences.
- The findings from consultations should be disaggregated by gender.
- Gender awareness should be built into all consultations, so that those involved in the consultations may understand the relevance of gender to the consultations being carried out.
- It is recommended that a diverse range of consultations take place, as in some cases it may be relevant to hold women-only or men-only consultations to enable women, men and transgender persons to speak openly about their health needs.
- If women or men are under-represented in consultation exercises, it is recommended to examine the reasons for this and put in place targeted consultations to redress under-representation. This may particularly be the case for 'hard to reach' groups, for example, minority ethnic women, including Traveller women, men and transgender persons, young women or men, socially isolated women, men and transgender persons, asylum seekers living in direct provision, women experiencing domestic violence, LGBT people, etc.
- It is recommended that the HSE consult with the groups or organisations that represent 'hard to reach' groups, such as community-based women's groups in disadvantaged communities and men's groups.
- Gender awareness to be built into all guidelines on consulting with all stakeholders, including staff, service users and community groups.
- The ongoing implementation, monitoring and review of this Gender Mainstreaming Framework should take place in consultation with women's and men's organisations and health care unions.

Specific actions for the HSE:

Action	Responsibility	Date
4.1 All services should carry out consultations with service users, unions and the staff involved in delivering services from a gender perspective.	All Directorates / HSE Advocacy Unit QPS / HP	2012 onwards
4.2 Ensure that all service user consultations undertaken by the HSE include a question and a specific focus on gender differences.	All Directorates & HSE Advocacy Unit, QPS	2012 onwards
4.3 Disaggregate all findings from consultations, complaints or other feedback by gender, and make these publicly available.	HSE Advocacy Unit, QPS	2012 onwards
4.4 Build gender awareness into all consultations, so that those who are being consulted understand the relevance of gender to the consultations.	All Directorates & HSE Advocacy Unit, QPS	2012 onwards
4.5 Enable a diverse range of consultations to take place, including women-only and men-only consultations where appropriate.	All Directorates & HSE Advocacy Unit, QPS	2012 onwards
4.6 Examine strategies to address the under-representation of specific groups of women, men and transgender persons in consultation exercises, and where necessary put in place targeted consultations to redress this.	All Directorates & HSE Advocacy Unit, QPS	2012 onwards
4.7 Consult with the groups or organisations that represent disadvantaged women, men and transgender persons.	All Directorates & HSE Advocacy Unit, QPS	2012 onwards
4.8 Build gender awareness into all guidelines on consulting with all stakeholders, including staff, service users and community groups.	All Directorates & HSE Advocacy Unit, QPS	2012 onwards
4.9 The ongoing implementation, monitoring and review of this Gender Mainstreaming Framework should take place in consultation with women's and men's organisations and health care unions.	HSE Advocacy Unit QPS / HP	2012 onwards

Step 5 Gender proofing: assessing gender relevance and carrying out gender impact assessments

A core part of the Gender Mainstreaming Framework is the gender proofing of policies, planning and service delivery. As a first step it will be important to assess the gender relevance of a particular policy or service, which is informed by data and consultations (addressed under (3) and (4) above). This will inform the basis upon which decisions can be made about the targeting, restructuring or reconfiguring of services in order to address gender inequalities. Where gender relevance has been identified, the second 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. The policy or service provision should aim to equally benefit women, men and transgender persons.

These two steps are set out below and are illustrative of an approach that can be taken to assessing gender relevance and in carrying out gender impact assessments.⁵

Stage 1: Is the policy or service area gender relevant?

As a starting point it is necessary to identify whether there is an unintended adverse impact on one gender of a particular policy or service delivery function. In order to do this it is important to carry out an initial screening exercise in order to identify if gender is relevant. Identifying if there is gender relevance in relation to gender roles and responsibilities, including access to resources and power, means considering the impact on:

- Risks and vulnerability to a health problem
- Health seeking behaviour
- Ability to access health services
- Preventative and treatment options
- Experiences with health services and health providers
- Health outcomes
- Social and economic consequences of illness

Ideally this should be carried out by all current services, of future and current policies and future service and business plans, in relation to the following two questions:

- Does the policy or service concern one or more target groups? Does it/will it affect the daily life of part(s) of the population?
- Are there differences between women, men and transgender persons in this policy field or service area (with regard to rights, resources, participation, values and norms related to gender)?

If the answer to these two questions is yes, then gender is relevant to the issue being examined and a gender impact assessment should be carried out.

Stage 2: Gender Impact Assessment

Gender impact assessment is a tool that should be systematically built into all of the HSE's activities and functions where there is gender relevance. Gender impact assessment is a tool for comparing and assessing, according to gender relevant criteria, the current situation and trend with the expected policy or service. In carrying out a gender impact assessment, account will need to be taken of existing disparities between women, men and transgender persons using the following criteria:

- *Participation:* sex and gender composition of the target group and representation of women, men and transgender persons in decision-making positions
- *Resources:* distribution of resources such as time, information, money, political and economic power, education and training, jobs and career positions, health care, housing, transport, leisure, childcare etc.
- *Norms and values:* how these influence gender roles, division of labour by gender, attitudes and behaviour of women, men and transgender persons, inequalities in the value attached to men and women, sex stereotyping etc.
- *Rights:* regarding direct or indirect discrimination, human rights, access to legal, political or socio-economic justice

In carrying out the gender impact assessment it will be necessary to:

- Assess the relevance of gender to the service or policy and how gender differences that exist can be acted upon. This requires a process of screening to identify if there is gender relevance and if there are implications for either the policy or the service being assessed.
- Identify where there is gender relevance and translate into service or policy interventions.
- Assess the evidence from consultations and the data gathered to identify gender differences or inequalities.
- Decide on the strategies and develop a plan to change the design or the delivery of the policy or service.
- Monitor the implementation of the policy or service.

Key questions to address in relation to service provision are:

- Do biological differences between women, men and transgender persons impact on their health?
- How do women's and men's social roles affect their health?

⁵ This is drawn from models developed by the United Nations, the European Union and in countries that have developed specific initiatives on gender impact assessment, including, Sweden, Canada, England, Scotland, Wales and Northern Ireland.

- Do gender norms/values affect women's and men's health?
- How does access to resources impact on women's and men's health and their ability to take up services?
- Are there certain groups of women, men and transgender persons that are not taking up services?
- Are women, men and transgender persons receiving the same quality of diagnosis of health problems?
- What are the main health risks identified for different groups of women, men and transgender persons and are they being addressed?
- What health outcomes result from the service provided?

Key questions to address in relation to HSE policies and plans:

- Have the specific or different needs of women, men and transgender persons been taken into account in the planning process
- Have factors relating to women's and men's health over their lifecourse and in relation to diversity and status been taken into account. In particular, has due consideration been given to the intersection of gender with other social determinants of health, age, Traveller status, disability, ethnicity, geographic location, sexual orientation, family status etc.)?
- Is there a specific commitment in the policy or plan to promote gender equality and address gender differences?
- Are there areas of the policy or plan that perpetuate gender differences or gender stereotypes?
- Are there any areas of the policy or plan that unintentionally disadvantage different groups of women, men and transgender persons or negatively impact on different groups of women, men and transgender persons?
- Are there any areas where specific services need to be developed (positive action) for different groups of women, men and transgender persons?
- Have services users and organisations that represent service users from women's and men's organisations participated in

giving feedback on the services that are being planned or on the policy that is being drawn up?

Example: community health needs assessments in primary care:

This example illustrates the types of questions that could frame a gender impact assessment of community needs assessments in primary care. Gender is very relevant to community health needs assessments, which are part of current and ongoing development of primary care services:

- Has the community health needs assessment collected data on women's and men's health?
- Have women, men and transgender persons participated in the consultations and data gathering exercises carried out in the community?
- Have the specific needs and experiences of women, men and transgender persons been taken into account?
- Have factors such as women's, men's and transgender persons' experiences of poverty, social isolation, care responsibilities and access to employment been taken into account?

Recommendations

- All future service plans, business plans and corporate plans should be gender proofed and should integrate a gender perspective where this is relevant. This applies to services provided in a hospital or in a community setting, and to policies developed by the DOHC.
- All future HSE policies should be gender proofed and should integrate a gender perspective where this is relevant.
- All hospital and community based services should carry out a gender impact assessment, on the basis of the model illustrated above, every three years and report on the outcomes to the HSE Management Team.
- Specific guidelines should be drawn up on how to gender proof service plans, business plans and corporate plans, current and future policies and service delivery.

Specific actions for the HSE:

Action	Responsibility	Date
5.1 Gender proof all future service plans and corporate plans by integrating a gender perspective into the service and business planning cycle in each service and across the HSE (covering policy, planning, resource allocation, implementation and monitoring)	All Directorates and CPCP	Annually starting with the 2013 Service Plan / 2012 Corporate Plan
5.2 Draw up practical guidelines and a template on how to gender proof service plans and corporate plans.	QPS / HP	2012 / 2013
5.3 All future HSE policies should be gender proofed and should be required to integrate a gender perspective where relevant.	HSE Management Team	Ongoing
5.4 Draw up practical guidelines and a template on how to gender proof policies	QPS / HP	2012
5.5 All services to carry out a gender relevance test 'screening' and gender impact assessment (every three years)	All Directorates	2013
5.6 Draw up practical guidelines on how to gender proof specific services through gender impact assessment, with practical examples of how this can be put in place	QPS / HP	2012

Step 6 Develop priorities for service planning and delivery that address identified gender differences

Once a gender impact assessment has been completed it is recommended that all findings from the assessment be implemented. Depending on the findings of the gender impact assessment priorities should be established to redress existing inequalities and re configure resources and services to meet these priorities.

Recommendations:

- The HSE will develop priorities for service planning and service delivery based on biological or social gender differences that have been identified from the gender impact assessment.
- These priorities will be written into an action plan setting out goals, actions and timeframes to meet these priorities; and systematically built into local service planning and delivery, the annual service plan and translated into KPI's.
- In addition, when setting out the priorities to address gender differences there should be an explicit commitment to gender equality built into the future design and evaluation of the programme or policy. This should be built into the design or restructuring of future health interventions and into the business and service planning process.
- All services that have carried out a gender impact assessment should report on the outcomes, in terms of the priorities established, to the HSE Management Team.

Specific actions for the HSE:

Action	Responsibility	Date
6.1 Put in place a system for ensuring that the outcomes of a gender impact assessment result in reconfiguration of service delivery and are factored into future service plans.	All Directorates	2013
6.2 Actions plans should be drawn up setting out goals, actions and timeframes to meet priorities identified. Ensure that these are built into local service planning and delivery and translated into KPI's where relevant in the annual service plan.	All Directorates	2013
6.3 All gender mainstreaming demonstration projects and services that have carried out a gender impact assessment should report on the outcomes and priorities established, to the HSE Management Team.	All Directorates	2013 onwards

Step 7 Gender mainstreaming projects in specific services

Gender mainstreaming demonstration projects are the best way to develop the expertise, awareness and application of this framework. The outcomes of the demonstration projects should be widely disseminated and result in the drawing up of new KPI's for future service delivery.

Recommendations:

- It is proposed that specific gender mainstreaming demonstration projects be developed in all or some of the following areas:
 - > Primary care
 - > Mental health
 - > Cancer care
 - > Cardiovascular care
 - > Emergency services
 - > Older people's services
 - > Health promotion
 - > Social inclusion
- Each demonstration project should undertake awareness raising and training of staff on gender, collection of gender and sex disaggregated data and carry out a gender impact assessment. The outcome should be to draw up draft KPIs for dissemination across all service areas. It is recommended to involve managers, clinicians and nursing staff in the projects.
- Managers for each of the services should be responsible for identifying specific projects and putting in place a reporting system so that the outcomes and the methods used can be disseminated across the HSE's learning networks.
- The HSE's women's and men's health officers will have a key role to play in supporting the learning and awareness raising of staff involved in projects and in assisting projects to draw up schemes for gender impact assessment, data collection and the drafting of health indicators.
- The HSE's funded health workers in the NWCI and the Men's Development Network should play a key role in supporting this work.
- The HSE should work closely with the NWCI, the Men's Health Forum and the Men's Development Network in drawing up gender mainstreaming tools, including a gender mainstreaming and health manual and gender mainstreaming training guidelines, that can be used in the demonstration projects.

Specific actions for the HSE:

Action	Responsibility	Date
7.1 Establish specific gender mainstreaming demonstration projects on a phased basis in primary care, mental health, cancer care, cardiovascular care, emergency services, older people's services, health promotion and social inclusion. Commence with two demonstration projects in 2012 in primary care and mental health.	HSE Management Team / lead on gender mainstreaming	2012-2014
7.2 Each demonstration project should undertake specific activities which lead to the development of draft KPIs for dissemination across all service areas.	HSE Management Team / lead on gender mainstreaming	2012-2014
7.3 Draw up specific practical guidelines and training on gender mainstreaming for the demonstration projects.	Lead on gender mainstreaming / women's and men's NGOs	2012
7.4 On the basis of the demonstration projects draw up a gender mainstreaming and health manual for wide dissemination across the HSE.	HSE Management Team / lead on gender mainstreaming	2015

Step 8 Monitoring, review and reporting

Gender mainstreaming is not a one-off event or activity. It should be systematically built into the monitoring and review of all policies, procedures and service delivery.

Recommendations:

- A plan should also be drawn up for monitoring and evaluating future service plans, policies or service delivery from a gender perspective.
- The implementation of gender mainstreaming also should be built into the HSE's performance monitoring system in order to monitor progress against the gender mainstreaming goals.
- Monitoring should be tied into the systems developed under the Health Inequalities Framework 2010-2012 and reporting on KPIs. These indicators will be very important to measuring the impact of gender mainstreaming and whether a gender perspective has been taken into account.
- An annual report on gender mainstreaming should be presented to the HSE Management Team and the HSE Board.

Specific actions for the HSE:

Action	Responsibility	Date
8.1 Draw up a plan for monitoring and evaluating future service plans, policies and service delivery from a gender perspective, including demonstration projects outlined above.	HSE Management Team / lead responsible for gender mainstreaming	2012
8.2 Draw up an annual report on gender mainstreaming and measure progress against the goals set out in this framework and under the Health Inequalities Framework 2010-2012, including reporting against KPIs. Present to the HSE Management Team and the HSE Board for approval annually.	Lead responsible for gender mainstreaming / HSE Management Team / HSE Board	2012 onwards

APPENDICES



APPENDIX 1: Members of the Gender Mainstreaming Steering Group

Brian Neeson, Health Promotion, Health Service Executive (Chair)

Eddie Ward, Health Promotion, Health Service Executive

Diane Nurse, Social Inclusion, Health Service Executive

Finian Murray, Health Promotion, Health Service Executive

Rosalie Doherty, Health Promotion, Health Service Executive

June Bolger, Advocacy Unit, Health Service Executive

Alessandra Fantini, Department of Health and Children

Stefania Minervino, The Equality Authority

Carol Baxter, The Equality Authority

Pauline Moreau, Department of Justice, Equality and Defence

Rachel Doyle, National Women's Council of Ireland

Jacqueline Healy, National Women's Council of Ireland

Joanne Vance, Irish Cancer Society

Miriam Daly, Irish College of General Practitioners

Alan O'Neill, Men's Development Network

Sé Franklin, Men's Development Network

Noel Richardson, Centre for Men's Health, Carlow Institute of Technology

Owen Metcalfe, Institute of Public Health in Ireland

APPENDIX 2: Summary of issues raised in consultations and interviews in drawing up the Gender Mainstreaming Framework

1. Consultation workshop held with member organisations of the National Women's Council of Ireland, 1 February 2011

The following summarises the main issues raised in the consultation workshop held with women's organisations across Ireland who are member organisations of the National Women's Council of Ireland:

- The draft Gender Mainstreaming Framework was seen as a comprehensive and important document that had the potential to transform gender inequalities in health. This will be important in saving lives, preventing disease, promoting health and will save the HSE money in the long-term.
- Traveller women experience significant health inequalities. The Traveller Primary Health Projects across Ireland have had a positive impact on Traveller women's health, including improving Traveller women's access to screening and preventative health care. Significant concerns exist for Traveller men, amongst whom there is evidence of widening health inequalities and an increase in the suicide rate.
- The findings from the All-Ireland Traveller Health Study should be acted upon and there should be more targeted resources and a commitment in policy to address living conditions.
- More awareness raising training on Traveller health should be carried out, so that health care staff understand Traveller culture and health needs, and discriminatory practices and views are eradicated.
- Women with Hepatitis C frequently experience discrimination in accessing services and are often given the last appointment of the day, which reduces women's choices.
- Although data on cancer prevalence is disaggregated by gender there is a need to monitor the take up of screening services by gender, for example, in promoting the bowel cancer screening programme.
- Training for professional health care staff should include a gender perspective and this should be integrated into the DOHC's current *Review of Undergraduate Nursing and Midwifery Degree Programmes*.
- It is important that there is a joined up approach to implementing gender mainstreaming as this needs to extend beyond health to all areas of government policy and service delivery.

- A short 1-3 page document or leaflet, or a series of postcards, setting out the Gender Mainstreaming Framework should be drawn up and widely disseminated across the HSE and women's organisations and groups.
- The Gender Mainstreaming Framework will need to be aligned to the new structure that will be introduced in the HSE in 2012.
- More resources should be provided on the ground to community based women's groups, local development companies and family resource centres to promote equality in health.
- Women's health officers in the HSE have an important role to play in ensuring that there is a 'gender lens' in health.
- There needs to be an organisation-wide commitment in the HSE to raising awareness and providing training to key health care staff on gender inequalities in health, domestic violence and gender mainstreaming.
- High level political commitment needs to be given to the Gender Mainstreaming Framework from the CEO of the HSE and the Minister for Health. This should be embedded in a positive duty to promote equality in health in legislation.
- Member organisations of the NWCI should be mobilised to lobby for the implementation of the Gender Mainstreaming Framework.

2. Consultation workshop with men and men's organisations, HSE Health Promotion Office, Kilkenny, 2 December 2011

The following summarises the main issues raised at the consultation workshop with men and men's organisations:

- The gender lens is important to showing how gender inequalities impact on men and women.
- Men's health is affected by gender conditioning. Stereotypes of men's roles and masculinity pervade all aspects of health care, including medical training. Challenging male stereotypes is complex.
- How the HSE addresses these challenges should be effectively communicated across the HSE. The evidence of the impact of gender mainstreaming should be documented by showing the impact in reducing inequalities in health between women and men. The impact should be documented through qualitative evidence, collated through consultations with men.

- A key role will be to raise awareness of how men's social roles impact on men's access to health care and their utilisation of preventative services.
- There are lessons from the implementation of gender mainstreaming in Northern Ireland that can be used to inform the HSE's gender mainstreaming framework. This includes having a broad statement that commits the organisation to gender mainstreaming and a regulatory approach. The Gender Equality Strategy in Northern Ireland has shown that men are affected by gender equality.
- Feminism is an important framework for gender mainstreaming; this approach is a strength and should be promoted.
- The National Men's Health Policy spells out the core issues affecting men's health. This shows that men need to reflect on their power roles, that a relational approach is of importance. This approach benefits men and women. One important lesson from this is the inter-dependence of women's and men's health status and the importance of situating men's health within the social determinants of health. Specific sub-groups of disadvantaged men experience significant health inequalities.
- Practitioners may not be aware of the barriers experienced by men regarding their health status and the impact of men's social roles regarding their health seeking behaviour. A key role needs to be played in health promotion and prevention of ill-health.
- The gender mainstreaming framework needs to focus on policy, planning and service delivery. The HSE should be required to draw up an action plan setting out goals and timeframes for implementation. Governance, accountability and monitoring will be key to the success of the framework. The implementation of the gender mainstreaming framework should be led by an implementation group.
- The National Women's Council of Ireland, the Centre for Men's Health (Carlow Institute of Technology), the Men's Development Network and the Men's Health Forum have a key role to play in the monitoring of the implementation of the gender mainstreaming framework.

3. Consultation workshop with HSE women's and men's health officers, 19 December 2011, Equality Authority, Dublin

The following summarises the main issues raised at the consultation workshop with the HSE's three women's health officers and the men's health officer:

- It is important to name the problem that is being addressed and set out the vision. The challenges faced by women and men in accessing health care need to be clearly articulated within the Gender Mainstreaming Framework.
- It needs to be recognised that gender mainstreaming is complex and is a long-term approach. If gender

mainstreaming is to be implemented in all HSE policies this would represent a huge step forward for the HSE.

- There is a lot of resistance to gender equality from men and from senior managers in the HSE; this is ideological and based on vested interests, the hegemonic patriarchal character of Irish society, the invisibility of gender inequalities, which results in denial that gender inequalities exist.
- Gender mainstreaming needs to be implemented by all managers and assistant managers in the HSE. There need to be champions in the HSE who have expertise and commitment to drive gender mainstreaming. For example, there could be one gender mainstreaming champion for each HSE region, who is linked into a national structure and who can then cascade expertise down to the local level.
- Training is needed for staff in gender awareness and in how to carry out gender mainstreaming in all Service Plans. Gender awareness training should address the beliefs, behaviours, attitudes and values held by managers and staff. Training in gender awareness also needs to be embedded in professional education and training at under-graduate and post-graduate levels.
- Existing gender mainstreaming initiatives by the government in Ireland have been limited in their scope, have paid lip service to gender equality and have been implemented in a piecemeal way. It is important to evaluate why these initiatives have not worked.
- It is essential that there is a strong policy and regulatory framework that cuts across government and that is embedded in the equality legislation as a positive equality duty. Without this it will be much harder to persuade senior decision-makers to implement gender mainstreaming as a priority and to have a vision for gender equality. An example of this is the HSE's work on domestic violence, which took 10 years to write into policy. Having a policy framework is essential to the HSE in implementing services that address domestic violence.
- There needs to be a clear focus on who will implement the framework and a designated senior manager responsible. The issue was raised that senior managers are men and it will be difficult to persuade them to take gender mainstreaming seriously, particularly in the light of cuts in the budget and to services.
- It can be very demoralising to put energy into a new policy framework if this is not implemented. There is a danger that gender mainstreaming will not be seen as a priority and its relevance poorly understood.
- There is an ideal opportunity to carry out a gender mainstreaming exercise of the new Public Health Policy.
- Gender mainstreaming can help to show the different effects of health interventions on women, men and transgender persons and there needs to be more awareness of the specific experiences of women, men and transgender

persons. For example, medication to reduce cholesterol may have an adverse effect on women who may lose bone density. There is very good learning from the Women's Health Councils work on gender mainstreaming in emergency cardiovascular care services. This type of approach needs to be taken for all services and in all plans for services.

4. Interviews with key informants

The following interviews were held with key informants from the HSE, DOHC and other organisations to inform the preparation of the Gender Mainstreaming Framework

- Diane Nurse (Assistant National Director, Social Inclusion)
- Rachel McEvoy and June Bolger (HSE Advocacy Unit)
- Caoimhe Gleeson (HSE Advocacy Unit)
- Michele Guerin, Equality Officer, Dublin NE
- Michael Shannon, Director of Nursing and Midwifery Services
- Noel Mulvihill, Assistant National Director for Older Persons Services
- Philip Crowley, National Director, Quality and Clinical Care
- Phil Garland, Assistant National Director, Children and Families
- Eilish Croke (Director of Nursing and Midwifery Planning and Development Unit, DML)
- Anne Gallen (Director of Nursing Midwifery Planning and Development, West) and members of the Nursing and Midwifery Planning and Development Directorate
- Martina Brennan (HSE Performance and Development Manager DNE)
- Brian Murphy, Assistant National Director for Primary Care
- Patrick O'Leary and Pauline Moreau, Gender Equality Unit, Department of Justice, Equality and Defence
- Mirian Daly, ICGP
- Geraldine Luddy and Alessandra Fantini, Department of Health and Children
- John Brehony, Workforce Planning, Human Resources Directorate
- Joanne Vance, Irish Cancer Society
- Maureen Mulvihill, Irish Heart Foundation
- Helen McAvoy, Institute of Public Health in Ireland

Summary of the key issues raised in interviews with key informants:

Gender mainstreaming as a new priority for the HSE

- Service managers and policy makers broadly welcomed the work being carried out to develop a framework on

gender mainstreaming for the HSE. Many expressed a lack of knowledge of gender mainstreaming and the processes involved in carrying out gender mainstreaming activities.

- Gender mainstreaming is seen to have significant relevance to improving the quality of services provided. However, there is limited awareness of how this could be progressed in the HSE.
- Gender mainstreaming is a goal set out in the National Women's Strategy and could point the way forward for other areas of government policy and services.

Data on gender inequalities in health

- Data gaps exist in many services and more attention needs to be given to collating and analysing disaggregated data.
- It is suggested that guidance on how to draw up relevant gender disaggregated data would be very useful.
- There should be a systematic approach to collecting gender based data and to ensuring that analyses of findings are systematically addressed in service developments and service plans.

Gender mainstreaming in the HSE workforce

- Although the HSE as an employer is committed to fully implementing equality legislation and promoting good practices on equality in human resources, there is a need to make this work more visible and to publish data on gender balance in the workforce.
- Although women represent the majority of nursing and midwifery staff they are under-represented in senior positions.
- Women have made good progress in recent years in reaching managerial positions in the HSE; the challenge will be to ensure that there are no barriers for women in gaining senior level positions.
- There is a need for further work to be carried out in the HSE to promote the sharing of work and family responsibilities through flexible working time policies and work-life balance. The male culture in the HSE works against work-life balance.
- A specific initiative should be carried out to undertake a gender equality impact assessment of the HSE workforce, including human resources policies, the under-representation of women in senior positions in the HSE, the gender pay gap and the undervaluing of women's care work.

Linking gender inequalities and the social determinants of health

- There is limited knowledge of the HSE Strategy on Health Inequalities and how it is being implemented. However, all informants welcomed the approach to integrate a gender analysis into a broad based approach to addressing inequalities in health and to address the social determinants of health.

- It is important that the HSE takes into account women's multiple roles and experiences of discrimination as social determinants of health.

Challenges raised by service managers and policy makers

- Challenges raised by service managers and policy makers include difficulties in persuading the HSE to prioritise gender mainstreaming at a time of budgetary cuts, a general lack of awareness of the benefits of gender mainstreaming amongst HSE staff and managers, difficulties in collating gender based data, difficulties in countering embedded values and stereotypes, the need to carry out gender mainstreaming within existing resources and to avoid possible tensions that may be raised by trade unions if staff are asked to carry out additional tasks.
- Some informants stated that there was limited appetite in the HSE for another strategy and several key decision-makers stated that a strategy would have limited currency in the present climate. However, practical guidelines on gender mainstreaming were seen as a way to develop awareness in specific projects and a way forward for the HSE.
- As a result the most commonly held view was that the outcome of the work should be a practical set of tools to help raise awareness and provide practical guidelines on how to implement gender mainstreaming, and that this should be implemented through a reallocation of resources at no extra cost to the HSE.
- A number of informants stated that a key challenge is to gain organisational commitment from the senior levels of the HSE, with targets built in to implement gender mainstreaming and the ongoing monitoring of implementation.

Recommendations to progress gender mainstreaming in health

- Specific recommendations include practical awareness raising activities and training for HSE staff, a practical gender mainstreaming toolkit and pilot projects in specific services. Suggestions for specific pilot projects include a gender analysis of primary care services, access to community based mental health services for women, men and transgender persons, gender disaggregated data on local mental health services, residential services for older people, older men's access to day services, health promotion targeted to women's and men's health, a gender analysis of addiction services and a specific assessment of the needs of women living in direct provision.
- There is a need for gender awareness to be built into the accredited and ongoing education and training of health care staff and progressed through professional bodies.
- The management of complaints within the HSE needs to take account of gender differences. There should be gender

disaggregation of complaints made by women, men and transgender persons and any specific trends of issues acted upon.

- Specific guidelines on providing gender sensitive services should be drawn up by professional and regulatory bodies through clinical guidelines and practice standards for health care professionals.
- The DOHC should be required to carry out a gender impact assessment of all new health care policies, prior to a policy being finalised.
- There is some useful learning from the WHC's work on gender mainstreaming, with specific projects and guidelines already drawn up on gender mainstreaming. There needs to be a commitment to ensure that all learning from pilot projects is mainstreamed throughout the health care system, that the issues are championed by senior management and embedded in strong policy commitments and a regulatory framework that commits the HSE to implement gender mainstreaming in full.

Appendix 3: Data sources on inequalities in health

There is a wide range of health data available in Ireland. However, not all data are broken down by sex and gender, and where this does occur the data is not always analysed as a basis for service improvements. The following is a selection of published data and shows some differences in health service utilisation and health status of women and men. The majority of this data concern biological health status.

Life expectancy and death rates

- Male life expectancy at birth in Ireland is now 76.8 years; female life expectancy at birth is 81.6 years (CSO 2011).
- Men have both a lower life expectancy and a lower number of healthy years at the age of 65 years, compared to women. Data for 2005-2007 shows male life expectancy at 65 years to be 18.7 years for men and 19.8 for women (CSO 2011).
- When life expectancy is expressed as years lived in good health (i.e. healthy life years), the difference between women and men is much less significant, indicating that women live longer but with more health problems (CSO 2011).
- The mortality rate due to accidents for men was more than twice that of women in 2009 (at 33 per 1,000 population) (CSO 2011).
- Regarding Traveller women's and men's death rates, Traveller men have a life expectancy 15 years less than the general population, and 10 years less for Traveller women. Female Travellers experience significantly higher rates of heart disease and stroke than male Travellers (337 males to every 100 in the general population, compared to 489 females to every 100 in the general population). Life expectancy is 61.7 years for men (compared to 76.8 in the general population) and 70.1 for females (compared to 81.6 years in the general population) (All Ireland Traveller Health Study 2011).
- The death rate is higher for men than women in all age groups. The biggest difference is in the 15-24 year age group where the male rate was more than three times that of the female rate (CSO 2011).

Health status

- Although higher numbers of men than women smoke (25.9% of men, 23.9% of women), there is evidence of increasing rates of smoking amongst younger women (SILC 2006).
- Two-thirds of treated alcohol cases are male. The proportion has decreased from 68.6% in 2005 to 64.8% in 2010.

- High proportions of men have low levels of employment and live in unstable accommodation (HRB, National Drug Treatment Programme 2010).
- Overall 1.8% of older Irish adults report a diagnosed history of alcohol or substance abuse. The rate is highest in men aged 65-74 years (3.9%) (Trinity College Dublin, TILDA database 2011).
- In 2007, 59% of males and 41% of females reported that they were either overweight or obese. This is an increase of 16% and 17% for males and females respectively between 1998 and 2007 (SLÁN 1998-2007).
- Men are more likely to report a BMI that is overweight or obese, compared to women. In 2007, 43% of men reported an overweight BMI and 16% an obese BMI, compared to 28% and 16% respectively for women. 63% of women reported a healthy BMI, compared to 40% of men (SLÁN 1998-2007).
- A higher proportion of women (44%) reported at least one health condition when compared with men (40%) (CSO, QNHS 2011).
- The prevalence of arthritis (osteo and rheumatoid) was higher in women (9%) than in men (5%) and also increases with age in both sexes. (CSO, QNHS 2011)
- Women, men and transgender persons have experienced differences in cardiovascular health, in diagnosis, treatment and health outcomes (WHC & IAEM 2007).

Mental health and well-being

- For both women and men the highest cause of admission was for depressive disorders (CSO 2010).
- Psychiatric hospital and unit admissions have gradually declined over the last decade and are now 17% lower than in 1999. However, the ratio of female to male admissions has continuously increased over the period, from 54.9% male admissions and 45.1% female admissions in 1999 to 49.7% male admissions and 45.1% female admissions in 2008 (data from Health Research Board and Mental Health Commission, cited by DOHC 2010).
- The rate of admission of men to psychiatric units for non-alcohol related drug disorders was nearly three times the rate for women in 2008. The male rate of admission for schizophrenia was nearly two-thirds higher than the female rate while the female rate of admission for depressive disorders was over one third higher than the male rate (CSO 2010).

- Rates of male deaths due to suicide stood at 17.5 per 100,000 population in 2008. The rate of female suicide was 5.4 in 2008 (Office for Suicide Prevention, Annual Report 2010).
- In 2003, the rate of deliberate self-harm for women was 241 per 100,000 and for men was 177 per 100,000 (Vision for Change, DOHC 2006).
- Positive feelings related to mental health are in equal proportions for women and men, with 80% feeling happy. However, 67% of men reported feeling calm or peaceful all or most of the time as compared with 59% of women. (CSO, QNHS 2011).
- When it comes to energy/vitality, 16% of women reported feeling worn out or tired all or most of the time compared with 10% of men. 65% of men reported having felt full of life compared with 59% of women. (CSO, QNHS 2011)

Disability

- Higher numbers of male adults and children (56.6%), registered on the HRB's Intellectual Disability Database in 2009, had a mild, moderate, profound or severe intellectual disability, as compared to 43.4% women. The number of males exceeded the number of females at all levels of intellectual disability, and in all age groups, except the 55-years-and-over age group. (HRB, National Intellectual Disability Database 2010).
- Higher numbers of males (52.9%), registered on the HRB's Physical and Sensory Disability database in 2010, had a physical or sensory disability in 2010, as compared to 47.1% of females. Of these, 35.8% of males were under 18 years of age and 24% were females under 18 years of age (HRB, National Physical and Sensory Disability Database 2011).

Hospital in-patient data

- Women report a higher percentage of attendance as hospital in-patients, day patients and out-patients than men (CSO, QNHS Quarter 3, 2011).
- Of the eight in every ten patient stays that were in public hospitals, men were more likely to have an in-patient stay in a private hospital, compared to women.
- Women stayed an average of 10.0 nights (excluding childbirth) as compared with 8.9 for men (CSO, QNHS Quarter 3, 2011).

Acute hospital sex-specific discharge data

- More than half of total hospital discharges (53.8%) in 2009 were female (HIPE 2010). Overall discharges from acute hospital care in 2009 represented 293.8 per 1,000 population for men, and 338.5 per 1,000 population for women (CSO 2010).
- A higher proportion of males were discharged as day patients than females (63.2% and 53.8% respectively). Women have a higher utilisation of acute in-patient hospital services. The discharge rate for acute female in-patient

discharges of 154.0 per 1,000 was 48.8% greater than for males, which stood at 103.5 per 1,000 in 2010. The use of obstetric services by females in the 15-44 year age group largely accounts for the different patterns of utilisation by women and men (HIPE 2010).

- The average length of stay for acute in-patient discharges was more than half a day longer for males (4.9 days) compared to females (4.2 days). Average length of stay for extended stay in-patients was over two days longer for females compared to males (66.0 days and 63.9 days respectively) (HIPE 2010).

Difference in diagnosis and health conditions

- Differences exist in the principal diagnoses reported for women and men (not taking into account obstetric and gynecological diagnoses). Male principal discharges were 72.4% of those related to 'mental and behavioural disorders due to alcohol'. Similarly, there were a higher proportion of male discharges for 'other ischaemic heart disease' and 'other injuries to the head (including skull fracture)'. Conversely, 'fracture of femur' was more common among female discharges (HIPE 2010).
- Male discharges were higher in the categories of dialysis, injury and poisoning, circulatory diseases, whereas female discharges were higher in the categories of genitourinary diseases, diseases of the nervous system and sense organs and neoplasms in 2009 (CSO 2010).
- Women are more likely to report a chronic health illnesses or health problem (23.3% of men and 26.8% of women in 2008), which represents an increase in reported ill health for women since 2006 (SILC 2008).
- Over 52% of men and 55% of women aged 65 and over reported suffering from a chronic illness or condition, while 42.7% and 47.3% of males and females respectively reported some limitation in activity due to health problems in this age group (SILC 2008).

Self-reported health and well-being

- Women were less likely to report very good or good health status, compared to men, with 14.3% of men and 16.8% of women reporting fair, bad or very bad health. The proportions of women and men reporting very good or good health were slightly higher for men than women (SILC 2008).
- Slightly higher numbers of men experienced significant limitations in activity due to health problems, whereas a higher proportion of women experienced some limitations in activity, compared to men. Overall, men were less likely to have limitations in activity caused by health problems, 81.4% men, compared to 79.6% female (SILC 2008).

Consultation with a GP

- Men were less likely to have consulted with a GP than women, with 34% of men having no GP consultation in the previous twelve months, compared with 19% for women. The average number of consultations by men was 2.5, while for women this was 3.8 consultations (CSO, QNHS 2011).
- In all age groups a higher proportion of women consulted with a GP than men, and this was particularly evident among younger age groups. For example, 54% of 18-24 year old men reported that they had consulted with a GP in the previous twelve months and they averaged 1.3 consultations in this period compared with 77% of women who averaged 3.4 consultations (CSO, QNHS 2011).

Medical card and health insurance

- In 2011, 37.9% of women had a medical card, compared to 34.1% of men (CSO 2011).
- Overall, more men rely solely on general public health cover than women, with 26% of men not having either a medical card or private health insurance, compared with 19% of women (QNHS, Quarter 3, 2011).
- More women than men had medical cards only, 33% as compared with 26% of men. The proportions of both men and women with medical cards have increased from 2007 to 2010 (24% to 31% for males and 34% to 41% for females) (QNHS, Quarter 3, 2011).
- More men than women have private insurance (47.9% of men and 46.4% of women respectively (SILC 2006).

Carers in Ireland

- Data from the Census shows that there were 50,139 persons in receipt of Carer's Allowance or Carer's Benefit in 2009, a number that has trebled since 1999. Four-fifths of recipients were women in 2009 (CSO, QNHS 3rd Quarter 2010).
- Women Carer's were more likely to be in full-time care roles and have a lower participation in the labour market than men (representing 73.2% labour force participation for men and 52.8% for women (CSO, QNHS 3rd Quarter 2010).
- The Irish Time-Use Survey found that women spend a greater amount of time, compared to men, on caring responsibilities (Cullen *et al* 2004).

Gender breakdown of employees in the Irish health service

- In 2010, four out of five employees in the Irish health service were women (CSO 2010).
- Women (excluding home helps) were in the majority in most grades within the health service, accounting for 91.8% of nurses, 85.2% of managers and administrators, and 83.5% of health and social care professionals. However, in the Medical/Dental category women were in the minority, accounting for just over a third of medical and dental consultants (CSO 2010).

The following data sources were used in carrying out this overview of data on gender inequalities in health:

Department of Health and Children (2010) Key Health Trends
http://www.dohc.ie/statistics/key_trends/

Department of Health and Children (2008) Health Statistics
http://www.dohc.ie/statistics/health_statistics_2008.html

National Cancer Registry
http://www.ncri.ie/data.cgi/client/generate_stats.php

HRB (2011) Irish Psychiatric Units and Hospitals Census 2006
http://www.hrb.ie/uploads/tx_hrbpublications/Census_2010_Bulletin.pdf

http://www.hrb.ie/uploads/tx_hrbpublications/HRB_Statistics_Series_12_-_Irish_Psychiatric_Units_and_Hospitals_Census_2010_Web_Version.pdf

WISDOM Mental Health Information System

<http://www.hrb.ie/health-information-in-house-research/mental-health/information-systems/wisdom/>

HRB Nation Drug-Related Deaths Index (NDRDI)

HRB National Drug Treatment Reporting System (NDTRS)

HRB National Drug Treatment Reporting System (NDTRS)

HRB National Drug Related Death Index (NRDI)

National Psychiatric In-patient Reporting System (NPIRS)

HRB National Community Care Database

HRB National Intellectual Disability Database

HRB National Physical and Sensory Disability Database

CSO (2009) Survey on Income and Living Conditions
<http://www.cso.ie/releasespublications/documents/silc/current/silc.pdf>

Health Protection Surveillance Centre

Hospital In-Patient Enquiry (HIPE)
http://www.esri.ie/health_information/latest_hipe_nprs_reports/2009_hipe_report/index.xml

Survey of Lifestyle, Attitudes and Nutrition in Ireland (SLÁN)
<http://www.slano6.ie/>

National Perinatal Reporting System, Economic and Social Research Institute (ESRI)
http://www.esri.ie/health_information/nprs/

CSO, QNHS 3rd Quarter 2010

CSO, QNHS 2011

Appendix 4: International and European obligations on gender mainstreaming and the right to health

United Nations - Beijing Platform for Action

Ireland has signed up to the Platform for Action agreed at the 1995 Beijing Conference on women, the main provisions of which have been incorporated into the Government's National Women's Strategy. The Beijing Platform for Action states that:

Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. (para 89)

Gender mainstreaming was first recognised as a strategy for tackling gender equality at the Fourth World Conference on Women in Beijing in 1995. The resulting Beijing Platform for Action introduced, for the first time, the requirement that all States Parties establish gender mainstreaming in order to promote a gender perspective in all legislation and policies in promoting gender equality. It also established the requirement for gender-disaggregated data to reflect the problems and issues related to women and men in society. On this basis governments are required to:

Seek to ensure that before policy decisions are taken, an analysis of their impact on women and men, respectively, is carried out (para 204).

The Beijing Platform for Action specified that gender mainstreaming be incorporated into both 'operational' mainstreaming, which concerns the gender mainstreaming of policies and programmes, and 'institutional mainstreaming', which concerns the structures for formulating, implementing and monitoring gender mainstreaming. The commitments on health under the Beijing Platform for Action include the requirement to design and implement gender-sensitive health programmes that take account of women's multiple roles and responsibilities, in cooperation with community-based women's organisations. Specific actions are also included to combat discrimination against women in access to health care on the basis that "women's health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate medical services to women".

Gender mainstreaming was defined in 1997 by the United Nations Economic and Social Council as follows:

Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or

programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate aim is to achieve gender equality.'

In progressing gender mainstreaming the United Nations has also developed a range of gender mainstreaming tools for use by governments and within the United Nations System (United Nations 2002 and 2010). Since 1995 gender mainstreaming has been adopted and reinforced by other international organisations.

Convention on the Elimination of Discrimination Against Women

As a signatory to the UN Convention on the Elimination of Discrimination Against Women (CEDAW) since 1985 Ireland is committed to implementing the wide ranging gender equality provisions, including Article 12 on health, which requires that:

States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

International Covenant on Economic, Social and Cultural Rights

The International Covenant on Economic Social and Cultural Rights (ICESCR) promotes the right to health within a social determinants framework and advocates that a gender perspective be introduced in health.

The United Nations (UN) has a mechanism to monitor how states comply with their obligations, as well as enabling redress for violations of rights:

- In 2011 the Irish government produced its draft report on progress in meeting the provisions under ICESCR, under its third periodic report to ICESCR (Department of Foreign Affairs 2011). The Women's Human Rights Alliance has produced a report on Women's Right to Health, on the basis of extensive consultations with women across Ireland (WHRA 2010). It highlights key issues of gender inequalities arising from a two-tier health care system and the specific experiences of women living in disadvantaged communities.

- Ireland's international human rights obligations were also reviewed in 2011 under the UN Universal Periodic Review (UPR), which highlighted the importance of progressing equality in health. A stakeholder group of NGOs submitted a report to the UPR in 2011 highlighting key issues of equality, access to universal health care and the need for the full implementation of health care policies, particularly in primary care and mental health, while also taking into account poverty and disadvantage on women's and men's health (ICCL 2011).⁶

World Health Organisation (WHO)

The WHO views mainstreaming gender in health as the most effective strategy for achieving gender equity and in ensuring that women and men achieve the highest health status. The specific goal of gender mainstreaming in health has been operationalised by the World Health Organisation in its Gender Policy (2002a). This specifies that gender mainstreaming in health research, policies and programmes should contribute to better health outcomes, and equity and equality for women and men across the lifecourse. Gender mainstreaming, as a strategy for achieving gender equity, is reinforced by the WHO Mainstreaming Gender Equity in Health, Madrid Statement (WHO 2002b). This sets out four pre-requisites for gender mainstreaming:

- Government commitment to gender mainstreaming health policies at all levels.
- Allocation of financial and human resources to implement gender-sensitive measures where evidence of gender disparities exist.
- A gender dimension should be made transparent in all public health policies and programmes.
- Develop structures for coordinating and implementing bodies across all sectors.

"To achieve the highest standard of health, health policies have to recognize that women, men and transgender persons, owing to their biological differences and their gender roles, have different needs, obstacles and opportunities".

"Mainstreaming gender in health is both a political and a technical process, which requires shifts in organizational cultures and ways of thinking, as well as in the goals, structures and resource allocations of international agencies, governments and nongovernmental organizations".

World Health Organisation *Mainstreaming Gender Equity in Health*, Madrid Statement, 2002

The WHO's Gender, Women and Health Department has produced a number of tools on gender mainstreaming, on the collection of sex-disaggregated data for policy makers, guidance

on integrating gender into health research on tuberculosis, mental health and lung cancer, a WHO Gender Manual for Addressing Gender Differences and Discrimination in Health Institutions and actions on women's health in relation to mental health, gender based violence, tobacco use, occupational health and the health impact of care work (WHO 2005 and 2008). More recently a focus has been given to the health of boys and men (WHO 2010).

Council of Europe

The Council of Europe (2008) recommends that gender should be a priority area for government action in the development of health policies and strategies, in promoting gender equality across the health care system, including health promotion and disease prevention, and improving access and quality of health services that relate to the different needs and situations of women, men and transgender persons. It is further recommended that a prerequisite for gender sensitive knowledge and evidence-based interventions is the requirement for sex-disaggregated data, and the monitoring and reporting of progress and outcomes.

European Union gender equality policy

A European Union gender mainstreaming policy framework has been in place since the mid 1990s. The European Commission's most recent gender equality strategy, the *Strategy for Gender Equality 2010-2014*, stresses the importance of gender mainstreaming as a core objective of gender equality policy. The Strategy refers to the importance of assessing the differential health risks faced by women, men and transgender persons, and marks the first time that gender in relation to mainstream health care policy has been addressed at EU level. Specific actions include drawing up a Men's Health report and a Women's Health report. The annex to the Strategy highlights specific actions that Member States should consider including, to "Promote health and gender impact assessment of policies and programmes", and to:

Promote gender mainstreaming in health policies in line with the EU's Health Strategy and initiatives linked to the health strand of the social Open Method of Coordination, as well as the 2009 Communication on Health Inequalities, notably in the EU quality framework for social and health services, HIV/AIDS, tobacco and cancer. (2010: 13)

Gender equality issues in health are also relevant within the context of the EU's public health strategy *Together for Health: A Strategic Approach for the EU, 2008 -2013* which highlights the importance of the social determinants of health and provides a framework for how health can be integrated into all EU policies, and in the current five year Strategy for Safety and Health at Work 2007-2012, *Improving quality and productivity at work: Community strategy 2007-2012* on health and safety at work, in relation to occupational safety and health.

⁶ The report is available from the ICCL web site, which also documents the UPR process

Appendix 5: Existing policy frameworks on gender mainstreaming in Ireland

a) Commitments to gender mainstreaming

The National Women's Strategy and gender mainstreaming health

The current National Development Plan (2007-2016) refers to gender mainstreaming in the context of the National Women's Strategy (2007-2016). In relation to health this states that:

In line with policy development generally, at international and national level, the emphasis today is on the incorporation of a gender perspective into mainstream health policy and the implementation of positive action measures to ensure that the health of women in this country is promoted and protected.

The vision of the National Women's Strategy's 2007-2016 is of "an Ireland where all women enjoy equality with men and can achieve their full potential, while enjoying a safe and fulfilling life" (DJELR 2006). The Strategy makes specific reference to certain groups of women, including Traveller women, migrant women, women with a disability, women living in rural areas, and lesbian & bisexual women.

In relation to health the National Women's Strategy has a commitment to "improve the health status of women in Ireland through gender focused policies" (Objective 8). It makes a commitment to incorporate a gender dimension into health policy planning at the earliest possible stage and to ensure ongoing development of health services structures, including representation of women at all decision-making levels. A further commitment is made to put in place health policies and services that allow women full access (e.g. transport, childcare/elder care privacy) and health policies and services to support carers such as respite, counselling, information, financial security. Further commitments refer to; improving women's physical health through improving cancer screening and services for women including the national provision of Breastcheck and cervical screening and to reduce the numbers of women dying from cardiovascular disease.

Men's Health Policy

In 2008 a Men's Health Policy 2008-2013 was launched by the DOHC. The policy recognises the specific and underlying social context of men's health and was drawn up in consultation with a broad cross-section of organisations, men's groups and individual men in Ireland. The policy uses a gendered approach to men's

health "in the context of culturally defined masculine and feminine traits that are deemed to be socially acceptable to the sexes" and "that typically reflect wider cultural and institutional masculine ideologies". It also stresses that there are multiple masculinities, reflecting different health issues between different groups of men. The policy adopts a relational approach to gender in addressing policy and service delivery measures that are equitable for both men and women:

"A 'gender mainstreaming' approach recognises that gender equality is best achieved through the integration of men's and women's health concerns in the development, implementation and evaluation of policies, both within and beyond health. A relational approach to gender also enables an exploration of patterns of difference as well as similarity between men and not just a focus on differences between men and women."

The policy stresses the importance of viewing men's health in the broader context of gender and the wider socio-cultural context of men's lives in areas such as social class, education, age, employment status, race, ethnicity, sexual orientation and disability. In particular, it recognises that there is a diversity of health experiences across different groups of men that can best be understood within a wider set of social determinants of health approach. It recommends that men's health can best be advanced through a community development and health promotion approach that seeks to promote inter-sectoral engagement, that approaches men's health from a perspective that is positive and holistic, and that enables men to be active agents and advocates of their own health.

Previous gender mainstreaming frameworks and activities

There are a number of existing frameworks that provide an important context for gender mainstreaming in health:

- Gender mainstreaming was an integral part of the National Development Plan (2000-2006), where the Gender Equality Unit at the time carried out a range of specific actions, including training for civil servants, information and awareness raising activities and a *Gender Proofing Handbook* produced with six County Development Boards in Ireland (Crawley & O'Meara 2002, McGauran 2005), and a framework for gender budgeting based on a gender-based analysis of the budgetary process (Barry, Pillinger and Quinn 2005).

- The Department of Justice, Equality and Defence participated in an EU gender mainstreaming project in 2010. This led to the drawing up of a draft report, *Implementing Gender Mainstreaming: Guidance Document for Government Departments*. The aim of the guide is to provide an information resource for government departments about gender mainstreaming. The guidelines are currently in a draft form and will be further progressed in 2012.
- The Equality Authority has also been involved in developing tools and methods for equality proofing, for example, an *Equality Proofing Template for City and County Development Boards*. In addition there is ongoing work on equality mainstreaming for education, labour market and training providers, progressed through the Equality Mainstreaming Unit. A specific tool has been developed for public sector organisations for embedding equality into their services through a systematic framework for equality. *The Equality Benefit Tool; Your Service Users and You: Realising the Benefits for the Public Sector* (2011) sets out the rationale for equality and provides nine specific equality tools for organisations.
- Extensive work has been carried out by the former Women's Health Council on gender mainstreaming. This has included specific initiatives on integrating a gender-sensitive health service (Women's Health Council 2007a), in integrating a gender perspective into cardiovascular health and mental health (Women's Health Council 2007b and 2007c), and in the assessment of acute coronary syndrome in Emergency Departments (Women's Health Council undated). These provide learning for an important evidence base that can be applied to the HSE's Gender Mainstreaming Framework.

b) Gender as a ground in the equality legislation and application in a health context

The Equal Status Acts 2000-2011 and the Employment Equality Acts 1998-2011 outlaw discrimination in service delivery and employment. Gender is one of the nine 'equality grounds' covered in the legislation (gender, civil status, family status, sexual orientation, religion, race, age, disability, and membership of the Traveller community). The gender ground refers to a man, a woman or a transsexual/transgender person.⁷ This means that equality in the health care system, in employment and in the provision of services is a fundamental right for everyone.

In particular, the Equal Status Acts prohibit, with exemptions, discrimination, sexual harassment, and victimisation across the nine grounds in the provision of goods and services, accommodation and education. They allow positive action to promote equality of opportunity for disadvantaged persons and

to cater for special needs. This applies to people who buy and sell goods and services, use or provide services, including, health, and services (subject to certain exemptions), obtain or dispose of accommodation and attend or are in charge of educational establishments. Health service organisations are permitted to provide preferential treatment or to take positive measures that are genuinely intended to promote equality of opportunity for those who are disadvantaged. They may also provide preferential treatment or take positive measures that cater for the special needs of those who may require facilities, arrangements, services or assistance. The Acts also allow people to be treated differently on any of the nine grounds in relation to the use of premises/accommodation for religious purposes, refuges, nursing homes, retirement homes, homes for persons with a disability or hostels for homeless persons or for a similar purpose, or in the treatment of non- Irish nationals.

Equality in health has been an important element of the Equality Authority's work in health care in recent years, and was a core objective of the Equality Authority's strategic plan in 2005-6. A guide 'Equal Status in Health 2000 and 2004 and Provision of Health Services' was produced by the Equality Authority in 2005 and provides guidance to health policy makers and service providers on how to implement equal status policies and practices. The approach to equality in health, across the nine 'equality' grounds, requires that there is equality in access to resources, to the valuing of diversity, to having a say in decision making and to relationships of respect for women, men and transgender persons.

A number of *Equal Status Reviews* have been carried out to assess the role of health service providers in meeting the goals of equality across the nine grounds, and to put in place equality proofing of services. The framework for these reviews and a template for equality proofing in health was established under the first review carried out in partnership with the Equality Authority, the Department of Justice Equality and Law Reform and the HSE in the North-West in 2005 (Equality Authority 2005). This review also recommended that specific policies on gender mainstreaming be integrated into the equality proofing process in order to draw out the specific issues related to gender. As mentioned above, equality proofing has also been progressed through an initiative to equality proof City and County Development Plans and activities.

⁷ The European Court of Justice in *P v S* (C-13/94) held that discrimination against a transsexual person constituted discrimination on the ground of sex.

Appendix 6: Irish health care policy and gender relevance

The following is a brief overview of health care policies that have gender relevance. HSE policy requires that services take account of the role of patients/service users, their families and representative organisations in assessing needs and designing, delivering and evaluating health and social care services, in promoting patient-centred care and improving the quality of health and social care services (HSE 2010). HSE principles underpin high quality including equity and “...care that respects your culture, beliefs, values and other characteristics such as your age and gender, sexual orientation, faith, political belief or disability in line with clinical decision making” (HSE 2010:2).

The HSE also has developed a focus on health inequalities. The HSE Corporate Plan 2008-2011 states “We will reduce health inequalities by adopting population health approach to health improvement and delivery of health services” (2008:23). This includes the development and implementation of a health inequalities framework (see below), the collection and analysis of socioeconomic data on service users to improve the targeting of health resources with the aim of reducing health inequalities.

Quality and Fairness, a Health System for You (DOHC 2001)

The Health Strategy acknowledges the need to reduce health inequalities on the basis that inequalities arise because of gender, age and ethnicity and socio-economic status. The strategy highlights the need to integrate equality into health care on the basis of the increasing diversity of Irish society. Equity is one of the four principles underpinning Quality and Fairness. Equity refers to the provision of services that are fair and result in equality of outcomes. It makes provision for the development of a gender equality policy in the health system and a policy for managing diversity in the workplace.

“Inequalities in health can exist for a variety of reasons, including geographical location, gender, age, ethnicity, hereditary factors and socio-economic status. Poverty, unemployment, education, access to health services and environmental factors including housing and water quality, all play important roles in determining the health of individuals. Disparities in health status within the population lead to consideration of the links between socio-economic factors and health. There are clear occupational class gradients in mortality”.

Quality and Fairness: A Health System for You (Department of Health and Children 2001:31)

National Strategy for Service User Involvement in the Irish Health Service 2008-13 (DOHC & HSE, 2008)

The National Strategy for Service User Involvement is based on the principle that “the service user should be central to their own care and to the design and delivery of health and personal social services”. The strategy marks a significant development for the HSE and DOHC, which has the potential to be further refined in relation to gender equality and gender mainstreaming. The strategy acknowledges that:

Involvement must be based on inclusion, diversity and equity – health services must engage socially excluded groups including those who are socio-economically disadvantaged, ethnic minorities and Travellers, people with disabilities, lesbian, gay, bisexual and transgendered people, children, young people and older people and users of mental health services (2008:11).

Vision for Change: Report of the Expert Group on Mental Health Policy (DOHC 2006)

Vision for Change is a vitally important policy in relation to women’s and men’s mental health. It highlights the risk factors associated with “socio-economic stresses, suicide or violence within the family, anxieties about gender and sexuality, same-sex attraction, incarceration in custody, and homelessness” (2006: 160). It shows that there are significant gender differences in suicide, self-harm, in-patient care and depressive disorders. On the basis of the positive framework presented for mental health, there is significant scope for integrating a gender perspective into the monitoring and reporting on the implementation of the policy, including data collection.

HSE Population Health Strategy (HSE 2008)

A commitment to reduce inequalities in health is contained in the HSE’s Population Health Strategy, which states that “A Population Health approach is one which promotes and protects the health of the whole population or sub-groups, with particular emphasis on reducing health inequalities” (HSE 2008:3).

HSE Corporate Plan (HSE 2008)

The HSE Corporate Plan 2008-2011 states “We will reduce health inequalities by adopting a population health approach to health improvement and delivery of health services” (2008:23).

A Public Health Policy Framework for a Healthier Ireland 2012-2020 for Health Promotion

A new public health strategy is to be launched in 2012. At the time of writing a consultation process for the strategy: *A Public Health Policy Framework for a Healthier Ireland 2012-2020* for

Health Promotion was underway. This represents an ideal opportunity for gender to be integrated into the final drafting of the strategy, through a gender proofing exercise of the document. As the NWCI (2011) stated in their submission there is a need for a universal health care system that provides for equality of access to public health services for women and men and for “A public health policy that has a gender perspective embedded in it with proper resource allocation to ensure delivery on targets related to women’s health”. An example of the gender mainstreaming of the new public health policy in Sweden is discussed below.

The Public Health Policy Framework will build on the social determinants of health approach that underpins the HSE *Population Health Strategy*. The strategy aims to “Maintain and improve the health of the entire population and to reduce inequalities in health status between population groups” (HSE, 2008b:2). It was progressed under the National Health Promotion Strategy 2000-2005, which focused on the link between health promotion and the determinants of health, while also highlighting the importance of inter-sectoral and multi-disciplinary approaches. The strategy also refers to poverty as a key determinant of health, the importance of poverty proofing and for the specific health needs of men, women, children and older people to be met.

HSE Health Inequalities Framework 2010-2012

The HSE Health Inequalities Framework 2010-2012 aims to improve and promote a comprehensive approach to reducing health inequalities within a population health approach.

This Gender Mainstreaming Framework has been drawn up as a key element of the implementation of the HSE’s Health Inequalities Framework 2010-2012, which sets out the HSE’s commitment to addressing health inequalities through a population health approach through a commitment “...to maintain and improve the health of the entire population and to reduce inequalities in health status between population groups” (HSE 2010: 2). The HSE Health Inequalities Framework 2010-2012 aims to improve and promote a comprehensive approach to reducing health inequalities within a population health approach. Specific actions are set out for health care services, health care management, clinicians and professionals across each of the nine priority areas in the Population Health Strategy. Gender is one of the target groups set out in the framework. The framework is currently being implemented by the HSE and includes a health inequalities audit in demonstration sites in Primary Care Teams and hospitals.

Specific actions are set out for health care services, health care management, clinicians and professionals across each of the nine priority areas in the Population Health Strategy:

- Addressing the wider determinants of health and tackling health inequalities.
- Planning for health and social well-being and not just health and social care services.

- Developing and employing reliable evidence to improve health and social care outcomes.
- Making choices for health investment.
- Measuring and demonstrating the return for investment in health and social care services.
- Shifting the balance from hospital to primary care and health promotion.
- Integrating services across the continuum of care.
- Proactively engaging and working with other sectors to improve health.
- Engaging the population on the issue of their own health.

Primary Care Strategy - A New Direction (DOHC 2001)

The ongoing development and roll-out of Primary Care Teams under the national primary care strategy: *Primary Care Strategy - A New Direction 2001* is very important to the development of gender focussed services, particularly since the strategy envisages that people will access up to 95% of the care they need within their local community. This includes promotion of health and screening for disease, assessment, diagnosis, treatment and rehabilitation, personal social services and work with communities and individuals to improve their health and social well-being. Community participation is now embedded into the roll-out and development of Primary Care Teams across the country and this will be important to addressing gender inequalities. Although many factors that reproduced gender health inequalities are outside of the health care system, the HSE has a commitment to work with local communities and statutory and voluntary agencies in order to reduce health inequalities in a primary care context (HSE 2010). Community participation in primary care is one example where there has been a tangible impact on the focus and impact of primary care teams in addressing inequalities in health in disadvantaged communities (HSE & DSP 2011).

Social Inclusion

In the area of Social Inclusion there is an important connection between social inclusion target groups and initiatives on gender inequalities in health.⁸ A core objective of the Social Inclusion Care Group is to develop and promote a mainstreaming approach to the delivery of services for groups such as asylum seekers, Travellers, LGBT people and homeless people, so that mainstream service providers can be better equipped to provide services to groups that experience marginalisation. The *National Traveller Health Strategy 2002-2005* has highlighted the central role of women’s health to improving access to health services with a focus on the broader determinants of health. Similarly the *National Intercultural Strategy in Health 2007-2012* (HSE 2007) has shown the specific issues faced by minority ethnic and migrant women and men.

⁸ The Social Inclusion Care Group provides the following services: drug and alcohol services, homeless services, services for minority ethnic communities, Traveller health services, community development, HSE RAPID and CLAR programmes, HIV / STI services, services for LGBT communities, and Community Welfare Services.

Appendix 7: Examples of different approaches to gender mainstreaming in health: Sweden, Canada, England, Scotland, Wales and Northern Ireland

Sweden

Gender mainstreaming was first implemented in Sweden in 1994 and is one of the best examples of a broad-based societal approach and strong political leadership. There is a stated political objective to remove the structural inequalities that lead to gender inequalities and unequal power relations between women and men. All statistics have to be disaggregated by sex and all government policies have to integrate a gender perspective, including health research. A systematic approach to gender mainstreaming has led to tools such as the 3-R method for analysing gender differences in health, which assesses difference in Representation, differences in Resources and Reasons for differences in women's and men's health. This method has been used by other European countries and also incorporated into the European Commission's own guidelines on gender mainstreaming.

All government policy proposals have to be analysed and discussed from a gender perspective and the gender impact has to be described. The aim is that gender impact analysis will become a routine part of policy making at all levels. In local government the JAMKOM project has introduced gender mainstreaming and a gender perspective in local policy processes. Gender mainstreaming training courses for public officials has been an important part of the implementation of gender mainstreaming.

The Swedish public health policy (2003) is an example of how gender can be effectively integrated into a public health strategy. Gender is presented as a cross-cutting category that is linked to reducing inequalities across indicators on socio-economic status, ethnicity and geography (Östlin and Diderichsen 2010). A wide-ranging consultative process took place involving health professionals and policy makers, women's and men's organisations, community organisations, trade unions and employers.

Canada

In 2009 the Canadian government adopted a strategy for 'Sex and Gender-based Analysis (SGBA)'.⁹ The SGBA is an analytical method for assessing and analysing health research, policies and programmes to uncover the biological and gender based

differences between women and men. The objective is that SGBA is also applied to other broader determinants of health (notably age, ethnicity, socio-economic status, disability, sexual orientation, migration status, geography etc.) in order to identify exposure to health risks, ill-health and health outcomes. SGBA has resulted in a better knowledge base of the health needs of specific groups of women and men, for example, in relation to cardiovascular risk factors. SGBA builds on the government's *Gender Based Analysis Policy*, introduced in 2000, a substantial number of federal and provincial reports on women's health, and a longstanding commitment in population health to addressing socio-economic inequalities in health. The Bureau for Women's Health is currently drawing up a set of indicators to assess women's inequalities in health on access to, quality and outcomes of health care. The indicators will take account of gender and diversity in order to monitor changes in women's health status.

A gender analysis of the Canadian Federal Mental Health and Addictions Policy is a good example of how sex and gender can be integrated into mental health policy (Salmon *et al* 2006). The analysis addresses mental health/ illness and substance use/ addictions for both women and men in Canada. It argues that the intersection of sex and gender with other forms of social difference (e.g., race, ethnicity, socioeconomic status, sexual orientation, and ability) should be integrated into research programmes and policy responses on mental health and addictions. It highlights how and why an examination of sex differences and gender influences is a crucial component to any policy work in mental health, illness and substance use, and addictions. This has had implications for the provision of gender-specific care, mental health promotion and prevention. The analysis also shows that gendered factors such as poverty, housing, caregiving, stress and coping, trauma and pregnancy need to be taken into account in the development of service responses, assessment and diagnosis, treatment services and mental health promotion and illness prevention.

England, Scotland and Wales

In the UK the government first adopted gender mainstreaming as its gender policy in 1998 (Cabinet Office 1998) and since then has been developing a series of policy instruments to implement this policy, first through a Gender Equality Duty and more recently through an Equality duty. Gender is now one

⁹ Available from Health Canada <http://www.hc-sc.gc.ca/hl-vs/gender-genre/analys/gender-sexes-eng.php>

dimension of the broader equalities framework in the UK. In the UK the 'equality duty' has been important in requiring a gender perspective to be integrated into the development of policy, planning and service delivery.

This has built on the introduction of the Gender Equality Duty (GED), introduced in 2007. The GED represented a significant change to gender equality legislation and effectively made gender mainstreaming legally enforceable, by requiring the public authorities to build gender equality into all of their activities. It builds on over a decade and a half of work on gender mainstreaming and gender budgeting in the UK. The introduction of a GED on public bodies represented a substantial shift in emphasis towards a proactive approach to gender equality.

The Equality Act, 2010, further developed the government's approach to equality by implementing a simplified, integrated and cross-cutting legislative framework in relation to anti-discrimination and the promotion of equality, positive action in recruitment and promotion and a public sector Equality Duty. The implementation of the Act has resulted in guidance material and the development, by the Equality and Human Rights Commission (EHRC), of Codes of Practice on employment, services and equal pay. On 5 April 2011 the new public sector Equality Duty came into force. It replaced the Race Duty, Disability Duty and Gender Duty and extended the law to cover age, sexual orientation, religion or belief, pregnancy and maternity, and gender reassignment.

The Equality Duty applies to England, Scotland and in Wales. Separate provisions exist for Northern Ireland, under Section 75 of the Northern Ireland Act, which place similar equality duties on public bodies. The general Equality Duty, set out in section 149 of the Equality Act, covers unlawful discrimination, harassment and victimisation and provides for equality of opportunity between different groups. It requires public bodies to consider and implement policies and provisions to meet the needs of all individuals, in relation to policy, service provision and in relation to employees.

All health care organisations involved in delivering and commissioning care are required to draw up equality plans to meet the goals of the duty. Gender disaggregated data on health is now more systematically provided on measures of health, rather than health need or gendered experiences of care (Payne 2011, Alkire *et al* 2009). The Equality and Human Rights Commission has drawn up health indicators that have a gender equality focus on self-reported health status and treatment, covering limiting illness, disability and mental health, subjective evaluation of current health status, and dignity and respect in health treatment (Alkire *et al* 2009).

Other guidance on implementing the Gender Equality Duty, as part of the 'Fair for All' policy, has been produced by the NHS in Scotland (NHS Scotland & Fitzgerald 2008, NHS Scotland 2009). In England and Wales Sectoral Guidance for England:

Health, was produced by the former Equality Opportunities Commission (2007). These guidance documents were valid until April 2011 and have been replaced by new guidance on the public sector equality duty. This requires public authorities to draw up equality schemes and carry out impact assessments that pay 'due regard' to the equality duty in decision making and that identify methods avoiding any adverse impact on one group.

Northern Ireland

The Northern Ireland Gender Equality Strategy 2006-2016 (Office of the First Minister and Deputy First Minister 2006) contains actions for tackling gender equalities, including a commitment to use gender mainstreaming and specific positive actions in implementing the strategy.¹⁰ Under the strategy two cross-departmental equality action plans have been drawn up, one for women and one for men.¹¹ These define departmental objectives, anticipated outcomes and performance targets set by departments.

Specific legal duties to promote equality, human rights and good relations exist under Section 75 of the Northern Ireland Act 1998 and the Human Rights Act 1998 (covering age, disability, racial group, religious belief, political opinion, gender, sexual orientation, marital status, having or not having dependants).

Under Section 75 of the Northern Ireland Act 1998, public authorities are required to implement equality mainstreaming and carry out an equality screening exercise in order to determine if a proposed strategy and action plan creates any unintentional or adverse impacts on equality and the promotion of equality of opportunity. If this is determined to be the case, a full equality impact assessment is required. A key role of the Department of Health, Social Services and Public Safety is to support the development of equality initiatives in health, and through this, tackle the underlying determinants of health inequalities, including the achievement of targets to reduce health inequalities and to provide equitable access to Health and Social Care services. Equality impact assessments are required to cover strategy and policy developments, legislation, spending plans, service design and service delivery. The overriding objective is to ensure that equality and human rights are integrated into all health care functions.

In April 2010 the Equality Commission for Northern Ireland (ECNI) published new guidance for public authorities on the implementation of Section 75 of the Northern Ireland Act 1998.¹² The guidance recommended that public authorities include within their equality scheme: "...a commitment to develop action measures/action plans which detail how they will undertake the promotion of equality of opportunity for the nine equality categories and good relations for the three good relations

¹⁰ Northern Ireland Gender Equality Strategy
<http://www.genderequalityni.gov.uk/>

¹¹ See http://www.ofmdfmi.gov.uk/implementation_of_the_ges_progress_report_2006-09_-_action_plan-3.pdf

¹² <http://www.equalityni.org/archive/word/S75GuideforPublicAuthoritiesApril2010.doc>

categories.” It is recommended that in drawing up action plans, public authorities should carry out an audit of inequalities and develop action measures based on inequalities identified. It is recommended that the audit of inequalities be drawn up on the basis of information from research and consultations with stakeholders, as well as an audit of internal data on user feedback and complaints about the relevant public authority or body. Eighteen themes were identified for consideration.¹³ Specifically in relation to health, an Inequalities Monitoring system has been drawn up on the basis of key indicators that are monitored on morbidity, utilisation and access to Health and Social Care services in Northern Ireland.

An example of this is the recent report: *A Section 75 Analysis of Mortality Patterns in Northern Ireland 2003-2007* (Department of Health, Social Services and Public Safety 2012) established under the Health and Social Care Inequalities Monitoring System. The report provides baseline data on mortality across different equality groups that can be monitored and expanded over time.

The Northern Ireland Department of Health, Social Services and Public Safety (2008) *Equality, Good Relations and Human Rights Strategy and Action Plan* states that mainstreaming equality and human rights leads to informed policy making, greater transparency, better decision-making and a culture of equality and human rights by “helping policy makers and those at the front line delivering Health and Social Care services to consider the needs of different communities and groups and to assess how decisions, policies and practices impact upon their lives” (2008: 28). Many of the actions contained in the plan are designed to make the best use of available resources and are implemented through existing resources.

¹³ The themes are: information and communications; awareness of cultural/religious needs; staff attitudes; elder care; needs of carers; teenage pregnancy; reproductive health; sexual health; domestic violence; sexual violence and abuse; mortality rates; suicide rates; mental health; smoking; drug; alcohol and substance abuse; service delivery and access; obesity; equality screening; research and complaints.
[http://www.equalityni.org/archive/pdf/Keyinequalities\(F\)1107.pdf](http://www.equalityni.org/archive/pdf/Keyinequalities(F)1107.pdf)

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