Women's Health in Ireland:

Meeting International Standards

National Women's Council of Ireland

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foreword

While gender affects the health of both men and women, there are significant health consequences of discrimination against women in nearly every society. Poverty, unequal power relations between women and men, and unequal access to resources, are powerful barriers to women in achieving, and maintaining, optimal levels of health.

The NWCI considers the health of women in Ireland from a feminist perspective, highlighting the relationships between women's unequal status in society, their access to resources, and the health care that they receive. This is a most opportune time to address policy on women's health in Ireland, in the light of the forthcoming National Women's Strategy and the new Social Partnership Agreement 2006-2016.

The National Women's Strategy represents the Irish Government's international commitment made in Beijing in 1995 to produce a national plan for women. In signing the Beijing Platform for Action, the Government gives, among other commitments, explicit recognition and reaffirmation of the right of all women to control all aspects of their health, to ensure equal access to, and equal treatment of women and men, in health care and to enhance women's sexual and reproductive health.

The Social Partnership Agreement 2006 – 2016 adopts a life cycle approach to equality and social justice. Social Partnership offers opportunities to promote equitable access to a well-functioning health care system, which will be in the interests of everyone. We are seeking the achievement of a vision of health where all women are enabled to reach and maintain optimal levels of health across their life cycle.

The National Women's Council of Ireland has produced this paper on women's health in order to influence policy and offer ways forward in developing a health service that meets the interests and needs of women in Ireland. The policy outcome we are aiming for is a national women's health action plan and a gender perspective reflected in all health policies and programmes.

The National Women's Council of Ireland advocates a rights-based approach to women's health, by which we mean services based on the individual's right to dignity, respect and self-determination. A rights based approach includes the availability, accessibility and affordability of services to meet people's needs; access to information provided in a confidential setting, and appropriate technologies and resources necessary for women to make their own decisions and choices regarding their health throughout their lifetimes. We have adopted an international framework of human rights to inform health policy that addresses women's needs; we have drawn on standards set by the World Health Organisation, as well as the rights set out in the Beijing Platform for Action and the Convention on the Elimination of All forms of Discrimination against Women.

It is our intention that this policy paper will stimulate dialogue between policy makers, health professionals and women's groups and organisations in the development of health policy, in the interests of all women in Ireland.

Dr. Joanna McMinn, Director

26 July 2006

4 executive summary

The NWCI has prepared this position paper addressing women's health in Ireland to highlight the impact of inequality on women's health status, on their experience of health, and on health care delivery. The paper demonstrates the relationships between women's health, gender equality, and the current social and economic context in which women live. The overarching purpose of the paper is to influence policy and offer ways forward in developing a health service that meets the interests and needs of women.

The paper sets out a framework of international human rights conventions together with the principles of the World Health Organization, from which a model for women's health policy and services could be developed in Ireland. Assessing current Irish health policies in light of these international standards, the paper argues that the Irish health system does not adequately address or consider women's health from an equality perspective.

The paper aims to provide a clear policy framework for women's health, grounded in international human rights standards, from which objectives and goals can be identified to achieve a vision of health where all women are enabled to reach and maintain optimal levels of health across their lifecycle.

Drawing on this policy framework, the NWCI proposes the adoption of international standards in women's health as the strategic goals for a new National Plan for Women's Health, and makes recommendations for taking this Plan forward.

Rationale

Given the Irish Government's commitment to a National Women's Strategy, and its reaffirmation of the Beijing Platform for Action in 2005, the NWCI considers it both timely and opportune to address the issue of the health of women in Ireland from a feminist perspective, highlighting the relationships between women's unequal status in society. Their access to resources, and the health care that they receive.

While women's position in Irish society has undoubtedly improved, their unequal status in society persists. Women are still seriously under-represented in the political system, are still disadvantaged in the labour market, and still carry the main responsibility for unpaid care work. Fundamental inequalities between men and women in Ireland also pervade every aspect of our health system, including decision-making at senior level, service delivery and policy development. Men hold the majority of key decision-making positions at Government department level, in hospitals and on regional authorities. 'The services of health are highly gender segregated in their design and delivery. The top specialists posts in hospitals, including obstetrics and gynaecology are held predominantly by men; by contrast, the nursing profession, except for Mental Health, is predominantly female' (Conroy 2001:13).

The different experiences of health among women and men are not reflected in general health policy, and specific mention of women is most often confined to women-only illnesses. The differences in the impact of social determinants on men and women are not made explicit; instead there is an assumption of a generic consequence on people, which is predominantly the impact on men. This approach has failed to recognise the structural inequalities between women and men in Irish society and the experience of multiple discrimination and inequality for many women. Recognition that women have less access to economic resources and power must form the basis of any analysis of women's health and must be incorporated into the design and delivery of health policy and provision.

The roles and responsibilities ascribed to women by a patriarchal society, together with women's differential access to resources and opportunities are important determinants of their health. Women are more likely than men to be poor, to parent alone, to earn low wages, to be reliant on public transport, to be at risk of sexual violence and to be in poorly protected employment. Race, social class, culture and ethnic identity, income poverty, location and access to social and health services, sexual orientation, age and other differences can all contribute to the vulnerability of

women's lives and consequently to the status of their health and well-being. These factors have significant consequences for the effectiveness and efficiency of health policy and health care.

Rights and International Standards

Health and health care play key roles in women's equality. Ireland's international human rights commitments and commitments to EU policy require gender to be considered as a factor that influences the structures and services of health care.

An approach to health that takes gender and international commitments into account means integrating human rights standards and principles in the design, implementation, monitoring and evaluation of health-based policies and programmes.

A human rights approach to health offers guidance on the legal and programmatic responses within national health policy to ensure compliance with international standards. This approach includes:

- An acknowledgement of the significance of the determinants of health and the interdependence of health and other human rights
- The adoption of policies designed to eliminate poverty among women and the inclusion of a gender perspective in all policies and programmes affecting women's health
- A recognition of the need for universal access to high-quality and affordable health care appropriate to women's diverse needs
- The need for a national strategy to promote women's right to health throughout their lifecycle with specific policies, indicators and benchmarks on women's health backed by high-level institutional mechanisms to monitor its implementation
- The need to engage with women's organisations in decision-making and planning in relation to health and to resource their engagement
- The importance of gender-inclusive data, gender-sensitive research, and training on gender equality for health service personnel

International human rights instruments and standards thus provide a valuable framework in which to consider national policy and programme responses to women's health in Ireland.

Review of Current Policies

In less than a decade there have been significant institutional and policy changes across the health sector in Ireland, including the production of a number of new health policy documents. Though there is growing recognition of the impact of inequality on health in Ireland and elsewhere, a review of the main health policy and strategy documents in Ireland reveals little evidence of gender analysis or action on women's health beyond the focus on reproduction, maternity health and conditions specific to or more prevalent in women. The case studies from Canada and Australia included in this paper demonstrate how other countries have adopted international human rights standards in their national health policies. The NWCI believes that the development of Irish health policy looking specifically at women's health would benefit substantially from adopting a similar approach.

A Framework for Women's Health

Given the changes and developments in health policy and health service delivery that have taken place and are planned over the coming years, the NWCI considers that urgent attention needs to be given to how to address women's health needs into the future from a women's equality perspective. The NWCI aspires to a vision of women's health in Ireland where:

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All women are enabled to reach and maintain optimal levels of health across their life cycle.

This requires a health service based on the following principles:

1. Equality and human rights
2. Recognition of the social determinants of women's health
3. Provision of an integrated and adequately resourced public health system
4. Proactive promotion of social inclusion among the most excluded groups
5. Participation by all groups of women in decision-making at all levels
6. Recognition of women as a diverse health population with particular health needs
7. Investment in research to bridge knowledge gaps and inform policy

These principles should underpin the development of a women's health plan that meets international standards, contains timeframes and targets, and identifies resources for implementation.

Recommendations

The NWCI recommends that this paper be examined by the Oireachtas Committee on Women's Affairs, the Department of Health and Children, the Health Service Executive, the Health Information and Quality Authority and the Health Research Board. The recommendations of the paper should also be incorporated into the National Women's Strategy.

1. A Women's Health Plan which clearly meets the commitments in the Convention to Eliminate Discrimination Against Women (CEDAW) and the Beijing Platform for Action (BPFA)
2. The development of a five-year gender-equitable Women's Health Plan as a mechanism to orient health policy towards gender equality outcomes This Plan should be backed by an adequately resourced infrastructure in which women's organisations play a key role
3. Integration of the social determinants of women's health into all policy and programme development so as to effectively address the health impact of sustained inequality on women
4. Development of an accessible, coherent, integrated public health system, which is proactive and sensitive to women's health needs and adopts a holistic approach that includes disease prevention and reduction, health promotion, and access to primary and secondary care across the life cycle when required
5. Maximising the participation of all women in policy development, programme planning and service delivery, including targeting groups of women who have traditionally been excluded and those with the least resources to participate
6. Adoption of a population health approach to women's health that is women-centred, acknowledges that women comprise a diverse health population and recognises the impact of discrimination as a determinant of health
7. Investment in research to bridge knowledge gaps and inform policy
8. Implementation of gender mainstreaming strategies

chapter 1

Introduction

EQUALITY
CHOICE
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chapter one

1.1 Introduction

Health is popularly perceived as being largely determined by a person's genetic heritage, sex and personal behaviour. However, increasing attention at national, EU and international level is being given to other social determinants of health, with clear evidence that gendered social and structural inequalities are significant determinants of women's health.

The last decade has seen significant developments in the arena of Irish health policy, health care and health service delivery. The NWCI considers it both timely and opportune to address the issue of the health of women in Ireland from a feminist perspective that recognises the relationships between women's unequal status in society, their access to resources, and the health care that they receive. This document will draw attention to women's health and equality within the Irish health sector, and provide arguments and proposals to influence change in the way women's health, health policy and health care, are perceived and addressed.

1.2 Purpose of this Position Paper

The Paper aims to provide the NWCI and its affiliate organisations with **an analysis of women's health**, from which to develop a strategy of equality for women in accessing and using health services. The NWCI vision is for a health system where all women are enabled to reach and maintain optimal levels of health across their life cycle.

The purpose of the document is:

- to highlight how the inequality of women's position affects their health status, experience of health and health care; and
- to demonstrate the relationship between women's ill-health and the social and economic context in which they live

1.3 The NWCI – its approach and its work to date on women's health

The NWCI has a long track record in addressing women's health concerns. The organisation played a key role in facilitating an 18 month-long consultation with women throughout Ireland contributing to *A Plan for Women's Health 1977–1999* produced by the Department of Health (1997). An extensive research initiative, the Millennium Project, undertaken by the NWCI between 1999 and 2001 revealed that promises made in the Plan had not resulted in change for women. The Millennium Report (NWCI, 2001) identified health as 'an issue of human rights for women', drew attention to the continued emphasis on an outdated bio-medical approach to health, and critiqued the 'paternalistic relationship' between the woman client and the service provider. In conclusion, the NWCI (2001: 28–29) called for:

- Greater consultation with women about the health services and their provision, and inter-departmental and agency links on women's health
- Research on the effectiveness of current service provision in meeting women's health needs, in particular the funding of women's groups to identify the health issues of different groups of women, including older women, Traveller women, lesbians, ethnic minority women, women with disabilities, women living in poverty and refugee and asylum-seeking women
- Training of health care providers on gender and diversity
- Client participation in decision-making about their health needs
- Reform and expansion of services for carers
- Better information on health and women's health issues
- Free and accessible childcare so that women can attend to their own health needs (NWCI, 2001: 28–29)

The NWCI's *Strategic Work Plan 2002–2005* identified health

as a key area for the achievement of women's 'Social and Cultural Equality'. It included the objective of developing a policy and women's health strategy that aimed to eliminate discrimination against women in the field of health care and ensure equality of access to health care facilities and services, including those related to family planning.

1.4 The 'In From The Margin' Project (2002-2004)

From 2002 to 2004, the NWCI In From the Margin (IFM) project focused explicitly on understanding and addressing women's poverty and marginalisation in order to bring about change for those who need it most. The report concluded;

It is impossible to be committed to gender equality without having a clear and unambiguous commitment to eliminating poverty and marginalisation. An urgent need exists for the voices of marginalised women to be heard and addressed by policy makers and service providers. The sidelining and silencing has meant that political, social and economic development in Ireland does not adequately respond to their needs or prioritise their rights. (NWCI, 2004:6)

In its report on the IFM initiative, *Women Creating Change*, the NWCI described the impact of women's gender roles, gender-based violence and poverty on their health. It identified the following areas of critical concern to women and their health:

1. Lack of money	2. Poor and inappropriate accommodation
3. Racism	4. Lack of affordable childcare
5. The negative impact of unsupported care work	6. The recognition of health as a human right.
7. Lack of locally-based services and access to transport	8. The need for better health information, promotion and prevention services
9. Increased choice and access to reproductive health services	10. Culturally appropriate health care and information
11. The need for an equitable universal health care system	12. Education and training for health service staff and policy makers
13. More research into women's health status and more sex-disaggregated health data	14. Participatory approaches to health, including in the planning and delivery of health care
	15. The negative effects of marginalisation on mental health

The report concluded that addressing women's health inequalities requires a focus on the underlying causes and effects of sexism, poverty and discrimination. Specifically, it called for gender mainstreaming and the participation of women who need change most in health service planning and policy. It also highlighted the need for targeted community development and primary health care projects for effective health care planning and delivery.

The In From the Margin project marked a significant development in the NWCI's understanding of and approach to women's health. Subsequently, the NWCI adopted the World Health Organization (WHO) definition of health as '[a] dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity'. The NWCI decided to approach health from a determinants perspective, drawing on the work of WHO (1978) and the Public Health Alliance of Ireland (2004) that identified a range of social and economic determinants of health, and highlighted the different consequences of sex and gender on women's health.

1.5 Outline of this Position Paper

Chapter 2 provides a feminist analysis of gender inequality and explores the social determinants of health that particularly impact on women's health status and on their experience of health and health care. We argue that women's unequal status in society has a critical impact on their health.

Chapter 3 sets out and discusses the human rights conventions that directly address women's right to health and the World Health Organization principles that must inform national policies on health. We provide an overview of developments in an international human rights context and argue for their relevance for national approaches to addressing women's health.

Chapter 4 assesses Irish health policies in light of international standards, with case studies from Canada and Australia that demonstrate how other countries have adopted these standards in their national health policies. We provide an analysis of health policies in Ireland from a women's equality perspective and conclude that a renewed commitment to women's health set within best practice internationally is required.

Chapter 5 sets out a proposed framework for a National Plan for Women's Health in Ireland, based on international standards, and outlines strategic objectives and actions to be a focus of resources over the next 10 years.

chapter 2

Women, equality and health

EQUALITY
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chapter two

2.1 Introduction

People's health depends on many factors, not just on whether they are male or female, or on behavioural factors such as whether they smoke or not. Women's social status and the inequalities they may experience also impact on their health. For example, women are statistically more likely than men to be poor, to parent alone, to earn low wages, to be reliant on public transport, to be at risk of sexual violence and to be in poorly protected employment, all of which negatively impact on their health. In addition, differences in women's identities and circumstances also have significant health implications, particularly if they experience poverty. Our argument is that, while women's health is influenced by sex, lifestyle and risk factors, it is also socially determined by women's experience of inequality and multiple discriminations.

2.2 How inequality influences health

Poverty and inequality are strongly linked to levels of ill-health and death rates (Black, 1980; Acheson, 1998). Even in the most affluent countries, people who are less well off have substantially shorter life expectancies and more illnesses than those who are wealthy. It is widely recognised that, globally, societies with higher levels of inequality have lower average standards of health and shorter life expectancy (Wilkinson, 2005).

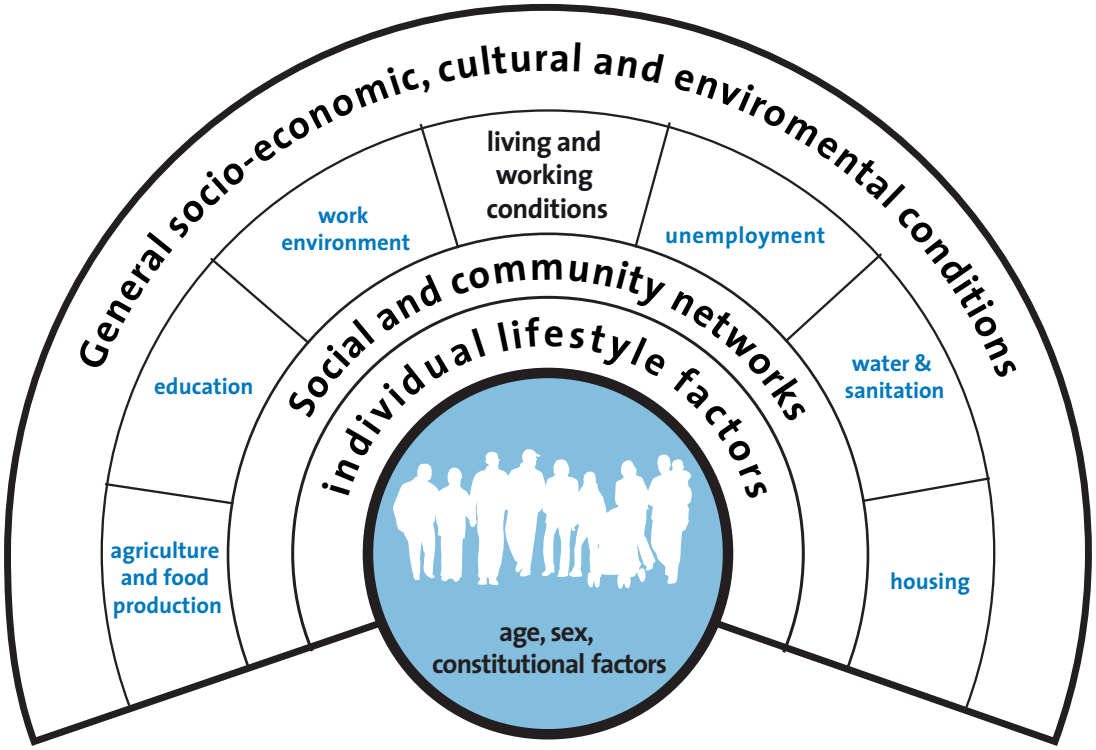
How inequality affects health becomes clearer if we look at the major determinants of health. These are the economic, social, political and environmental factors that influence levels of health in a society and the incidence of disease (morbidity), disability and death (mortality). The World Health Organization, in a recent publication, focused on the following ten areas as determinants of health (WHO, 2003):

● The social gradient	● Stress
● Early life	● Social exclusion
● Work	● Unemployment
● Social support	● Addiction
● Food	● Transport

Furthermore, studies have shown that health is also highly dependent on the quality of social relations in society – on how cohesive a society is, the degree to which people trust each other and the extent to which they get involved in community life (Institute of Public Health in Ireland, 2003).

Societies with higher levels of income inequality have social relationships that are more conflictual and show higher levels of mistrust, more racism, more violent crime and more homicide (Wilkinson, 2005).

Figure 2.1 Model describing the social determinants of health



2.2.1 Definitions

The term *health inequality* has been used to define differences in health that are unnecessary, avoidable, unjust or unfair (Whitehead, 1990). Inequities in health put groups of people who are already disadvantaged at further disadvantage, as health is essential to well-being and to overcoming other effects of social disadvantage. Focusing on *equality in health* means looking at the distribution of resources in society; it means seeking to eliminate systematic disparities in health for different social groups (Braveman, 2004: 180–185) and to achieve fairness and justice in health (Braveman *et al.*, 2000: 232–4).

Women in Ireland clearly experience a range of health inequalities, which are compounded by social exclusion. The following provide some examples, ranging from women's capacity to improve their health status, the impact of poverty on women's health and the type and level of services available.

- Lack of income was cited as the major barrier to improving health by the participants in the 'In From The Margin' project
- Unemployed women have been found to be more than twice as likely to give birth to low-birth-weight babies than those in higher professional groups (Barry *et al*, 2001)
- Women on low incomes who qualify for medical cards have a higher rate of colposcopy treatment for abnormal cervical smear test results (DWWC, 2004)
- Women from more deprived areas are less likely to undergo surgery for colorectal cancer and have lower survival rates than those from more affluent areas (NCRI and WHC, 2006)
- Women from lower socio-economic groups have a higher incidence of cardiovascular disease, the major cause of death among Irish women (WHC, 2003)

- Women experiencing a heart attack are more likely than men to be misdiagnosed and less likely than men to be referred to a specialist (WHC and DoH&C, 2004)

- Women undertake the majority of unpaid care work, which can have a negative impact on their mental and physical health, in that it can lead to exhaustion, depression, headache, injury and greater vulnerability to illness generally (National Coordinating Group on Women And Health Care Reform, 2002)

2.3 Women, sex, gender and health

Historically, women's health has been defined in health literature and policy largely in terms of the female reproductive system, or in terms of those diseases which are either specific to or most common in women, such as osteoporosis or breast cancer. The biological features of sex can explain important differences in men's and women's health. Research over the last fifteen years has resulted in a large body of evidence on sex differences at many levels (Wizemann and Pardue, 2001). For example, there is growing evidence of differences between women and men in the incidence, symptoms and prognosis of disease (for example, HIV/AIDS and cardiovascular disease) and it is now known that women and men metabolise some drugs differently, and in some instances, such as cardiovascular episodes, are treated differently.

However, the historical prevalence of the male-as-norm as the standard in medical research and in health care has meant that women's experience of disease and health has been often denied and ignored. This has two implications for women and their health. First, the outcomes of research on health and disease can be considered only partial in the sense of being applicable to only part of the population; and second, research on women's health has largely concentrated on the reproductive system, resulting in an approach that tends to view menstruation and childbirth, for example, as medical problems.

The World Health Organization's seminal work on gender and health in 1998 identified gender as a critical lens through which to look at women's health. It described how gender influences health status and health care and argued that, for women, health policies needed to move beyond merely meeting women's medical health needs and towards addressing women's equality and challenging existing gender roles and stereotypes (WHO, 1998). It has been suggested that social structural and psychosocial determinants of health have a greater effect on women, while behavioural determinants have a greater effect on men (Denton, *et al.*, 2003: 2585–2600). This and other research has contributed greatly to a better understanding of how sex and gender interact and how gender inequality shapes the individual and collective health of women. Moss (2002) developed a framework for an integrated approach to women's health based on the recognition that the causes of health differences among women are rooted in the economic, political, historical and social contexts that impact on women's lives.

In the economic context, for example, the goal of economic competitiveness can take precedence over considerations of women's equality, making wage restraint, and subsequently low pay, a cornerstone of wage policy. Because women form the majority of those working for the minimum wage, they are at greater risk of poverty and economic disadvantage, which has serious negative consequences for their health. Historically, the status of women in Ireland as defined in the Irish Constitution places them in a subordinate position. This has reinforced women's roles as the primary care workers and has limited their access to economic independence. This impacts on women's participation in all aspects of society – the labour market, decision-making and political life, and civil society. Women's under-representation in political decision-making means that their experiences and perceptions are less likely to be taken into account, their concerns are given lower priority and, consequently, there is a lack of appropriate action by the State.

2.4 The implications of inequality for the determinants of women's health

Table 2.1 outlines how women's unequal status in society can impact on each of the recognised determinants of health

Table 2.1 Health determinants

Health determinant	The impact of inequality
Income and social status	Poverty has a significant negative impact on health status. Women remain the majority of those at risk of and experiencing poverty and form the majority of the two groups most at risk of poverty – lone parents and older people (Central Statistics Office, 2005). The social welfare system is based on a male breadwinner model, treats women as adult dependants and does not fully recognise parenting or care responsibilities. Women on lower incomes and from lower social class backgrounds are more likely to take prescribed medication to cope with everyday life.
Education	It is now widely accepted that lack of education has a negative impact on health. Older women are at a marked disadvantage in this regard. For women who wish to return to informal or formal education, care responsibilities and prohibitive costs are significant barriers to access and participation. Women with lower levels of education are less likely to be knowledgeable about preventative health practices, such as attending ante-natal classes or having smear tests and breast exams (Wiley and Merriman, 1996).
Employment and working conditions	The gender pay gap in Ireland is 14%. While paid employment has a positive effect on women's health, women's work patterns can place them at a health risk. More women work part-time and women predominate in lower-level and less-well-paid work. Discrimination in recruitment and promotion persists, as does sexual harassment in the workplace. Women predominantly perform work within the home, yet the home is not regarded as a workplace under health and safety regulations (Östlin, 2000) or under employment protection regulations (Migrants Rights Centre Ireland, 2004). For women on work permits who may be earning very low wages, or are undocumented, accessing health care can be very problematic and prohibitively expensive (Migrants Rights Centre Ireland, 2004:30). For migrant women workers, poverty, geographical mobility, cultural and language problems and racism can play a role in limiting access to services (EHMA, 2004: 40).
Accommodation and housing	The affordability of and access to housing for women are strongly affected by their income and status in society. Furthermore, the design and location of housing and accommodation, together with the availability of services, can significantly affect women's control over their health. Homelessness among women often derives from their experience of violence within the home, and many women remain in violent relationships because they have nowhere else to go (O'Connor and Wilson, 2004).
Healthy child development	The healthy development of girls includes protecting them from sexual violence, sexually transmitted diseases and unwanted pregnancies; building their self-esteem and fostering their participation in sports and recreation. It means ensuring good ante-natal care, safe childbirth, post-partum care and family planning for women. It also requires good, comprehensive social and economic protection for mothers and access to affordable and accessible childcare (WHO, 2001).

Social environment	The values and norms of a society influence the health and well-being of its people and communities. Racism, prejudice, homophobia, crime and fear of crime can limit the freedom of women and girls to participate in society and avail of opportunities to fulfil their potential as human beings.
Social support networks	Support from families, friends and communities is positively associated with better health. Because women do most of the caring work in society, they can be at risk of social isolation. Whether in the home, in the community or in the workplace, the work of caring is largely invisible, often underpaid or unpaid, and hugely undervalued (WHC, 2005a).
Physical environment	Good health requires access to good quality air, water and food and freedom from exposure to pollutants. It also requires a healthy built environment with access to transport and communications. Women's access to and use of these differs from that of men. Lack of public and private transport can contribute to time poverty and lack of access to health services, particularly in rural areas, and can act as a barrier to accessing further education, training, employment, health care and social services.
Culture and identity	Dominant cultural values largely determine the social and economic environment of communities and how public services are delivered. For minority ethnic women, accessing services that do not recognise diversity can be stressful, difficult and unsatisfactory, contributing to the denigration and denial of their identity and leading to further exclusion.
Health care and service delivery	Women may experience different diagnosis and treatment depending on a number of factors, including socio-economic status, age and geographical location. Living in a rural area has been shown to have a negative impact on women's health, deriving from having to travel distances to access services and the variation in the level and nature of services between the regions.
Violence against women	Violence against women is a major barrier to their equality and can have a devastating impact on their health. In Ireland, the *Sexual Abuse and Violence in Ireland* (SAVI) report found that 42% of women had experienced some form of sexual violence in their lifetime, 24.4% as adults (McGee *et al.*, 2002). While the cost of the pain and suffering to the women affected is inestimable, one UK publication estimates at £1.4 billion in health care costs alone (Department of Health, 2005).

2.5 The implications of women's diversity for health

Women are not a homogenous group. Their different identities and circumstances have implications both for their health and for the responses of health care policy and provision. Difference can become a disadvantage when the prevailing model of health and health care treats all women as equal and ignores the implications of difference –for women's access to services, for example. The following table explores women's diverse identities with regard to health.

Table 2.2 Implications of diversity for health.

Women are different	Health implications
Age	**Older women:** Women live longer than men and their unequal access to economic resources means that they are at greater risk of dependency, isolation and poverty as they age. Older women are more likely to experience chronic and disabling illness. They are at risk of abuse, including financial exploitation. Older women are at a higher risk of developing cancer and, in Ireland, are much less likely to receive treatment than younger women (NCR and WHC 2006). **Young Women:** 90% of people with anorexia are women, which commonly occurs among adolescent girls and young women in their early twenties, while bulimia occurs predominantly among women between the ages of 15 and 25 years. (Bodywhys)
Family status/marital status	Research has shown that family demands have a greater impact on the health and health-related behaviours of women than they do on men. Despite women's increasing participation in the workplace, they still undertake the majority of work associated with running the household and caring for others. Lone parents are particularly disadvantaged, reporting poorer health than other women (Lahelma *et al.*, 2002: 727–740). Thus, the absence of supports for child and family care responsibilities can contribute to women's ill-health.
Race and ethnicity	The significance of race and ethnicity in relation to disparities in women's health has only recently begun to receive sustained attention. Evidence from the US and the UK has shown that, though socio-economic inequality can account for a sizeable proportion of the health disadvantage experienced by both men and women in ethnic minorities, gender inequality in health remains after adjusting for socio-economic characteristics (Cooper, 2002: 693–706).
Religion	Ethical issues about the delivery of holistic care for women have arisen when religious organisations have been involved in the delivery of health care, particularly in family planning and reproductive health care (Hess *et al.*, 2001).
Disability	Women with disabilities may experience additional barriers when trying to access basic health services and thus may be more vulnerable to inequalities in health (WHC, 2002b). Women with disabilities are often assumed by health professionals to be asexual and may be considered not to have reproductive health or fertility health needs. They can also be assumed to be unhealthy, though disability is not necessarily due to chronic disease. Having a disability is also equated with a higher risk of poverty (CSO, 2005) and of violence (CRIAW, 2001).

Sexual orientation	Evidence has shown that some lesbians may experience discrimination in health care (O'Hanlon, 2004: 227–234). Research has shown that lesbians are less likely to receive regular pap smears to test for cervical cancer because doctors incorrectly assume that they are not at risk of sexually transmitted disease. Systemic homophobia, stigmatisation and marginalisation negatively impact on the health of lesbians and bisexual women, who may, as a result be at disproportionately higher risk for behaviours that endanger their health, such as substance abuse and obesity (Health Canada, 1999).
Membership of the Traveller community	Traveller women live approximately 12 years less than settled women and their life expectancy is now that of the general population of the 1940s (Pavee Point, 2005). They are particularly disadvantaged in terms of access to health services. As primary carers for their families, they are the main negotiator with service providers and thus are more exposed to experiencing direct and indirect discrimination (National Traveller Women's Forum and Pavee Point, 2002). Their access to and information on preventative health care are poor and their uptake of such care is low. In addition, poor living conditions contribute to physical and mental ill-health (National Traveller Women's Forum and Pavee Point, 2002).

2.6 Conclusion

The purpose of this chapter was to look at health from a determinants and equality perspective and describe how inequality affects women's health. The unequal status of women, critically affecting their health status, we have argued, originates from structural gender inequalities, their different access to resources, and different vulnerability to adverse social forces. It is important to recognise the implications of women's diversity in understanding what affects their health; as identified in this chapter, age, disability and a range of other factors interact in different and often negative ways in women's experience of health and access to health services. It is clear that health policy and health care must approach health from a women's equality perspective if the needs of women are to be met in a manner that takes respectful cognisance of the reality of their lives. It is widely recognised that a human rights approach to health recognises inequalities between men and women and provides strategies for addressing gender inequalities in health.

chapter 3

Human rights approaches to women's health

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chapter 3

1.1 Introduction

Human rights law guarantees human rights, protecting people and groups against actions that interfere with fundamental freedoms and human dignity. It encompasses what are known as civil, cultural, economic, political and social rights and is principally concerned with the relationship between the individual (or groups) and the state. Human rights are described and contained in treaties or conventions, declarations, charters and other legal instruments.

3.2 A Human Rights Approach

The central elements of a *human rights approach* can be described in the following principles:

- All programmes and policies should further the realisation of human rights
- Human rights standards and principles should guide all development programming in all sectors and in all phases of the programming process
- Programmes should contribute to the development of the capacity of States (duty-bearers) to meet their obligations and of people and groups (rights-holders) to claim their rights

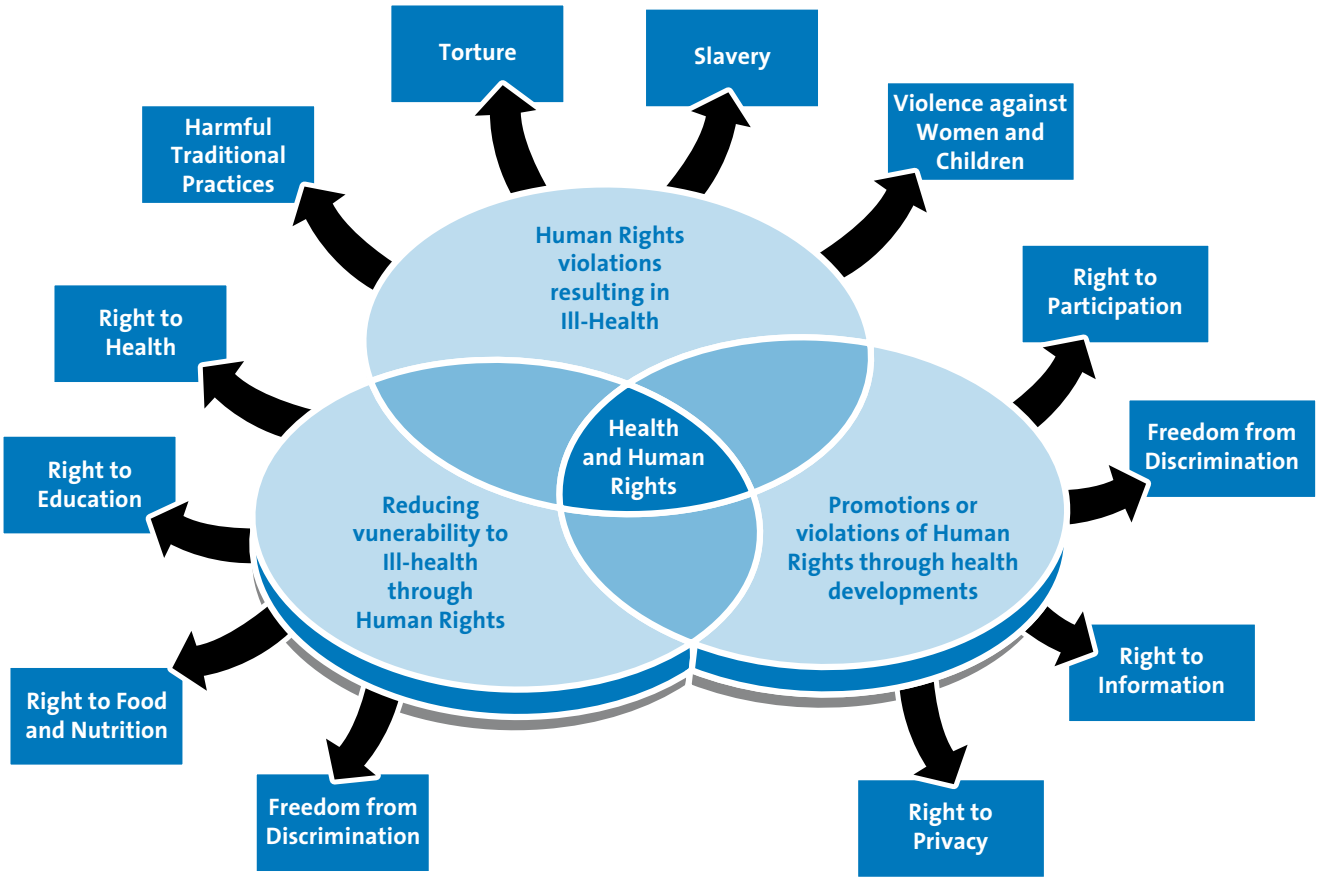
A rights-based approach to health means integrating human rights norms and principles into the design, implementation, monitoring and evaluation of health-based policies and programmes.

Central to this approach is the right of all stakeholders to participate in the design and implementation of any policy affecting them. Policies and programmes based on human rights approaches seek to address the immediate, underlying and structural causes behind the non-realisation of human rights, as well as ensuring that the most vulnerable groups in society, including the poorest, are targeted (WHO, 2005). The right to the highest attainable standard of health (the 'right to health') is contained or endorsed in numerous international and regional human rights instruments (Braveman, 2004). There are several ways in which human rights and health are linked, as outlined in Figure. 3.1. overleaf

For example:

- Vulnerability and the impact of ill-health can be reduced by taking steps to respect, protect and fulfil human rights (such as the right to education, the right to shelter and so on)
- Health policies and programmes can promote or violate human rights in the ways they are designed or implemented
- Violations or neglect of human rights can have serious health consequences (such as violence against women and children)

Figure 3.1 Examples of the linkages between health and human rights



Source: Human Rights, Health & Poverty Reduction Strategies WHO (2005)

3.3 Human Rights Instruments

The Irish Government has signed up to a range of human rights instruments, which contain clear commitments on the right to health. Strategies for achieving and implementing the right to health are also identified in some of the instruments.

3.3.1 International Covenant on Economic, Social and Cultural RightsArticle 12 (UN, 1966) and General Comment No. 14 on the Right to Health (CESCR, 2000)

The most authoritative interpretation of the right to health is contained in Article 12 of the UN Covenant on Economic, Social and Cultural Rights. In May 2000, the UN Committee on Economic, Social and Cultural Rights issued a 'General Comment' clarifying the nature of this right for States and for individuals (CESCR, 2000). This document recognises that the right to health is closely related to the realisation of other rights, including the right to food, the right to housing, the right to work, the right to education and the right to equality. The right to health extends not only to timely and appropriate health care but also to the underlying determinants of health, such as access to nutrition and housing and to healthy occupational and environmental conditions (para 3). In addition, the Committee notes that an important aspect of the right to health is the participation of the population in all health-related decision-making at the community, national and international levels.

The Committee identified four essential and inter-related elements contained in the right to health (para 12):

- *Availability* – Functioning public health and health care facilities, goods, services and programmes have to be available in sufficient quantity
- *Accessibility* - Health facilities, goods and services have to be accessible to everyone without discrimination, regardless of economic status or geographic location
- *Acceptability* –Health facilities, goods and services must be respectful of medical ethics and culturally appropriate
- *Quality* – Health facilities, goods and services must be scientifically and medically appropriate and of good quality

The Committee acknowledges that there is a need to develop and implement a comprehensive **national strategy for promoting women's right to health** throughout their lifespan. The strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. The Committee advises that a major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. It also states that the realisation of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including those in the area of sexual and reproductive health. Finally, the Committee notes that it is important to take preventative, promotional and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights (CESCR, 2000: para 21).

The Committee provides examples of what may constitute violations of the right to health. These include discrimination; the failure to protect women against violence or to prosecute perpetrators; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; and the failure to adopt a gender-sensitive approach to health.

The Committee states that the adoption of a national strategy to ensure the enjoyment of the right to health by all is required. The strategy should be based on human rights principles that define the strategy's objectives and the formulation of policies, indicators and benchmarks. In particular, the right of individuals and groups to participate in decision-making processes must be an integral

component of any policy, programme or strategy on the right to health.

Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States. (CESCR, 2000: paras 53-54)

3.3.1 International UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) – Article 12 and General Recommendation No. 24 on women and health

Containing 30 articles, CEDAW defines what constitutes discrimination against women and sets up an agenda for party States for action to end it. The following definition of the term 'discrimination against women' was adopted by CEDAW:

[T]he term 'discrimination against women' shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. (CEDAW, 1979: Article 1)

Article 12 of the Convention requires States to eliminate discrimination against women in their access to healthcare services throughout the life cycle, particularly in the areas of family planning, pregnancy and confinement and during the post-natal period. The Committee on the Elimination of Discrimination against Women issued a 'General Recommendation' on Women and Health in 1999, elaborating further on States' obligations (OHCHR, 1999).

CEDAW recognises the interdependence of the right to health and other human rights articles, such as the Covenant on Economic, Social and Cultural Rights. It highlights the significance of socio-economic factors to women's health and the differing health issues of different groups of women. It requests party States to report on how health care policies and measures address the health rights of women from the perspective of women's equality. Barriers to women's access to appropriate health care include laws that criminalise medical procedures only needed by women and that punish women who undergo these procedures. Examples of other barriers to be addressed included high fees for healthcare services, distance from health facilities and the absence of convenient and affordable public transport. It identifies gender-based violence as a critical health issue for women and describes appropriate state responses. The Committee defines acceptable health care services as 'those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives' (CEDAW 1999).

The Committee advocates that party States implement a comprehensive national strategy to promote women's health throughout their lifespan. The strategy should ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services. The Committee also advocates that party States

- 'Place a gender perspective at the centre of all policies and programmes affecting women's health and involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women
- Monitor the provision of health services to women by public, non-Governmental and private organisations, to ensure equal access and quality of care
- Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice' (CEDAW, 1999: para 31)

The concluding comments of the CEDAW Committee in July 2005 urged the Irish Government to

- continue to facilitate a national dialogue on women's right to reproductive health including on the very restrictive abortion laws; and
- Further strengthen family planning services ensuring their availability to all women, men, young adults and teenagers' (CEDAW 2005)

3.3.3 Beijing Declaration and Platform for Action

The 4th World Conference on Women in Beijing (1995) marked a significant milestone in committing Governments to implement initiatives to achieve equality for women within their own countries. This commitment is described in the contents of the Beijing Declaration and Platform for Action (BPfA) (BPfA, 1995), which identified twelve critical areas of concern,– one of which was 'inequalities and inadequacies in and unequal access to health care and related services' (UN General Assembly, 2000).

In its section on women and health, the BPfA affirmed the definition of health as a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. It adopted a determinants approach to health, stating that 'women's health... is determined by the social, political and economic context of their lives as well as by biology'. The BPfA outlined five strategic objectives for women and health, each with a comprehensive list of actions to be taken by Governments to ensure progress. The table below lists the five objectives and includes a selection of the recommended actions for each:

Objectives in the Beijing Platform for Action; Women and Health

- Increase women's access throughout their life cycles to appropriate affordable and quality health care, information and related services
- Strengthen preventative programmes that promote women's health
- Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues
- Promote research and disseminate information on women's health
- Increase resources and monitor follow up for women's health

A key direction of the BPfA was that, ideally by the end of 1996, Governments should have produced national implementation strategies or plans of action for the Platform, in consultation and partnership with non-Governmental organisations.

After a review of progress in implementing the BPfA, the UN General Assembly adopted a Resolution in May 2000 on further actions and initiatives to implement the BPfA(UN General Assembly, 2000). These included:

- The collection and dissemination of updated and reliable data on mortality and morbidity of women and the conduct of further research regarding how social and economic factors affect the health of girls and women of all ages, as well as research about the provision of health-care services to girls and women and the patterns of use of such services
- The adoption, enactment, review and revision, where necessary or appropriate, and implementation of health legislation, policies and programmes, in consultation with women's organisations and other actors of civil society and the allocation of the necessary budgetary resources to ensure the highest attainable standard of physical and mental health, so that all women have full and equal access to comprehensive, high-quality and affordable health care, information and services throughout their life cycle
- The incorporation of a gender perspective in the design,

development, adoption and execution of all budgetary processes

On the 10th Anniversary of the BPfA in New York in 2005, representatives of Governments at the 49th Session of the Commission on the Status of Women reaffirmed the Beijing Platform for Action in its totality.

3.3 International Standards

Complementing the human rights instruments are international standards on health set out by internationally recognised bodies, namely the World Health Organization and the Council of Europe. These standards embody clear commitments and best practice with regard to attaining and guaranteeing a high level of health for the population.

3.4.1 WHO Strategic Action Plan for the Health of Women in Europe (2001)

The World Health Organization is the specialised UN agency for health and its objective is the attainment of the highest possible level of health by all peoples. In 2001, the WHO's European Regional Office produced the *Strategic Action Plan for the Health of Women in Europe* that highlighted the need for an specific focus on the health of women. WHO stated that, for women, the impact of gender on health is determined by their subordinate status in society and that any health policy that seriously aimed to improve the health of the population must take this into account (WHO, 2001). Any national action plan must therefore include the following five elements:

- Life-course approach This means giving importance to the period of motherhood and also aiming to protect the health of young girls, adolescents and elderly women

- Participation by women Self-help and patients' rights groups should be 'institutionalised' as main interested parties in all health programmes It should be ensured that women's interest groups receive adequate funding to represent the weakest within the health care system

- Improvement in health care practice and provision This includes addressing the negative impact on women of the partial privatisation that has come about in the process of health care reform, formalising responses to gender-based violence, undertaking research on access to and use of health services and health-seeking behaviour and applying quality assurance and standards of health care that address women's concerns

- Research This calls for disaggregation of statistics by sex, undertaking research that appreciates the differences in patterns of health and illness between the sexes and greater recognition of the need for qualitative research methods to document and explore gender inequalities in health

- Involving men This recognises that the promotion of positive activity for men must be included in any comprehensive approach to women's health, and that many health problems experienced by women stem directly from their relationships with men, for example in sexual and reproductive health matters and in domestic violence

WHO recommends, as a matter of necessity, the establishment of a national coordinating committee on women's health with responsibility for developing, implementing and monitoring national action plans on women's health with specific targets and timetables for implementation. By 2005, adequately funded national action plans for the health of women should be drawn up, and countries should prepare and publish every two years a comprehensive report on the plans, identifying priority areas for intervention.

3.4.2 The Revised European Social Charter of the Council of Europe

The European Social Charter is a treaty of the Council of Europe signed in 1961. A revised Social Charter entered into force in July 1999. Ireland ratified the Revised European Social Charter (European Social Charter, 1996, No. 163) (RESC) on 4th November 2000, entering it into force on

1st January 2001. Article 11 of the RESC on the right to protection of health obliges party States to commit to undertake measures designed to 'remove as far as possible the *causes* of ill-health'. This means guaranteeing the best possible state of health for the population according to existing scientific knowledge and the delivery of a health care system accessible 'to everyone' (Council of Europe, 2005). The RESC also includes a provision on medical insurance benefits that covers key rules for the financing of health services for those insured (Council of Europe, 2005: Article 12.1). Article 13 states: 'Anyone without adequate resources has the right to social and medical assistance.'. States parties are thus committed to ensuring that 'any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition'.

The right to social and medical assistance must be:

- Clearly defined in law and based on objective criteria
- Not subject to any condition other than need
- Enforceable

In particular, the individual right to social assistance is genuine when:

- Assistance is provided to all those in need
- The level of benefits is adequate (Council of Europe, 2005: 64)

Thus, in principle, the whole population should be covered for health care. The implementation of the RESC is monitored by the European Committee of Social Rights, which receives reports each year from party States. The Committee publishes decisions, known as 'conclusions' each year. Complaints of violations of the Social Charter can be lodged with the Committee.

3.3 Conclusion

A human rights approach to health offers guidance to States on their legal and programmatic responses within national health policy to ensure compliance with human rights standards. Such an approach involves:

- An acknowledgement of the significance of the determinants of health and the interdependence of health and other human rights
- The pursuit of policies that eliminate women's poverty and the inclusion of a gender perspective in all policies and programmes affecting women's health
- A recognition of the need for universal access to high-quality and affordable health care appropriate to women's diverse needs
- The need for a national strategy to promote women's right to health throughout their lifecycle with specific policies, indicators and benchmarks on women's health backed by high-level institutional mechanisms to monitor its implementation
- The need to engage with women's organisations on decision-making and planning on health and to resource their engagement
- The importance of gender inclusive data, gender sensitive research and training on gender equality for health service personnel

International human rights instruments and standards provide a valuable framework in which to consider national policy and programme responses to women's health in Ireland.

chapter 4

Women's Health in Ireland and a Review of Health Policies

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chapter 4

4.1 Introduction

In less than a decade, there have been significant institutional and policy changes across the health sector in Ireland, including the production of a number of new health policy documents. Given the range and distinct nature of women's health issues in Ireland, we assess recent health policies to see whether they have adopted international standards and whether they recognise the determinants of health, the right to health and women's health as a specific issue. We look at case studies from Canada and Australia to demonstrate how other countries have adopted these standards in their national health policies, and conclude that the development of Irish health policy regarding women's health would benefit substantially from adopting a similar approach.

4.2 Current position of women's health in Ireland

In Ireland and internationally women tend to live longer than men, although women generally have poorer health and suffer more chronic disease during their later years than men.[1] In Ireland women lose 10.3% of their life expectancy, in comparison to 8.5% of men. Traveller women live approximately 12 years less than settled women (Pavee Point, 2005).

While the causes of death are similar between women and men, their experiences of illness and disease are different and their medical treatment also differs. Investment in preventative treatment for women is also low by international standards.

Table 4.1: Percentages of women having preventative examinations in Ireland in comparison with average in 15 EU countries

Prevention	Ireland %	EU %
General gynaecological examination	6.7	21.5
Mammogram	9.7	21
Cervical cancer screening	16.4	32
Osteoporosis screening	5.9	7.1
Ovarian examination	2.8	16.6

Source: CSO (2004)

4.2.1 Disease

Cardiovascular disease: Irish Studies in relation to cardiovascular disease have shown the significant negative differences for women in treatment and outcomes.[2] For example, when presenting with heart attack, women experience crucial delays in obtaining life-saving treatment (O'Donnell *et al*., 2005: 14-21). This is particularly significant for women at risk of poverty as cardiovascular disease occurs more frequently among women in lower socio-economic groups.

Cancer: Cancer is the second most common cause of death among women in Ireland. The number of women diagnosed with cancer has risen steadily over the past decade. Survival for several cancers is relatively poor by international standards.

1 Life expectancy at birth for women in Ireland is 80.3 years, which is below the EU 25 average of 81.1 years, compared with 75.1 years for men (CSO 2006).

2 Women are less likely than men to have their risk factors (body mass index, smoking, blood pressure) recorded, and are less likely to be prescribed treatment, including aspirin, beta-blockers and cholesterol-lowering drugs (WHC and DoH&C 2004).

- The all-cancer incidence in women in Ireland is among the highest in Western Europe

- The all-cancer mortality (death) rate in women in Ireland is second highest in Western Europe (exceeded only by Denmark)

There are differences in the treatment received by different groups of women. Older women are much less likely to receive treatment for cancer than women in younger age groups. Women living in socio-economically deprived areas have a lower chance of having surgery for colorectal cancer and have a lower survival rate.

Breast Cancer:

- Cancer of the breast is the most commonly diagnosed cancer and the leading cause of cancer-related death in women in Ireland

- Every year an average of 1,726 women are diagnosed with breast cancer (NCR and WHC, 2006)

Specialist breast clinics are recommended as the most effective method of dealing with breast cancer, which is an extremely complex form of the disease. Mammography screening is a proven method of reducing breast cancer rates by early detection. The national breast screening programme, BreastCheck, which commenced in 2000 remains a partial service and is not expected to be fully available nationally until 2007.

Cervical cancer:

- Unlike other cancers, cancer of the cervix (neck of the womb) occurs more commonly in women aged under 50 years, with half of all cases diagnosed in Ireland in women aged 46 or under The average age of death is 56 years

- Survival rates in Ireland are slightly lower than the European average There has been an annual increase of 1.5% in death rates from cervical cancer in Ireland, in contrast with the steady decline in the UK since screening was introduced (Comber et al, 2004)

- For women living in a deprived area, the risk of developing cervical cancer is 2.6 times higher than the national average

- Regular smear-based cervical screening can prevent cervical cancer (NCRI and WHC, 2006) The first phase of the Irish Cervical Screening Programme (ICSP) commenced in 2000 in the mid-West area and currently remains unavailable to women outside that area Recommendations have been made for the immediate rollout of the service (McGoogan, 2004) However, the programme is not scheduled to be fully available nationally until 2008

4.2.2 Reproductive Health

Women's reproductive health spans the life cycle and includes maternity, obstetrics, gynaecology, contraception and sexually transmitted infection (STI) prevention and treatment, health information and health promotion services. Women's reproductive health issues range from menstruation to menopause and beyond and, by their nature, frequently relate to women's sexuality and to their right to control their own fertility.

Contraception: The Crisis Pregnancy Agency (2004) has highlighted that contraceptive services in Ireland are 'poorly developed', particularly in relation to the lack of services in rural areas, the cost of contraceptives and the need to deregulate emergency contraception in order to prevent crisis pregnancies. There is clear evidence that emergency contraception is not locally accessible nationwide.

Abortion: Abortion is unlawful in Ireland except to save the life of a pregnant woman. The concluding comments of the UN CEDAW Committee (2005) relating to the report from the Irish Government raised the issue of the continued restrictive abortion legislation.

- At least 111,456 women travelled from Ireland for abortions between January 1980 and December 2003

(IFPA, 2005)[3] A total of 84.6% of all non-resident abortions carried out in England and Wales in 2004 were on women from the island of Ireland (Government Statistical Service, 2006)

Maternity:

Since the 1970s many changes have occurred in Ireland. Women are giving birth at a later age and having fewer babies. At the same time, active management of birth (obstetric intervention) has increased significantly (Kennedy, 2004). Women-centred childbirth and choices, such as for midwife-led services and home or domiciliary birth, are not freely available to women despite the internal report of the Domiciliary Birth Group (Submitted Dec. 2004), which examined the outcomes of various models including home birth and domino projects run in former health board areas. The Group recommended midwife-led units and continuity of care, as well as home birth, as options for women at low risk. (*Irish Times*, 2005) Currently, there is a midwifery-led pilot project in the North Eastern Region.

- Deliveries by caesarean section now account for 22.4 % of all births, representing a 72% increase since 1993 and a 2% increase since 2001
- In 2002, 5% of babies were born weighing less than 2,500g, ie 'low birth weight', a rise of almost 1% since 1993 Reducing low birth weight is a target of the Government's National Anti-Poverty Strategy
- Breastfeeding rates are low by international standards, at 41.1% in 2002

3 The figures for 2004 show a significant decrease; the IFPA notes that this decrease reflects the fact that women are now travelling elsewhere in Europe to access termination of pregnancy as a result of the euro–sterling difference in cost (IFPA, 2006).

3.3.3 Mental Health

There are gender specific differences in people's experience of mental ill health. Statistics in Ireland and abroad show that, while mental health difficulties affect women and men in equal measure, they experience different kinds of problems and are affected by them in different ways. Worldwide, women are twice as likely to be diagnosed with depression. It is estimated that women throughout Europe and North America are prescribed approximately twice as many psychotropic drugs per head as men, and men are more likely to be referred to mental health specialists for treatment (WHC, 2005b).

The Department of Health and Children (1997) acknowledged that the mental health services do not meet women's needs, identified the need for research on women's mental health and noted the need for action. The Women's Health Council has also highlighted the absence of a gendered approach to both policy and service provision on mental health in Ireland (WHC, 2005). During consultation on the Green Paper on Women's Health (1995) and in the course of NWCI consultations with member organisations, women raised the need for holistic, person-centered and equitable approaches to women's mental health, and for locally accessible services. In the absence of such services, community-based women's organisations have provided counselling and self-help groups to meet women's mental health needs.

3.3.4 Body Image, Weight Reduction and Eating Disorders

Despite the fact that, statistically, men have a higher rate of overweight and obesity than women, a large percentage of women and girls diet and consider themselves to be overweight. Publicly funded, out-patient and day care programmes for the treatment of eating disorders are scarce and often do not provide a comprehensive, long-term strategy for each individual patient. There are only three specialist beds for treating such disorders, all located in Dublin (Bodywhys, 2006).

- Almost 20% of women respondents in a Department of Health and Children Survey of Lifestyle Attitudes and Nutrition reported being on a weight reducing diet and 18.5% of girls said they were 'on a diet or doing something to lose weight' In relation to body image 31% of girls believed they were above average weight and almost 40% thought their body was 'a bit too fat or much too fat' (DoH &C 2003)

- Dieting is one of the greatest risk factors for the development of eating disorders, which are 10 times more common among girls than boys

4.2.5 Violence Against Women

Violence against women is a crucial barrier to their equality. Violence against women, including sexual violence, is widespread and has far-reaching health consequences; it can have serious implications for a woman's sexual reproductive health as well as resulting in physical or psychological harm. In addition to the health consequences, violence against women is also a denial of their human rights.

- 42% of Irish women experience sexual abuse (including child sexual abuse) or violence over their lifetime (McGee et al, 2002)

- One in every 11 women have experienced severe physical abuse in a relationship and one in 12 were found to have experienced severe sexual abuse in a relationship (Watson et al, 2005)

- Women who have been exposed to violence are at greater risk of developing a range of health problems, including stress, anxiety, depression, pain syndrome, phobias and medical symptoms (WHO, 2000)

4.3 A framework for reviewing key health policy and strategy documents

In order to undertake an analysis of national health policy and strategy, the following health policy documents were selected for review:

- *'Quality and Fairness – A Health System for You'* (DoH&C, 2001a)

- *'Primary Care – A New Direction'* (DoH&C, 2001b)

- *The National Health Promotion Strategy 2001–2005* (DoH&C, 2000)

- *Health Information: A National Strategy* (DoH&C, 2004)

- The part of the *National Anti-Poverty Strategy (NAPS) (DSFA, 1997)* that addresses health

Each of these documents was reviewed to see whether it addressed

- the determinants of health

- the right to health

- women's health as a specific issue

4.3.1 Quality and Fairness –A Health System for You (2001)

Quality and Fairness is the blueprint health strategy document produced by the Department of Health and Children, following a process that involved public consultation. It describes its vision as:

- A health system that supports and empowers you, your family and community to achieve your full health potential

- A health system that is there when you need it, that is fair, and that you can trust

- A health system that encourages you to have your say, listens to you, and ensures that your views are taken into account

The document's principles are described as equality, people-centeredness, quality and accountability It identifies overarching goals to guide planning and activity in the health system for a 7–10 year period and details actions to achieve objectives on health and health care delivery *Quality and Fairness* contains limited reference to inequalities in health and limited recognition of the impact of poverty on health While it contains many references to women's health, these are largely in relation to behaviour and health (impact of smoking and alcohol) and women's physiology and reproductive role and services (breastfeeding, breast and cervical cancer screening, maternity care and family support) It makes minimal reference to gender inequality; it does, however, include recognition of domestic violence and a target to include domestic violence initiatives in all health board plans from 2002

4.3.2 Primary Care – A New Direction (2001)

Primary Care developed from *Quality and Fairness* and, operating within a similar 10-year timeframe, focuses on the role of primary care within the health service. It describes a new model of primary health care provision in Ireland based on the introduction of inter-disciplinary teams to deliver and respond to primary care needs. This new model is designed to shift emphasis from hospital-based to community-based service delivery. As primary care covers front-line health service provision and is the type of care that women are in contact with most frequently throughout their lives, it has a crucial role in responding to women's health needs.

The document is a description of the new primary care model and is a guide to the actions necessary to establish the new primary care infrastructure across the country. The document does not include any reference to women's health, the determinants of health or a human rights approach to health. However, it clearly establishes a longer-term direction where 'a higher percentage of patients [will] be cared for in the community'. There is no mention of any planned impact assessment of what this means to formal and informal care giving, other than passing reference to increased numbers of home helps.

4.3.3 The National Health Promotion Strategy 2000-2005

The second national health promotion strategy states that it is guided by the Ottawa Charter (DoH&C, 2000: 11). That Charter contains a strong emphasis on equality in health and specifically addresses gender equality as a core element of effective health promotion activity. However, a distinct gap between the approaches of both documents can be identified. Specifically, the Strategy outlines three approaches to health promotion – population groups, topics and settings, each to be inter-linked and of equal importance. But there is no gender-based analysis of the three constituent elements of the approach, nor are plans to undertake one identified.

Women are identified as one of six population groups targeted and the strategic aim for women is described as 'to promote women's physical and mental well-being through the continued development and implementation of relevant policies'. The objectives identified for action in relation to women's health relate to women's reproductive role, physiology and behavioural health; working in partnership with the Women's Health Council; initiating research on women's health; and developing 'women friendly approaches in partnership with community and voluntary organisations designed to maximise women's participation in their health'. Of the six 'priority population groups' for which health goals are identified, 'women' and 'maternal health' constitute two. For 'women', one outcome identified is the publication of a Plan for Women's Health, though no timeframe is specified.

Recognition of the determinants of health is a core part of the document, as are recognition of health inequalities and working in partnership with stakeholders. There are three main shortcomings.

- Goals and objectives are largely limited to initiatives to influence choice in behaviour and lifestyle
- Action to tackle determinants is limited to closer interdepartmental working
- Partnership working with communities is reduced to consultation with consumers

4.3.4 *Health Information – A National Strategy* (2004) and *Making Knowledge Work for Health – A Strategy for Health Research* (2001)

A five-year plan to develop a co-ordinated national approach and infrastructure to research on health, *Making Knowledge Work for Health* describes a twin approach to health research through the establishment of a research and development function within the health services and enhanced support for 'science for health'. It makes no reference to any specific health area or issue to be addressed. Furthermore, it shows no recognition of the need to encompass sex and gender considerations in health research.

The more recent *Health Information – A National Strategy* (2004) seeks to ensure that health information becomes more readily available and appropriately used throughout the health sector. It is based on principles of safeguarding the privacy and confidentiality of personal health information, ensuring the efficiency and effectiveness of health information systems, high quality and optimal use of health information. Its objectives include the adoption of a national integrated approach to the development and expansion of information sources and systems to best meet strategic health information needs. It also describes the establishment of processes and structures to ensure the fuller use of health information in policy making, service planning and implementation processes.

From a women's health perspective, there are a number of statements that offer potential. In relation to inequalities in health, this strategy states:

In general, the population health surveillance function is under-developed, and information on morbidity, health inequalities, health status and health determinants of the population and subgroups is limited and fragmentary. At present, information on the health needs and health status of disadvantaged groups, such as Travellers, or asylum seekers, is not routinely available (DoH&C, 2004).

It acknowledges the link between poverty and poor health status and states that 'inequalities arising from gender, age and family status, e.g. being a lone parent, can also increase the risk of poverty and of ill-health'. Action 12 states that relevant health information systems will record data on the factors that contribute to health inequalities, including gender, age, socio-economic group, race and other factors, thereby enabling analysis and monitoring of the health targets in the *National Anti-Poverty Strategy* (1997).

The strategy announced the establishment of an independent population health observatory whose functions include the provision of advice on health impact assessment and on initiatives to address health inequalities. There is explicit recognition of participatory decision-making with the 'wider community' on services at national, regional and local level.

The weak recognition of the significance of information, data systems and research is a cause of concern, given the need for research on women's health in Ireland. The Women's Health Council published a report (Conlon, 1999)[4] before either of the national strategies on health information and health research was published.

4 This report (1999) found a clear need for a better information base and research on women's health. Specifically, it found that the collection and analysis of data in relation to mortality and morbidity needed to be developed.

4.3.5 The *National Anti-Poverty Strategy* (NAPS) (1997), NAPS Inclusion and Health

Originally published in 1997, the *National Anti-Poverty Strategy* (NAPS) is a ten-year Government plan to reduce poverty. The current plan, *Building an Inclusive Society,* was launched in 2002 and is a revision of the 1997 plan. The *National Action Plan against Poverty and Social Exclusion* (NAPSincl) (2003–2005) is the Government's plan submitted to the EU under the Nice Agreement, which required each member State to draw up plans outlining strategies, measures and institutional arrangements. The two NAPS plans are being amalgamated, with the new NAPSincl to be launched in 2006.

The existing NAPSincl document contains an overall target relating to women: 'to reduce consistent poverty for women to 2% and eliminate if possible' (Office for Social Inclusion, 2003: 23). It also contains an overall health objective to reduce health inequalities, and three specific targets relating to women:

- Reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10% for circulatory diseases, cancers and injuries and poisoning by 2007
- Reduce the gap in low birth weight rates between children from the lowest and highest socio-economic groups by 10% from the 2001 level, by 2007
- Reduce the gap in life expectancy between the Traveller community and the whole population by at least 10% by 2007

NAPSincl specifies that, to meet the target on low birth weights, action will be co-ordinated in relation to health promotion on nutrition, smoking and alcohol use during pregnancy, reducing teenage pregnancy and encouraging early attendance for ante-natal care. It also describes 'additional' measures targeted at women, including a planning forum established by the Women's Health Council, the continuation of current measures to prevent violence against women and the Equality for Women Measure.

Neither the NAPS or the NAPSincl include any analysis of the impact of poverty on women's health. Its health targets are not gender disaggregated and specific targets on women's health are not included. Both documents fail to address the implications of diversity, including women's diversity, on health, in any comprehensive manner (Office for Social Inclusion 2002: 12).

4.3.6 A review of *A Plan for Women's Health 1997–1999* –(1997) and *Promoting Women's Health: A population investment for Ireland's future* (2002)

The *Report to Government by the Second Commission on the Status of Women* (1993) recommended the development of a national plan for women's health. In 1997 *A Plan for Women's Health 1997–1999* was published following extensive consultation with women and women's organisations. The Plan had four main objectives:

- To maximise the health and social gain of Irish women
- To create a woman-friendly health service
- To increase consultation and representation of women in the health services
- To enhance the contribution of the health services to promoting women's health in the developing world

The Plan included chapters on reproductive health, violence against women, promoting mental health, responding to Hepatitis C infection, women with special needs (including women in prison, Traveller women, women in prostitution and lesbian women), women's health in the developing world, the representation of women in positions of responsibility within the health services and creating a woman-friendly health service. Unfortunately, the Plan did not refer to any of Ireland's international commitments on women's equality, nor did it refer to health commitments made in the Beijing Platform for Action. Significantly, the

Plan did not include any reference to resource requirements to support identified actions nor to timeframes or targets with which to monitor progress. However, the Plan did result in the development of a women's health infrastructure consisting of the Women's Health Council (WHC) (an advisory body to the Minister for Health and Children), a Women's Health Policy Unit (within the Department of Health and Children) and Women's Health Advisory Committees (established in health board areas).

The WHC undertook research to evaluate progress in implementing the Plan and published a position paper on its findings – *Promoting Women's Health: A population investment for Ireland's future* (2002**).** The WHC research focused mainly on the infrastructure, tellingly stating that the Plan's achievements 'are more visible in structures than in changed practice' (WHC, 2002a: 4). The research documented various difficulties and delays in establishing the infrastructure in the early years of the Plan, but concluded that that the infrastructure now provided 'a solid basis on which future work can be built'. It also highlighted the ongoing lack of awareness of the need for women-focused health initiatives within the health services, as well as the absence of any strategic direction and leadership on women's health (WHC 2002a: 37).

The WHC's recommendations focused mainly on enhancing the effectiveness of the infrastructure at regional and national level. For example, it recommended that the DoH&C develop criteria, models, structures and procedures for gender-proofing national and regional policy and practice, to be implemented by 'appropriate bodies' at national and local level.

The WHC's research on the Plan could have benefited from the inclusion of references to EU and international initiatives on health and women's equality as signposts on direction and strategy to enhance national policy and programme responses to women's health. Its overwhelming focus on the development and operation of the infrastructure, though an important aspect of the Plan and a critical element of any national strategy on women's health, excluded consideration of other important areas, such as

- recommended funding levels required to progress initiatives
- further analysis of available information on the level of activity and progress on women's health issues
- targets and timeframes for the introduction and implementation of gender-based analysis across all health policy and programmes
- the representation of women in the health services and the quality and nature of consultation with women
- continuing difficulties experienced by women with health care and service delivery

4.3.7 National Planning Forum for Women's Health

In *Promoting Women's Health* the WHC committed itself to establishing a forum of key stakeholders in order to 'assist it to define the principles and parameters for policy and action in the field of women's health'. The National Planning Forum for Women's Health final report in June 2004 called for the introduction of 'a body competent to develop, promote and oversee the introduction of gender mainstreaming in the field of health' with ring-fenced budgets. The report also called for gender balance on high-level health bodies, and agreement on the approach to consultation and participation between the statutory and community sectors. Specifically, it proposed the convening of a biannual Forum of regional service providers and advocacy groups to offer their perspectives on national policy and planning (WHC, 2004). In 2005 the WHC published two reports (WHC, 2005c,2005d), which recommended the need for a gendered approach to policy so that women's health needs can be met.

4.4 Implications

The key documents on national health policy and strategy reviewed above fail to demonstrate a comprehensive approach to addressing women's health issues from a women's equality perspective. There is an absence of any reference to the right to health as enunciated by international human rights instruments and to the health objectives and actions of the Beijing Platform for Action. It is indeed telling that A *Plan for Women's Health* (1997–1999), now seven years out of date, remains the statement of current Government policy on women's health.

The absence of any strategic direction on women's health into the future means that women's health issues are unlikely to be addressed comprehensively or to be in line with available knowledge, standards and approaches. Outcomes for women's health and for women's equality will continue to remain weak and unclear. The failure to address these issues is contrary to the thrust of the national health strategy *Quality and Fairness* (2001) which seeks to reduce and eliminate inequalities in health status.

The lack of priority given to women's health, and the narrow approach taken to women's health issues, are evident in the main health policy and strategy documents released subsequent to *A Plan for Women's Health*. It would appear that women's health issues and concerns have not, to date, been effectively mainstreamed into health policy despite recommendations to Government from both the Women's Health Council and the Women's Health Development Officers for a gender mainstreaming approach to progress a national response to women's health. From a women's human rights perspective, current Irish health policy is at variance with recognised human rights standards and approaches. These gaps and omissions in Irish health policy require the development of a new approach to women's health.

The following case studies relating to Canada and Australia demonstrate how policy on women's health, based on the combination of a rights-based approach a and women's equality focus, can be developed and incorporated in national health policies and programmes.

4.5 Case Study 1: Canada

Canada has addressed women's health by putting in place a national Women's Health Strategy. Some Canadian provinces have also developed their own provincial women's health strategies, as have smaller regions within the provinces and territories. Canada's Women's Health Strategy (Health Canada, 1999) demonstrates how international and domestic commitments to gender equality can be included within a national women's health strategy. The strategy makes explicit the Government's commitment to improved health for women through action on the social determinants of health.

Adopted in 1999, the Canadian strategy is a framework to ensure that the situations and needs of women are taken into account in the department's programme and policy development. Developed to promote understanding of the distinct nature of women's health issues and address the biases and insensitivities of the health system as they affect women, the overarching goal of the strategy is

> *[To] improve the health of women in Canada by making the health system more responsive to women and women's health.*

The Canadian strategy has seven main attributes: it is balanced, respectful of diversity, egalitarian, evidence-based, coherent, multi-sectoral and incremental. It has four main objectives:

1. To ensure that Health Canada's policies and programmes are responsive to sex and gender differences and to women's health needs
2. To increase knowledge and understanding of women's health and women's health needs
3. To support the provision of effective health services for women
4. To promote good health through preventative measures and the reduction of risk factors that most imperil the health of women (Health Canada, 1999)

To meet these objectives, activities are identified, including:

- Applying gender-based analysis to programmes and policies in the areas of health system modernization, population health, risk management, direct services and research
- Consulting with women's organisations and health organisations interested in women's health on key policy files
- Developing comprehensive health status and utilization indicators to capture age, sex and gender differences and to reflect the 12 health determinants recognised by Health Canada
- Monitoring the effects of health system restructuring on women's roles as paid and unpaid workers, with particular attention to the following issues: job loss, retraining, workplace environment, ability to deliver quality care, privatisation and the shifting of responsibility to unpaid care givers
- Supporting prevention programs for women at risk for HIV/AIDS, in collaboration with community groups, public health and national and professional organisations

The most notable progress has been made in relation to the objective of increasing knowledge and understanding of women's health and their needs There has been a significant increase in policy-relevant research undertaken The Institute on Gender and Health was created in 2000 to undertake multi-disciplinary research addressing knowledge gaps The Women's Health Indicators Project was established as a research initiative to develop indicators that improve the way women's health is measured, address women's diversity and monitor changes in women's health status and outcomes The first stage of the Women's Health Indicators Project identified gaps in women's health data and indicators Health Canada is now undertaking research to develop and validate health indicators that reflect gender differences and diversity in such areas as social exclusion and women's health The *Women's Health Surveillance Report* (2003) provided, for the first time, an overview of information on descriptive statistics on the determinants of health, health status and health outcomes for women (Health Canada, 2003)

4.6.1 Vancouver/Richmond Health Board (2001)

In 2001, the Vancouver/Richmond Health Board (V/RHB) approved the use of the *Framework for Women-Centred Health* (V/RHB, 2001) to guide its policies, programmes, services and structures. The Framework takes a comprehensive approach so that women's health is integral to the whole system, rather than being an 'add-on' issue. It incorporates issues that extend beyond traditional medical interventions, placing health in its broader context of social determinants. This 12-element framework was derived from a Women's Health Planning Project (V/RHB, 2001), the participants of which included community representatives and people working in health services, ranging from community settings to hospital care, health planning, research and policy making.

The first four elements of the framework deal with processes that empower women:

- The need for respect and safety
- The importance of empowering women
- Involvement and participation of women
- Collaborative and inclusive work environments

The second four address gender differences that affect women's health and access to health care:

- Women's patterns or preferences in obtaining health care
- Women's forms of communication and interaction
- The need for information

- Women's decision-making processes

The next three explain methods that support a women-centred approach:

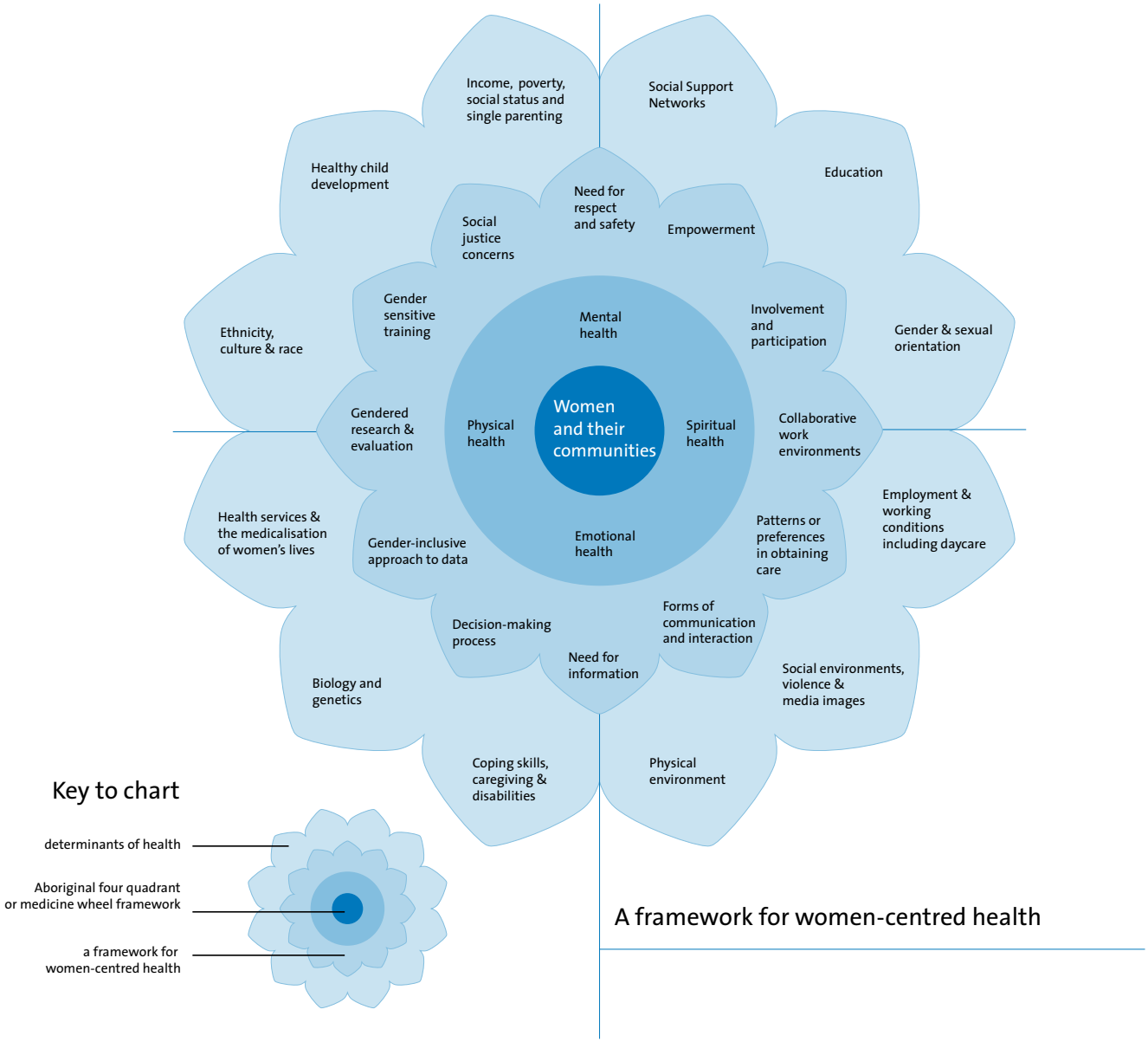
- A gender-inclusive approach to data
- Gendered research and evaluation
- Gender-sensitive training

The last element discusses systemic inequalities

- Social justice concerns

Each element is accompanied by information on its importance to women's health and a description of ways of applying the element in practice. A diagram locates the framework within Health Canada's determinants of health and the four-quadrant Aboriginal medicine wheel framework.

Figure 4.1 A framework for women-centred health. Source: Vancouver/Richmond Health Board (2001)



Canada's Women's Health Strategy originates from, and is located within, international and domestic commitments to women's equality and identifies gender as a determinant of health. It acknowledges many of the health issues that derive from women's inequality including violence, poverty, and the implications of women's longevity and ascribed caring roles. It also acknowledges historic gender biases in the health system effecting women as users and as care givers. Though Canada can be described as being very different to Ireland in terms of population profile, size and other features, its wide-ranging policy framework, strategy and institutional mechanisms offer a valuable model of a national response to women's health from a gender equality perspective that merits further attention.

4.7 Case Study 2: Australia

Australian Women's Health Policy

The Australian National Women's Health Policy, *Advancing Women's Health in Australia,* was published in 1989 following extensive consultation with women throughout the country. The policy originated as a result of a national conference, 'Women's Health In a Changing Society', organised by the women's health movement and attended by over 700 women. As a result of pressure from the conference, a special advisor in women's health was appointed by Federal Government to coordinate the development of the policy.

The policy was set in the context of a social health and primary health care perspective, noting the link between socio-economic status and social attitudes to women. It focused on issues of concern to all women, as well as recognising and taking account of the needs of particular groups of women.

Seven priority policy areas were identified:

- Reproductive health and sexuality
- The health of ageing women
- Emotional and mental health
- Violence against women
- Occupational health and safety
- The health needs of women as carers
- The health effects of sex role stereotyping on women

Five key action areas were noted:

- Improvements in health services for women
- Provision of health information for women
- Research and data collection in the area of women's health
- Women's participation in decision-making
- Training of health care providers

The recommendations were implemented through the establishment of the National Women's Health Programme and funding was allocated over four years to achieve the key actions. In 1992 a steering committee was appointed to evaluate the programme. The committee's report (1993) found that it was effective in reaching the target groups and meeting some of the actions, but found a lack of funding in the promotion of women in decision-making and in research, which were key areas to ensure success of the overall programme. The committee recommended that priority, funding and resources be given to these areas, particularly to the development of a research strategy to enable the programme to develop further. The evaluation report recommended funding until 2001 in order to achieve the actions. A new Government meant that the programme was funded only for a further four years. However, funding is now in place until 2009; therefore, apart from a period of uncertainty between 1996 and 1998 a strong budget line has been available from 1989 up to 2009.

At a national level the 'Australian Longitudinal Study' on women's health commenced in 1995, involving 40,000 women across Australia. When completed in 2016 it will provide significant evidence on health trends and issues among Australian women across their lifespan. At the half-way mark, substantial evidence has already been gathered and further funding allocated to ensure the success of the programme.

4.8 Discussion of case studies

There is much in common between the Canadian, Australian and Irish policy contexts, despite our different cultures and global locations. After Australia, Ireland was the second country to produce a women's health policy, later followed by Canada. All policies were developed in response to national and international commitments relating to gender equality and women's health, although in Australia the groundswell for change, which came from women themselves, had a marked impact in generating action by Government. Each of the three policies was developed in a women-centred, participative and collaborative way and based on women's stated health experience and need. All policies were located in the context of a social model of health.

It was groundbreaking at the time for each of the countries to have met their equality commitments in producing women's health policies. Women's health policy was not seen as providing services for sick women, but rather it was about keeping women in optimal health by addressing women's inequality, addressing disease prevention and health promotion for women and providing appropriate women-centred services based on women's health needs and experiences. At the same time, the recognition of women's diversity was inherent in all three policies. Each made particular reference to the health status of indigenous women – aboriginal women in Canada and Australia and Traveller women in Ireland – all particularly marginalised in terms of health, as evidenced by the significant gap in life expectancy between them and women in mainstream society.

Given the commonalities between the three countries' original women's health policies, Ireland is well placed to draw on and learn from the experience of both Australia and Canada. Since the original policies were launched, they have developed in different ways in each country, depending on multiple factors including allocation of resources, commitment at Government and local level, involvement of women and a willingness to evaluate, reflect and build on the initial stage of policy development.

In Canada there has been a focus on development of policy-relevant research to address knowledge gaps, particularly in the area of the social determinants of women's health. A whole-system approach is taken which makes policy relevant at regional and local level, for example the Vancouver framework for women-centred health. Recently, Canadian health service restructuring has resulted in the development of an academic critique by women's health experts, among whose recommendations is that women's health is supported within the restructuring process and a gendered analysis applied. They go further, to call for a 'universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment' (CWHN, 2001).

The innovative Australian longitudinal study on women's health ensures that data is becoming available to enable continued evidence-based policy and programme development. One of the marked differences between the Irish and the Australian experience is in the allocation of the funding required to implement the policy and ensure developments in women's health policy and service delivery. The willingness to learn from evaluation and to continue to fund developments ensured that, in Australia, earlier work could be built upon so that 17 years later women's health is still very much on the health policy agenda.

Developments in women's health in Ireland over the past decade contrast negatively with Canada and Australia. Despite a period of unprecedented economic growth, there has been a lack of political commitment to providing the

necessary resources to develop an effective policy and service for women's health. Aside from the shortcomings of Ireland's women's health policy *A Plan for Women's Health 1997–1999* (DoH&C, 1997), the lack of resource allocation ensured that the policy could achieve only individual, rather than systemic, developments at national level. This contrasts sharply with the Australian experience, where sustained funding has been allocated for women's health over a 20-year period. Both Australia and Canada have also invested heavily in addressing knowledge gaps through policy-related research and research related to women's specific health status and requirements across the lifespan and in different groups. This ensures that continued policy development in women's health is based on sound evidence relevant to the women in that country.

Women in Ireland also have had a lower level of participation in the planning, development and delivery of health services for women. Ireland has much to learn from the Canadian and Australian approaches to working in partnership and collaborating with community-based women's organisations and women health workers to ensure women's participation in the development of appropriate health services.

Conclusion

The lack of priority given to women's health, and the narrow approach taken to women's health issues, are evident in the main health policy and strategy documents in Ireland. From a women's human rights perspective, current Irish health policy is at variance with recognised human rights standards and approaches. The learning from the approaches adopted in Canada and Australia highlight the need for a renewed commitment to women's health, set within best practice internationally and meeting international and rights-based standards. This would require a women's health strategy that addresses:

- The prevention and treatment of diseases affecting women
- Availability, accessibility, acceptability and quality of health care responses
- Measures to reduce health risks to women, including violence against women
- The right of participation by women and women's groups in all health-related decision-making at community, national and international levels
- Right to health indicators and benchmarks

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chapter 5

A National Plan for Women's Health

EQUALITY
CHOICE
action
UNIVERSAL ACCESS
DIVERSE NEEDS

chapter five

A National Plan for Women's Health

In this chapter the NWCI sets out a vision and proposes a framework for women's health.

We present strategic objectives drawn from international standards, identify key areas that require allocation of resources and development and recommend a time frame for achieving gender equality for women's health. International standards provide and inform the development of the proposed framework.

Vision of Women's Health

NWCI aspires to a vision of women's health in Ireland where:

All women are enabled to reach and maintain optimal levels of health across their life cycle.

To achieve this vision, our health service must:

1. Embrace the principles of equality and human rights
2. Recognise the social determinants of women's health
3. Function as an integrated and adequately resourced public health system
4. Proactively promote social inclusion among the most excluded groups
5. Encourage participation by all groups of women in decision-making at all levels
6. Recognise women as a diverse health population with particular health needs
7. Invest in research to bridge knowledge gaps and inform policy
8. Adopt gender mainstreaming strategies

These principles should underpin the development of a women's health plan that meets international standards, contains timeframes, targets and identifies resources for implementation.

Strategic Objectives

1 Adopt the principles of equality and human rights

Objective

A Women's Health Plan which clearly meets the commitments in the Convention to Eliminate Discrimination Against Women (CEDAW) and the Beijing Platform for Action (BPFA). This objective overarches all other objectives in this chapter.

Key Action

- Women's right to health and health services must be incorporated in health policy and programme development, including Department of Health and Children national plan's for health, HSE corporate plans and HSE annual service plans

2 Recognise the social determinants of women's health

Objective

To integrate the social determinants of women's health into all policy and programme development so as to effectively address the impact of sustained inequality on women's health.

Key Actions

- Inter-departmental and inter-agency work

Development of a programme of key actions across departments and agencies to devise and implement

interventions that will address the social causes of ill heath and eliminate health inequalities among women.

- Collaboration with all stakeholders

Collaboration with all stakeholders, particularly those who experience inequality through exclusion and discrimination, and community-based women's organisations that currently undertake primary health care and health promotion initiatives, to address health inequality among women.

3. Function as an integrated and adequately resourced public health system

Objective

To develop an accessible coherent integrated public health system, which is proactive and sensitive to women's health needs and adopts a holistic approach that includes disease prevention and reduction, health promotion and primary and secondary care across the life cycle.

Key Actions

- Resource women's health policy and programmes

- Develop a budget line for women's health within the Department of Health and Children and at HSE level for comprehensive work on women's health

- Allocate resources to the development of an integrated, universally accessible public health service

- Resource women's health activities

- Recognise the health promotion and health service delivery work of locally based women's organisations and enable their contribution to women's health and their collaboration with the public health system

- Ensure that a budget line is developed to provide multi-annual funding for women's groups and NGOs to enable them to continue to provide primary health care and health promotion services which they have developed in response to local need and to participate, collaborate and contribute to national women's health policy and programmes

- Education and training

- Provide education and training for health service personnel and policy makers on gender equality and women's diverse health needs

4 Proactively promote social inclusion among the most excluded groups

Objective

Promote the inclusion of women among the most excluded groups in order to bring about change for those who need it most.

Key Actions

- Poverty and equality proofing of policy

Undertake poverty and equality proofing of all health and social policy.

- Community development and primary health care

Resource women's community-based organisations to continue their work in health promotion, provision of services otherwise unavailable and provision of community-based adult education, all of which contribute to empowering women to address their exclusion and are known to address inequities and promote health.

- National Action Plan for Social Inclusion

- Include women's equality as a target within health policy and provision

- Include a recognition of the link between poverty among women and inequality, particular for marginalised

women and women living in disadvantaged communities, including Travellers, minority ethnic women, women with disabilities, lesbian and bisexual women, lone parents, women in prison, women working in prostitution and women at various stages in their lives, particularly older women, girls and young women

5 Encourage participation by all groups of women in decision-making at all levels

Objective

To maximise the participation of all women in policy development, programme planning and service delivery, including targeting groups of women who have traditionally had the least resources to participate, and hence have been socially excluded.

Key Actions

- Promotion of women's participation in health policy

Through positive action programmes, promote women's participation in policy development and decision-making at all levels, recognising that women interact with the health service as paid and unpaid providers of health care and as services users.

- Promotion of women's participation in their health

Through resourcing women's organisations and community-based women's groups, promote women's participation and collaboration in their health by developing methods to ensure that all policy, programme development and service delivery place women at the centre and recognise women's diversity.

6. Recognise women as a diverse health population with particular health needs

Objective

Adopt a population health approach to women's health that is women-centred, acknowledges that women comprise a diverse health population and recognises the impact of women's continued inequality as a determinant of health.

It is not possible here to make recommendations on all areas relating to women's population health. Taking note of all the strategic objectives in this chapter would go a long way towards addressing women's diverse population health needs. The NWCI has chosen to highlight four key areas among many requiring action, namely: cardiovascular disease and cancer –the two major causes of premature death among women in Ireland – and mental health and reproductive health – two areas of health care that has been neglected and underdeveloped;

Key Actions

- Cardiovascular disease

- Incorporate a gendered perspective into national cardiovascular strategies to ensure reduction of premature death among women in Ireland, through provision of women specific health promotion and disease prevention measures and effective primary and secondary care

- Implement recommendations by the Women's Health Council relating to gender and cardiovascular disease, and cardiovascular disease among women living in poverty and disadvantage

- Develop and implement education programmes for health care providers to ensure up-to-date knowledge and information on women's particular needs in the full range of cardiovascular disease prevention and treatment

- Cancer

- Implement the recommendations of the Cancer Registry of Ireland and the Women's Health Council *Report on Women and Cancer in Ireland* (2006), including provision

of specialist cancer services and the promotion of healthy lifestyles and the European Code Against Cancer (2003), particularly in relation to screening programmes for women

- Ensure that the implementation of the *Strategy for Cancer Control* (2006) takes account of the needs of all women in Ireland, sets targets to achieve higher levels of prevention coverage and survival rates, particularly for older women and women living in poverty

- Mental health

- The Department of Health and Children to adopt a gendered approach to policy, programme development and service provision as recommended by the Women's Health Council (2005)

- The Mental Health Commission to take account of the recommendations of the Women's Health Council (2005) on the need for a gendered approach to mental health policy and service provision

- Develop provision of locally accessible mental health services, including a range of counselling, support and self-help groups

- Promote a recovery model that takes account of women's mental health needs and experience

- Recognise and resource current mental health promotion and mental health services provided by community-based women's organisations

- Promote participation by women service users, women's community-based organisations and representative organisations in current and future development in the area of mental health

- Provide education and training for mental health care workers, including:

- gender-sensitive, equality and cultural awareness training to enable them to promote understanding of women's mental health needs, including recognition of the mental health consequences of gender-based violence[5]

- Women's reproductive health

- The Government must take action on its international commitments to women's reproductive health equality, including those related to the closing comments made by the UN Commission on the Status of women (CSW) at the CEDAW Committee in 2005, which called for the Government to strengthen family planning services, ensuring their availability to women and men including young adults and teenagers; facilitate a dialogue on women's right to reproductive health, including the issue of restrictive abortion laws (CEDAW, 2005)

- Develop and implement a National Sexual Health Strategy as recommended by the Crisis Pregnancy Agency (2004) to ensure a coherent and accessible service that includes the full range of services, information and education required for optimal sexual health across the life cycle

- Provide free contraception and deregulate emergency contraception to prevent crisis pregnancies and provide access, particularly for women in rural areas

- Provide accessible women-centred maternity services that include choice for women, such as midwife-led care, domino and home birth as options

7 Invest in research to bridge knowledge gaps and inform policy

Objective

- Develop a comprehensive profile of women's health based on the evidence of high-quality quantitative and qualitative research

5 CEDAW Recommendation 24

Key Actions

- Develop research on women's health that:

- Is Innovative

- Facilitates participation and collaboration of key stakeholders involved in research, including statutory, academic, community-based women's organisations and organisations representing women

- Ensures that all research, including that undertaken by women's groups, is disseminated and shared centrally to maximise learning As well as providing evidence for policy development, this could form the basis for a significant longitudinal study on women's health in Ireland

- Is qualitative, focusing on the different experiences of women, particularly those of Traveller women, older women, lesbians and women with disabilities

- Addresses data gaps generally in the area of women's health needs and experiences

8 Adopt gender mainstreaming strategies

Objective

The Government should take account of the health impact of policy on different groups of women, women's health and women's equality. Policy should be formulated as healthy public policy.

Key Actions

- Gender analysis of policy

- Include a gender perspective in policy development; an analysis of women's continued inequality and the negative impact on women's health as well as women's specific health needs, as recommended by the WHO, the UN and the Women's Health Council

- Gender proofing of policy

- Gender proof all health and social policy development and delivery

- Positive action

- Undertake positive action to promote equality for diverse groups of marginalised women, including Traveller and ethnic minority women, women with disabilities, lesbians, one parents and older women

- Quality assurance

- Develop quality assurance measures and frameworks for health services to address the implications of sex and gender in their measurement of the effectiveness, efficiency and appropriateness of responses The health services should aim for equality of outcome and indicators to measure such should be included in any measurement of quality

- Health impact assessment (HIA)

- Include gender in health impact assessment of policies, which impact on social determinants of health, including transport, housing, education and employment

- Development of an updated policy on women's health

- Immediate development of an updated women's health policy that is informed by international standards and experience, takes account of lessons learned from previous women's health policy development and women's experience and needs in Ireland To achieve this aim, all stakeholders should be involved and commitment ensured at all relevant health department and HSE levels, including population health

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Implementation

In line with the timeframe established by the WHO in its Strategic Action Plan for the Health of Women in Europe, we propose the following as an appropriate timeframe for effective delivery.

A five-year Gender-Equitable Women's Health Plan should be developed in line with current thinking on best practice on women's health and equality at international and EU levels. It should address and conform to the features of a gender-equitable approach to health as described earlier. It should include the following:

- A commitment to gender equality in health and a description of what that means in relation to the health care system and health care delivery

- A list of gender equality goals and objectives in relation to the health system and to health care, backed by a detailed plan of action and an implementation strategy This should include targets and benchmarks to track progress Objectives and targets should reflect the social determinants of health and address the health issues of diverse groups of women

- A description of the initiatives to be developed and implemented This includes gender equality policies across the health service and in health care It will include details of training, protocols on research, indicators and data gathering and their use, participation in decision-making by women's organisations and a complaints and redress mechanism It will set out how current initiatives can be changed to better address women's equality concerns, both currently and in the future

- A description of the infrastructure on women's equality throughout the various aspects of the system, the institutional focal points with responsibility for women's equality, and their roles The infrastructure should be capable of delivering on the aims identified above

- A description of the mechanisms for the participation of women's organisations and other relevant stakeholders in consultation, decision-making, monitoring and review

- A description of the monitoring and review mechanisms

- An outline of funding commitments, ring-fenced where necessary

- Implementation mechanism

- Establish a National Coordinating Committee on Women's Health to monitor progress and actions

Using the timeframes specified by WHO would result in the following timetable overleaf for the next seven years.

Table 7.1 Timeframe for implementation

Target date	Deliverable	Details
2007	5-year national gender-equitable Women's Health Plan produced.	Plan contains objectives and realistic targets on women's health, backed by adequate resources and operational infrastructure. Contains information, statistics and insights on the determinants of health, health status and health outcomes for women, with a particular focus on the health of vulnerable groups of women and diversity. Identifies gaps in information, health care and management capacity.
2009	First progress report on women's health plan produced.	Tracks progress with the priorities and actions identified in the Plan.
2011	Second report on progress on women's health produced.	Identifies progress and priority areas for attention.
2013	Third report on progress on women's health produced.	Independent review and evaluation undertaken.
2014	Report of independent review and evaluation published.	Contains recommendations for health policy and health care to ensure equitable outcomes for women on health.
2015	Moving Forward: Development of updated policy based on the recommendations made in evaluation.	Integration of learning/recommendations made in evaluation (2014) and moving forward. National Conference on women's health.

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