

Training Handbook

Gender Mainstreaming in Health



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

Gender Matters

Training Handbook on Gender Mainstreaming in Health

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Orla O'Connor
National Women's Council of Ireland
Brian Neeson
Health Service Executive



INTRODUCTION TO GENDER MATTERS 'TRAINING THE TRAINERS' HANDBOOK FOR GENDER MAINSTREAMING

BACKGROUND

This Training handbook has been prepared under the auspices of the Health Service Executive (HSE) / National Women's Council of Ireland's (NWCi) project on Gender Mainstreaming in Health. It is one of the actions set out in the framework on gender mainstreaming drawn up by the HSE / NWCi in 2012 'Equal but Different: A framework for integrating gender equality in health service policy, planning and service delivery'.

In addition, the HSE has developed a separate training programme on health inequalities for HSE Health Promotion Officers. The training programme 'Getting to Work on Health Inequalities' builds on the HSE's Health Inequalities Framework (2010 – 2012). This gender mainstreaming training handbook is intended to be complementary to the health inequalities training. As a result it is recommended that trainers involved in delivering gender mainstreaming training refer to the training materials 'Getting to Work on Health Inequalities'.

OBJECTIVES OF THE TRAINING PROGRAMME

The objectives of this handbook are to:

- Improve understanding and awareness about how gender inequalities impact on the health of women and men and transgender people, including their access to healthcare.
- Raise awareness about how services can be provided so that they take account of the needs and experiences of women and men; a specific focus to be given to addressing attitudes and stereotypes, and how people think and act as a result of learned gender roles.
- Show how gender mainstreaming tools can be used to provide gender-sensitive health services, so that services are provided in equal and non-discriminatory ways.
- Enhance capacity for the planning and delivery of health-care services by focusing on the gender specific health needs of women and men.

RATIONALE FOR THE TRAINING

GENDER MAINSTREAMING IS WIDELY USED AS A TOOL FOR ADDRESSING GENDER INEQUALITIES IN HEALTH. THE NWC GENDER MAINSTREAMING IN HEALTH PROJECT REPRESENTS A FIRST STEP TO SYSTEMATICALLY ADDRESSING GENDER IN HEALTH IN AN IRISH CONTEXT.

There is substantial international evidence that addressing gender inequalities can lead to improved outcomes for women's and men's health. Of importance also, and taken into account in this training guide, is that gender cuts across other determinants of health, e.g. poverty and economic disadvantage, age, ethnicity, disability, sexual orientation and gender identity.

A specific focus is given in the training to how policy-makers, service planners, managers and front-line staff can build their knowledge and understanding of gender-related health issues and how they impact on the health and well being of women and men. It looks at how gender norms, gender roles and gender relations play a part in determining women's and men's health and their access to health services. With this understanding, policy, planning and service delivery can provide services that are responsive to the needs and experiences of women and men.

WHAT DOES THE TRAINING HANDBOOK COVER?

This handbook covers:

- An introduction to gender inequalities in health within the context of the broader determinants of health / health inequalities; key to this approach is that we are looking at the social, economic and cultural factors that impact on women's and men's health and well being.
- Awareness raising, discussion and reflection about the causes of gender-related differences in health.
- Discussion of how gender stereotypes shape attitudes and the way that we deliver services to women and men, including women and men from different social groups.
- The importance of inclusive and anti-discriminatory attitudes and practices in a health-care setting.
- Discussion of gender mainstreaming as a tool for integrating gender into the planning and provision of health services.

TARGET AUDIENCE

THE TARGET AUDIENCE FOR THIS GUIDE IS EDUCATION AND TRAINING PROVIDERS WHO PROVIDE TRAINING WITHIN AND OUTSIDE OF THE HSE.

The guide provides resources, information and examples of activities that can be carried out in stand-alone training programmes, with suggestions for integrating the resources provided in this guide into existing training programmes.

It is intended that the materials can be used to provide training and awareness programmes for:

- Health policy-makers and service planners;
- Staff working in front-line services, such as primary care, mental health, hospital-based services and residential-care services;
- Health promotion officers;
- Training and education providers involved in training health-care staff in the HSE, in colleges and universities;
- Community groups and organisations involved in community-based health programmes with women and men.

THE ROLE OF A TRAINER / FACILITATOR IN DELIVERING GENDER MAINSTREAMING TRAINING

Trainers / facilitators should have a good grounding in gender inequalities and / or health inequalities and be able to apply insights into how gender shapes women's and men's health and their access to health services.

You will need skills to facilitate discussion about issues that people may disagree strongly about or when you are dealing with resistance. Women's and men's health needs and experiences are complex issues that often lead to heated discussion in a group setting. A key role is to avoid conflict and promote calm discussion, inviting participants to acknowledge the experience of gender from other perspectives as well as their own. Participants may debate the issue in a manner which places men and women against each other, and which can polarise the group. It is preferable to encourage a reflective and analytical discussion to take place. It is important to stress that the approach taken is to identify the gender dimensions of health to improve health outcomes.

A component of the training is to raise awareness about gender inequalities and how they impact on health. This also means using and building on participants' own experiences and backgrounds. However, it is important to be prepared through discussion to give examples that may challenge people's stereotypes and values, and to do this in a constructive way.

When discussions are taking place and you are asking participants to brainstorm, participants to give examples drawn from the areas that they work in or from their own wider experiences.

If there is confusion or resistance to challenging gender roles or norms, it is important to stress that the purpose of gender mainstreaming in health is to **change attitudes, behaviours and practices that are potentially harmful to women's and men's health**, with the purpose of reducing the health risks for different groups of women and men. For example, women and men are exposed to different risk factors in the workplace because of the gender-based division of labour. The Mandate trade union describes some work as 'precarious and uncertain, unpredictable, and risky from the point of view of the worker'. They also find that women are over-represented in this 'precariat which has suffered an above average rate of job loss', with female employment being worst hit

WHAT ARE THE BENEFITS OF GENDER MAINSTREAMING FOR HEALTH PROVIDERS?

The HSE / NWCI report – 'Equal but different: a framework for integrating gender equality in health service policy, planning and service delivery' - sets out a framework for integrating gender into the planning and delivery of healthcare. It argues that this makes good business sense because it enables the HSE to:

- Improve access to health-care services for everyone: through a change in culture and by providing services that respond to gender differences between women and men.
- Plan and deliver services that are evidence based and informed: by allocating and targeting resources in the most effective way to take account of gender-based differences, and thereby achieve better 'value for money'.
- Meet its strategic objectives and targets to reduce inequalities in health: this will make a difference to women's and men's health.
- Have access to tools to address gender inequality in health: and through this to ensure that services are provided in gender-sensitive ways that also empower women and men in the promotion of health and well being.

SOME BASIC STARTING POINTS

As a starting point trainers and facilitators using this guide should read and be familiar with the following documents:

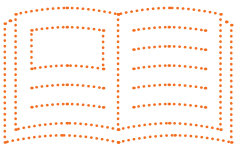
- '*GENDER MATTERS: User-friendly guide to gender mainstreaming*', NWCI / HSE, (2014).
- '*GENDER MATTERS: Toolkit on gender mainstreaming in health*', NWCI / HSE, (on line resource 2014).
- '*Equal but Different: A framework for integrating gender inequality in health service policy, planning and service delivery*', NWCI / HSE (2012).
- *National Men's Health Policy 2008 – 2013* (2008) (Department of Health and Children)
- *Health Inequalities Framework 2010 – 2012* (2010) available from HSE
- *National Women's Strategy 2008 – 2016* (Department of Justice)

HOW ARE THE TRAINING MATERIALS ORGANISED?

THE MATERIALS ARE ORGANISED INTO EIGHT SPECIFIC TRAINING SESSIONS. EACH SESSION HAS; A) BACKGROUND BRIEFING FOR TRAINERS AND FACILITATORS COVERING THE MAIN POINTS AND SETTING THE 'SCENE' FOR EACH SESSION, AND B) STRUCTURED GROUP WORK ACTIVITIES.

Appendix 1 provides a glossary of terminology used in the guide; Appendix 2 has some extracts of background reading materials that can be read by course participants; and Appendix 3 has a list of web sites, reading and further resources.

The following symbols are used throughout the guide to show the location of background briefings for trainers and facilitators, activities and trainer / facilitator notes.



Background briefings for trainers / facilitators and participants.



Activities, which can be run in breakout groups or the full group.



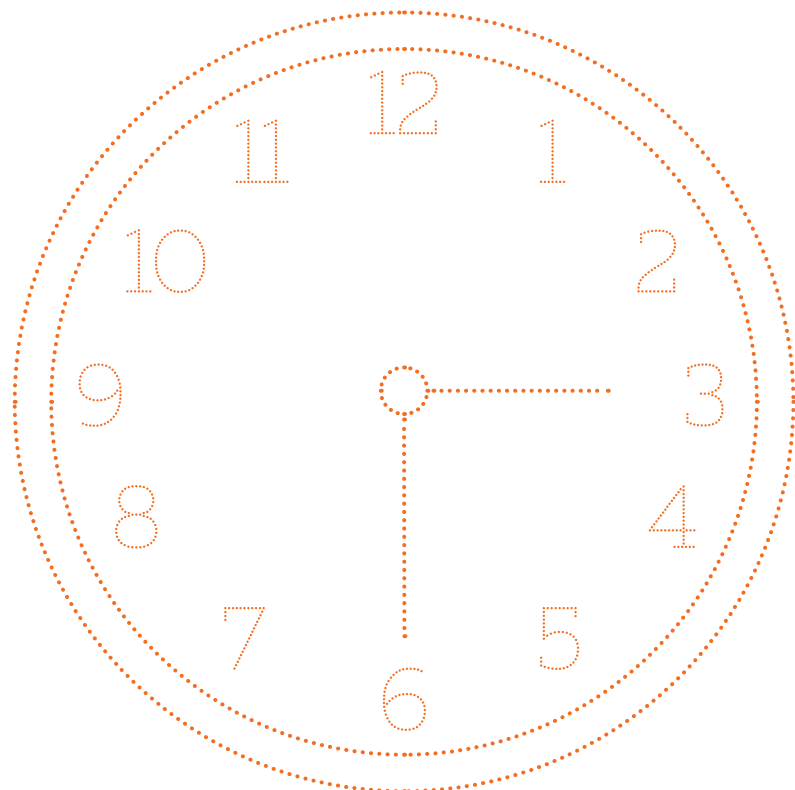
Trainer / facilitators notes, with prompts for discussion.

A set of power point slides has been prepared for trainers and facilitators to use in the training sessions. These can be found on the NWCi website – www.nwci.ie/index.php/learn/publications/gendermatters_health_training_slides

The guide provides a programme for a **two-day training course**. However, tutors / facilitators may wish to provide a shorter course or select activities that are relevant to the target group. The programme can be used as a menu of activities, according to the time available. It can be shortened by selecting fewer activities or by introducing and discussing the themes covered in the activities in full group sessions.

TIMEFRAMES FOR CARRYING OUT EACH SESSION

The suggested times for carrying out each session are calculated on the basis of the background briefing / introduction from the tutor, carrying out one group work activity and for report backs from group work activities and discussion in the full group. Tutors may wish to adapt these activities according to the needs and experiences of the group, and in accordance with the time available. For example, if time is limited fewer activities could be run. However, it will be important to provide participants with an overview of the background information provided in each session.



THE FOLLOWING TABLE SETS OUT A GUIDE TO THE STRUCTURE OF THE TRAINING SESSIONS, THE AIM OF EACH SESSION AND THE LEARNING MATERIALS THAT ARE RELEVANT TO EACH SESSION.

PROGRAMME OUTLINE

It is important to state at the outset that the time outlined for each session may vary according to the level of previous training received by the participants and the number and variety of activities used under each heading. In some sessions, there are multiple activities and the trainer may choose to use only one.

SESSION	AIM	LEARNING MATERIALS
<p>Session 1: Introduction Time: 1 hour and 15 minutes.</p>	<p>To introduce participants to the course and provide two ice-breaking activities.</p>	<p>Background briefing 1: Introduction This provides some briefing materials for the trainer / facilitator to give a short introduction about the course to the group (10 minutes). Activity 1.1: Introduction to participants (20 minutes). Activity 1.2: This contains two icebreakers</p> <ul style="list-style-type: none"> • Icebreaker 1 – Where do you stand on gender equality? (30 minutes) including discussion in the full group. • Icebreaker 2 – Gender assumptions (15 minutes) including discussion in the full group.
<p>Session 2: The concept of health and how gender interacts with it. Time: 1 hour and 15 minutes.</p>	<p>To give participants an opportunity to explore the concept of health and the right to health in a personal context.</p>	<p>Background briefing 2: What is your understanding of health? (15 minutes). Activity 2: Exploring what health means to you (30 minutes).</p> <p><i>Allow at least 30 minutes for discussion.</i></p>
<p>Session 3: Sex and gender and their impact on health. Time: 45 minutes (30 minutes for one activity, 30 minutes for reporting back and discussion).</p>	<p>To introduce participants to the differences between sex and gender, and how they impact on health; followed by case studies.</p>	<p>Background briefing 3: Sex and gender – what are the differences? (15 minutes). Activity 3.1: Brainstorm on sex and gender (30 minutes). Activity 3.2: Case study: Gender bias in detection of heart disease (30 minutes). Activity 3.3: Case study: Men and the risk of cancer (30 minutes). Activity 3.4: Case study: Men and breast cancer (30 minutes). 3.5 HPV virus – girls and boys (30 minutes). 3.6 Gender identity and health care (30 minutes).</p> <p><i>Allow 30 minutes for report back and discussion.</i></p>
<p>Session 4: The social construction of gender: gender as a determinant of health Time: 2 hours (based on one group activity being carried out).</p>	<p>To introduce participants to gender as a determinant of health and the other determinants that impact on women's and men's health.</p>	<p>Background briefing 4.1: Gender as a determinant of health – the factors that impact on women's and men's health? (15 minutes). Activity 4.1: Gender norms, roles and relations (30 minutes). Background briefing 4.2: How does gender interact with other determinants of health? (15 minutes). Activity 4.2: The determinants of health (30 minutes). Activity 4.3: Older women with cardiovascular disease (30 minutes). Activity 4.4: Health and well being of men (30 minutes). Activity 4.5: Gender and disability (30 minutes). Activity 4.6: Women, economic disadvantage and smoking (30 minutes).</p> <p><i>Allow 30 minutes for report back and discussion.</i></p>

SESSION	AIM	LEARNING MATERIALS
<p>Session 5: Gender-sensitive services – examples from different health services Time: 1 hour and 15 minutes (based on one group activity being carried out).</p>	<p>To introduce participants to some examples of how to make health services gender sensitive.</p>	<p>Background briefing 5.1: Introduction (15 minutes). Activity 5.1: Men's access to primary care services – case study on men and obesity (30 minutes). Activity 5.2: Gender and mental health (30 minutes).</p> <p><i>Allow 30 minutes for report back and discussion.</i></p>
<p>Session 6: Gender mainstreaming in health Time: 2 hours</p>	<p>To introduce participants to gender mainstreaming in health, and to discuss how gender mainstreaming can be applied in specific health-care settings.</p>	<p>Background briefing 6.1: Introduction to gender mainstreaming in health (30 minutes). Background briefing 6.2: Carrying out a gender impact assessment (GIA) (30 minutes) Activity 6.1: Carrying out a gender impact assessment (GIA) (30 minutes).</p> <p><i>Allow 30 minutes for report back and discussion.</i></p>
<p>Session 7: Working together to address healthcare needs Time: 1 hour and 30 minutes.</p>	<p>To support participants to identify how they will embed their learning on gender and health in their work.</p>	<p>Background briefing 7.1: Carrying the learning forward in your work (15 minutes) Working towards gender sensitive services Background briefing 7.2: Eight steps to achieving gender mainstreaming Activity 7.1: Carrying the learning forward (30 minutes).</p> <p><i>Allow 30 minutes for report back and discussion.</i></p>
<p>Session 8: Evaluation Time: 30 minutes.</p>	<p>To gain feedback from participants about the training.</p>	<p>Verbal and written evaluation.</p>

<p>Appendix 1: Glossary of terminology</p>	<p>The glossary provides definitions for the terminology used in the training and reference should be made to these definitions throughout the training.</p>
<p>Appendix 2: Background reading</p>	<p>A number of extracts from publications are found in this section. These can be used in the training as background reading.</p>
<p>Appendix 3: Further reading and resources</p>	<p>This provides further resources, including reading materials and web links.</p>

Session 1

Introduction to the course and to gender-related health issues

AIMS:

- To introduce participants to the course and to each other, what will be covered and how it will be delivered
- To provide opportunities for initial discussion and reflection on gender.

LENGTH OF SESSION:

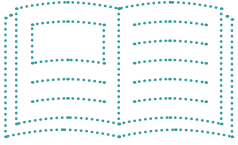
- 1 hour and 15 minutes

LEARNING OUTCOMES:

- Understanding of the course content.
- An appreciation of how gendered assumptions impact on health.

LEARNING MATERIALS:

- **Background briefing 1:** Introduction. This provides some briefing materials for the trainer / facilitator to give a short introduction about the course to the group (10 minutes).
- **Activity 1.1:** Introduction of participants (20 minutes).
- **Activity 1.2:** Ice-breaking activities.
There are two activities that can be used.
 - Where do you stand on gender equality? (30 minutes) including discussion in the full group. This can be used as an opportunity for participants to get to know each other.
 - Gender assumptions (15 minutes) including discussion in the full group



Background Briefing 1

Introduction to gender mainstreaming and to the course

IN THIS SESSION PARTICIPANTS WILL BE INTRODUCED TO EACH OTHER AND TO THE TRAINING COURSE, THE COURSE OBJECTIVES AND COURSE CONTENT.

There are two ice-breaking activities that can be used to enable participants to explore their initial understanding of gender-related health issues. This will also help the trainer / facilitator to identify participants' understanding and awareness of gender and gender-related health issues.

The trainer / facilitator should provide a short overview of the training programme's objectives, content, and a brief introduction to gender mainstreaming. (These can all be found in the 'Introduction' chapter of this handbook).

- It will be important to spell out that gender mainstreaming is now a well-established tool for addressing gender inequalities in health (for example, in Northern Ireland, England, Wales, Scotland, Canada, Australia and Sweden). The World Health Organisation has also prioritised a gender analysis approach to their work on health and implements gender mainstreaming activities at every level globally. The aim is to shift thinking and attitudes so that the gender-related causes of ill health can be addressed by health professionals. Core to this is providing gender-sensitive services.
- Gender equality means giving equal visibility, empowerment and participation to women and men in all spheres of public life and in the delivery of services. In a health context it is important to address the factors that lead to gender inequalities in health and to show how they can be addressed by policy makers, planners and service providers. For example, in conducting clinical trials, working on smoking cessation with women or treating obesity in men.

It is also important to set the context, including the following points:

- Gender mainstreaming is not just about women's health; it is a process for identifying and acting upon the gender-related factors that affect women's and men's health. This is important as gender norms, gender roles and gender relations impact on women's and men's health in different ways.
- Gender mainstreaming has implications for a whole range of health interventions. In this training guide the focus is given to providing gender sensitive health services. There are other areas that potentially could be included, but are not the part of the content of the training. For example, women are often not included in clinical trials and clinical data is often not subject to a specific gender data analysis. Even if women are included in clinical trials the results are not always analysed by gender. This is also relevant for medical education and training.
- In gender mainstreaming, a broad approach is taken to health, so that the factors or determinants that influence health are addressed across the broad spectrum of inequalities in health. This is important because gender intersects with other population groups such as older people, minority ethnic groups including Travellers, LGBT people, and across other determinants such as poverty and disadvantage.
- A key focus is given to raising awareness of gender inequalities. This is done by getting participants to challenge stereotypes, gender power relations and gendered assumptions about the factors that influence women's and men's health. Participants are encouraged to explore how services can be provided to women and men in gender-sensitive ways.
- The goal of gender mainstreaming is to transform health policy, planning and service delivery ensuring equal outcomes for women and men.
- Core to this is bringing the experience, knowledge, interests and voice of women and men into policy making, service planning and service delivery.
- Gender mainstreaming requires a whole systems approach. This means policy makers, planners, managers and front-line service providers make a commitment to implementing gender mainstreaming in practice.

THE LEGAL CONTEXT

- It is important to recognise that there is also a legal framework in relation to gender equality that places obligations on service providers. Gender is one of the nine equality grounds protected under the **Equal Status Act 2000** and the **Employment Equality Act 1998**, which outlaw discrimination on the gender ground against women or men on the gender ground in service delivery and employment. The gender ground refers to a man, a woman and a transgender person. In a healthcare setting, this means providing services that are non-discriminatory and that promote equality of opportunity.
- Gender mainstreaming is a commitment under the Irish National Women's Strategy 2007 – 2016 and the Department of Health's National Men's Policy 2008 – 2013.



Activity 1.1

Introduction of course participants

Ask participants to introduce themselves and set out their expectations of the course. This can be done through 'paired peer introductions', by asking participants to split up into pairs – in each pair ask participants to 'interview' each other and then present their partner to the full group.

Alternatively you can ask each individual in the group to introduce her/himself.

Here are some suggestions of what to cover:

- What is your name and where do you work?
- Do you have any experience of working on gender equality issues as part of your job?
- Why did you decide to attend this course?
- What are your expectations of the course?

Hello! My
name is...



Activity 1.2 Icebreakers

There are two icebreakers that can be used.

ICEBREAKER 1: WHERE DO YOU STAND ON GENDER EQUALITY? (30 MINUTES)

IN THIS ACTIVITY WE WILL LOOK AT PARTICIPANT'S VIEWS ON AND EXPERIENCES OF GENDER EQUALITY. THIS ACTIVITY CAN BE CARRIED OUT IN THE FULL GROUP.

Place three flip charts around the room marked 'yes', 'no' and 'not sure'. From the list below, read one statement at a time and ask participants to stand by the flip chart that best reflects their answer to the question.

At each stage of the activity ask participants to explain why they are standing beside their chosen flip chart. Encourage discussion amongst participants on each statement. You can use all of the statements on the list or select a few of them.

Where do you stand on the following statements:

- Women's place is to care for children and their families.
- Men carry out more important work than women.
- Women's work and skills in the home and in the labour market are under-valued.
- Differences between men and women are determined by differences in reproductive systems and hormones.
- Women are more caring than men and therefore more fit for certain kinds of jobs than men.
- Three times as many men die in car accidents than women.
- Women undergoing heart surgery are more likely to die than men.
- Women are less likely than men to have access to both economic and social resources.
- Wealth and poverty are nearly equally divided between women and men.
- Women and men have equality and equal social status.

ICEBREAKER 2: HOW WE MAKE GENDER ASSUMPTIONS (15 MINUTES)

Read out the following scenario:

A father and his son were travelling from the capital city to a city 100 kilometers away. Their car bursts a tire, somersaults and crashes into the railings at the side of the road. The father died on the spot and his son was rushed to the nearest hospital in a critical condition, requiring surgery to save his life. The surgeon on duty, who was a very prominent person in the country, was called to come and attend to the boy. On arriving on the ward to examine the boy, a loud gasp was heard from the surgeon who said: 'I can't operate on this boy, he is my son!'.

Ask participants to respond immediately to 'who is the surgeon'. Most people get this wrong! Use this example to discuss gender stereotypes and how, without realising it, we hold many gender assumptions.

Session 2

How do we understand health and how does gender interact with health?

AIMS:

- To give participants an opportunity to explore what health means in the context of the right to health and in a personal context.

LENGTH OF SESSION:

- 1 hour and 15 minutes

LEARNING OUTCOMES:

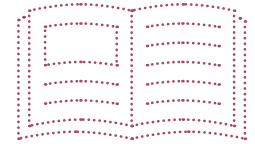
- Understanding health in the context of the broad determinants of health.
- Appreciation that gender equality is central to understanding health.

LEARNING MATERIALS:

- **Background briefing 2:** How do we understand health? This provides some briefing materials to for the trainer / facilitator to give a short introduction to the group (15 minutes).
- **Activity 2.1:** Exploring what health means to you. This activity should be carried out in small groups (30 minutes), with report back and discussion in the full group.

Background Briefing 2

What is your understanding of health?



LET US START BY LOOKING AT WHAT WE MEAN BY HEALTH. THE WORLD HEALTH ORGANIZATION DEFINES HEALTH AS 'A STATE OF COMPLETE PHYSICAL, SOCIAL AND MENTAL WELL BEING, NOT MERELY THE ABSENCE OF DISEASE OR INFIRMITY'. IT HAS ESTABLISHED A HEALTH EQUITY GOAL OF 'HEALTH FOR ALL'.

The starting point for this is to recognise that in achieving 'health for all' we need to uncover the reasons why some population groups experience worse health or poorer access to health services than others. Introducing a gender perspective can help to uncover the gender-related causes of ill health and how this impacts on the health and well being of men and women.

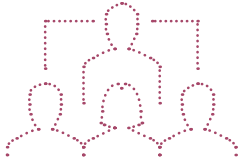
The right to health is a fundamental human right that is enshrined in the Universal Declaration on Human Rights (UDHR) and the International Convention on Economic, Social and Cultural Rights (ICESCR). Article 12 of ICESCR sets out 'The right of everyone to the enjoyment of the highest standard of physical and mental health'. This covers accessibility, acceptability and quality of healthcare; gender inequalities in health; gender-based violence; participation in decision-making processes; non-discrimination in access to healthcare. It is recommended in the ICESCR that nation states should:

'integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women'

(CESCR General Comment 14, para 20 p. 16).

It is important to note and reinforce the fact that health outcomes are closely related to the social processes that influence gender equality. On this basis equality can benefit everyone and has wider societal outcomes. For example, if men's mental health improves or if risk-taking behaviour, which also has an impact on communities, is reduced, this will benefit the health and well being of women and children in their families and their participation in family life. If women's poverty is reduced, for example, through participation in good quality employment, this benefits children and men in their families and in the local community.

Note: The HSE's training course for health promotion officers on inequalities in health 'Getting to work on health inequalities' covers this issue in more detail – if the group has already participated in this training, you may wish to skip the next activity. If this is the case you should still get participants to reflect on the learning from the training 'Getting to work on health inequalities' in relation to what health means in the broader context of the right to health and the social determinants of health.



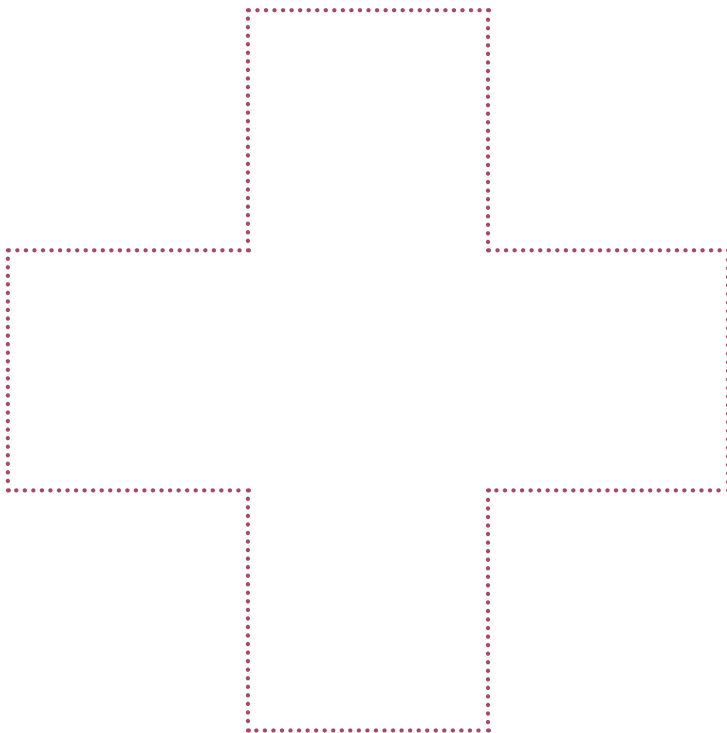
Activity 2.1

Exploring what health means to you

IN THIS ACTIVITY WE WILL LOOK AT THE MEANING OF HEALTH AND WHETHER WE GIVE DIFFERENT MEANINGS TO WOMEN'S AND MEN'S HEALTH. THIS ACTIVITY CAN BE CARRIED OUT IN SMALL GROUPS.

- In your small groups spend a few minutes discussing what health means to you. Jot these definitions down on a flip chart.
 - How far do you think that the WHO definition of health 'A state of complete physical, social and mental well being, not merely the absence of disease or infirmity' reflects how healthcare is delivered in Ireland?
- Have a brief discussion about what do you think the right to health means to you in terms of a) women's health and b) men's health?
 - Have a brief discussion about what you think are the main factors that impact on your own health (as either a woman or a man). Consider the role of biological factors and the broader social and cultural factors (and how they interact).

Note: the next session will look at the difference between sex and gender (and how they interact), for now you will be exploring your initial thoughts about this.



Session 3

Sex and gender: what are the differences and how do they impact on health?

AIMS:

- To introduce participants to the differences between sex and gender and how they impact on health

LENGTH OF SESSION:

- 45 minutes – 2 hour and 45 minutes (depending how many activities are used)

LEARNING OUTCOMES:

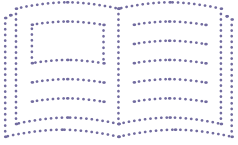
- Understanding of the course content.
- An appreciation of how gendered assumptions impact on health.

LEARNING MATERIALS:

- Background briefing 3: Sex and gender – what are the differences? This provides some briefing materials for the trainer / facilitator to give a short introduction to the group (15 minutes).

- **Activity 3.1:** Brainstorm on sex and gender (30 minutes), with report back and discussion in the full group.
- **Activity 3.2:** Case Study: Women and detection of heart disease (30 minutes).
- **Activity 3.3:** Case Study: Men and the risk of cancer (30 minutes).
- **Activity 3.4:** Case Study: Men and breast cancer (30 minutes).
- **Activity 3.5:** HPV Virus
- **Activity 3.6:** Gender identity and healthcare.

In this session Activities 3.2 – 3.5 can be followed in sequence or they can be divided up between the group. Allow up to 15 minutes for discussion for each activity.



Background Briefing 3

Sex and Gender, what are the differences?

IN ORDER TO BE ABLE TO INCORPORATE A GENDER PERSPECTIVE INTO HEALTH, IT IS IMPORTANT TO DISTINGUISH BETWEEN SEX AND GENDER. EACH PERSON HAS A SEX, GENDER AND A GENDER IDENTITY AND THESE ARE ALL DIFFERENT BUT RELATED. IT IS ALSO IMPORTANT TO SHOW HOW SEX AND GENDER OVERLAP IN RELATION TO WOMEN'S AND MEN'S HEALTH.

In practice there are often confusions about sex and gender. For example, official registration forms often ask 'what gender are you?', when what is actually being asked is 'are you male or female?'. It is important from the outset to be clear that gender (i.e. social factors and expected gender roles) is not the same as sex (i.e. whether you are biologically a man or a woman).

DEFINITIONS OF SEX AND GENDER

A) Sex (biological) differences

Women's and men's biological, genetic and hormonal make-up are biologically determined. There are, however, variations among men and women.

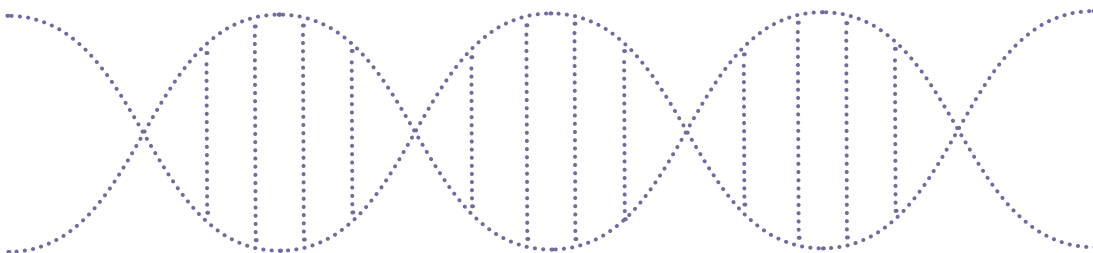
'Sex' relates to genetic make up, hormones, body parts, in other words the biological and physiological characteristics that define men and women. These are the characteristics which are biologically determined and result in different illnesses and symptoms. There are obvious differences related to women's reproduction or in relation to cancer risks, and to the fact that men have higher rates of mortality than women.

B) Gender differences

Gender refers to differences between women and men that are socially constructed and may influence health behaviour and health outcomes. This is related to differences in the social roles, social contexts and power relations between women and men. Gender norms, roles and relations are not universally prescribed; rather they change over time. For example, men are often constrained by societal notions of masculinity, and women are constrained by prescribed gender roles as carers. Women are the primary providers of care for children, elderly or disabled family members, which can impact on their health and well being.

Men's roles are often influenced by pressures to be 'masculine', which may result in health risks associated with risk-seeking behaviour or reluctance to seek healthcare. Feminine and masculine traits are ways of behaving that society usually associates with being a girl/woman or a boy/man. Feminine characteristics are commonly held to be emotional, sensitive, quiet and nurturing. Words commonly used to describe men are independent, non emotional, tough and strong. These categories are unrealistic and both men and women show different traits at different times.

Gender inequality means that women do not enjoy the same opportunities and rights and do not share equally in the distribution of power and influence. This inequality is one of the most influential determinants of health and operates across all areas of life, including how people live, work and relate to one another.



Some examples of gender inequalities are:

- Women earn significantly less money than men in the workplace (in Ireland there is a gender pay gap of around 15%). Often the work carried out by women is not rewarded as being of an equal value to work carried out by men. For more information about the factors that cause the gender pay gap see ‘Tackling the gender pay gap in the European Union’. www.ec.europa.eu/justice/gender-equality/files/gender_pay_gap/gpg_brochure_2013_final_en.pdf.
- Women carry out more housework and care responsibilities than men. (For more information about gender differences in housework and care see: ‘The distribution of caring, housework and employment among women and men in Ireland’, by Frances McGinnity and Helen Russell www.equality.ie/Files/Gender-Inequalities-in-Time-Use.pdf). and Who Cares, Challenging the Myths about Gender and Care in Ireland www.nwci.ie/download/pdf/who_cares_october_2009.pdf.
- Traditionally men have been seen as the breadwinner, earning a ‘family wage’, with economic responsibility for providing for their families.
- Patriarchy and the structures therein means that societal and family roles which retain power, control and prestige are predominantly held by men, and women are more often found in subservient roles.

WOMEN'S AND MEN'S ROLES ARE AFFECTED BY HOW GENDER IS VIEWED IN A PARTICULAR CULTURE OR SOCIETY. GENDER DIFFERENCES ARE NOT FIXED AND CAN CHANGE OVER TIME, FOR EXAMPLE WE CAN SEE HOW THE PHYSICAL IDEAL OF WOMAN HAS CHANGED THROUGHOUT HISTORY.

C) Gender Identity

Gender identity is how a person feels about and expresses their gender role; through clothing, behaviour and personal appearance. Some people feel that their gender identity does not match their biological sex. This person may identify as transgender.

D) Sex and gender have overlapping effects

It is important to see how sex and gender overlap in relation to health. For example, alcohol consumption among men can be related to societal culture about what is expected ‘masculine’ behaviour. However, there are biological differences between women and men that influence alcohol consumption. Changes are also apparent over time seen, for example, in relation to the rising numbers of young women who drink and smoke. Another example is that on average women live longer than men. However, when we look at ‘healthy life expectancy’ the gap narrows; this is because many older women live with disability and ill health in their later years.

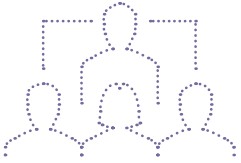
EVEN THOUGH MEN BENEFIT FROM HIGHER LEVELS OF POWER AND RESOURCES THAN WOMEN, MEN EXPERIENCE HIGHER MORTALITY RATES FOR ALL LEADING CAUSES OF DEATH AND LOWER LIFE EXPECTANCIES – THESE CAN BE EXPLAINED BY BOTH BIOLOGICAL AND SOCIAL FACTORS.

For example, the association of male gender roles with risk taking behaviour around drinking and driving accounts for significantly higher mortality rates in younger age groups.

Rates of breast or cervical cancer amongst women and of testicular or prostate cancer among men are biologically determined. However, gender affects health-seeking behaviour, for example, in the take up of screening or other services. Men, particularly in lower socio-economic groups, are less likely to visit the GP and talk about their health concerns. Women, particularly those living in poverty, may have difficulties in accessing health care because of an absence of childcare, a lower level of education, a lack of time because of multiple work, family and caring responsibilities, or because of lack of access to transport.

Women’s and men’s symptoms of disease or ill health may be interpreted differently by a doctor. For example, women may have symptoms of angina that do not mimic those of men and this can result in a female patient’s heart condition remaining undiagnosed or under-treated.

ALTHOUGH THERE MAY BE BIOLOGICAL DIFFERENCES IN THE WAY THAT DOCTORS MAKE A DIAGNOSIS, GENDER AWARENESS CAN HELP DOCTORS TO UNDERSTAND THE DIFFERENT RISK FACTORS, PRESENTATION, DIAGNOSIS AND TREATMENT OF A DISEASE THAT MAY BE OVERLOOKED.



Activity 3.1

Brainstorm on sex and gender



Firstly, in your small groups discuss what you think are the main biological differences between women and men (physiology, hormones, genetics). Make a short list of what you think are the most important differences/factors which have an impact on health.

Secondly, go on to discuss, using your own experiences, what you think are the main social and cultural factors that lead to gender construction and consequent inequalities. Think about this in relation to women's and men's roles. Do we value women's and men's roles and behaviour equally? See if you can find some examples of how expectations are made of women's and men's roles vis a vis responsibilities and behaviour.

Thirdly, looking back at your discussion of sex and gender, find some examples of how sex and gender might overlap in a healthcare setting. Are there cases where gender impacts on how a diagnosis is made or what type of treatment is provided?

BE PREPARED TO REPORT BACK AND DISCUSS IN THE FULL GROUP

Using the worksheet A3.1 on the page following, compile a list of the main social/cultural and biological factors in the worksheet provided and be prepared to provide a summary of your discussions and discuss in the full group.

TRAINER / FACILITATOR NOTES

- 1 Draw out a discussion, with examples, of the differences between sex and gender.
 - 2 Encourage participants to examine ways in which sex and gender interact
 - 3 Are there areas where specific aspects of women's and men's health are overlooked because we do not have a lens on gender-related issues?
-

Worksheet A 3.1

What are the factors that impact on your own health as a woman or a man?

Biological Factors

Social and Cultural Factors

1

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2

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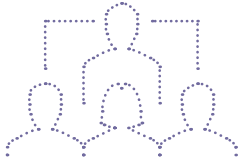
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8

Cases where sex and gender overlap e.g.

Cases where gender might impact on diagnosis e.g.



Activity 3.2

Case Study: Gender bias in detection of heart disease

The next example can be discussed in the full group or can be run as a role play (see suggested role play below). It shows how gender bias can exist in diagnosis and treatment of Acute Coronary Syndrome (ACS) in women. It is an example of how biological (sex) and social factors (gender) impact on heart disease.

WOMEN AND MEN HAVE DIFFERENT EXPERIENCES OF CARDIOVASCULAR HEALTH IN DIAGNOSIS, TREATMENT AND HEALTH OUTCOMES. HOWEVER, HEALTH STRATEGIES RARELY MADE REFERENCE TO BIOLOGICAL DIFFERENCES.

Gender bias exists in the fact that the usual heart disease patient has been male, with diagnosis based on male symptoms. Whereas men's symptoms are typically related to severe chest pain, women are more likely to be misdiagnosed than men, while men are more likely to be referred for further tests.

The Women's Health Council and the Irish Association for Emergency Medicine found that there is gender bias in current policy and practice on cardiovascular health, and a lack of knowledge of appropriate ways to provide services and treatment for women. They sought to raise awareness among emergency medicine health-care professionals in identifying, diagnosing and treating women with ACS who present in emergency departments.

The postcard below was produced for healthcare professionals which recommends that the full spectrum of ACS symptoms be considered in women – including chest pain, fatigue, shoulder / neck pain, nausea, abdominal discomfort and syncope (loss of consciousness).

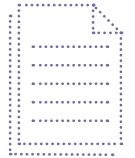
The Emergency Department Assessment of Women with Acute Coronary Syndrome

Are you aware that...?

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

Trainer / Facilitator Notes 3.2

Case Study: Gender bias in detection of heart disease



ENCOURAGE DISCUSSION ABOUT HOW SEX AND GENDER INTERACT IN THIS EXAMPLE.

- 1 You may wish to highlight the low level of women's participation in clinical trials and medical research, and how this has perpetuated a 'male model' of disease; this also applies to medical education.
- 2 Ask participants to discuss this in relation to how health practitioners can take greater account of sex and gender in relation to a wide range of clinical programmes.

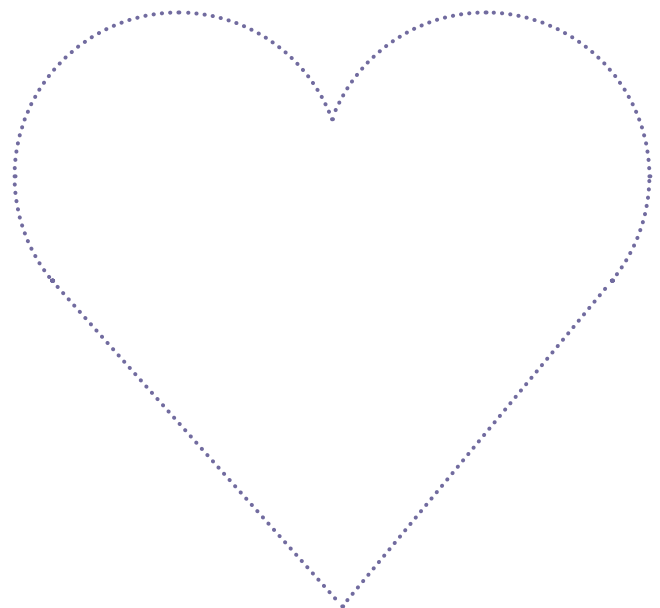
Role play activity (15 minutes)

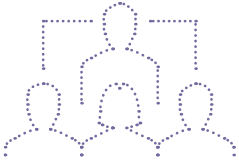
In this role play activity split the group into threes. One participant is a male emergency doctor, one is a female patient and one is an observer. Carry out a role play of a discussion between the doctor and the patient. If there is time, swap roles so that each participant can experience each role.

A 58-year-old female patient presents to the emergency department with fatigue, shoulder / neck pain, nausea and a recent bout of fainting. She tells the doctor her symptoms and that she had recently been experiencing symptoms related to the menopause. The doctor suggests that she take medication for her menopausal symptoms and take some rest. However, she is not happy with the diagnosis and is worried that her symptoms might be heart related.

Take notes of the main areas of discussion and have a debrief in your small group highlighting where the consultation adopts gendered assumptions. Give feedback on the role play to the full group.

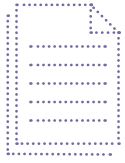
Note: There is another role play on this theme of women and cardiovascular disease in Session 4 (Activity 4.3).





Activity 3.3

Case Study: Men and the risk of cancer



This activity and Activity 3.4 (on men and breast cancer below) deal with how a gender perspective can help to address men's risk of cancer. This is another example that can be used of how sex and gender interact.

There are a number of gender-related risk factors that impact on a higher incidence of cancers (and lower survival rates of cancer and greater risk of death) in men. Although sex differences exist between men and women in relation to cancer, gender-related issues are also likely to have an impact on help-seeking behaviour, prevention and treatment.

SOCIAL FACTORS SUCH AS HIGHER SMOKING RATES, OBESITY, LACK OF PHYSICAL ACTIVITY AND MEN'S RELUCTANCE TO SEEK HELP ALL IMPACT ON PREVENTION AND SURVIVAL RATES.

These risk factors are affected by the broader determinants of health. Men with a lower socio-economic status are more at risk of developing and dying from cancer than men with a higher socio-economic status.

In your small groups discuss how gender-specific actions can be put in place to address men's risk of cancer. These can include:

- Gender-specific health awareness and health information for men, for example, in settings such as the workplace where men are likely to access information.
- Health information and health awareness initiatives that target lower socio-economic groups of men.
- Initiatives that promote early access to prevention and help seeking for men.

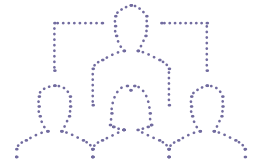
NOTE YOUR MAIN SUGGESTIONS ON A FLIP CHART AND BE PREPARED TO REPORT BACK AND DISCUSS IN THE FULL GROUP.

TRAINER / FACILITATOR NOTES

- 1 Reference can also be made to the extract from the 'Report on the excess burden of cancer among men in Ireland', by N. Clarke, L. Sharp, E. O'Leary and N. Richardson – see background reading in Appendix 2.
- 2 Further information on men's risks of cancer can be found on the Irish Cancer Society's web site: www.cancer.ie/reduce-your-risk/mens-health

Activity 3.4

Case Study: Men and breast cancer



This activity gives an example of men and breast cancer to show how sex and gender interact. It is an example of how we often have gendered assumptions about the incidence of cancer in men and women. Although the incidence of breast cancer is predominantly found in women, around 16 men in Ireland are diagnosed with breast cancer every year.

According to the Irish Cancer Society increasing age is the main risk factor in women and men. Today most men who get breast cancer tend to be over 60 years of age. Men with high estrogen levels are most at risk – high estrogen occurs in men with chronic liver damage, obesity and some genetic conditions. Some men have Klinefelter's syndrome, a rare genetic condition where a man is born with an extra female chromosome. Other risk factors include repeated and prolonged exposure to radiation treatment to the chest wall, and a family history of female breast cancer.

Men tend to receive the same treatment for breast cancer as women. Breast screening services are targeted at women and there is limited knowledge and information about breast cancer in men.

In your small groups discuss the following questions:

- Were you aware that men have a risk of breast cancer? What gendered assumptions does society make of the incidence of breast cancer?
- How do you think that breast screening and treatment programmes can be made accessible to men (by taking gender into account)?
- What needs to be done to ensure that men are more aware about the risks and signs of breast cancer, and in encouraging men to seek help from a health practitioner?
- Have a discussion about how services can be tailored to men's needs and experiences in relation to: a) the role of health promotion and information materials, b) the physical design of the environment in screening services and clinics.

NOTE YOUR MAIN SUGGESTIONS ON A FLIP CHART AND BE PREPARED TO REPORT BACK AND DISCUSS IN THE FULL GROUP.

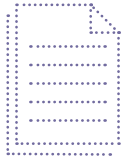
TRAINER / FACILITATOR NOTES

- 1 Make available to the group some examples of materials from breast cancer campaigns to show how breast cancer is targeted at women. See for example: Irish Cancer Society: www.cancer.ie/get-involved/fundraise/action-breast-cancer and Breast Check: www.breastcheck.ie
 - 2 See also men and breast cancer factsheet: www.cancer.ie/sites/default/files/content-attachments/male_breast_cancer_4pp_0.pdf#overlay-context=cancer-information/breast-cancer/about
-



Activity 3.5

HPV virus – girls and boys?



There has been a lot of debate in recent years about the immunisation of girls against the human papillomavirus virus (HPV), in order to prevent girls from becoming infected with the HPV virus and contracting cervical cancer in adulthood. In 2011 the HSE introduced a national HPV vaccination programme for girls.

HPV IS A SEXUALLY TRANSMITTED DISEASE MOST OFTEN ASSOCIATED WITH CERVICAL CANCER IN WOMEN. IT HAS BEEN ESTIMATED THAT HALF OF ALL SEXUALLY ACTIVE PEOPLE BECOME HPV POSITIVE AT SOME TIME IN THEIR LIVES, BUT IN THE VAST MAJORITY OF CASES THE DISEASE IS SYMPTOM FREE.

Until recently HPV was closely connected to cervical cancer. However, in recent years links have been shown between HPV and other cancers, such as oral cancer and cancer of the penis. For example, research from the US shows that HPV has replaced alcohol and smoking as the leading cause of oropharyngeal cancer.

A coalition of organisations in the UK – HPV Action – is campaigning for gender-neutral HPV vaccination and the extension of HPV vaccination programmes to boys. The argument is that vaccinating boys as well as girls would ensure the maximum possible protection for women against cervical cancer and other HPV-related cancers in men.

In your small groups discuss the following:

Are there gendered assumptions about the prevention of the HPV virus?

- Are there assumptions about ‘protecting girls’ inherent in vaccination programmes?
- Do you think that the HPV vaccine should be given to girls and boys?
- What would be the benefits of taking this approach?

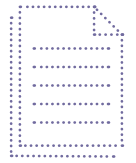
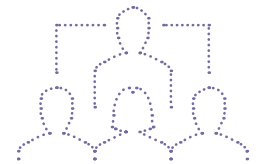
NOTE YOUR MAIN SUGGESTIONS ON A FLIP CHART AND BE PREPARED TO REPORT BACK AND DISCUSS IN THE FULL GROUP.

TRAINER / FACILITATOR NOTES

- 1 Make available to the group some examples of materials about HPV. See, for example Irish Cancer Society Cancer Information Factsheet www.cancer.ie/sites/default/files/content-attachments/factsheet_hpv_vaccine_06.10.10.pdf, men, HPV and throat cancer: www.mensjournal.com/health-fitness/health/the-mans-guide-to-hpv-20130607, and HPV and men fact sheet www.cdc.gov/std/hpv/stdfact-hpv-and-men.html
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Activity 3.6

Gender identity and health-care issues



This activity deals with how gender identity and transgender issues may arise in the health-care setting. People who are transgender may be at greater risk for particular health problems because they don't always see a health-care provider when they need to. This may be because they feel embarrassed, have had a bad experience, fear judgement, or have a health-care provider who is not fully informed.

Transgender people may experience mental health issues as they struggle to identify with their gender identity and / or sexuality. They may have difficulty sharing such personal information with family and friends. They may feel depressed or anxious.

General healthcare for transgender patients is much the same as it is for others. However, there are certain guidelines that may be helpful to health-care professionals as they approach primary care for transgender patients. One important rule is to remember that medical care should focus on the body parts a person has, whether those are congruent with the gender identity or not. An affirmed male may still have a cervix, in which case he should be followed with PAP smears. An affirmed female most likely still has a prostate, in which case she should be screened for prostate cancer at the appropriate age.

Read out the following scenario:

A female in her mid-fifties is referred to the Department of Urology from A&E with a urinary difficulty. On closer inspection it is discovered that the patient has a prostate gland, following discussions with the patient it is discovered that this woman has had Gender Reassignment Surgery (GRS) over 20 years ago. The team need a plan for treating this patient.

In your small groups discuss the following:

What is your reaction to this scenario? What issues arise for you / do you feel would arise for health professionals?? How confident would you be in this situation? What policies are in place for responding to this scenario so that the patient feels respected and dealt with in a professional manner? Note your main suggestions on a flip chart and be prepared to report back and discuss in the full group.

TRAINER / FACILITATOR NOTES

- 1 Make available to the group some examples of materials about Transgender issues. See the Transgender Equality Network website, www.teni.ie, they provide information and assistance and are members of the HSE led Transgender Health Working Group. They provide training to health-care providers, schools, employers etc. and provide support and information to Transgender people and their families accessing and navigating the health-care system. The website has a list of health professionals with experience in this area; www.teni.ie/page.aspx?contentid=1166 also information publications at: www.teni.ie/page.aspx?contentid=78
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Session 4

The Social Construction of Gender: gender as a determinant of health

AIMS:

- To introduce participants to gender as a determinant of health and the factors that impact on women's and men's health.

LENGTH OF SESSION:

- 1 hour to 3 hours

LEARNING OUTCOMES:

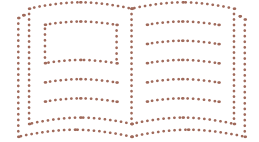
- Understanding how gender norms, roles and relations impact on women's and men's health.
- Appreciation of how gender cross-cuts with other determinants of health.

LEARNING MATERIALS:

- **Background briefing 4.1:** Gender as a determinant of health – the factors that impact on women's and men's health. This provides some briefing materials for the trainer / facilitator to provide a short introduction to the group.
 - **Activity 4.1:** Gender norms, roles and relations (30 minutes).
 - **Background Briefing 4.2:** How does gender interact with other determinants of health? (15 minutes).
 - **Activity 4.2:** The determinants of health (15 minutes).
 - **Activity 4.3:** Older women with cardiovascular disease (30 minutes).
 - **Activity 4.4:** Health and well being of disadvantaged men (30 minutes).
 - **Activity 4.5:** Gender and disability (30 minutes).
 - **Activity 4.6:** Women, disadvantage and smoking (30 minutes).

Background Briefing 4.1

Gender as a determinant of health



AS A STARTING POINT IT IS IMPORTANT THAT THERE IS AN UNDERSTANDING OF HOW GENDER NORMS, ROLES AND RELATVIONS IMPACT ON WOMEN'S AND MEN'S HEALTH AND WELL BEING.

According to the World Health Organization Factsheet 334 Women's Health (2011): Gender norms, roles and relations serve as both protective and risk factors for health among groups of women and men. However, women's disadvantaged social, economic and political status often makes it more difficult to protect and promote their physical and mental health, including their effective use of health information and services. Although women live longer than men do in many contexts, these additional years of life are often spent in poor health. Women experience avoidable morbidity and mortality as a direct consequence of gender-based discrimination.

Let us now look at how gender norms, roles and relations are constructed and how they influence women's and men's health and well being.

Health behaviour, health outcomes and how services are provided are affected by gender norms, gender roles and gender relations. By understanding these it is possible to see how male and female roles are socially constructed and how unequal power relations affect health outcomes for different groups of women and men. With an understanding of the gender-related causes of ill health and inequality, appropriate policies and services can then be developed in the health sector.

Gender norms, roles and relations affect the health of women and men across the lifecourse, across all ages and social groups. They also impact on women's and men's health in different ways.

A GENDER PERSPECTIVE CAN HELP US LOOK AT INEQUALITIES IN WOMEN'S AND MEN'S ROLES, WHICH ARE A RESULT OF UNEQUAL POWER RELATIONS BETWEEN WOMEN AND MEN.

It enables us to address other factors such as social class, poverty, ethnicity or sexual orientation and how these broader inequalities impact on the lives, health and well being of women and men. The way power is distributed means that women have less access to and control over resources to protect their health, are less likely to be involved in decision making and are more likely to be responsible for caring for the health of family members and others.

WHAT ARE GENDER NORMS?

GENDER NORMS ARE THE EXPECTATIONS PLACED ON WOMEN AND MEN BY SOCIETY TO BEHAVE OR CONDUCT THEMSELVES IN A PARTICULAR WAY.

A gender norm is a behaviour or attribute that society accords to a particular sex. Gender norms change from culture to culture and over time since they are **expectations** of societies that are consistently evolving. Things as simple as the colours boys and girls typically wear are gender norms; pink is for girls, blue is for boys.

Gender norms may make it more difficult for men to come forward to seek help for a health problem. As a result it is important to analyse how gender norms affect women's and men's capacities and health-seeking behaviour if health service provision is to be effective. Norms and stereotypes that value male authority and privilege increase health risks for women. Unequal power relations between women and men, reinforced by cultural traditions, contribute to gender-based violence and to unsafe practices such as female genital mutilation. It is worth remembering that FGM is now illegal in Ireland. Men's working conditions, for example, in construction, may require heavy physical demands and the association of physical labour with male gender roles and responsibilities. This often means that men are more vulnerable to work-related injuries.

Heterosexual norms can also lead to discrimination that adversely affects the health of lesbian, gay, bisexual and transgender people. Discrimination and homophobia can lead to social exclusion, marginalisation and stigmatisation. The health effects can include substance misuse, eating disorders, mental ill health (including suicide and other forms of self-harm).

WHAT ARE GENDER ROLES?

GENDER ROLES RESULT WHEN THE AGREED NORMS OF SOCIETY IMPACT ON WOMEN AND MEN AND THEY ADOPT AND PLAY THE ROLES BELIEVED TO BE APPROPRIATE TO THE NORMS OF THEIR SEX.

Women's lower levels of access to power and resources can result in negative health consequences. Assumptions about men's roles as being the 'breadwinner' can also have damaging health consequences for men, particularly if they want to take on care roles in the family.

Women's lower status in society takes place through social, economic and political structures. Women experience inequalities in relation to employment, participation in policy making and health planning. Women are also the main providers of child care and care of older and disabled people.

Gender norms affect women's and men's roles in the labour market and the jobs that they carry out, which have changed over time. In the past most women didn't carry out paid work and were expected to take care of the family and the home. In 2011 56% of women were in paid employment, compared to 26% in 1961. However, women make up 68% (QNHS Q42012) of part-time workers (compared to 12% of men) in order to balance work and family / care responsibilities.

However, changes seem to be taking place with a minority of men taking on roles of full-time parenting. Certain male gender roles and socially ascribed notions of 'masculinity' can constrain men and lead to behaviour and attitudes that are health damaging. Health damaging or risk behaviours are closely associated with 'proving' one's masculinity, while health-seeking behaviour can often be associated with femininity.

WHAT ARE GENDER RELATIONS?

Definition of relations: How different groups or individuals interact with each other.

Gender roles and gender norms impact on gender relations. Gender relations define how women and men interact with each other. The relations of power and dominance structure the life chances of women and men.

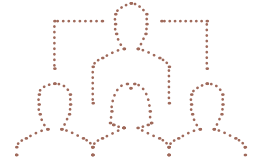
For example, women's care roles are undervalued and restrict women's broader participation in work and society. This results in unequal relationships within the family, in relation to care and in access to employment, education and training, and in the wider society. Unequal gender relations impact on women's and men's health in different ways.

TO SUM UP

Improving the health of women and men means that we need to address the social and cultural factors that lead to gender inequalities – in other words this means focusing on the gender-related causes of ill health. By becoming aware of how gender constructs different roles for women and men, and by taking account of unequal power relations between women and men, health service providers will be able to address different health risks and vulnerabilities experienced by women and men, as well as their health-seeking behaviour.

Activity 4.1

Gender norms, roles and relations



DIVIDE INTO THREE GROUPS. IN EACH GROUP DISCUSS ONE CONCEPT: **A) GENDER NORMS, B) GENDER ROLES, OR C) GENDER RELATIONS.**

In your groups see how many examples you can come up with on the concept you are discussing. Draw on your own experiences and your experiences of working in a health-care setting. What do you think the impact is on women's and men's health of the example(s) you came up with?

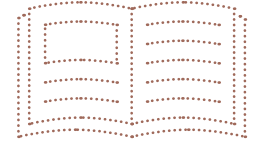
You can use the grids overleaf to jot down your examples of gender norms, gender roles and gender relations – these can be in the family, in the community, in the workplace and in wider society.

In the full group present the examples you have discussed to the other two groups. Then go on to discuss, using your examples, any differences and similarities between your examples and how they impact on women and men differently. See if you can show gender norms, gender roles and gender relations interact with each other.

	EXAMPLE	IMPACT ON WOMEN'S HEALTH	IMPACT ON MEN'S HEALTH
Gender norms	e.g. men are traditionally expected to be self confident, non emotional, ambitious or aggressive.		
1			
2			
3			
Gender roles	e.g. women the main carers of children.		
1			
2			
3			
Gender relations	e.g. women experience inequalities in the workplace and an undervaluing of their work and skills.		
1			
2			
3			

Background Briefing 4.2

How does gender interact with other determinants of health?



GENDER IS AN IMPORTANT DETERMINANT OF HEALTH. IT IS NOT HOWEVER AN ISOLATED DETERMINANT OF HEALTH – HAVING A GENDER PERSPECTIVE MEANS THAT WE ALSO NEED TO UNDERSTAND HOW GENDER INTERACTS WITH OTHER DETERMINANTS OF HEALTH.

Women's and men's health status is affected to a very large extent by the broader determinants of health. The determinants of health include a person's income, status, support networks, education, employment and working conditions, the physical environment in which they live and their access to healthcare. They also include differences across population groups based on a person's gender, ethnicity, age or sexual orientation and gender identity. See Briefing 4.1 for more on the determinants of health.

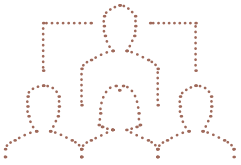
Having a gender perspective can also help to highlight some of the different and overlapping health issues faced by different groups of:

- Women and men living in poverty and disadvantage.
- Women and men who are socially isolated.
- Women and men who lack of access to transport, particularly in rural areas.
- Women and men from minority ethnic communities.
- Women and men asylum seekers living in direct provision.
- Traveller men and women.
- Lesbian, gay, bisexual and transgender people.
- Young women and men; older women and men.
- Disabled women and men.

Having an understanding of how gender interacts with ethnicity and religion for example may impact on the provision of female GPs for Muslim women, or in providing male GPs for men, if this is requested. It may also help to alert health providers, for example in maternity services, to the impact of Female Genital Mutilation (FGM) on women during pregnancy and childbirth, and the need for services that are culturally sensitive. If health-care providers do not have a gender and cultural perspective patients may avoid attending pre-natal appointments and suffer serious consequences during childbirth.

The activities that follow give examples of how gender interacts with other determinants of health. These include having awareness of the specific disadvantages faced by older women and men (see Activity 4.3), or attitudes and assumptions made about women and men with disabilities (see Activity 4.5). Specific gender-related health issues may also face different groups of men. For example, men from lower socio-economic groups and Traveller men may experience poor health and encounter particular barriers in accessing health care (see Activity 4.5 below). Gender-related issues may also affect women's smoking patterns (see Activity 4.6 ahead).

In presenting these examples trainers/ facilitators can decide to use all of the examples by asking each small group to take one or two examples. Alternatively each example could be discussed sequentially. This will depend on the amount of time available. However, it is important that all participants consider Activity 4.2; this can either be carried out in a brainstorm in the full group or in smaller groups, again depending on the time available.



Activity 4.2

The determinants of health

THERE ARE MANY FACTORS THAT DETERMINE THE HEALTH OF POPULATIONS.

To get a full picture of the determinants of health we need to a) recognise the social, cultural, political, economic and environmental factors that impact on our health, and b) how they impact on the health of different groups of women and men.

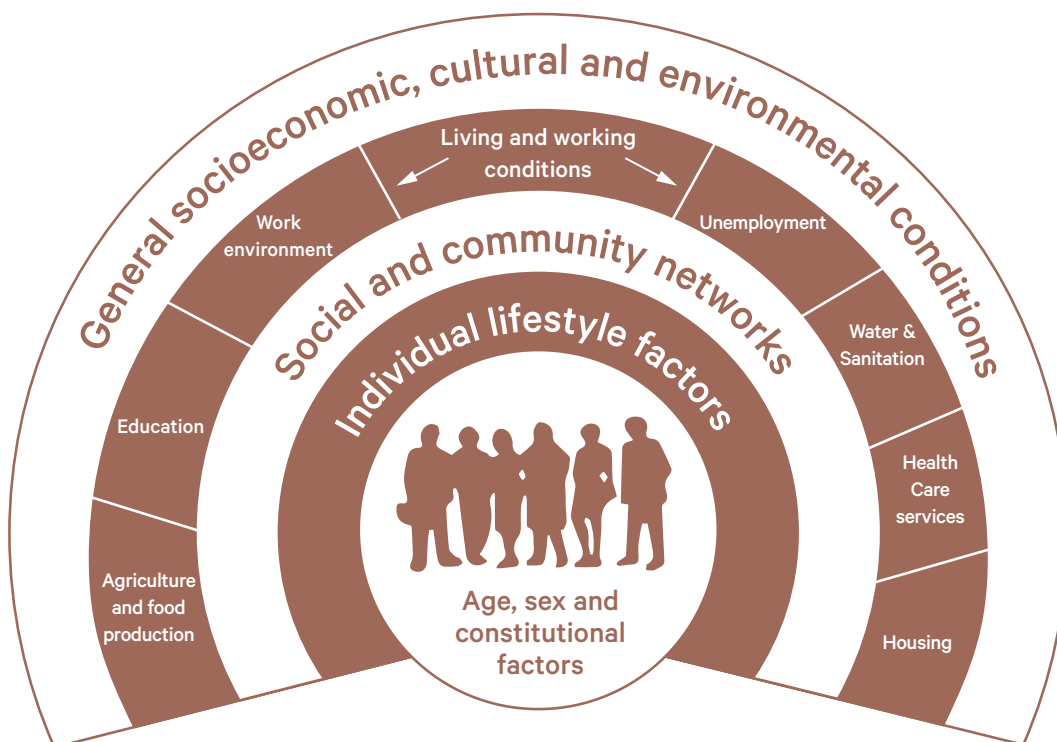
See Diagram below.

In your small groups:

Make a list of what you consider to be the most important determinants of health that impact on a) women's health and b) men's health. Do they differ, and if so, how do they differ?

Next have a short brainstorm about how you think women's and men's access to health care may be affected by these factors.

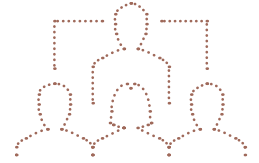
BE PREPARED TO REPORT BACK AND DISCUSS WITH THE FULL GROUP.



Source: Dahlgren and Whitehead 1991

Activity 4.3

Older women and cardiovascular disease – role play



USING THE FOLLOWING CASE STUDY SPLIT UP INTO GROUPS OF THREE FOR A ROLE PLAY. IN EACH GROUP ONE PARTICIPANT IS THE GP, ONE IS THE PATIENT AND ONE IS THE OBSERVER. IF THERE IS TIME, SWAP ROLES SO THAT EACH PARTICIPANT CAN EXPERIENCE EACH ROLE. READ THE CASE STUDY AND CARRY OUT A ROLE PLAY.

An elderly woman presents to her GP with what she thinks are the signs of indigestion, which also include nausea and pressure in her chest when she was walking up hill to the shops. This has worsened since her husband died a year ago and life has been difficult as she has for the first time in her life had to take responsibility for the bills and manage the household finances, which her husband had always looked after. Living alone she has not eaten as well as she did when her husband was alive and she is often lonely and isolated. The GP asks her if she was depressed as she had been through some significant life changes; the woman agreed that this was probably the case. She was prescribed some antidepressants and booked her in for an abdominal ultrasound and Barium meal examination. However, the next day she was admitted into the emergency department in her local hospital with a heart attack.

At the end of the role play each participant should give feedback on the case from the perspective of the GP, the patient and the observer. Broaden this out to a discussion about the biological and social factors that are relevant to the case. Suggest ways in which a gender perspective could help to address a range of issues faced by women in the case study.



Trainer / Facilitator Notes 4.3

Older women and cardiovascular disease – role play

ENCOURAGE A DISCUSSION ABOUT HOW SEX AND GENDER OVERLAP IN THIS EXAMPLE.

- 1 Because of traditions of the bread-winner model and of men controlling household finances, older widowed women may find it difficult to cope alone.
- 2 Social isolation of older people is a very big issue. Having good social networks is an important aspect of health and well being amongst older people.
- 3 Older people may experience poor nutrition – poverty amongst older people and living alone may make it difficult to be motivated to prepare healthy meals.
- 4 Although the woman in this example was depressed and eating badly, her symptoms were typical for heart disease; but this was not considered by the doctor as heart disease is often considered to be a men's disease.
- 5 Women may present with symptoms that are different from the cardiac symptoms doctors have been taught to recognise. Often women are diagnosed much later in the course of disease, and under-treated as a result.
- 6 Other things to consider include: support that could be provided by community groups and day centres for older people in helping widows to manage their finances and in providing skills training for men who need to learn how to cook, clean and shop, and to help older people to shop.

Activity 4.4

Health and well being of men from lower socio-economic groups



BACKGROUND

This activity looks at how we can develop a better understanding of how poverty and disadvantage interact with men's gender roles. Men living in poverty and disadvantage experience a range of barriers in accessing health services. Men from lower socio economic groups are less likely to adopt healthy lifestyles, they have poorer access to health care and have higher rates of illness and death in all age groups.

Men living in lower socio-economic groups have higher rates of death and poorer outcomes than men in higher socio-economic groups. Mortality rates arising from suicide, drug-related poisonings, accidents at work, lung cancer and heart disease are higher amongst men from these groups. Men from the Traveller community have a life expectancy of 15 years less than the general population, and 10 years less than Traveller women. (61.7 years for men, compared to 76.8 in the general population). ('All-Ireland Traveller health study', 2010).

Male gender roles and notions of masculinity can constrain men and tie them into behaviour and attitudes that are health damaging. Health damaging or risk behaviours are closely associated with 'proving' one's masculinity, while health-seeking behaviour can be associated with femininity.

ROLE PLAY ACTIVITY: HEALTH AND WELL BEING OF TRAVELLER MEN

This role play gives an example of men's health, with a particular focus on the health of Traveller men – it shows how gender assumptions and racism towards Travellers impact on Traveller men's health.

Role play 1

Split the group up into groups of three. One participant is a GP, one participant is a Traveller man, and one is an observer. Carry out the role play and observe the interactions between GP and patient. What do you think are the main problems and issues for the GP and the patient?

A man from the Traveller community goes to his local GP for a check up. He tries to explain what is wrong, but he is embarrassed and doesn't understand the words that the doctor uses. Because he has difficulty with reading he is unable to read the prescription and no explanation is given of the instructions on the prescription by the GP or the pharmacist. He goes away without asking any questions because he is embarrassed. Two days later he has finished the bottle of anti-biotics prescribed. (Case example cited in the 'All-Ireland traveller health study', 2010).

Role play 2

In the same group of three carry out the next role play. One participant is a public health nurse, one is a Traveller man and one is an observer. Carry out a role play of the interaction between the public health nurse and the patient. Observe the interactions and what needs to be done to ensure that services are Traveller-friendly, as well as sensitive to the specific needs of Traveller men.

After a bad experience with the GP a Traveller man was told about check-up sessions that were organised specifically for Traveller men run by a local public health nurse. Because he learns that the session is 'Traveller friendly' he feels encouraged to attend the check up. This is what one man said in an interview for the research carried out for the All Ireland Traveller Health Study:

'A load of us came in to it. I thought that was very good ... they would be more comfortable doing that than going to the doctor ... you come in and you know that when you go there they are going to be very sympathetic towards what you are saying because they are already Traveller-friendly you know what I mean.'

In the full group have a discussion of the two role plays and give feedback on how the different roles played out in the two case studies.

Note: In the next session (Session 5) there is a related activity on men and obesity in a primary health care setting (Activity 5.1: Men's access to primary care services).

TRAINER / FACILITATOR NOTES:

ENCOURAGE A DISCUSSION ABOUT HOW MEN'S GENDER ROLES ALSO INTERACT WITH THE SOCIAL DETERMINANTS OF HEALTH; AND HOW MEN'S HEALTH AND THEIR ACCESS TO HEALTH SERVICES ARE AFFECTED BY SOCIAL CONDITIONING OF MALE GENDER ROLES?

- 1 How can health promotion interventions and health services address gender-related issues when taking into account the needs of marginalised men, particularly in relation to the case studies presented of Traveller men's health?
- 2 Examine with the group how male gender roles and notions of masculinity impact on Traveller men's health and well being, and health seeking behaviour.
- 3 Discuss how health providers can have an impact on the health and well being of marginalised men, particularly through a better awareness of gender-related roles, and an understanding of how they interact with the determinants of health.

Activity 4.5

Gender and disability



BACKGROUND

This activity is designed to show how women and men with disabilities are often disadvantaged in their access to health services because of a range of social, physical, information and attitudinal barriers. There are many examples that can be drawn upon that can show how gender-related health issues interact with disability.

LIKE THE TERM 'GENDER', THE 'SOCIAL MODEL OF DISABILITY' AIMS TO LOCATE DISABILITY IN A SOCIAL CONTEXT IN ORDER TO PROMOTE INDEPENDENCE, PARTICIPATION AND EQUALITY FOR MEN AND WOMEN WITH DISABILITIES, FOR EXAMPLE, BY CHANGING ATTITUDES, AND INCREASING AWARENESS, COMMUNICATION AND INFORMATION.

Women and men with disabilities experience discrimination, stigma and exclusion in many aspects of their lives. Health inequalities experienced by men with disabilities arise from poverty and a lower level of access to health promotion and prevention, for example, cancer screening services, checks for diabetes or heart health. Adding a gender dimension can help to improve understanding of how gender-related issues interact with disability in promoting health and well being and in changing attitudes and assumptions about women and men with disabilities.

Research shows that women with disabilities may experience significant barriers in accessing health services. Approximately 38,500 women of child-bearing age have a disability. The most frequently cited disabilities for women of child-bearing age are mental health difficulties, chronic pain, mobility disabilities, intellectual disability and difficulties remembering and concentrating. Women's access to sexual and reproductive services is often impeded by poor communications, attitudinal barriers and a double burden of inequality faced by women with disabilities (See: O'Connor, Barry and Murphy 2006). For example, according to the Irish Deaf Society, deaf women may not be aware of breast-screening services because information is not provided in an accessible way. Women with intellectual disabilities might not be regarded as being sexually active which may affect their access to cervical screening or sexual-health services.

Experiences of women with disabilities in accessing maternity services shows a lack of awareness of the communication and accessibility needs of women, resulting in poor quality care, discrimination, and patronising and stigmatising attitudes. Assumptions are often made that women with intellectual disabilities and mental-health disabilities pose a risk to their child, regardless of whether or not there was any evidence to support this perception.

Women with physical and sensory disabilities experience difficulties in accessibility in terms of the location and delivery model, accommodation and acceptability of care. Further barriers faced by women with mental-health difficulties arise because of reluctance to disclose because of a perceived stigmatisation that they are not capable of being good mothers (See: Begley et al 2010).

Role play: Disabled women’s access to maternity services

In this role play activity split the group into threes. One participant is a mid-wifery manager, one is a female patient and one is an observer. Carry out a role play of a discussion between the mid-wifery manager and the patient. If there is time, swap roles so that each participant can experience each role. When you have completed the role play have a discussion about the gender assumptions that are made in this case, and also how this interacts with the woman’s disability.

A pregnant woman, who is a wheelchair user, wants to attend an ante-natal class at her local hospital. However, she finds out that the class is in an inaccessible part of the building. When she arrives at the hospital she asks to speak to the mid-wifery manager, who comes and meets her at the hospital reception. The mid-wifery manager is really apologetic and says ‘we don’t usually have disabled women coming to our services’. The pregnant woman is very distressed about the lack of accessibility and wants to access the service. They try to find a solution together.

PREPARE TO REPORT BACK AND DISCUSS WITH THE FULL GROUP.

TRAINER / FACILITATOR NOTES:

ENCOURAGE PARTICIPANTS TO LOOK AT HIDDEN ASSUMPTIONS, ATTITUDES AND STEREOTYPES THAT ARE MADE ABOUT WOMEN WITH DISABILITIES, PARTICULARLY IN THEIR ROLES IN PREGNANCY, CHILDBIRTH AND EARLY MOTHERHOOD. IT WILL BE IMPORTANT TO DISPEL MYTHS THAT DISABLED WOMEN DO NOT MAKE GOOD MOTHERS OR THAT THEY ARE NOT SEXUALLY ACTIVE.

- 1 Encourage discussion about what do health-service providers need to do to target women and men with disabilities more effectively to take up health-promotion, health-screening and cancer-screening programmes.
- 2 Explore why gender-related and disability-related assumptions, attitudes and stereotypes need to be taken into account.
- 3 Locate the discussion in a ‘social model’ of disability, rather than a ‘bio-medical’ model, and give focus to how adjustments can be made in the areas of accessible communications and physical accessibility.
- 4 Participants should also be encouraged to consider potential partners and groups outside of the HSE – are there groups and organisations in the community that need to be consulted and involved?
- 5 It will be important to encourage participants to reflect on how they can enhance communications and partnerships with men and women with disabilities, so that they receive patient-centred care on the basis that they are treated as experts in their own accessibility needs.

Activity 4.6

Women, economic disadvantage and smoking



BACKGROUND

WOMEN ARE DYING OF A PREVENTABLE DISEASE AND IT HAS TO DO WITH THE HIGH RATES OF SMOKING. NEARLY ONE IN THREE IRISH WOMEN ARE ADDICTED TO TOBACCO.

In 2013, a campaign by the Irish Cancer Society called for action to tackle a smoking epidemic among Irish women. Today more women die of lung cancer than breast cancer and it is the main cause of death from cancer for women in Ireland. Lung cancer is nearly twice as high amongst poorer women than better off women.

In collaboration with the NWC, the Irish Cancer Society published a report on women and smoking in 2012. See: Irish Cancer Society and NWC 'Women and smoking: time to face the crisis'. www.nwci.ie/download/pdf/womenandsmoking_finalreport2013.pdf

According to the report gender inequality and economic disadvantage in society are a major factor in women's smoking:

'The differences in smoking levels based on social class groups show that female smoking cannot be separated from the issue of health inequalities. Levels of smoking are highest in the poorest communities and are linked to multiple social and economic disadvantages, ill health, and poor life expectancy'

(2012, p. 2)

Women's social and work situations impact on smoking. According to the report:

'Women are also more likely to have part-time, or insecure, jobs and more likely to suffer from stress, and have less power at work and take on large amounts of unpaid work associated with low-status and low self-esteem, exhaustion and depression. This leads us right back to emotional work and mental-health issues women have and back to smoking. Hard work and being poor lead to stress, and as stress is linked to increased smoking, the cycle continues.'

(p.15)

The report provides evidence of the rise in smoking amongst women and ways that the tobacco industry targets women with specific marketing tactics designed to make cigarettes appear attractive and less dangerous than they are. Quotes from the tobacco industry discuss the reasons for and benefits of superslim cigarettes: 'Gallaher is launching a range of super-slim cigarettes under its Silk Cut brand packaged in 'perfume-shaped' boxes to appeal to the female market. Silk Cut Superslims is positioned as a premium cigarette that rivals Vogue Superslims. The female-friendly pack design would give it an edge,' said Jeremy Blackburn, Head of Communications at Gallaher. (p.20)

The report also addresses the social and psychological reasons which make it hard for women to quit smoking and calls on communities to provide supportive places for women to quit smoking. The report shows that the reasons women start and continue smoking are linked to their gender and gender inequalities in society. In addressing the issue, recommendations are made for taking gender differences between women and men into account in smoking cessation programmes, including the development of community-based smoking-cessation services for women, and particularly for women from disadvantaged communities.

Recommendations made in the report include:

- An acknowledgement is needed that the barriers to quitting smoking are multi-faceted and include psychological and social factors, access and availability of services, attitudes of health professionals, and tobacco industry manipulation.
- Community-based cessation programmes to encourage social interaction are needed to overcome these barriers. Smoking provides a sense of solidarity and belonging for many women and is the cultural norm in many communities.
- A national strategy and standards for spelt cessation services are required.
- Communities need to be supportive environments for people who want to quit.
- All health-care professionals should have the capacity to conduct cessation interventions and be encouraged to do so.
- Plain packaging would help counteract the fact that the tobacco industry is targeting young women through innovative packaging.

GROUP WORK

You have been asked to give a ten-minute presentation to a local community group about women and smoking, which should address the gender-related causes of smoking amongst women and particularly amongst women in disadvantaged communities. In your small group, you will plan your presentation using the following as guidelines:

- What are the gender-related causes of smoking?
- Why should smoking-cessation programmes address gender-related issues?
- What suggestions do you make for improving information, community programmes and support for women to quit smoking?
- Are there specific issues that need to be addressed for young women?

BE PREPARED TO GIVE A SUMMARY AND OUTLINE OF YOUR PRESENTATION TO THE FULL GROUP, AND TO DISCUSS THE CONTENT OF YOUR PRESENTATION AND THE SUGGESTIONS YOU HAVE MADE.

Session 5

Gender-sensitive services: Analysis; primary care and mental health

AIMS:

- To introduce participants to some examples of how to make health services gender sensitive.

LENGTH OF SESSION:

- 1 hour and 15 minutes

LEARNING OUTCOMES:

- Understanding of how a gender lens can be applied to primary care and mental health.
- Appreciation of how gender as a determinant of health can be used as a lens to improve access to services.

LEARNING MATERIALS:

- **Activity 5.1:** Men's access to primary care services, including time for discussion in full group (30 minutes)
- **Activity 5.2:** Gender and mental health needs and experiences, including time for discussion in full group. (45 minutes)

This session looks at two examples to show how health services can integrate a gender dimension, while also taking into account other determinants of health.

Trainers and facilitators can use both examples set out below, either to run consecutively or by splitting the group up into smaller groups that follow one or other of the activities. If the latter is the case it will be important to provide a longer period of time for discussion so that everyone in the group is familiar with the two examples.

Each activity provides some background reading.



Activity 5.1

Men's access to primary care: case study of men and obesity



BACKGROUND

THIS ACTIVITY WILL SHOW HOW A GENDER PERSPECTIVE CAN LEAD TO GREATER EFFECTIVENESS IN TERMS OF HEALTH OUTCOMES FOR MEN.

Inequitable gender norms influence how men interact with their partners, families and children on a wide range of issues. This also has implications for how men engage with services and men's health-seeking behaviour.

Men are often reluctant to take up primary care and health screening services. Redesigning services so that they take account of men's working patterns benefits women and men, for example by opening GP or screening services into the evenings or early mornings or designing specific health clinics and services for men. Men may feel uncomfortable attending a GP surgery or health-care centre because they have to wait in a waiting room with women and children. Waiting rooms in GP surgeries and health-care centres often create environments that are more conducive to women, with décor and magazines targeted to women rather than men. A way forward is to have more publicity targeted to men in GP surgeries and health centres, and provision of health checks in the workplace for blood pressure, cholesterol, body mass index etc., and special outreach clinics for young men engaged in risk-taking behaviour, such as drugs or alcohol.

Example: Redesigning services to encourage men's participation in obesity clinics in a primary health-care setting

The following is an example of how a gender-aware approach can be applied to developing best practices in working with obese men in a primary care setting. Male obesity is largely ignored in primary care settings and where services exist obese men are less likely than women to access them. The National Men's Health Policy highlighted the significant rate of increase in obesity in men in Ireland and the need for a gender-specific approach in tackling male obesity through targeted action and specific lifestyle interventions. Male obesity rates have tripled since 1990 (43.8% of men are overweight and 25.8% are obese). Men's diets are less healthy than women's diets; men who are overweight or obese do not see their weight as a cause of concern and men are less knowledgeable about healthy eating. Men's dietary habits are influenced by long working hours, an approach to food that is pleasure orientated and an association of size with masculinity. Men are less likely than women to observe advice about healthy eating and consider dieting to lose weight.

In responding to these challenges a study of obese men who had attended Community Nutrition and Dietitian Services (CNDS) in HSE South in 2008 led to the development of a resource book on best practice approaches for health-care professionals working with obese men in a primary care setting.

It points to the need for a gender lens on male obesity, with lifestyle interventions that are tailored to men's dietary and lifestyle behaviours. This approach was shown to have a positive impact in raising men's awareness and changing their dietary habits, in promoting higher levels of physical activity and reducing alcohol consumption. (Giving men and women personal choice to enable them to take responsibility for their health is a process described as shared decision-making).

The following best practice guidelines were made for health-care professionals working with obese men in a primary care setting:

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

In your small groups read the background briefing above and discuss the following questions:

- How do you think men are disadvantaged by their gender roles? How do different power relations between women and men, and other social and cultural factors, impact on men's roles, and ultimately their health?
- What do health-service providers need to do to more effectively target men who show a reluctance to engage with GP and primary care services, including health promotion and health screening programmes? You can do this by drawing on the example of men and obesity above.
- When having this discussion have a look at what assumptions need to be challenged and think about this in relation to how services can be planned to take account of gender norms, roles and relations. How can these take account of gender stereotypes, attitudes and assumptions?

PREPARE TO REPORT BACK AND DISCUSS WITH THE FULL GROUP.

TRAINER / FACILITATOR NOTES:

- 1 It is important to stress that gender mainstreaming is not about providing services in the same way to everyone – in some cases it may be necessary to provide targeted services for one group.
- 2 Encourage participants to think widely and broadly about gender norms, gender roles and gender relations in influencing men's participation in and take up of primary care services.
- 3 Participants can be encouraged to use the example of the specific obesity clinic for men to discuss other ways in which primary care services can target men who have a low take up of services.
- 4 Discuss how gender interacts with other determinants of health, for example, in addressing access to primary care services by men working long hours, disadvantaged men, Traveller men or gay or transgender men.
- 5 Participants should also be encouraged to consider potential partners and groups outside of the HSE – are there groups and organisations in the community that need to be consulted and involved?



Activity 5.2

Gender and mental health



BACKGROUND

TAKING ACCOUNT OF THE SOCIAL ROLES AND LIFE SITUATIONS OF WOMEN AND MEN IS ESSENTIAL TO PROVIDING GENDER SENSITIVE MENTAL HEALTH SERVICES.

Gender inequalities impact on women's and men's risks of mental ill health in different ways. Women and men have different experiences of their roles, participation and status in the family, work and society. Issues of wider inequalities, poverty and isolation, race and ethnicity, disability, sexual orientation, gender identity, etc., as well biological factors such as the hormonal changes, all play a part in women's and men's mental health.

Age is a factor. For example, gender stereotyping, gender roles and expectations impact on young people's transitions into adulthood. Cultural and gender stereotypes such as 'sugar and spice and everything nice, that's what little girls are made of' or 'boys don't cry' affect young people's views of themselves. Other factors that are important are expectations about body size and sexuality, which affect body image, sexual violence or abuse, social relationships and networks, and differences in help-seeking behaviour. During adolescence, girls have a much higher prevalence of depression and eating disorders. Boys experience more problems with anger, engage in high-risk behaviours and die by suicide more frequently than girls.

In general, adolescent girls are more prone to symptoms that are directed inwardly, while adolescent boys are more prone to act out.

In adulthood, data shows us that the prevalence of depression and anxiety is much higher in women, while substance use disorders and anti-social behaviours are higher in men. In the case of severe mental disorders such as schizophrenia and bi-polar depression, there are no consistent sex differences in prevalence, but men typically have an earlier onset of schizophrenia, while women are more likely to exhibit serious forms of bi-polar depression.

IN OLDER AGE GROUPS, ALTHOUGH THE INCIDENCE RATES FOR ALZHEIMER'S DISEASE IS SIMILAR FOR WOMEN AND MEN, WOMEN'S LONGER LIFE EXPECTANCY MEANS THAT THERE ARE MORE WOMEN THAN MEN LIVING WITH THE CONDITION.

Gender-related experiences and preconceived ideas on the part of health professionals may influence the diagnosis of depression and the higher rates of prescription of psychotropic drugs to women. Gender stereotyping may also lead to under-diagnosis of mental health problems in men. The socialisation of men to keep their emotions to themselves may contribute to high levels of distress among them when faced with situations such as divorce or bereavement.

GENDER ROLES OFTEN RESULT IN WOMEN EXPERIENCING GREATER PROBLEMS RELATED TO SELF-ESTEEM, SELF-WORTH AND NEGATIVITY. SOME FAMILY CARERS, SINGLE PARENTS AND YOUNG MOTHERS MAY EXPERIENCE DEPRESSION BECAUSE OF ISOLATION AND LACK OF SUPPORT.

Many women experience mental-health problems and much higher levels of stress associated with sexual violence.

Men may experience mental ill health because their social roles expect 'masculine' behaviour or because of difficulty in expressing themselves. Gender conditioning may also mean that men do not report or seek support if they have experienced domestic violence.

Women are more likely to have treatment for a mental-health problem than men, which may be a reflection of women's greater willingness to talk about mental ill health and to seek help. It may also reflect health practitioner's expectations of the problems that women and men experience. Anxiety, depression and eating disorders are two times more common in women. A significant number of women experience post-natal depression and some post-partum psychosis after pregnancy. Post-natal depression is believed to affect up to 15% of women after they have given birth. Women are twice as likely to experience anxiety disorders as men. Many more girls than boys self-harm; research from the UK suggests that 1 in 15 young people self-harm. Women tend to suffer from 'internal problems' such as depression or sleep problems, whereas men tend to experience 'external problems' that result in alcohol or anger problems.

Some researchers believe that there is significant under reporting of men's depression because of men's reluctance to talk and seek help. Substance misuse and anti-social difficulties are more common in men. Men's depression and other mental health problems often go undetected and under-treated. Male depression is often manifested through more 'acceptable' male outlets, such as alcohol abuse and aggressive behaviour. Although depression is linked to over half of all suicides, men are less likely to be diagnosed with depression than women and are three times more likely to commit suicide than women.

ALTHOUGH ORGANISATIONS SUCH AS THE WORLD HEALTH ORGANISATION HAVE STATED THAT MENTAL HEALTH PROBLEMS AFFECT WOMEN AND MEN FAIRLY EQUALLY, THIS HAS BEEN CONTESTED IN RECENT RESEARCH.

Research evidence from epidemiological studies from the UK, US, Europe, Australia and New Zealand, show that women are up to 40% more likely than men to develop mental ill health; women are around 75% more likely than men to report having recently suffered from depression, and around 60% more likely to report an anxiety disorder. Men are more likely to report substance misuse disorders – around two and a half times more frequently than women. Conditions such as ADHD and schizophrenia do not show significant gender differences.

(See Daniel Freeman and Jason Freeman (2013) *The Stressed Sex: Uncovering the Truth about Men, Women and Mental Health*, Oxford University Press).

GROUP WORK ACTIVITY

This activity can take place in small groups. It is designed for use with mental health staff and managers.

Mental health staff are often very well aware that women and men using services come with different experiences and needs. Responding to these needs and putting in place programmes of prevention requires much greater attention to be given to gender norms, gender roles and gender relations.

In small groups read the background briefing above and discuss the following:

- How do you think that gender norms, gender roles and gender relations impact on women's and men's mental health?
- Are there specific issues faced by young women and men? How do you think mental health services can become gender sensitive?
- You should consider what can be done to improve practice so that women's and men's health needs and experiences are taken into account.

PREPARE TO REPORT BACK AND DISCUSS IN THE FULL GROUP.

TRAINER / FACILITATOR NOTES:

- 1 Encourage participants to discuss the social factors that impact on mental health, and particularly how gender norms, roles and relations can play a part in understanding women's and men's mental health. It will be important to stress the importance of gender and the social construction of mental ill health.
- 2 Consider also how gender interacts with other determinants of health, by taking into account poverty, disadvantage and inequality. Giving a focus to young people may also be relevant to the discussion, on the basis that there has been a significant increase in recent years in young women and young men experiencing mental health difficulty. It will be important to discuss some of the different problems that young men and young women may face.
- 3 Stress the importance of working from a sound evidence base. For example, how service providers can be informed through their practice, and by using data and consultations to identify gender differences.
- 4 Participants should also be encouraged to consider potential partners and groups outside of the HSE – are there groups and organisations in the community that need to be consulted and involved?
- 5 Encourage participants to think broadly about mental health in society and to be creative in their responses.

Session 6

Gender mainstreaming in health

AIMS:

- To introduce participants to gender mainstreaming in health
- To discuss how gender mainstreaming can be applied in specific healthcare settings

LENGTH OF SESSION:

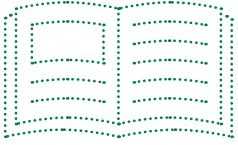
- 2 hours

LEARNING OUTCOMES:

- Understanding the concept of gender mainstreaming.
- Appreciation of how gender mainstreaming can be used as tool for gender-sensitive health services.

LEARNING MATERIALS:

- **Background briefing 6.1:** Introduction to gender mainstreaming in health? (30 minutes)
- **Background briefing 6.2:** Carrying out gender impact assessment (GIA) (30 minutes)
- **Activity 6.1:** Carrying out a gender impact assessment (GIA) (30 minutes)
- Report back and discussion in the full group. (30 minutes)



Background Briefing 6.1

Introduction to gender mainstreaming in health

IN THIS SESSION WE WILL BE EXPLORING HOW GENDER MAINSTREAMING CAN BE APPLIED IN A HEALTH-CARE SETTING. THE FOCUS WILL BE ON:

- How gender mainstreaming can be used as a tool to address gender-related health issues and thereby improve women's and men's health and well being, and to look at these across different population groups.
- Uncovering the impact of gender norms, roles and relations and how they influence the health-seeking behaviour of women and men.
- Using practical tools to provide an evidence base for gender sensitive health services.

Trainers and facilitators may wish to read up on and have further information about definitions and international examples of how gender mainstreaming has been applied in a health-care setting see: HSE / NWCI 'Equal but Different: A framework for integrating gender equality in Health Service Executive policy, planning and service delivery', and has a focus on reducing gender inequalities between women and men. This means integrating a gender perspective into how health services are provided.

Gender mainstreaming provides tools that can be used by policy-makers, health-planners and health-service providers to address gender inequalities and thereby contribute to better health for women and men.

The NWCI **Gender Mainstreaming Project**, funded by the HSE, is addressing this issue by providing managers and staff with the tools they need to identify and act upon gender inequalities.

UNITED NATIONS DEFINITION OF GENDER MAINSTREAMING

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

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

(United Nations, Economic and Social Council, 1997).

GENDER MAINSTREAMING AND NATIONAL POLICY

Gender mainstreaming is a commitment under the Irish National Women's Strategy 2007–2016 and the HSE's National Men's Health Policy 2008–2013.

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

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

(National Women's Strategy, 2007–2016).

There is a wide range of gender mainstreaming tools that have been developed across the world – at the core of all of these is gender impact assessment (GIA) (sometimes also referred to as gender analysis).

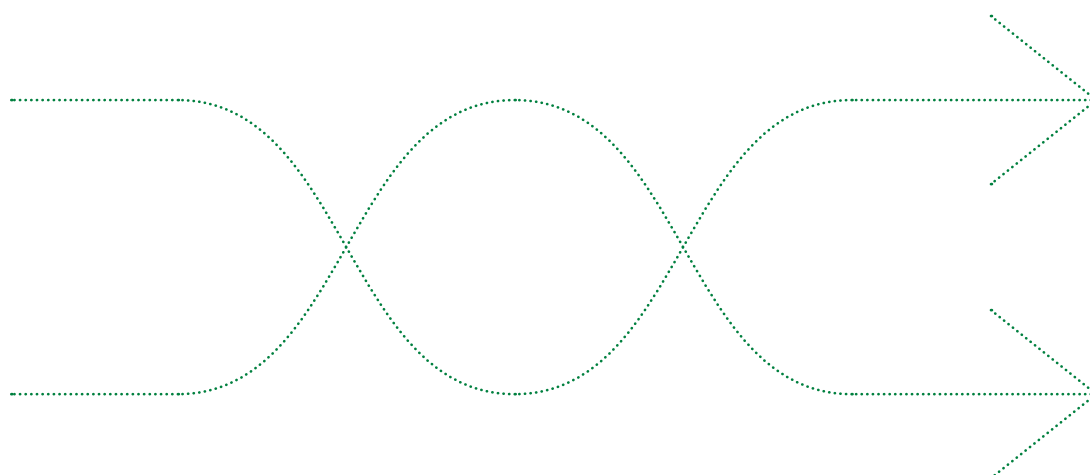
There are two different, but complementary approaches to gender mainstreaming:

PROGRAMMATIC (OR OPERATIONAL) GENDER MAINSTREAMING

This approach addresses equality and non-discrimination by applying tools of gender impact analysis to health. It takes account of gender-related causes of health and is informed by an understanding of how gender norms, gender roles and gender relations affect the health of different groups of women and men. The objective is to ensure that gender inequality is addressed and is built into health-policy making, planning and service delivery. Central to this approach is that practical tools are provided to enable staff and managers to uncover how gender (as a social process) interacts with sex (biology) in the provision of health.

INSTITUTIONAL GENDER MAINSTREAMING

The second approach to gender mainstreaming examines policy and administrative issues across an institution or organisation, so that gender equality is promoted through policy, staffing or governance, health planning, organisational policies and allocation of sufficient financial resources. It aims to deal with the structural or underlying causes of gender inequality within an institution or organisation.



In a health-care setting, gender mainstreaming means that health providers, planners and managers have a responsibility to:

- Raise awareness among the whole organisation on the benefits of gender mainstreaming.
- Ensure organisational policies are reviewed so that they do not reinforce gender inequality in staffing or governance.
- Ensure that policy makers, planners and service providers give the time, commitment and resources to implement gender mainstreaming and to monitor its outcomes.
- Work to change behaviour, attitudes and practices that impact negatively on women's or men's health status.
- Carry out, where relevant, specific activities that empower women or men to address risky or harmful behaviour and to promote their health and well being.
- Encourage women and men from all population groups to participate in influencing health priorities.

In presenting gender mainstreaming as a tool, trainers and facilitators need to be aware that:

- Implementing gender mainstreaming in health requires an integrated and comprehensive approach to women's and men's health, rather than a separate focus on women's health or men's health.
- Differences between and within population sub-groups of women and men need to be identified and responded to with gender sensitive solutions.
- Gender mainstreaming is an approach that should benefit everyone and can have wider societal benefits.
- The objective is to give visibility to gender inequalities recognising that to treat people equally sometimes requires treating people differently.

GENDER IMPACT ASSESSMENT (GIA)

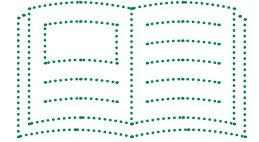
The Gender Mainstreaming Framework 'Equal but different' sets out a model for carrying out a gender impact assessment of health policies, planning and service delivery. This session will introduce participants to gender impact assessment and to the tools that have been developed.

Establishing whether there is *gender relevance* will be important to making decisions about whether changes need to be made, for example, by targeting, restructuring or reconfiguring services to address gender inequalities.

Gender impact assessment is a tool to inform actions to address gender inequality. It takes into account how different gender norms, roles and relations impact on health, including unequal power relations between and among groups of men and women. It also takes into account other factors that interact with gender such as sexual orientation, gender identity, age, ethnicity, poverty, education or employment status. Gender impact analysis also examines how health behaviour and health services are affected by the interaction between sex (biological) and gender (socio-cultural factors).

Background Briefing 6.2

Carrying out gender impact assessment



THIS BRIEFING SETS OUT THE TWO STEPS THAT CAN BE TAKEN TO ASSESS GENDER RELEVANCE AND CARRY OUT GENDER IMPACT ASSESSMENTS.

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

As a first step it will be important to assess the gender relevance of a particular policy or service. This can be informed by consultations with service users, and also with staff working directly with service users. In most cases you will find that there is a gender relevance.

Some questions to consider

- Does the policy or service concern one or more target group? Do women and men participate in the service to an equal degree?
- Is there evidence that women and men do not equally benefit from a service?
- Is there an unintended or adverse impact on one gender of a policy or service?
- What are the differences that have been raised?
- Are there differences between women and men in this policy or service area (with regard to rights, resources, participation, values and norms related to gender, or other social grounds)?
- If you are uncertain, do you think that it would be of benefit to carry out a full gender impact assessment?

Policies which appear gender neutral may on closer investigation actually affect women and men differently. As we have seen, there are substantial differences in the lives of women and men in most policy areas. Therefore, if the answer to these questions is positive then gender is relevant to the issue being examined and a full gender impact assessment should be carried out.

Stage 2: Gender Impact Assessment

Gender impact assessment is a tool for comparing and assessing, according to gender relevant criteria, the current situation and trend with the relevant policy or service. In carrying out a gender impact assessment, account will need to be taken of existing disparities between women and men using the following criteria:

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

- Assess the relevance of gender to the service or policy and how gender differences that exist can be acted upon in a specific service or policy.
- Assess the evidence from consultations and the data gathered to identify gender differences or inequalities.
- Decide on the strategies and develop a plan to change the design or the delivery of the policy or service.
- Monitor the implementation of the policy or service.

THE ROLE OF DATA

A key component of gender impact assessment is having access to good quality data and information that is disaggregated by sex. In some cases data may not be available and can be supplemented with qualitative data, for example, through consultations with women and men in a local community or with service users who have used a specific service. The National Strategy for Service User Involvement in the Irish Health Service 2008 – 2013 stresses the importance of user consultations to health service delivery. Even if there is little or no data available, there is still a lot that can be done to collect data locally, for example, by asking individual male and female service users or groups of service users about their health and their experiences of using services. Local community groups can provide a useful resource in this regard.

Key questions to address in relation to service provision are

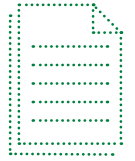
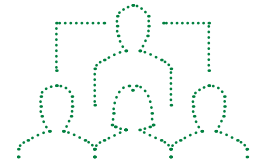
- Do biological differences between women and men impact on their health?
- How do women's and men's social roles affect their health?
- Do gender norms / values affect women's and men's health?
- How does access to resources impact on women's and men's health and their ability to take up services i.e. transport, childcare services, educational opportunities, etc?
- Are there certain groups of women and men that are not taking up services?
- Are women and men receiving the same quality of diagnosis of health problems?
- What are the main health risks identified for different groups of women and men, and are they being addressed?
- What health outcomes result from the service provided?

Key questions to address in relation to HSE policies and plans

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

Activity 6.1

Carrying out a Gender Impact Assessment (GIA)



THIS ACTIVITY AIMS TO GET PARTICIPANTS WORKING IN SMALL GROUPS TO PLAN HOW THEY WOULD CARRY OUT A GENDER IMPACT ASSESSMENT ON A SPECIFIC TOPIC (SELECTED FROM THE LIST BELOW). IF YOU ARE WORKING WITHIN A SPECIFIC SERVICE YOU COULD ALSO CONSIDER USING YOUR SERVICE AS AN EXAMPLE TO WORK THROUGH.

In small groups, select one of the examples below (or use an example from the service you are working in) to plan a gender impact assessment. Set out the steps you have taken in planning a gender impact assessment, highlighting areas that you think may be difficult or complex. See if you can find a solution to complex issues, by taking a small step rather than doing everything at this stage. What other information would you need to put in place? What steps will you put in place to plan to implement and monitor changes?

1) IMPROVING MEN'S ACCESS TO A LOCAL HEALTH CENTRE

A local health centre wants to improve information about and access to its services. There is some on the ground evidence that men are not taking up GP, primary care and preventative services.

Some issues to consider in your small groups

- How would you carry out a gender impact assessment?
- What gender-related issues and assumptions would you need to take into account?
- What data would you need; and if there is no data available, how would you go about collecting this?
- What questions would you ask?
- Who would you consult with to find out how services can respond to men's roles, needs and working patterns?
- How would you provide information that is accessible to men, and that takes account of men's needs and experiences?
- Who would you partner with in the community?

2) GENDER IMPACT ASSESSMENT OF A GP SERVICE

A local Muslim women's group has identified the need to have a choice as to whether they use the services of a General Practitioner who is a woman or a man. The concern is that Muslim women may not be as willing to attend for health care if a woman is not available to them and that these gender and religious / cultural considerations need to be catered for.

Some issues to consider in your small groups

- How would you carry out a gender impact assessment to enable you to facilitate appropriate access to clinicians.
- What gender-related issues would you need to take account of?
- What information and data would you need to collect? What questions would you ask?
- How would you consult with women to find out their needs and preferences?
- Who would you partner with in the community?

3) ACCESS TO SEXUAL-HEALTH SERVICES

There is some concern that young women and young men are not accessing sexual-health services. Some of this concern is that services do not reach young women and men, that information is not appropriately targeted to young women's and men's experiences, and that staff do not take account of gender-related roles and assumptions about young men's and women's sexual health.

Some issues to consider in your small groups

- How would you carry out a gender impact assessment to improve access to services for young women and men?
- What gender-related issues and assumptions would you need to take into account?
- How would you provide information that is appropriate for young women and young men?
- What data would you need; and if there is no data available, how would you go about collecting this? How would you carry this out?
- Who would you need to consult with about this issue?
- What questions would you ask?
- Who would you partner with in the community?

4) PROVIDING APPROPRIATE CARE AND RECREATIONAL SERVICES FOR OLDER PEOPLE MEN IN RESIDENTIAL CARE

A residential home for older people wants to improve the services it provides, including one-to-one care and recreational activities. There have been some indications from residents in the home that recreational activities tend to be focused on traditional men's activities such as poker. Some older women and men have also expressed a concern about their privacy and personal bodily integrity, where personal and intimate care is carried out by an opposite-sex nurse or care worker.

Some issues to consider in your small groups

- How would you carry out a gender impact assessment of the social and care needs of older women and men?
- What gender-related issues and assumptions would you need to take into account?
- What data would you need; and if there is no data available, how would you go about collecting this?
- What questions would you ask?
- Who would you consult with to gain information about this issue?
- Is there anyone that you should partner with in the community to help in carrying out the assessment?

5) LOCAL COMMUNITY-BASED MENTAL HEALTH SERVICES

A community mental health team wants to improve the take up of services in the local community and respond to the different mental health needs of women and men. Your task is to examine how these services can take account of gender-related issues to enable services to be provided in gender sensitive ways.

Some issues to consider in your small groups

- How would you carry out a gender impact assessment?
- What gender-related issues and assumptions would you need to take into account?
- What data would you need and if there is no data available, how would you go about collecting this?
- How would you take account factors such as gender stereotypes, of the needs of young LGBT people, of women with a heavy burden of care responsibilities, and of women and men living in disadvantaged and/or isolated communities?
- What questions would you ask?
- Is there anyone that you should partner with in the community to help in carrying out the assessment?

Discuss the steps taken in the full group. From this a discussion can be held in the group to identify practical ways in which you think a gender impact assessment can be carried out in the service(s) that you work in.

TRAINER / FACILITATOR NOTES:

- 1 Encourage participants to look closely at the two steps to carrying out a gender impact assessment. (A print out of the steps could be provided with the briefing).
 - 2 Note: in all of these examples there is gender relevance. It will be important to encourage participants to set out why there is gender relevance.
 - 3 Ask participants for feedback on what gaps in information or data were anticipated, and any other problems they encountered.
 - 4 Also it will be important to get participants thinking about what practical steps could be taken to remedy any unforeseen gender impacts, and to set out how they would monitor the outcome of changes put in place.
-

Session 7

Working together to address healthcare needs

AIMS:

- To support participants to identify how they will embed their learning on gender and health in their work

LENGTH OF SESSION:

- 1 hour and 30 minutes

LEARNING OUTCOMES:

- Appreciation of how learning about gender-sensitive health services can apply to each participants work setting.
- A plan for carrying forward the learning.

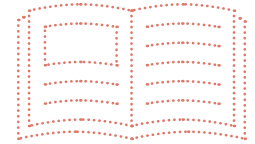
LEARNING MATERIALS:

- **Background briefing 7.1:** Carrying the learning forward (15 minutes)
- **Activity 7.1:** Working towards gender-sensitive services – taking the learning forward (30 minutes)
- **Background briefing 7.2:** Eight steps to achieving gender mainstreaming (15 minutes)

Allow 30 minutes for report back and discussion

Background Briefing 7.1

Carrying the Learning Forward in your Work



THIS FINAL SESSION DRAWS TOGETHER THE TRAINING PROGRAMME BY ASKING PARTICIPANTS TO IDENTIFY HOW THEY WILL CARRY THEIR LEARNING ON GENDER AND HEALTH FORWARD. SIX SPECIFIC THEMES ARE IDENTIFIED BELOW WHICH SHOULD BE USED AS GUIDANCE.

Trainers and facilitators should introduce participants to the six themes and encourage participants to think actively and creatively about what they can do to implement the learning from the training.

1. GENDER IMPACT ASSESSMENT (GIA)

Whatever service you work in, whether it is a primary care team, a community mental health team, in a hospital service or a service provided by a voluntary organisation or NGO, you should now be able to start planning a gender impact assessment.

You may be involved in carrying out a review of your services – and you can apply gender mainstreaming tools to this. Use the learning from the training to start the process of carrying out a gender impact assessment. Take small steps to begin with and gradually build on them. Remember that gender mainstreaming is a process that is ongoing, not a once-off activity.

2. DATA GATHERING

Collecting useful data is very important to addressing gender in a health context. It can sometimes be difficult to point to differences in the incidence of ill health and disease amongst women and men since health data is not always disaggregated by sex. In particular, it can be even harder to find evidence of gender-related implications, as a gender analysis may not have been carried out.

When looking at what data is available it is important to identify data gaps. If there is no data, consider putting in place a plan to collect data in the future.

3. GENDER BUDGETING

GENDER BUDGETING IS AN ATTEMPT TO TRACK ORGANISATIONAL PRIORITIES AS THEY GET REFLECTED THROUGH INCOME AND EXPENDITURE, AND EXAMINE HOW THEY IMPACT ON WOMEN AND MEN AND WITHIN THAT, CERTAIN GROUPS OF WOMEN AND MEN.

Gender budgets do not look at whether or not the same amount is spent on men and women but rather at the impact of the spending and whether or not budgets respond to the needs adequately. This approach challenges the idea of gender neutrality within budgets and raises awareness and understanding that budgets will impact differently on men and women because of their different social and economic positions. This way of budgeting is a tool for testing the organisation's gender-mainstreaming commitments – linking policy commitments with budgetary decisions and the necessary economic underpinning.

Gender budgeting also brings internal benefits to the organisation. By strengthening the collection and analysis of data and improving the ability to determine the real value of resources targeted towards women and men – gender budgets can provide a better understanding of how resources are being spent and increase efficiency.

Essentially gender budget analysis works by

- Analysing any form of expenditure, or method of raising money, from a gender perspective.
- Identifying the implications and impacts for women and girls, as well as men and boys.

4. INFORMING COLLEAGUES AND RAISING AWARENESS WITHIN YOUR TEAM OR DEPARTMENT

Gender mainstreaming is an ongoing process and requires individuals, departments and the whole health system to address gender-related factors that impact on women's and men's health. As a result it will be important to make sure that gender-related issues are raised in staff and team meetings and when holding discussions with colleagues and managers about plans for services.

5. WORKING IN PARTNERSHIPS WITH OTHER ORGANISATIONS

As this training programme has shown addressing gender as a determinant of health is not something that can be tackled solely within the health-care system. If this is to be addressed in a systematic way there is a need to engage with organisations within and outside the health-care system – this is sometimes referred to as a multi-sectoral approach.

Consider how you can link up with local women's and men's groups in your community and other local organisations, such as local development companies, community projects, Traveller groups, Migrant groups, and others who can work with you to promote awareness and actions to address gender-related health inequalities.

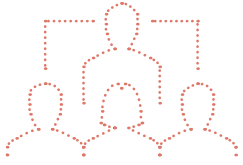
WIDER PARTNERSHIP WITH LOCAL AUTHORITIES, SCHOOLS AND COLLEGES, EMPLOYERS AND TRADE UNIONS CAN ALSO BRING VERY VALUABLE OUTCOMES.

The **National Women’s Council of Ireland** (NWC) www.nwci.ie and its member organisations have played an important role in countering gender based discrimination and promoting women’s health. This is on the basis that women experience social, economic and political inequalities that affect their physical and mental health, and which in turn can be a barrier to accessing health care. The NWC provide resources, policy briefings, training and support to women’s groups on this issue. The NWC’s ‘Y’ Factor Project www.yfactor.ie has a specific focus on young women, including young women’s health.

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

6. FINDING OUT MORE INFORMATION TO HELP YOU IN PROVIDING GENDER SENSITIVE SERVICES

One of the things that you can do is to keep yourself informed and up-to-date! Use the resources in this pack (see Appendix 1: Further reading and resources) to widen your knowledge about gender and health.



Activity 7.1

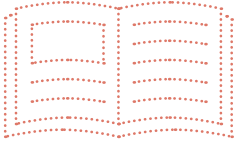
Carrying the Learning Forward

SMALL GROUP WORK

In your small groups, work together to draw up a plan to identify the steps that you will take to implement the learning from the training in the areas identified above (which can be used as guidance). It is suggested that you take small steps to begin with and plan to build on this step-by-step. In addition to the areas identified, space has been left to identify up to two other actions that can be put in place.

ACTION POINT	STEP 1	STEP 2	STEP 3
1 Carry out a gender impact assessment of your service			
2 Data gathering and identifying data gaps			
3 Gender budgeting and policy development			
4 Informing colleagues and raising awareness within your team or department			
5 Partnerships with other organisation to help progress gender mainstreaming			
6 Finding out more information to help you in providing gender sensitive services			
7 Other			
8 Other			

HANDOUT



Background Briefing 7.2

8 steps to achieving gender mainstreaming

GENDER MAINSTREAMING FRAMEWORK*

Eight steps to success

The following eight steps set out the key actions that need to be taken to put in place a gender mainstreaming process.

ALL STEPS WILL NEED TO BE IMPLEMENTED TO IMPROVE ACCESS TO QUALITY HEALTH CARE AND REDUCE HEALTH INEQUALITIES BETWEEN WOMEN AND MEN.

1 Senior level commitment and leadership in health-care services

There must be full commitment to gender mainstreaming at the senior levels of the Department of Health and in the current and future structures of the HSE. This commitment needs to be visible, championed and reflected in financial and budgetary decisions.

2 Improve awareness about gender differences in health

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

3 Collate and analyse gender and sex-disaggregated data

There is a need for improved data and indicators on gender inequalities in health and how they relate to social determinants of health. This will provide the evidence upon which services can be assessed for any gender differences in health.

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

The HSE should consult and involve women and men from different population groups in creating a gender-sensitive health system. With this participation services can be more responsive to the actual experiences of women and men from all communities.

5 Assessing gender relevance and carrying out gender impact assessments

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

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

Once a gender impact assessment has been completed priorities will need to be set to address existing inequalities and resources allocated to meet these priorities.

7 Gender mainstreaming projects in specific services

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

8 Monitoring, review and reporting

Gender mainstreaming is not a one-off activity. All policies, procedures and service delivery should be monitored and reviewed and through the development of key performance indicators in the planning process.

*Extract from NWCI / HSE 'GENDER MATTERS: Equal but different: A framework for integrating gender equality in health service policy, planning and service delivery' (2012) p. 35. See: www.nwci.ie/download/pdf/equal_but_different_final_report.pdf

Session 8

Evaluation

It is recommended that a short verbal and written evaluation be carried out with the group, by asking participants to:

- 1** State one main thing that you have learnt on the course that has affected the way you think about health.
.....
- 2** Revisit the written expectation at the start of the training (on the flip chart or post-it note) and comment on how the expectation has been met or not.
.....
- 3** Complete a written evaluation by using the evaluation sheet overleaf.
.....

EVALUATION FORM

OVERALL COMMENTS ON THE TRAINING PROGRAMME		
Yes	No	Please explain in more detail
1 The training has given me a good grounding and understanding of gender-related health issues		
2 The training has provided me with tools to carry out gender impact assessment		
3 The activities and briefings were clear and understandable		

ADDITIONAL COMMENTS	
4 Please let us know if there are any gaps or omissions in the training programme	
5 Please make any further comments that may be relevant to help us improve the training in the future	

HANDOUT

Appendix 1

Glossary

Gender equality

Equal chances or opportunities for women and men to access and control social, economic and political resources, including protection under the law.

Gender dysphoria

Gender dysphoria is diagnosed when there is a marked difference between the individual's expressed /experienced gender and the gender others would assign him or her.

Gender equity

The different needs, preferences and interests of women and men. This may mean that different treatment is needed to ensure equality of opportunity. This is often referred to as substantive equality. In a health context this refers to a process of being fair to women and men with the objective of reducing unjust and avoidable inequality between women and men in health status, access to health services and their contributions to the health workforce.

Gender Identity

A person's deeply felt identification as male, female or some other gender. This may or may not correspond to the person's physical characteristics or the sex they were assigned at birth.

Gender impact assessment

Gender impact assessment is a tool to analyse, identify and inform policy makers, planners and service providers about gender inequalities.

Gender mainstreaming

The process for assessing the implications for women and men of any planned action, including legislation, policies, plans or service delivery. It takes account of women's and men's concerns and experiences in the design, implementation, monitoring and evaluation of policies, plans and services.

Gender norms

Attitudes and beliefs about women and men that result from socialisation – they change over time and vary in different societal or cultural contexts. Gender norms result in inequality when they reinforce and perpetuate power differences.

Gender relations

Social relations between and among women and men (based on gender norms and roles). Gender relations may create unequal power between women and men in the family, in the community, in the workplace and in political representation.

Gender roles

The roles that are expected of men and women in the family, community or workplace.

Gender-sensitive health services

Services that take account and address gender inequalities are gender sensitive – sometimes we refer to this as providing services with a gender ‘lens’.

Gender stereotypes

Images, beliefs, attitudes or assumptions about women and men – they are often reductive / limiting / negative and based on learned or assumed gender norms, roles and relations.

Gender

Socially constructed characteristics of women and men, which are affected by norms, roles and relationships between different groups of women and men. Gender varies across different societies and cultures and can change over time. Although most people are born either male or female, they are taught appropriate norms and behaviours. If individuals or groups do not ‘fit’ established gender norms they may face stigma, discrimination and social exclusion. Gender is influenced by gender norms and relations, which include stereotypes, values, attitudes, assumptions and activities that society deems appropriate for women and men. These are not fixed roles and change over time, and from one society or culture to another.

Social determinants of health

The social determinants of health are the conditions under which people are born and live. Health inequalities are usually explained by the social determinants of health, which relate to avoidable differences in health status.

Sex

Different biological and physiological characteristics of males and females, such as reproductive organs, chromosomes, hormones, genetic conditions etc. Sex defines whether a person is biologically male or female

Sexual Orientation

Refers to a person’s physical, emotional or romantic attraction to another person.

Transgender

A person whose gender identity and / or gender expression differs from the sex assigned to them at birth. This term can include diverse gender identities such as: transsexual, crossdresser, androgynous, genderqueer, gender variant or differently gendered people.

Appendix 2

Background reading

BACKGROUND READING: 'SOMETIMES MEN AND WOMEN MUST BE TREATED DIFFERENTLY'

by Jacky Jones

Reproduced from the Irish Times, 13th October 2013
[www.irishtimes.com/life-and-style/health-family/
sometimes-men-and-women-must-be-treated-
differently-1.1498878](http://www.irishtimes.com/life-and-style/health-family/sometimes-men-and-women-must-be-treated-differently-1.1498878)

There are times when men and women must be treated differently. These days sexism seems to be in the news more often than usual. A woman got €45,000 from the Equality Tribunal when she didn't get a job that was given to a less qualified man. A TD was reprimanded for pulling a female TD on to his knee during an all-night Dáil sitting. A sexual assault case involving a sailor who asked his female colleague for 'a quickie', slapped her buttocks and grabbed her by the breasts with both hands, was dismissed in a district court in Cork. A Senator accused another Senator of speaking through 'her fanny'. But are they all examples of sexism?

Sexism is direct or indirect discrimination against people based on whether they are men or women. The Equality Tribunal case was clearly sexism in practice. If Tom Barry wouldn't have manhandled a male colleague because he knew he wouldn't get away with it, his behaviour in the Dáil was sexist. If a man had grabbed another man's genitals and asked him for a quickie would the case have been dismissed? I think not. The case would probably never get to court because most men grabbed by their genitals would deal with it on the spot.

Would Senator Norris have used such offensive language towards a male Senator? Possibly, therefore this example is not sexism, which must involve discrimination and favourable or unfavourable treatment because of one's gender. Having bad manners, being boorish and engaging in horseplay, no matter how unpleasant, do not constitute sexism.

The World Health Organisation distinguishes between a person's 'sex' and 'gender'. Male and female are sex categories, while masculine and feminine are gender categories. Sex refers to the biological and physiological characteristics that define men and women, such as men having testicles and women menstruating.

Social constructs

Gender refers to the socially constructed roles, behaviours and attributes that society considers appropriate for men and women, such as women in Ireland being 50 times more likely to look after home and family, and men more likely to be radio presenters. Roles are not allocated in this unfair way because women are biologically better at housework or men have voices physiologically more suited to radio. They happen because of sexism.

While sexism is never okay, there are times when men and women must be treated differently. The HSE's recent document '*Equal but different: a framework for integrating gender equality in health service executive policy, planning and service delivery*', explains why gender is important to all health outcomes.

A typical heart-attack victim is often seen as a 60-year-old male, yet a woman is 10 times more likely to develop heart problems than breast cancer. She will also experience treatment delays at all stages of care because, somehow, heart disease is not seen as a woman's problem. Gender characteristics determine obesity rates in men and women, with men more likely to be overweight. Being big is seen as masculine, skinny men are weedy. Thin women are viewed favourably because small is feminine. A recent survey from the National Consumer Agency found that 72 per cent of food shoppers are women, so men do not control their food availability. Men are five times more likely to kill themselves than women because of gender characteristics such as male roles and attitudes to seeking help. In fact, everything about health, and all diseases, are influenced by gender.

Gender mainstreaming is the method used to assess the implications for women, men and transgender people of any planned action on health, including legislation, policies and programmes. The new framework means the HSE will always have to incorporate the gender perspective and analyse the gender consequences of every decision before it is made.

Within the health system, gender mainstreaming still has a long way to go. The team who produced 'The establishment of hospital groups as a transition to independent hospital trusts' (2013) had a strategic group consisting of six men and two women, and a project group consisting of six women and two men, one of whom replaced another woman. All four external experts were men. Typically, a strategic group does all the talking and makes all the decisions, and a project group does all the work. Does this explain the composition of the groups? The new framework should mean these imbalances and unfair distribution of power and labour cannot happen in the future. Watch this space.

BACKGROUND READING:

IRISH CANCER SOCIETY AND NWCI (2012) 'WOMEN AND SMOKING: TIME TO FACE THE CRISIS', DUBLIN: IRISH CANCER SOCIETY (EXECUTIVE SUMMARY).

Available at: www.nwci.ie/download/pdf/womenandsmoking_finalreport2013.pdf

Executive summary

Introduction and background

In 2011, the Irish Cancer Society was shocked to learn that more women in Ireland are now dying from lung cancer than from breast cancer. Smoking is the leading preventable cause of lung cancer. Despite all that is known about the dangers of smoking, almost 1 in 3 women in Ireland smoke. Women and girls in Ireland are in the midst of an epidemic of smoking-related disease and the burden of this disease is being carried by women who are socio-economically disadvantaged.

In order to address the crisis of women and smoking, the Irish Cancer Society set out to investigate why such high numbers of women are smoking and what can be done to tackle the problem. This marked the beginning of a collaboration with the National Women's Council of Ireland, which resulted in the Women and Smoking: Time to Face the Crisis conference. The conference was held in Dublin in July 2012 and brought together policymakers, health-care professionals, academics, and representatives from women's groups to explore why women are smoking and how they can be supported to quit.

In order to better understand the attitudes and behaviour of women who smoke, the society commissioned research into female attitudes to smoking and quitting. The results of the research and the key findings of the conference are summarised in this report.

Key findings

Smoking is the leading cause of preventable death and disease in Ireland. Half of all smokers will die because of a tobacco related illness (Peto et al, 1994). Smoking causes 9 in 10 lung cancers (IARC, 2004). Lung cancer has now become the main cause of cancer death in women, outnumbering breast cancer deaths. Lung cancer is the biggest cancer killer in Ireland for both men and women with 1,708 people dying in 2010 (1,006 men and 702 women) (CSO, 2011). Breast cancer deaths for the same period amounted to 634. New cases of lung cancer in women have increased by 17.6% in 2010 whereas breast cancer cases are increasing at a much lower rate (NCRI, 2011). In addition, smoking causes other cancers including cervical cancer, mouth, head and neck cancers, oesophageal cancer, stomach cancer, pancreatic cancer, cancer of the kidney and cancer of the bladder. Smoking also causes cardiovascular disease, chronic obstructive pulmonary disease and fertility problems.

Prevalence

Despite the introduction of significant measures to reduce smoking in Ireland such as the workplace smoking ban, Ireland's smoking rate remains stubbornly high at 29% (Brugha et al, 2009). Twenty-seven percent of women now smoke but the highest rate is seen among women aged 18 to 29 in the more deprived social class groups SC 5–6. More than half of women in these groups smoke. This is twice the rate among women in more affluent SC 1–2.

Health inequalities

The differences in smoking levels based on social-class groups show that female smoking cannot be separated from the issue of health inequalities. Levels of smoking are highest in the poorest communities and are linked to multiple social and economic disadvantages, ill health, and poor life expectancy (Graham, Inskip, Francis, & Harman, 2006; Marsh & McKay, 1994).

Disadvantaged groups in society are disproportionately likely to smoke and least likely to give up cigarettes. Those who can least afford to smoke suffer the most from it. Children growing up in poverty experience social environments where the majority of adults smoke. Smoking therefore becomes normal and acceptable adult behaviour (Jarvis and Wardle, 1999).

The health inequalities associated with smoking are highlighted by the fact that incidence of lung cancer among the most deprived women in Ireland is 1.7 times that of the least deprived (NCRI, 2011). The incidence of lung cancer among women is higher in areas of high unemployment. (National Cancer Registry / Northern Ireland Cancer Registry, 2011).

Social aspects of smoking

An analysis of the factors mediating the effects of social class in Ireland has suggested that social deprivation accounts for the higher levels of smoking and lower likelihood to quit smoking among lower socio-economic groups (Layte and Whelan, 2008).

Smoking is a cultural and social issue for women. A culture of smoking is embedded in many women's lives. Smoking provides opportunities for social bonding for women and this often reinforces addiction to smoking (Brigham, 2001).

Many women believe that smoking helps them to cope with stress. Over a third of women agreed that quitting smoking would make it harder to cope with stress (SLÁN, 2009).

Smoking is used as a form of stress management by some women, and more so by women in the lower social classes.

The Irish Cancer Society's focus group research found that many women feared that quitting smoking would affect their social lives, cause them to gain weight and make them irritable and difficult to live with.

Marketing

The tobacco industry constantly needs to recruit new smokers to replace the smokers who die because of their addiction. Female smokers are a lucrative market for the tobacco industry which is experiencing a decline in smokers. The tobacco industry has long recognised that women represent a different market from men and has developed policies to target women by segmenting the market by socio-economic grouping and developing products for these groups.

Tobacco companies recognise the power of packaging. The growth in new brands and packaging is aimed at appealing to young female smokers. Women say they hear about new brands via word of mouth. Women think lighter coloured packs are more elegant and feminine and less harmful. The introduction of plain packaging would reduce the appeal of cigarettes, increase the salience of health warnings and reduce consumer confusion about harm.

Recommendations to emerge from the group consultation at the Conference and from the focus group research are outlined below

- An acknowledgement is needed that the barriers to quitting smoking are multi-faceted. They include psychological and social factors, access and availability of services, attitudes of health professionals, and tobacco industry manipulation.
- To overcome these barriers, community-based cessation programmes to encourage social interaction are required. Smoking provides a sense of solidarity and belonging for many women and is the cultural norm in many communities.
- A national strategy and standards for cessation services are required.
- Communities need to be supportive environments for people who want to quit.
- All health-care professionals should have the capacity to conduct cessation interventions and be encouraged to do so.
- Plain packaging would help counteract the fact that the tobacco industry is targeting young women through innovative packaging.

BACKGROUND READING: MEN AND CANCER

Report on the excess burden of cancer among men in Ireland, by **Nicholas Clarke, Linda Sharp, Eamonn O'Leary** and **Noel Richardson**

Available at: www.cancer.ie/sites/default/files/report_on_excess_cancer_burden_in_men_in_ireland.pdf

The following is an extract from the above report (pages 9 – 10) about how gender needs to be factored into discussions about men's risk of cancer.

Factors underpinning disparities in cancer risk in men

In recent years, there has been an increased focus on factoring gender into studies in order to explain 'inequalities' in incidence and mortality based upon a number of diseases and causes of death, including cancer. Research on causes of cancer worldwide reported that, of the 7 million deaths from cancer in 2001, 35% were attributable to nine potentially modifiable risk factors, namely; overweight and obesity, low fruit and vegetable intake, physical inactivity, smoking, alcohol use, unsafe sex, urban air pollution, indoor smoke from household use of solid fuels, and contaminated injections in health care settings. Notably, these risk factors caused about twice as many deaths in men as in women, with 41% of worldwide cancer deaths in men being attributable to modifiable risk factors compared to 27% in women:

- Research has estimated that 29–38% of all cancers in men in Europe are attributable to smoking, compared to 2–10% of all cancers in women being attributed to smoking. Although rates of smoking in the Republic of Ireland are converging, the most recent SLÁN data indicates that 31% of the male population smokes compared to 27% of the female population.
- A recent study on the burden of alcohol consumption on incidence of cancer in eight European countries reported that up to 10% of cancers in men and 3% of cancers in women may be attributed to alcohol consumption. In the Republic of Ireland, the most recent SLÁN data indicates that men are approximately twice as likely as women to report drinking over the weekly limit and to binge drink.
- Research shows that high levels of body fat are associated with an increased risk of a number of cancers, including colorectal, oesophageal, gastric cardia, thyroid, renal, malignant melanoma, leukaemia, multiple myeloma and non-Hodgkin's lymphoma. The prevalence of overweight (46.3%) and obesity (20.1%) among men in the Republic of Ireland is currently ranked 8th in the EU25 and is rising at a rate of 1% per annum. It is projected that 33% of men on the island of Ireland will be clinically obese by 2015. Men also tend to deposit fat abdominally, thereby increasing their central obesity. This central or visceral fat is associated with an increased risk of fat-related cancers.

- There is a long established link between physical inactivity and ill health. Research at a European level investigating the relationship between physical activity and cancer prevention has estimated that approximately 17% of male colon cancer cases, 21% of male lung cancer cases and 14% of prostate cancer cases could be prevented if the male population engaged in sufficient levels of physical activity. Within an Irish context, the most recent SLÁN data indicates that only 48% of men engage in some form of regular physical exercise, with those reporting as sedentary almost doubling between the age categories of 18–29 and 30–39 years (9.9% and 18.3% respectively). The continuing shift towards sedentary occupations and more sedentary lifestyles generally for men has been paralleled by a five-fold increase in obesity between the beginning and end of the last century.
- A recent study on diet and cancer prevention in 10 European countries concluded that cancer risk was increased through high intake of red and processed meat, dairy products, salt and salty foods. Consumption of fruits, non-starchy vegetables, allium vegetables, selenium and foods containing selenium reduce one's risk of cancer. The most recent SLÁN data indicates that men's diets are less healthy than women's diets and that, despite two-thirds of Irish males surveyed being overweight / obese, 55% felt that they did not have to make changes to their diet as it was healthy enough.
- The first report on the State of Men's Health in Europe highlighted that infrequent use of health services among men is associated with men experiencing higher levels of potentially preventable health problems and having reduced treatment options when they do become ill. It has been reported that men are more likely to seek help for cancer symptoms if their help-seeking is sanctioned by family or friends or when symptoms interfere with their employment. In addition, men are more likely to undergo screening when it is recommended by a physician to do so.

Whilst these risk factors are clearly implicated in the higher incidence of cancers in men, it is more difficult to account for the effect of these factors on the lower survival from cancer that is also seen in men. Survival at one year post diagnosis was very similar in males and females for the majority of cancers in this report; however males were found to be at a significant disadvantage at 5 years post diagnosis. What drives this disparity from 1 year post diagnosis to 5 years post diagnosis is an altogether more difficult question to answer. While sex differences exist in relation to factors such as stage of disease at diagnosis and smoking, survival analysis indicates that even after adjusting for these factors, males are still at greater risk of death from their cancer. Evidence would suggest that women have a biological advantage over men in terms of being more robust in coping with their cancer. Smoking status at diagnosis increases risk of death, however smoking may also be an independent prognostic factor, with evidence suggesting various explanations including higher smoking rates in males and the possibility of poorer responses to treatment, poorer DNA repair capacity and poorer immune competence as a result of smoking. Treatment may also impact on the poorer survival of males. Males may also be at a survival disadvantage as a result of overweight and obesity, lack of physical activity as well as age related co-morbidity.

Risk factors underpinning cancer incidence and survival are also influenced by the broader social determinants of health and, in particular, by the impact of socio-economic status. Why lower socio-economic status seems to infer greater risk of developing and dying from cancer has been attributed, within a US context, to a number of factors, including differences in area-based smoking rates, tobacco regulation, advertising, availability of cigarettes, public awareness of the harmful effects of smoking, fatty diets, physical inactivity, reproductive factors, human papillomavirus (HPV) infection, sun exposure and other factors. Conversely, a more rapid adoption of healthier lifestyles and smoking cessation has been reported in populations with higher socio-economic status. Therefore it appears that the nature of the relationship between a man's socio-economic status (and indeed a woman's) and cancer risk behaviours are complex and are mediated both by the cultural context in which one lives, and by the values and attitudes that one develops in relation to health.

Appendix 3

Further reading and resources

WEB SITES FOR FURTHER INFORMATION

- National Women's Council of Ireland
www.nwci.ie
- Y-Factor Project (NWC)
www.yfactor.ie
- Health Service Executive
www.hse.ie
- Men's Development Network
www.mensdevelopmentnetwork.ie
- Men's Health Forum in Ireland
www.mhfi.org
- 'Manup' campaign
www.manup.ie
- Equality Authority
www.equality.ie
- Institute for Public Health
www.publichealth.ie
- Cairde
www.cairde.ie
- Pavee Point Travellers Centre
www.pavee.ie
- Department of Health
www.dohc.ie
- Irish Cancer Society
www.cancer.ie
- Irish Heart Foundation
www.irishheart.ie
- Gay and Lesbian Equality Network
www.glen.ie

- Transgender Equality Network Ireland
www.teni.ie
- Safe Ireland
www.safeireland.ie
- Dublin Rape Crisis Centre
www.drcc.ie
- Rape Crisis Centre Ireland
www.rcni.ie
- Women's Aid Domestic Violence Service Ireland
www.womensaid.ie
- National Advocacy Unit, HSE
www.hse.ie

TRAINING MATERIALS

Training material and a training programme for health staff have also been drawn up by the Men's Development Network on men's health: *'Engage: national men's health training'*. For further information contact the Men's Development Network (see web link opposite).

Further information about the HSE's programme of training in health inequalities for health promotion officers, contact Eddie Ward, HSE, email: eddie.ward@hse.ie

CORE DOCUMENTS

HSE / NWCi 'Equal but Different: A framework for integrating gender equality in health service policy, planning and service delivery'. Available from:

www.nwci.ie/download/pdf/equal_but_different_final_report.pdf

HSE (2009) *Health Inequalities Framework 2010 – 2012*. Available from the Health Inequalities section in the HSE.

Department of Health and Children (DOHC) (2008) *National men's health policy 2008–2013*, DOHC: Dublin. Available from: www.dohc.ie/publications/national_mens_health_policy.html

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

NWCi / HSE 'GENDER MATTERS: User-friendly guide to gender mainstreaming' (2014) available in hard copy and at www.nwci.ie/learn/publications

NWCi / HSE 'GENDER MATTERS: Toolkit for gender mainstreaming in health' (2014) available online at www.nwci.ie/learn/publications

GENDER MAINSTREAMING THEORY AND PRACTICE

Billington K (2003) *Mainstreaming Gender and Women's Mental Health Implementation Guide*, London: Department of Health

Commonwealth Secretariat (2002) *Gender mainstreaming in the health sector: Experiences from Commonwealth Countries*, London: Commonwealth Secretariat

Council of Europe (2004) 'A Methodology for Gender Mainstreaming', in *Gender Mainstreaming: Conceptual Framework, Methodology and Presentation of Good Practices*, Strasbourg: Council of Europe

Council of Europe (2008) Recommendation CM / Rec(2008)1 of the Committee of Ministers to member states on the inclusion of gender differences in health policy. (Adopted by the Committee of Ministers on 30 January 2008 at the 1016th meeting of the Ministers' Deputies)

Daly M (2005) Gender Mainstreaming in Theory and Practice. *Social Politics: International Studies in Gender, State and Society* 2005;12(3):433-50

EOC Wales / Welsh Consumer Council (2006) *Gender Equality in Public Services: Care for Older People*, EOC

Equality and Human Rights Commission / Fitzgerald R (2008) *Fair For All – Gender: NHS Scotland and the Gender Equality Duty – Improving Gender Equality Practice in NHS Scotland*

European Commission (2005) *EQUAL Guide on Gender Mainstreaming*, Employment and Social Affairs, Employment and European Social Fund, Luxembourg: Office for Official Publications of the European Communities

McGauran A M (2005) *Plus ca change...? Gender mainstreaming of the Irish National Development Plan Studies in Public Policy no.15*, The Policy Institute, Trinity College, Dublin

Moser C (2005) 'Has gender mainstreaming failed? A comment on international development agency experiences in the South', *International Feminist Journal of Politics*, 7:4 December 2005

NHS Scotland & EOC Scotland (2008) *Gender Equality Duty - Guidance for NHS Scotland*, Edinburgh: NHS Scotland

Ravindran S T K and Kelkar-Khambete A (2007) 'Women's health policies and programmes and gender-mainstreaming in health policies, programmes and within health sector institutions'. Background paper to the Women and Gender Equity

Ravindran T K S and Kelkar-Khambete A (2010) 'Gender Mainstreaming in Health: the Emperor's New Clothes' in Sen G and Östlin P (eds) *Gender Equity in Health: The Shifting Frontiers of Evidence and Action*, New York: Routledge

Tolhurst R, B Leach, J Price, J Robinson, E Ettore, A Scott-Samuel, N Kilonzo, L Savuni, S Pobertson, A Kapilashrami, K Bristow, R Lang, F Romano and S Theobald (2011) 'Intersectionality and gender mainstreaming in international health: Using a feminist participatory action research process to analyse voices and debates from the global south and north'. *Social Science and Medicine*, September 2011, 1–8

United Nations (2002) *Gender Mainstreaming: Strategy for Promoting Gender Equality*. New York: United Nations Office of the Special Advisor on Gender Issues and Advancement of Women

INEQUALITIES IN HEALTH AND THE SOCIAL DETERMINANTS OF HEALTH

Burke S (2009) *Tackling Poverty: Talking Inequalities in Health*. Combat Poverty Agency: Dublin

Burke S, Keenaghan C, O'Donovan D, and Quirke B (2004) *Health in Ireland – an unequal state*, Public Health Alliance Ireland

Commission on Social Determinants of Health (2008) *CSDH Final Report: Closing the gap in a generation: Health equity through action on the social determinants of health*. World Health Organisation

Farrell C, McAvoy H, Wilde J and Combat Poverty Agency (2008) *Tackling Health Inequalities – An All-Ireland Approach to Social Determinants*. Dublin: Combat Poverty

Graham H (2004) *Closing the Gap: Strategies for Action to Tackle Health Inequalities*. Presentation at the 1st Business Meeting of the EU Project 'Closing the Gap' on 27 / 28 October 2004, Cologne

Sen G and Östlin P (2010) 'Gender as a Social Determinant of Health: Evidence, Policies and Innovations', in Sen G and Östlin P (eds) *Gender Equity in Health: The Shifting Frontiers of Evidence and Action*, New York: Routledge

WOMEN'S HEALTH

Begley, C., et. al. (2010) *Women with disabilities: Barriers and facilitators to accessing services during pregnancy, childbirth, and early motherhood*. Dublin: National Disability Authority

Irish Cancer Society and NWCI (2012) *Women and Smoking: Time to Face the Crisis*. Dublin: Irish Cancer Society

Irish Heart Foundation (2009) *Red Alert for Women's Hearts Women and Cardiovascular Research in Europe*. Dublin: Irish Heart Foundation

Luddy G (2007) 'Women, disadvantage and health', *Irish Medical Journal*, Volume 100(8)

National Women's Council of Ireland (NWCI) (2006) *Women's Health in Ireland: Meeting International Standards*, Dublin: NWCI

National Women's Council of Ireland (NWCI) (2008) *Strategy on Health 2008 – 2010*, Dublin: NWCI

Östlin P and Diderichsen F (2010) Equity-oriented national strategy for public health in Sweden: A case study. European Centre for Health Policy

Östlin P, A George and G Sen (2001) 'Gender, Health, and Equity: The Intersection' in Evans T, Whitehead M, Diderichsen F, Bhuiya A and Wirth M (eds) (2001) *Challenging Health Inequities: From Ethics to Action*, Oxford University Press

Payne S (2009) *How can gender equity be addressed through health systems?*, Geneva: WHO

Payne S (2011) 'Beijing Fifteen Years On: The Persistence of Barriers to Gender Mainstreaming in Health Policy', in *Social Politics: International Studies in Gender, State and Society*

Payne S & Doyal L (2010) *Gender equity or gender equality in health? Policy & Politics*, 38, 171-175

Phillips S (2005) 'Defining and measuring gender: A social determinant of health whose time has come', in *International Journal of Equity in Health*, Volume 4:11

Thümmler K, Britton A & Kirch W (2009) *Data and information on women's health in the European Union*, European Commission DG for Health and Consumers www.ec.europa.eu/health/population_groups/docs/women_report_en.pdf

Y-Factor Project (NWCI) see various resources including poster and leaflet. Available at: www.yfactor.ie/index.php/blog/article/your-health-matters-campaign-launched

Women's Health Council (2004) *Women, disadvantage and cardiovascular disease: policy implications. Conference Proceedings*, Dublin: Women's Health Council

Women's Health Council (2005) *Women's Mental Health: Promoting a Gendered Approach to Policy and Service Provision*, Dublin: Women's Health Council

Women's Health Council (2006) *Women & Cancer in Ireland: 1994–2001*, Dublin: Women's Health Council

Women's Health Council (2007a) *A Guide to Creating Gender-Sensitive Health Services*, Dublin: Women's Health Council

Women's Health Council (2007b) *Gender and Health: Strategies for Implementation: Seminar Proceedings*, Dublin: Women's Health Council

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

Women's Health Council (2009) *Women & Substance Misuse in Ireland: An overview*, Dublin: Women's Health Council

Women's Health Council and World Health Organization (undated) *Integrating the Gender Perspective in Irish Health Policy: A Case Study*, Dublin: Women's Health Council

Women's Health Council and World Health Organization (undated) *Integrating the Gender Perspective in Irish Health Policy: A Case Study*, Dublin: Women's Health Council

Women's Human Rights Alliance (2010) *A Woman's Right to Health*, report of consultations carried out by the WHRA across Ireland by Dr Jane Pillinger, Dublin: WHRA

MEN'S HEALTH

- Carroll P (2009) 'Engaging Vulnerable Men in Ireland', in *Journal of Men's Health*, Volume 6, issue 3
- European Commission (2011) *State of Men's Health Europe Report*, Brussels: European Commission
- Evans J, Frank B, Oliffe J and Gregory D (2011) Health, Illness, Men and Masculinities (HIMM): a theoretical framework for understanding men and their health *Journal of Men's Health*, Volume 8, issue 1
- Francome C (2000) *Understanding Men's Health*. Farringdon, UK: Middlesex University Press
- McCarthy M and Richardson N (2011) *Report on best practice approaches to tailoring lifestyle interventions for obese men in the primary care setting. A Resource Booklet for Healthcare Professionals working with obese men in the primary care setting*. Centre for Men's Health, Institute of Technology Carlow
- Richardson N (2009) 'Ireland – the first National Men's Health Policy', *Journal of Men's Health*, Volume 8, issue 3
- Richardson N & Carroll P (2009) 'Getting Men's Health onto a Policy Agenda – Charting the Development of a National Men's Health Policy in Ireland.' *Journal of Men's Health*, 6(2): 105-13
- Richardson N & Carroll P (2009) Men's Health in Ireland, in Wilkins D and Savoye E (eds) *Men's Health Around the World: a review of policy and progress in 11 countries*. Brussels: European Men's Health Forum
- Smith J and Robertson S (2008) Men's Health Promotion: A New Frontier in Australia and the UK? *Health Promotion International* 2008;23(3):283-89
- Smith J, White A, Richardson N, & Robertson S (2009) 'The men's health policy contexts in Australia, the UK & Ireland: Advancement or abandonment?' *Critical Public Health*. Vol 9, Nos. 3-4; November- December; 427-440
- Stakelum A and Boland J (2001) *Men Talking: A Qualitative Study on Men's Health and Attitudes in the North Eastern Health Board*, Kells: NEHB
- White A & Richardson N (2011) Gendered epidemiology: 'Making men's health visible in epidemiological research', *Public Health*, 125 (2011)
- White A & Witty K (2009) 'Men's under use of health services – finding alternative approaches', *Journal of Men's Health*, Volume 6, issue 1
- White A, McKee M, Richardson N, De Visser R, Madsen S.A, de Sousa B, Makara P, & Zatonski W (2011) 'Men's health in Europe: Policy, practice and research challenges in the 21st century'. *British Medical Journal*

WORLD HEALTH ORGANIZATION – GENDER AND EQUITY IN HEALTH

- World Health Organization (2002) *Mainstreaming Gender Equity in Health: The need to move forward*, Madrid Statement, Geneva: WHO
- World Health Organization (2009) *Women and health: today's evidence tomorrow's agenda*. Geneva: WHO
- World Health Organization (2010) *Policy approaches to engaging men and boys in achieving gender equality and health equity*, Geneva: WHO
- World Health Organization (WHO) (2008b) *Closing the Gap in a Generation, Health Equity Through Action on the Social Determinants of Health*. WHO: Geneva

LGBT HEALTH

- Centre for Gender & Women Studies (CGWS), (2008) *Redefining Family in a Changing Ireland: The Experiences of Lesbian, Gay and Transgender Parents*. Trinity College. Dublin
- Collins B and Sheehan B (2004) *Access to Health Services for Transsexual People*, Equality Authority: Dublin
- Daley A E and MacDonnell J A (2011) 'Gender, sexuality and the discursive representation of access and equity in health services literature: implications for LGBT communities', in *International Journal for Equity in Health* 2011
- Health Services Executive (2009) *LGBT Health: Towards meeting the Healthcare needs of Lesbian, Gay, Bisexual and Transgender People*. National Social Inclusion Governance Group
- Higgins, A., Sharek, D., McCann, E., Sheerin, F., Glacken, M., Breen, M., McCarron, M., (2011) *Visible Lives: Identifying the experiences and needs of older Lesbian, Gay, Bisexual and Transgender (LGBT) people in Ireland*. Glen. Dublin
- Mayock, P., Bryan, A., Carr, N., Kitching, K. (2009) *Supporting LGBT Lives: A Study of the mental health and well being of lesbian, gay, bisexual and transgender people*. GLEN and BelongTo, Dublin
- Whittle, Turner, Combs and Rhodes, (2008) *Transgender EuroStudy: Legal Survey and Focus on the Transgender Experience of Healthcare*, Transgender Europe / ILGA-Europe: Brussels

GENDER, MEDICINE AND RESEARCH

Crolla E and Bamforth M (2011) 'Gender and medicine: the challenges for medical educators' in *Medical Education*, Volume 45, Issue 6, pages 544-546

Prichard D, Collins N, Boohan M and Wall C (2011) 'Junior Doctors and Undergraduate Teaching: The Influence of Gender on the Provision of Medical Education', in *Teaching and Learning in Medicine*, Volume 23, Issue 2

Ramasubbu K and Gurum H (2001) *Gender bias in clinical trials. Double standards still apply?* *Journal of Women's Health Based Medicine*, 10, 757-764

Risberg G, Johansson E and Hamberg K (2011) 'Important... but of low status': male education leaders' views on gender in medicine', in *Medical Education*, Volume 45, Issue 6, pages 613-624

GENDER AND MENTAL HEALTH

Freeman D and Freeman J (2013) *The Stressed Sex: Uncovering the Truth about Men, Women and Mental Health*, Oxford University Press.

Richardson N, Clarke N and Fowler C (2013) *Report on the All-Ireland Young Men and Suicide Project*.

MINORITY ETHNIC HEALTH / TRAVELLER HEALTH

Health Services Executive (HSE) (2007) *National Intercultural Strategy in Health 2007 – 2012*

School of Public Health, Physiotherapy and Population Science, University College Dublin (DOHC) (2010) *All Ireland Traveller Health Study 2007-2010: Summary of findings*, Dublin

STATISTICS ON WOMEN AND MEN

CSO (2010) *Women and Men in Ireland*, Stationery Office: Dublin
CSO (2011) *Women and Men in Ireland*, Stationery Office: Dublin

CSO (2011) *Health Status and Health Service Utilisation*, QNHS Quarter 2, August, Cork: CSO

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