Women's Health in Ireland

Evidence Base for the development of the Women's Health Action Plan

Commissioned by National Women's Council of Ireland, Department of Health, Health Service Executive

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Women's Health in Ireland

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The views and opinions expressed in this report are those of the author and do not necessarily reflect the official policy or position of the report's commissioners.

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Executive Summary

This paper provides the evidence base for the development of a Women's Health Action Plan (WHAP) – it provides an overview of what is known about women in Ireland in terms of demographics, health and engagement with health services, as well as the context for the development of women-specific health strategies internationally. This is an exploratory, desk-based evidence review. The information included in the review is based on publicly available, largely published data accessible for quick review. In drawing together key evidence about women's health in Ireland, this paper provides a crucial first step in documenting women's health needs in Ireland, to be supplemented by engagement with healthcare providers – and crucially – by national level consultations with women.

This review has been undertaken to examine how best to support a focus on women's health needs, within the broader context of the need to achieve gender equality in health outcomes for women and men in Ireland.

Over-arching Government policy, as stated in the Healthy Ireland Framework, is to reduce inequalities for all and addressing the impact of gender on health is a crucial element of this work.

A *Men's Health Action Plan* is already in existence and, once developed, the Women's Health Action Plan will complement this, in terms of a comprehensive health service response to gender differences in health behaviours, outcomes and engagement with health services. To achieve this, the WHAP must be informed by and connect with key women's health policies internationally – the UN's *Global Strategy for Women's, Children's and Adolescents' Health 2016-2030* and the WHO *Strategy on women's health and well-being in the WHO European Region.*

The evidence provided in this review confirms the need for a national women's health action plan which will facilitate and provide an enhanced response to the health inequalities experienced by women. The review documents the significant health needs of women spanning all categories of health from healthy lifestyles to chronic disease to mental health. In addition, the review identifies how particular groups of women, including women in prostitution and women living in homelessness, are experiencing particular health inequalities and barriers to care.

Structure of the paper

— **Section 1** presents an overview of women in Ireland – demographics, socio-economic profile, health, disability and caring - primarily based on Census 2016.

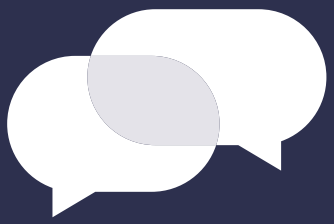
— **Section 2** discusses what is known about women's health in Ireland, across life-stages, diseases and lifestyle behaviours, as well as the impact of disadvantage and violence on women's wellbeing. This section also provides an overview of groups of women in Ireland experiencing particular health inequalities.

— **Section 3** moves focus to the health system, using existing national and international literature to describe women's engagement with the health service.

— **Section 4** turns to the international and national frameworks governing women's health and provides detail of health policies and services relevant to women's health in Ireland, Australia and the World Health Organisation European Region.

— **Section 5** provides conclusions arising from the evidence presented in this paper.

Introduction



Background

Recent years have seen increased levels of attention to women's health issues in Ireland. In particular, the national conversation about women's health issues during the Referendum to provide for abortion in Ireland and the scrutiny of women's experience of healthcare as part of the CervicalCheck controversy, has brought Ireland into a new stage in the drive to improve women's health experiences and outcomes. Greater understanding of the specific health needs of women and the inequalities in the outcomes faced by groups of women in Irish society – including Traveller women, migrant women and women experiencing violence – has further bolstered the need for a coordinated focus on women's health.

Reflecting the need to address women's health in a strategic way, the Government's National Strategy for Women and Girls commits to the development of a Women's Health Action Plan by the Health Service Executive (HSE), Department of Health and the National Women's Council of Ireland (NWCI) 'to address the particular physical and mental health needs of women and girls'(p.45).

This national commitment is reinforced by the World Health Organisation's *Strategy on women's health and wellbeing in the WHO European Region* which provides guidance to make national policies more responsive to women's health and wellbeing across the life-course.

Nationally, the focus on improving the health of women over the last two decades has primarily been on maternal health and reproductive services. For the next number of decades this focus must be broadened to encompass not only reproductive health but also mental health and chronic diseases (the leading cause of ill health and disability for women).[1]

As part of the process to develop Ireland's Women's Health Action Plan, the HSE, the Department of Health and NWCI project team identified the need for research evidence on women's health in Ireland. In particular, a need was identified to gather together existing data on women in Ireland, women's health and engagement with health services in Ireland and an assessment of existing national policies and international policy frameworks related to women's health. Funding for the development of the evidence base was provided by the HSE. NWCI undertook project management and following a public tender process, KW Research Associates Ltd. was commissioned to develop and draft this evidence paper.

The paper provides an overview of existing literature to provide a baseline of information about women's health in Ireland and identification of women-specific, or women related health policies, services and initiatives in Ireland and internationally. In gathering this information together, the paper aims to support work to ensure women's health needs across the lifecycle are reflected in the forthcoming WHAP and contribute to work to ensure women's health is integral to development of health policy, service planning and delivery. It is intended that the evidence provided in this paper will inform

1 Abel K M., Newbigging, K. (2018). *Addressing unmet needs in women's health*. British Medical Association. Retrieved from: https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/womens-health; Temmerman, M., Laski, L., Mathews, Z., Say, L. (2015). 'Women's health priorities and interventions'. *British Medical Journal*, 351:h4147. Retrieved from: https://www.bmj.com/content/351/bmj.h4147

further stages in the development of the WHAP, to include consultation with women and engagement with health staff and the women's sector to identify priority actions for the plan.

Purpose and approach

This purpose of this review is to provide an initial evidence base to support development of the Women's Health Action Plan (WHAP) specifically related to four areas:

- A picture of women in Ireland using key demographic, social and economic data;
- Evidence about women's health in Ireland;
- Detail of women's engagement with health services; and
- An overview of health policies in Ireland and internationally which address women's health.

This is an exploratory, desk-based evidence review. The information included in the review is based on publicly available, largely published data accessible for quick review. The review focuses on the determinants of women's health, without necessarily making comparisons between women and men. The review was limited in some areas by the lack of publicly available information in relation to key areas of women's health in Ireland and particularly in relation to women's engagement with health services. This reflects both the small number of women-specific health studies undertaken in Ireland and a lack of gender disaggregation in general health data and research. Lack of health data by gender is a feature in global health research[2] which necessitates increased prioritisation of women's health in international and national health research programmes.

The evidence gathered in this paper represents the first part of the evidence necessary to develop the WHAP. This will need to be supplemented with national consultation with a) listening exercises with women to gather their perspectives and health needs and b) engagement with health providers to better understand how health services currently respond to and support women's health needs. This engagement with women as experts in their own health and with health providers is necessary as part of any process to develop women-centred supports and services, but is particularly necessary in the Irish context given the limited data available on women's engagement with health services.

Why focus on women's health?

The World Health Organisation (WHO) recognises that the social construction of gender identity and unbalanced power relations between women and men affect the health seeking behaviour and health outcomes of women and men in different ways. [3]

As a consequence, health policies, practices and services need to reflect that women and men – because of their biological differences and gender roles – have different health needs and face different barriers in seeking to achieve good health.

The impact of gender on health

National policy, as stated in the *Healthy Ireland- a Framework for improved health and wellbeing 2013-25*[4], is to reduce inequalities for all and create a healthy Ireland, 'where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility'(p.5).

2 Sugimoto, C., Ahn, Y.Y., Smith, E., Macalusco, B., Larivière, V. (2019). 'Factors affecting sex-related reporting in medical research: a cross-disciplinary bibliometric analysis'. *The Lancet*, 393: 550-9. Retrieved from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32995-7/fulltext

3 World Health Organisation Europe. (2016). *Strategy on women's health and well-being in the WHO European Region*. Copenhagen: WHO. Retrieved from: http://www.euro.who.int/en/health-topics/health-determinants/gender/publications/2016/strategy-on-womens-health-and-well-being-in-the-who-european-region-2016

4 Government of Ireland. (2013). *Healthy Ireland – a framework for improved health and wellbeing.* Dublin: The Stationery Office. Retrieved from: https://health.gov.ie/wp-content/uploads/2014/03/HealthyIrelandBrochureWA2.pdf

There is an increasing focus on the health inequities which exist between groups in society in terms of the social determinants of health. The social determinants of health are the economic and social conditions that influence individual and group differences in health status. They arise from inequalities in the conditions of daily life and the fundamental drivers of these conditions - inequities in power, money and resources. The WHO *Strategy on women's health and wellbeing in the European Region*[5] states that 'gender is a determinant of health, alongside social and environmental determinants, and which identifies gender mainstreaming as a mechanism to achieve gender equity'.

Gender is a determinant of health because it shapes life experiences and socio-economic realities, resulting in different health outcomes and different health care needs for women and men.

Sex and gender are particularly relevant in some health sectors (mental health, cancer, cardiovascular disease, etc.) while gender inequalities cut across all forms of inequality including poverty, economic and educational disadvantage, disability, age, ethnicity and sexual orientation. For women to attain the optimum level of health over their lifetime, health systems need to plan for women's biological differences and gender roles.

It is also the situation that women and men use health services differently, with their experience of health influenced by gender differences, from employment to caring responsibilities. One of the ways that the Irish health service has responded to the impacts of gender on health has been through gender mainstreaming, an internationally recognised approach which integrates gender into the mainstream of policy planning and service delivery.[6] Gender mainstreaming seeks to achieve gender equality through assessment of gender inequality and integrating a gender sensitive approach into health service planning and delivery. Between 2010 and 2012, the HSE and NWCI undertook a major project on gender mainstreaming, publishing *Equal but Different: A Framework for integrating gender equality in Health Service Executive Policy, Planning and Service Delivery*[7].

The recognition of gender differences in health provides justification for the creation and use of specific plans and policies to address the distinct health needs of women and men. For example, there are areas of health (e.g. smoking, binge drinking, suicide) where men fare worse statistically, and others (such as self-harm, most aspects of reproductive health and certain cancers) where an increased focus and specific actions for women are necessary. Despite this, the different and distinct health experiences of women and men remains absent from general health policy and service development. It is also the case that many health services and policies remain built around expectations and features of male patients, with associated treatments also often based on male-dominated studies and trials. This approach presents difficulties for women.

Women's health needs

The headline news on women's health is good. The health status and life expectancy of women in Ireland has improved dramatically in the last two decades. Irish women live on average almost four years longer[8] than Irish men.

Women's health is determined not only by physical make-up, but also by a range of other factors including sex, and gender, as well as other social determinants across the life course. This means that health is a product of the conditions in which women are born, grow, live, work and

5 World Health Organisation (2016) Strategy on women's health and wellbeing in the WHO European Region. Copenhagen: WHO. Retrieved from: http://www.euro.who.int/en/health-topics/health-determinants/gender/publications/2016/strategy-on-womens-health-and-well-being-in-the-who-european-region-2016

6 Piang L.K., Khattar, P. & Nandan, D. (2010). 'Mainstreaming gender perspectives in the national health programmes: the challenges ahead'. *Health and Population: Perspectives and Issues.* 33 (1): 34-41.

7 Health Service Executive, National Women's Council of Ireland. (2012). *Equal but Different: A Framework for integrating gender equality in Health Service Executive Policy, Planning and Service Delivery.* Retrieved from: https://www.nwci.ie/download/pdf/equal_but_different_final_report.pdf

8 Department of Health. (2018). *Health in Ireland Key Trends 2018.* Retrieved from: https://health.gov.ie/wp-content/uploads/2018/12/Key-Health-Trends-2018.pdf

age as well as whether or not a woman has sufficient income, adequate housing, and social or community bonds and support, in addition to behaviour, diet and lifestyle. For example, women can experience particular inequalities in accessing healthcare, because the average income of a woman is less than that of a man. This in turn means that women are more reliant on public health services which often have long waits. Women generally provide most family care in Ireland, looking after children and older family members. The impact of these caring responsibilities can be detrimental to women's participation in paid employment, with consequences in older age of risk of poverty, poorer access to health and social care services and poor health.[9]

Women also have specific health concerns – such as maternal health – which men do not. Women are more likely to experience gender-based violence, eating disorders and depression, affecting women's wellbeing. Women generally live longer, but this also means that women tend to have more years of ill-health with chronic disease such as heart disease, cancer and COPD.

Women have been found to be more pro-active about their health (for example women are more likely to visit a dentist than men, while women also visit their GP more regularly).[10] However, many women report difficulties in accessing health services, linked to discriminatory or stereotypical views held by doctors and health care practitioners and poor diagnosis and treatment for the causes of mental ill health or heart disease.[11]

There are also large health inequities between women from different backgrounds. It is, for example, women from lower socio-economic groups who experience the greatest disadvantage in health, are at a greater risk of poor health, experience a higher burden of ill-health and live shorter lives than women from other groups. Women living in poverty and isolation, particularly lone parents and older women and women from marginalised social groups, including Traveller women, homeless women and women living in direct provision, regularly highlight the impact of low income on their health.[12]

9 Temmerman, M. et al. (2015). 'Women's health priorities and interventions'.

10 Department of Health. (2018). *Health in Ireland Key Trends 2018.*

11 Health Service Executive, National Women's Council of Ireland. (2012). *Equal but Different: A Framework for integrating gender equality in Health Service Executive Policy, Planning and Service Delivery.*

12 *Ibid.*

Women's health – European policy context

Internationally, women's health is also receiving increased consideration. In Europe, the WHO has developed a comprehensive framework to address women's health via the *Strategy on women's health and wellbeing in the WHO European Region* [13]. At its core, the WHO strategy recognises gender inequalities and inequalities linked to social and economic determinants of health as at the core of health inequities for girls and women. The four WHO priorities provide a coherent guide for the development of Ireland's WHAP:

1. Strengthening governance for women's health and well-being, with women at the centre
2. Eliminating discriminatory values, norms and practices that affect the health and well-being of girls and women
3. Tackling the impact of gender and social, economic, cultural and environmental determinants on women's health and well-being
4. Improving health system responses to women's health and well-being

The strategy further promotes a life-course approach to women's health, acknowledging that sex and gender, combined with social and environmental determinants of health, influence how health risks and benefits accumulate through life. The Strategy recognises women as powerful actors for change and supports their leadership of, and participation in, decision-making, including women who are socially disadvantaged or excluded, or belong to minority groups.

Prioritising women's health in Ireland – the Women's Health Action Plan

Ireland's first and only specific women's health policy (to-date) was the *Plan for Women's Health 1997-1999.* This had four objectives:

1. Maximise the health and social gain of Irish women
2. Create a woman-friendly health service
3. Increase consultation and representation of women in the health services
4. Enhance the contribution of the health services to promoting women's health in the developing world

As a part of the plan, a statutory Women's Health Council was established in 1997 to advise the Minister for Health and Children on all aspects of women's health. The Council was dissolved in 2009.

Current government action to address gender inequality across all sectors, including health, centres on the *National Strategy for Women and Girls 2017-2020.* This cross-government strategy aims to create 'an Ireland where all women enjoy equality with men and can achieve their full potential, while enjoying a safe and fulfilling life' (p.7). To drive this goal across the health sector the Strategy contains a formal commitment to the development of a Women's Health Action Plan (WHAP):

> *Objective Two:* Advance the Physical and Mental Health and Wellbeing of Women and Girls
>
> *Action 2.1:* Strengthen the partnership work with the National Women's Council of Ireland in identifying and implementing key actions to address the particular physical and mental health needs of women and girls in order to advance the integration of their needs into existing and emerging health strategies, policies and programmes through an action plan for women's health.

13 World Health Organisation Europe. (2016). *Strategy on women's health and well-being in the WHO European Region.* P. 2

Other health actions within the national Strategy aim for improvements for women and girls: as carers and cared-for women; increased physical activity level; improved health for women over 65; intercultural health support for women and girls; improved and standardised maternity care; improved sexual health and wellbeing; and wellbeing and inclusion of LGBTI+ young people. These national commitments to women's health and engagement with different groups of women are echoed across the service delivery commitments of the HSE in their Service Plan 2019, together with a strong focus on increasing patient and service user engagement, and actions in areas directly related to women's health, including developments in the National Screening Service, the HPV vaccination, maternity care, abortion care, Traveller and migrant health, actions to address Female Genital Mutilation (FGM), perinatal mental health, dementia care and youth mental health.

The commitment to develop a specific WHAP is part of a renewed focus on women's health in Ireland. This renewed focus can in turn be linked to a number of wider developments including:

— The sharing of women's experiences as part of the CervicalCheck controversy and linked to this the work and findings of the Scally Inquiry[14] into the cervical screening service which placed the voices and experiences of women at its centre and made recommendations that the Irish health system would better prioritise women's health. Recommendation 2 in particular called for 'consideration to how women's health issues can be given more consistent, expert and committed attention within the health system and the Department of Health' (p.22). In response to the Scally recommendations, the Department of Health and HSE Implementation Plan[15] identified 126 actions, including prioritisation of the development of the WHAP, alongside actions to 'identify high-potential solutions and necessary changes to policy analysis, processes and decision-making' (p.1) which can ensure women's health issues are prioritised within the health system.

— The passing of the 2018 referendum on the 8th amendment and subsequent development of HSE abortion services.

— The #MeToo movement, through which women have highlighted women's experience of sexual harassment and violence, creating a national and international dialogue about the need to prevent sexual violence, to hold perpetrators accountable and strategies needed to secure long-term change in response to survivors, including in the health system.

14 Scally, G. (2018). *Scoping Inquiry into the CervicalCheck Screening Programme.* Retrieved from: http://scallyreview.ie/wp-content/uploads/2018/09/Scoping-Inquiry-into-CervicalCheck-Final-Report.pdf

15 Department of Health, Health Service Executive. (2018). *Implementation Plan for the Scoping Inquiry into CervicalCheck Issues.* Retrieved from: https://health.gov.ie/wp-content/uploads/2018/12/Implementation-Plan-for-Recommendations-of-the-Scoping-Inquiry.pdf

Section 1 – Women in Ireland

This section, based primarily on data from Census 2016, provides an overview of women in Ireland, including demographic, social and economic and health-related statistics.

1.1 Total population

According to Census 2016 the total Irish population was 4,761,865, of which females accounted for 2,407,437 or 50.56%. There are 1,825,720 females aged 18 and over. The population in 2018 had grown by an estimated 2% since the 2016 Census. The total population is projected to reach 5.64 million with more than one in five people are expected to be aged 65 years or older by 2038[16].

1.2 Demographics

1.2.1 Age

Census data shows that the population of Ireland – female and male – has been getting steadily older since the 1980's. The proportion of the female population aged 25 to 64 years has increased by 8.9% over the period 1992-2016 (from 44.7% in 1992 to 53.6% in 2016). The proportion of the female population aged over 65 years increased by 1.2% from 1991 to 2016. A total of 14.2% of the population are 65 years and over with 340,730 women in this age group. Between 2011 and 2016 the number of females aged over 65 increased by 16.7%. The number of people over the age of 65 is currently increasing by over 20,000 a year with the number of people over the age of 85 projected to increase to over 2.5 times the current figure by 2038.[17] All younger age bands have decreased in their relative proportion of the female population demonstrating the increased ageing of the Irish population.

The population aged 65 and over has increased by 35% since 2009, which is considerably higher than the EU average of 16%.

Collectively, these changes will clearly have a significant impact on the nature and extent of demand for health care services in Ireland. For details, see **Appendix 1 Table A.1** Number of females by age band (1991-2016); **Table A.2** Proportion of females by age band, 1991–2016; and **Table A.3** Change in proportion of females by age band, 1991–2016.

Nationally, approximately 24.2% (581,717 individuals) of the female population are under 18 years old, 61.7% (1,484,990 individuals) are aged between 18 and 64 years, and 14.2% (340,730 individuals) are 65 years or over. The largest proportion of under 18-year-old females (27.1%) is in the Mid-East region of Ireland, with the largest proportion of adult women aged 18 to 64 years found in the Dublin region. The Border and West regions share the highest proportion of over 65 females at 15.7%. See **Appendix 1 Table A.4** Distribution of females by region and age, 2016.

At a county level Leitrim and Roscommon have the smallest proportion of adult women aged 18 to 64 at 57.6% and 57.5%, respectively. Counties

16 Department of Health. (2018). *Health in Ireland Key Trends 2018*. Retrieved from: https://health.gov.ie/wp-content/uploads/2018/12/Key-Health-Trends-2018.pdf

17 *Ibid.*

with the highest over 65 female population are Mayo (18%) and Kerry (17.6%). See **Appendix 1 Table A.5** Number and percentage of females by county and age.

1.2.2 Household composition and marital status

At the time of the last census (2016) there were 1,218,370 families nationally (for CSO Census purposes, a family is defined as a couple with or without children, or a one parent family with one or more children). 862,721 of these were families with children, an increase of 28,455 since 2011. The number of married couples with children increased by 1.7% to 568,317, while the number of cohabiting couples with children increased by 25.4% to 75,587. One parent families headed by a female with children increased by 1.5%. **Table 1.1** provides a breakdown of families which involved females as head/or shared heads of household.

Children in families of cohabiting couples had a younger profile with 76.6% of this family type having only children under the age of 15. This compares with just 47% of married couples having only children under the age of 15. Children in one parent families were likely to have an older age profile. Census 2016 shows 35.9% of females (654,917) over 18 years are single; 49% (895,037) are married (including same sex civil partnership); 3.3% are divorced; and 8.1% are widowed. See **Appendix 1 Table A.6** for details of the marital status of females in the state. Of women aged over 65 years, 31.5% are living alone in a private household which is notably higher than for males (21.3%). This may be linked to women's longer life expectancy, and to the fact that older women are more likely to be widowed (and not remarried) than older men.[18] See **Appendix 1 Table A.7** for details.

Table 1.1 Families which involve females (as part of a couple/or as head of a one parent family)

Family type		Sub-total	Total	Proportion
Married couple	Female is part of a married couple with one or more usually resident never-married children (of any age);	559,006	832,504	71%
	Female is part of a married couple without children	273,498		
One parent household with children	One parent household headed by a female with one or more usually resident never-married children (of any age);	186,391	186,391	16%
Cohabiting couple	Female is part of a cohabiting couple together with one or more usually resident never-married children (of any age)	74,854	148,749	13%
	Female is part of a cohabiting couple without children	73,895		
Total			**1,167,644**	

Source: CSO. (2017). Census 2016 Results: Profile 4 Households and Families

18 Stepler, R. (2016). *Gender gap in share of older adults living alone narrows*. Pew Research Center. Retrieved from: http://www.pewsocialtrends.org/2016/02/18/1-gender-gap-in-share-of-older-adults-living-alone-narrows/

1.2.3 Ethnicity and nationality

Of the female population usually resident in Ireland, 82.4% are White Irish. The largest minority group are those of any other white background (9.5%), Asian 2.1% and Other (including mixed backgrounds) 1.5%. See Appendix 1 Table A.8 for ethnic background of female population usually resident in the state.

The Dublin region has the lowest proportion of White Irish at 76.1%, followed by West and Midlands regions with 83.7%. The largest proportion of female Irish Travellers exists in the Midlands region where they account for 1.3% of the female population. All other minority groups exist in their largest relative proportions in the Dublin region. See **Appendix 1 Table A.9** Ethnic background of female population usually resident in the state by region, 2016.

Traveller women

The 2016 census recorded 15,610 Irish Travellers usually resident in the state. Irish Travellers make up 0.7% of the female population and the largest relative proportion of female Irish Travellers exists in the Midlands region where they account for 1.3% of the female population. **See Table A.10** for details of the 10 counties that have the highest proportion of Travellers among the female population. Longford is the county with the highest proportion at 2.5%.

Female Travellers aged 65 and over account for 3.1% of the female Traveller population, compared to 14.2% for over 65's in the general Irish population.

Traveller females aged 0 to 24 years also make up a larger relative proportion of the Traveller population (56.5%) compared to 0 to 24-year olds among the general population (24.2%). See **Appendix 1 Table A.11** for details.

Nationality

12.8% (302,587 individuals) of the female population are not Irish nationals. Proportionately, the Polish population represents 2.6% of the female population, while UK nationals make up 2.1% females nationally. See **Appendix 1 Table A.12** for breakdown of the total female population by nationality.

1.3 A socio-economic profile

1.3.1 Education

Nationally, 25.7% of females aged 15 and over, achieved education at degree level or higher. 15.6% achieved a third level education (non-degree), 26.7% have a secondary education while 9.5% have either no formal education or primary education, with a further 22.5% of females in the category of other (which includes not stated). The Dublin region has the highest proportion of females with a degree level education or higher at 29.8%. The Midlands region has the lowest proportion (21%). The Border region has the highest proportion of females with no formal education or a primary education only (12.75%). See **Appendix 1 Table A.13** for details of highest education completed.

1.3.2 Employment

At the time of the last Census 126,466 (6.6%) women aged 15 years and over were unemployed (the equivalent male unemployment rate was 9.3%), while 48.6% of women were employed, 11.3% were students, 14.9% were looking after the family/home, 14.1% were retired and 4.2% were unable to work because of sickness or disability, with 0.4% females falling into the category of other (e.g. not in the workforce). See **Appendix 1 Table A.14** for details of economic status of females over 15 years.

In Q2 of 2017 the employment rate among females with a third level education was 81%, in contrast to a 60% employment rate for upper secondary educated females and 25% for females with a primary education only. Since 2009, the employment rate for women with a primary education only and upper secondary education has dropped by 5% and 2% points respectively. The employment rate among third level educated

females has risen by 3% points since 2009. Unemployment levels among females over 15 of all ethnic or cultural backgrounds was 6.6%. Unemployment was highest among Irish Travellers (37%) and Black or Black Irish – African (20.5%). See **Appendix 1 Table A.15** for details of education level and employment rates and **Table A.16** for details of female unemployment by ethnic group.

1.4 Health, disability and caring

1.4.1 Health

Almost three out of five women (59.3%) described their health as very good in Census 2016. This response varied greatly by age and fell to 23.2% for females aged 65 years and over. See **Appendix 1 Table A.17** for details.

1.4.2 Disability

Of the total female population 13.8% have at least one disability.

Appendix 1 Table A.18 provides details on the types of disabilities experienced by females in the state. The proportion of the female population aged 15 years and over who are unable to work due to permanent sickness or disability has increased by 2% points since 1991 to 4.2%. The proportion of females with a disability is highest in the Mid-West region at 14.6% and lowest in the West region at 13.4%. See **Appendix 1 Table A.19** for details.

1.4.3 Caring and carers

The CSO defines a carer as anyone who provides regular unpaid personal help for a friend or family member with a long-term illness, health problem or disability. The CSO does not include caring for 'own children' within its definition. A total of 195,263 persons in the state identified themselves as carers (providing unpaid assistance to others) at the time of the last census. Of persons in caring roles, females accounted for 118,151 or 60.5% of this group. 80% of female cares were aged between 25 and 64 years; 14.2% were 65 years and over; 5.9% were 24 and under (see **Appendix 1, Table A.20**). A much smaller number of individuals (70,459 individuals (including 53,978 (76.6%) women) were in receipt of the means-tested Carer's Allowance in 2016[19] with eligibility for the Carer's Allowance, limited to individuals on low incomes, and requiring that individual to not be engaged in employment, self-employment, training or education courses outside the home for more than 15 hours a week[20].

The hours of unpaid care provided by female carers varied significantly – 41.2% of female carers provided 1-14 hours of unpaid help per week, while 10.2% of female carers provided 168 hours per week. See **Appendix 1, Table A.21** details the hours of unpaid care provided by female carers (aged 15 and over).

19 CSO. (2016). *Women and Men in Ireland 2016*. Retrieved from: https://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2016/health/ and http://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2016/introduction/

20 Citizen's Information. (2019). *Carers Allowance*. Retrieved From: https://www.citizensinformation.ie/en/social_welfare/social_welfare_payments/carers/carers_allowance.html

1.5 Fertility rates and life expectancy

1.5.1 Fertility rates[21]

Since 2009, there has been a gradual decrease in the number of live births, however Ireland still has the third highest fertility rate in the EU behind France and Sweden. This is due in part to the reduction in fertility rates but, more significantly, to the fact that the number of women in the child-bearing age groups has declined in recent years[22]. This is likely to result in a steady reduction in the number of births over the coming decade even if, as expected, Ireland continues to experience fertility rates which are higher than most other EU countries. See **Appendix 1 Table A.22** for details.

1.5.2 Life expectancy (by age and gender)[23]

Life expectancy in Ireland continues to rise for women (and men), with the gender gap narrowing slightly. A female child born in 2015 is now expected to live for 83.6 years (and an Irish man for 79.9 years). The number of healthy life years is 69.8 years for females and 67.3 years for males in Ireland compared with EU averages of 64.2 years for female, 63.5 years for males. These improvements are largely due to lower mortality and better survival from conditions such as heart disease and cancer affecting older age groups.[24] See **Appendix 1 Table A.23** for life expectancy by age and gender.

1.5.3 Rural Women

Approximately 36.6% of the female population live in rural areas (see **Appendix 1 Table A.24** for female population by urban and rural area. For many this means that they have limited access to public transport to access health facilities. It is also the case that 20% of households nationally, the vast majority of which are in rural areas, do not have access to high speed broadband, which in turns limits their capacity to access health information online[25].

21 Total Fertility Rate (TFR) is a measure of the average number of children a woman could expect to have if the fertility rates for a given year pertained throughout her fertile years

22 Department of Health. (2017). *Health in Ireland Key Trends 2017.* Retrieved from: https://health.gov.ie/wp-content/uploads/2018/01/Key-Trends.pdf

23 *Ibid*

24 *Ibid*

25 Fibre Roll Out. (2019). *National Broadband Plan.* Retrieved from: https://fibrerollout.ie/rural-ireland/nbp/

Section 2 – Women's Health in Ireland

2.1 Health

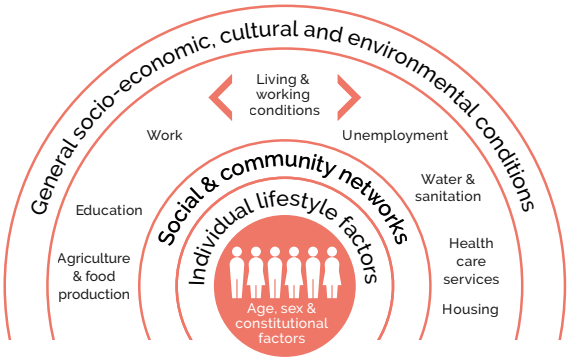
2.1.1 Health and gender

Women and men are biologically different; they are also different because of socially constructed norms and beliefs. There are also many other issues such as access to health services, cost of recovery, distance to health facilities, etc. that have differential connotations and implications on the health of women and men.

Women's health therefore is determined not only by physical make-up, but also by a range of other factors including sex, and gender, as well as other social determinants across the life course.

This means that health is a product of the conditions in which women are born, grow, live, work and age as well as whether or not a woman has sufficient income, adequate housing, and social or community bonds and support, in addition to behaviour, diet and lifestyle. In this way, the totality of women's life experiences impact on their health and wellbeing. See Figure 2.1 for details of some of these social determinants and the links and interactions between them.

Figure 2.1 Determinants of health



(Source: Dahlgren & Whitehead,1992)

2.1.2 Health and gender inequalities

Whilst women in Ireland have a higher life expectancy than men, women in most communities report more illness and distress than men. Women are also more likely to: earn less than men and be less financially secure; be employed in casual, part time work; undertake the majority of work in the home; experience violence from their partner; be discriminated against; be the victims of sexual assault; experience anxiety and depression; and have caring responsibilities for children, partners, parents and other family members. Women are also often a key influence for their partners and children in terms of seeking appropriate and timely healthcare[26]. Women's health must therefore be understood within the broader contexts in which women live and work.

26 Women's Health Council. (2002). *Promoting women's health: A population investment for Ireland's future. A position paper of the Women's Health Council*. Retrieved from: https://health.gov.ie/wp-content/uploads/2014/04/promoting_womens_health.pdf

2.1.3 Health inequalities and gender

Those who are poorer and disadvantaged (e.g. women who tend to earn less and be less financially secure) are more likely to face more illness during their lifetime and die younger than those who are better off. This means that the chances of a long and healthy life are not the same for all women and while a certain amount of variation in health, based on biological or genetic factors is to be expected, notwithstanding there is a distinct health gap between rich and poor. There is also a clear social gradient in health whereby health generally improves with income with particular social groups (defined by ethnicity, gender or geography for example) more affected by these inequalities than other groups. Health inequalities tend to be persistent through time and have three distinguishing features as follows:[27]

— They are systematic, that is they are not random but follow a consistent social pattern.

— They are socially produced, rather than the result of biological or other fixed processes, and are therefore regarded as modifiable.

— They are widely perceived to be unfair or inequitable.

Health inequalities do not arise by chance; neither can they be simply attributed to genetic makeup, 'bad' behaviour, or difficulties in access to medical care.[28] Even though these factors may have a role to play, the reality is that social and economic differences in health status are a reflection of larger and more far reaching social and economic inequalities in society. These larger inequalities can be related to economic arrangements, the quality of governance, social policies and programmes, etc. which in turn with other factors ultimately can have a direct and profound impact on the lives people are able to lead in terms of: their early years; education; working conditions; employment and incomes levels; engagement in community; and engagement in public health and health systems.[29] A 2002 Northern Ireland study estimated that 5,400 fewer people would die prematurely each year across the island of Ireland if social deprivation and inequalities were tackled (p23).[30]

2.2 What we know about women's health in Ireland

2.2.1 Women's general health

According to Healthy Ireland self-reported surveys, slightly more women (86%) than men (84%) perceive their health to be very good or good. The gender gap in self-reported good health is largest among those aged 55 to 64. 81% of women in this age group perceive their health to be good or very good, compared with 73% of men. Self-reported good health is also higher both among those who are working than among those who are unemployed (93% and 78% respectively) and among those living in more affluent areas than those living in more deprived areas (90% and 79% respectively)[31]. Women are also more likely than men to describe their oral health as good or very good (82% and 76% respectively)[32]. The proportion describing their oral health as good or very good declines with age. Women have been found to be more pro-active about their health (for example, women between the ages of 35 and 74, women are more likely to visit a dentist than men (53% and 42% respectively), while women also visit their GP more regularly and are more likely to receive the flu vaccine (27% and 23% respectively)[33].

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27 Dahlgren, G. & Whitehead, M. (2006). *European Strategies for Tackling Social Inequities in Health. WHO, Geneva.* Retrieved from: http://www.euro.who.int/___data/assets/pdf_file/0018/103824/E89384.pdf

28 Marmot Review. (2010). *Fair Society, Healthy Lives- Strategic review of health Inequalities in England post 2010.* Retrieved from: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

29 World Health Organisation. (2010). *Interim First Report on Social Determinants of Health and the Health Divide in the European Region.* Retrieved from: http://www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity/publications/2010/interim-first-report-on-social-determinants-of-health-and-the-health-divide-in-the-who-european-region

30 Department of Health, Social Services and Public Safety. (2002). *Investing for Health.* Belfast: DHSSPS. Retrieved from: http://publichealthwell.ie/node/3481

31 Ipsos MRBI and Department of Health. (2018). *Healthy Ireland Survey 2018 Summary of Findings.* Department of Health: Dublin. Retrieved from: https://health.gov.ie/wp-content/uploads/2018/10/Healthy-Ireland-Survey-2018.pdf

32 *Ibid.*

33 *Ibid.*

2.2.1.1 Women and chronic diseases

As people age, chronic conditions become more prevalent with females having a somewhat higher prevalence of chronic conditions compared to males. See Table 2.1 for details.

Table 2.1 Chronic conditions and limitations by gender

Description	% Male	% Female
People with a long-standing illness or health problem	26.4	27.8
Self-perceived long-standing limitations (some and severe limitations) in usual activities due to health problems	16.8	18.6

Source: Table 2.2 and 2.3 in Dept of Health (2016) Health in Ireland Key Trends 2016 (EU-SILC, Eurostat)

Women are for example 2.7 times more likely to suffer autoimmune conditions than men, and comprise 78.8% of sufferers in the US[34]. Autoimmune conditions can include rheumatoid arthritis[35], celiac disease, Type 1 diabetes, lupus erythromatosis, and Addison's disease, etc. The prevalence of both migraine[36] and other chronic pain conditions is also higher in women than in men[37].

At least 6 out of 10 Irish adults are either overweight or obese. 53% of women are overweight compared with 70% of men. The proportion of the population that has a normal weight declines with age, with 63% of those aged 15 to 24 having a normal weight, declining to 24% of those aged 65 and older. Women in all age groups are more likely than men of the same age to have a normal weight. The Metabolic Risk Classification devised by the WHO uses waist measurements to identify whether individuals have a normal, increased or substantially increased level of risk of premature death due to obesity. Women are more likely to be at risk than men, with 45% of women having a substantially increased level of risk, compared with 27% of men. Women aged 75 and older have the highest level of risk, with 19% having an increased level of risk and 67% having a substantially increased level of risk[38].

2.2.1.2 Women's mortality

As the Irish population ages, cancers and related tumors are now the most common cause of death (just ahead of diseases of the circulatory system), and an annual average of about 8,770 deaths from invasive cancer occurred during 2012-2014[39]. Lung cancer was the leading cause of cancer death in both sexes, accounting for 19% of cancer deaths in women and 23% in men. Death rates for respiratory issues are indeed high in Ireland by comparison to the EU15 average[40]. The burden of respiratory death in women points to the burden of illness from smoking and from other contributory factors, including a cold climate with high humidity levels (but insufficient deep cold to curtail the transmission of infection) and high damp levels in under-insulated and under-damp proofed older housing. The fact that there is a high incidence of both allergic respiratory disorders (rhinitis, asthma) and of genetic respiratory disease in Ireland (e.g. Cystic Fibrosis, Alpha-1 antitrypsin deficiency) are also significant contributory factors. Approximately one in 19 Irish people are carriers of cystic fibrosis and one in 25 are carriers of Alpha-1. These carriers are also at higher risk of various

34 Jacobson DL., Gange SJ., Rose N.R, Graham NM. (1997). 'Epidemiology and estimated population burden of selected autoimmune diseases in the United States'. *Clin Immunol Immunopathology.* Sep;84(3):223-43. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/9281381

35 The Migraine Trust. (No Date). *Facts and Figures.* Retrieved from: https://www.migrainetrust.org/about-migraine/migraine-what-is-it/facts-figures/

36 Save Lives. (2015). *Who are the victims of domestic abuse?* Retrieved from: http://www.safelives.org.uk/policy-evidence/about-domestic-abuse/who-are-victims-domestic-abuse

37 Fillingim, RB., King, CD., Ribeiro-Dasilva, MC., Rahim-Williams, B., Riley, JL. (2009) 'Sex, gender, and pain: a review of recent clinical and experimental findings'. *J Pain.* 2009;10(5):447-85. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/19411059

38 Ipsos MRBI and Department of Health. (2017). *Healthy Ireland Survey 2017 Summary of Findings.* Department of Health: Dublin. Retrieved from: https://health.gov.ie/wp-content/uploads/2017/10/16-048825-Healthy-Ireland-Survey-18-October_for-printing.pdf

39 National Cancer Registry Ireland (2017) *Cancer in Ireland: 1994-2015 with estimates for 2015-17.* National Cancer Registry Ireland.

40 Jennings, S.M. (2014). *Preventing chronic disease: defining the problem – Report from the Prevention of Chronic Diseases Programme.* HSE, Royal College of Physicians of Ireland, Office of Nursing and Midwifery Services Director, Healthy Ireland. Retrieved from: https://www.lenus.ie/handle/10147/338212

respiratory illnesses, including asthma. Given the high burden of respiratory disease, Healthy Ireland/Department of Communications, Climate Action and Environment/HSE Warmth and Wellbeing scheme provides funding for those with respiratory disease (not solely due to genetic issues) to improve insulation, damp-proofing, etc. in their homes.

Women's risk of dying of cancer is about 34% lower than for men. Survival has improved markedly for cancers as a whole and for the most common cancer types in females the five-year net survival increased from 48% during 1994-1998 to 60% during 2010-2014[41]. The top four most common cancers represented among the surviving (prevalent) cancer patient population were: breast cancer (23% of all cancer survivors), prostate cancer (20%), colorectal cancer (12%) and skin melanoma (7%). Ireland however remains below the OECD average for survival rates, with the exception of prostate cancer[42].

Table 2.2 Social gradients in relation to cancer incidence

Cancer Type	Irish Statistics[43]	Description
Lung	— The risk of lung cancer is 74% greater for women and 54% greater for men living in high density areas than it is for those living in lower density areas. — Areas with the highest levels of unemployment had higher rates of female and male lung cancer than those with the lowest levels. (The relative risk between the highest and lowest quintiles for men was 1.40 (95%CI=1.32-1.49). — Women and men in areas with the poorest education levels had greater risk (23% for women; 32% for men) of lung cancer than individuals living in the areas with the highest level of educational attainment. — Areas with the highest proportions of elderly living alone also had an elevated risk of lung cancer.	— Smoking is the principal cause of lung cancer. The International Agency for Research on Cancer (2004) estimated that in populations with prolonged cigarette use, 90% of lung cancer cases are due to cigarette smoking). Risk increases with younger age at smoking commencement and longer duration of smoking. Passive smoking is a cause of lung cancer in those who have never smoked. — According to the All Island Health Atlas the consistent relationship between higher lung cancer risk and lower socio-economic status probably reflects social class variations in tobacco exposure.

41 Department of Health. (2017). *National Cancer Strategy (2017-2025)*, Dublin: Department of Health. Retrieved from: https://health.gov.ie/wp-content/uploads/2017/07/National-Cancer-Strategy-2017-2026.pdf

42 *Ibid*, p.24.

43 National Cancer Registry/Northern Ireland Cancer. (2011). *All-Ireland Cancer Atlas 1995-2007*. Cork/Belfast. Retrieved from: https://www.ncri.ie/publications/cancer-atlases-and-geographic-studies/all-ireland-cancer-atlas-1995-2007

Table 2.2 (continued) Social gradients in relation to cancer incidence

Cancer Type	Irish Statistics	Description
Stomach	— Those with low socio-economic status have increased stomach cancer risk, probably in part reflecting variations in tobacco use by social class. — The risk of stomach cancer for women and men is greater in high density than in low density areas. — Stomach cancer risk also increased for both women and men as the proportion of unemployed in an area increased. The same pattern was seen for educational attainment; people living in areas with low levels of educational attainment had the greatest risk of stomach cancer. — The relationship between female stomach cancer risk and areas where there were higher levels of elderly people living alone was stronger (1.26 (95%CI=1.11-1.43)) than that for men.	— Infection with the common bacterium, Helicobacter pylori (H pylori), which lives in the stomach and causes inflammation and ulcers, is associated with a six-fold raised risk of stomach cancer. Smoking is also firmly established as a cause of stomach cancer. Other risk factors include higher intakes of salt, salty foods or foods preserved in salt with risks reduced for individuals with higher intakes of fruit and non-starchy or fresh vegetables.
Cervical	— Women of lower socio-economic status have raised cervical cancer risk which is partly a function of variations in exposure to risk factors. It also is a reflection of social class differences in access to cervical smear tests or participation in organised screening programmes. — The risk of cervical cancer increases with increasing population density. Those resident in areas of highest density have a 48% greater risk. — Areas with the highest levels of unemployment had higher rates of cervical cancer than those with the lowest levels. (The relative risk between the lowest and highest groups was 1.21 (95% CI= 1.06-1.37) — Women in areas with the lowest education levels had a 66% greater risk of cervical cancer than those in areas with the highest levels of educational attainment.	— The association between cervical cancer and high-risk types of human papilloma viruses (HPV) infection is so strong that HPV is considered to be a necessary cause of the disease (Bosch et al., 2002). Infection with human immunodeficiency virus, type 1 (HIV-1) is also recognised as a cause of cervical cancer. There is also a causal relationship between smoking and squamous cell cancer of the cervix, which persists after adjustment for HPV infection.

Cancers of the uterus and ovary are also common cancers in women. Whilst ovarian cancer incidence rates have fallen slightly over the last number of years, uterine (womb) cancer incidence is rising. Contributors to this rise include increases in obesity, increased use of tamoxifen and a decline in the rates of hysterectomies for sterilisation or treatment of heavy menstrual bleeding.[44]

Major cancers with the highest proportions of emergency presentation during 2014-2016 were cancers of the pancreas (36%), liver (34%), brain & CNS (31%) and lung (25%). Lifestyle changes that can help reduce risk of breast cancer, include eating healthily, being active, limiting alcohol and not smoking. Breastfeeding helps to prevent risk of breast cancer. It should be noted in this context that steep social gradients exist in relation to the incidence of some cancers (lung, stomach, upper aero digestive tract (UADT), and cervical cancer in particular). [45] See Table 2.2 for details.

Screening can help protect women's health through early detection.[46] BreastCheck, the National Breast Screening Programme, offers all women aged 50 to 67 a free mammogram every two years. CervicalCheck, Ireland's National Cervical Screening programme, provides free smear tests to women aged 25 to 60. BowelScreen, the National Bowel Screening programme, offers a free home test to women and men aged 60-69 every two years. Its purpose is to detect changes in the bowel before cancer develops. It can also help detect cancer at an early stage, making it more treatable[47]. Since April 2018, a number of failings have come to light in relation to CervicalCheck, because of a failed attempt to disclose the results of a retrospective audit to a large group of women who had developed cervical cancer. The Scally Scoping Inquiry into the CervicalCheck Screening Programme made a number of recommendations in relation to how the screening programme could be improved. It also recommended giving 'consistent, expert and committed attention within the health system' to women's health.

2.2.2 Women's mental health

There are differences between women and men in how they express mental distress. This is seen in the prevalence of mental illness (particularly common mental disorders such as anxiety and depression, self-harm, substance misuse and suicide); pathways into treatment and support; and in therapeutic preferences[48]. It is also the case that many women's preferred intervention are talking therapies/counselling, this is despite the fact that women believe there is an over-reliance on medication as a solution to women's mental health issues.[49]

There are well-established links between the risks of mental illness and the social realities of women's lives. These include women's relatively lower incomes and access to household resources and responsibility for childcare and other caring responsibilities, as well as sexual abuse and domestic violence.

Abel and Newbigging (2018)[50] argue that *'gender neutral approaches to service provision fail to recognise the specific needs of women'.* See Table 2.3 for details of some of the key gender differences in mental health.

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44 National Cancer Intelligence Network. (2013). *Outline of Uterine Cancer in the United Kingdom: Incidence, Mortality and Survival.* Retrieved from: http://www.ncin.org.uk/view?rid=2398

45 Kogevinas M, Pearce N, Susser M, Boffetta P (1997) Social inequalities and cancer. Lyon: *IARC, IARC Scientific Publications*

46 National Cancer Registry Ireland. (2018). *Cancer in Ireland 1994-2016 - With Estimates For 2016-2018: Annual Report Of the National Cancer Registry.* Retrieved from: https://www.documentcloud.org/documents/5331697-CANCER-IN-IRELAND-1994-2016-with-estimates-for.html

47 The National Bowel Screening Service. (2012). Retrieved from: https://www.bowelscreen.ie/

48 Government of Ireland. (2006). *A Vision for Change- Report of the Expert Group on Mental Health Policy.* Retrieved from: https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf

49 National Women's Council of Ireland. (2018). *Out of Silence- Women's mental health in their own words.* Retrieved from: https://www.nwci.ie/images/uploads/Out_of_Silence_Report_-_NWCI_-_2018.pdf

50 Abel K M., Newbigging, K. (2018). *Addressing unmet needs in women's health.* British Medical Association. Retrieved from: https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/womens-health

Table 2.3 Gender differences in mental health

Themes	Women	Men
Life experiences	— Over a quarter (26%) of women surveyed in Ireland had experienced physical and/or sexual violence by a partner or non-partner since the age of 15.[51] — Caring responsibilities	— Accidents (e.g. at work) — Social isolation — Homelessness — Prison
Socio-economic realities	— Poverty — Gender pay gap — Juggling demands of care and work — Backbone of caring services but few in leadership positions	— Full-time employment — Unemployment — Retirement
Expressions of mental distress and symptoms	— Depression — Anxiety — Eating disorders (anorexia and bulimia nervosa) — Somatic disorders — Self-harm — Post-traumatic stress disorder — Perinatal mental health — Borderline personality disorder	— Early onset psychosis — Suicide — Substance abuse — Anti-social personality disorder — Behaviour and personality difficulties, including alcohol and drug dependence
Pathways into services	— Primary care — Community services — Maternity services	— Emergency Department — Drug/alcohol services — Criminal justice system
Treatment needs and responses	— Community-based and informal (e.g. women's groups) — Gender specific services — Greater risk of victimisation and exploitation	— Activity based (e.g. men's shed) — Assertive outreach — Early intervention

Source: Table adapted from presentation by Dr. Karen Newbigging, Senior Lecturer in Health Policy and Management, University of Birmingham at NWCI 'Gender and Mental Health' Roundtable, November 2016.

51 Fundamental Rights Agency. (2014). *Report on violence against women across the EU: abuse at home, work, in public and online.* Retrieved from: http://www.cosc.ie/en/COSC/FRA%20EU%20Survey%20on%20Violence%20Against%20Women%20-%20Full%20report.pdf/Files/FRA%20EU%20Survey%20on%20Violence%20Against%20Women%20-%20Full%20report.pdf

Given the gender differences detailed in Table 2.3 it is not surprising to find that within the Healthy Ireland survey[52] higher levels of female participants (13%) indicated probable mental health problems in comparison with males (6%).

It is the case too that 19% more women than men attempt suicide, while men are four times more likely to die by suicide than women.[53,54] Female rates of self-harm in contrast were 21% higher than male rates in 2017.[55]

Groups at particular risk of suicidal behaviour include middle aged women and women experiencing violence.[56]

Issues also exist in relation to peri-natal mental health[57] and the *National Maternity Strategy 2016-2026*[58] includes a number of actions in relation to mental health supports. The HSE's *Specialist Perinatal Mental Health Service Model of Care* was launched in November 2017 and includes a model for an overall perinatal mental health service clinical pathway. This provides for screening for mental health problems such as depression, anxiety, psychosis at the first visit to the maternity service, called the booking visit. The project is currently at implementation stage with full time services available in the Rotunda and National Maternity Hospitals for the first time, with services currently being developed in Limerick, Cork and Galway.

Research[59] shows too that marginalised women (including asylum seekers, homeless women, Traveller and Roma women, LGBTQI+ women and women with disabilities) are disproportionately impacted by poor mental health. See Table 2.4 for characteristics of gender sensitive services. A 2017 analysis of admissions to Irish psychiatric units and hospitals found that there was an equal proportion of male and female admissions (all), with males having a slightly higher rate of all admissions, at 353.8 per 100,000 compared with 349.4 for females. Forty-seven per cent of first admissions were female and females also had a lower rate of first admissions, at 115.1 per 100,000 compared with 133.2 for males[60.] 43% of all admissions to general hospital psychiatric units and psychiatric hospitals/continuing care units (53%) were female compared with a 60% admission rate for females to independent/private and private charitable centres. Similarly, females accounted for 56% of first admissions to independent/private and private charitable centres. One-third of patient's resident on 31 December 2017 had a diagnosis of schizophrenia, 13% had a diagnosis of depressive disorders, 12% had a diagnosis of organic mental disorders and 8% had a diagnosis of mania. Schizophrenia had the highest rate of hospitalisation, at 16.1 per 100,000, followed by depressive disorders, at 6.5 and organic mental disorders, at 5.7. Females had

52 Ipsos MRBI and Department of Health. (2015). *Healthy Ireland Survey 2015 Summary of Findings*. Department of Health: Dublin. Retrieved from: https://health.gov.ie/wp-content/uploads/2015/10/Healthy-Ireland-Survey-2015-Summary-of-Findings.pdf

53 Arensman, E., Wall, A., McAuliffe, C., Corcoran, P., Williamson, E., McCarthy, J., Duggan, A., Perry, I., (2013). *Second Report of the Suicide Support and Information System*. National Suicide Research Foundation 2013. Retrieved from: https://www.nsrf.ie/wp-content/uploads/reports/SSISReport2013.pdf (accessed 24th March 2019

54 Corcoran, Keeley, O'Sullivan, and Perry. (2004). 'The incidence and repetition of attempted suicide in Ireland.' *European Journal of Public Health*, 2004 Mar;14(1):19-23.

55 Griffin, E., Dillon, CB., McTernan, N., Arensman, E., Williamson, E., Perry, IJ., Corcoran, P. (2018). *National Self-Harm Registry Ireland Annual Report 2017*. Cork: National Suicide Research Foundation. Retrieved from: https://www.drugsandalcohol.ie/29774/1/nsrf-national-self-harm-registry-ireland-2017.pdf

56 Department of Health, Healthy Ireland, National Office of Suicide Prevention, HSE. (2015). *Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015-2020*. Retrieved from: https://www.healthpromotion.ie/hp-files/docs/HME00945.pdf

57 Department of Health (2016) *The National Maternity Strategy 2016-2026: Creating a Better Future Together*. Retrieved from: https://health.gov.ie/wp-content/uploads/2016/01/Final-version-27.01.16.pdf

58 *Ibid.*

59 Department of Justice and Equality. (2017). *National Traveller and Roma Inclusion Strategy 2017-21*. Retrieved from: http://www.justice.ie/en/JELR/National%20Traveller%20and%20Roma%20Inclusion%20Strategy,%202017-2021.pdf/Files/National%20Traveller%20and%20Roma%20Inclusion%20Strategy,%202017-2021.pdf; Health Service Executive, Glen, BelongTo, TCD. (2016). *The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland*. Retrieved from: http://belongto.org/wp-content/uploads/2018/05/LGBT-Ireland-Full-Reportpdf.pdf; and Mental Health Reform and Simon Community (2017) *Homelessness and Mental Health: Voices of Experience*. Retrieved from: https://www.mentalhealthreform.ie/wp-content/uploads/2017/06/Homelessness-and-mental-health-report.pdf

60 Daly, A., & Craig, S. (2018). *Activities of Irish Psychiatric Units and Hospitals 2017 Main Findings*. HRB Statistics Series 38.

a lower rate of hospitalisation for schizophrenia than males, at 12 per 100,000 compared with for 20.3 per 100,000 for males. Females also had a lower rate of hospitalisation for organic mental disorders, at 4.4 compared with 7.1 per 100,000 for males.

Table 2.4 Characteristics of gender sensitive services
Prioritise understanding mental distress in the context of women's lives
Are co-designed with women with lived experience
Enable all dimensions of the problems experienced to be addressed
Address sexual abuse, domestic violence, body image concerns, reproductive and life stage elements of health and wellbeing
Are sensitive to the diversity of women's needs, experiences and backgrounds including race, sexuality and disability
Enable women to make choices about their care and treatment
Empower women to develop skills for addressing their difficulties
Promote self-advocacy and advocacy for women who need support to voice their views
Value women's strengths and potential for recovery

Source: Abel K M., Newbigging, K. (2018). Addressing unmet needs in women's health. British Medical Association. Retrieved from: https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/womens-health

2.2.3 Women's sexual, reproductive and maternal health

2.2.3.1 Women's sexual health

The majority of the adult population have engaged in sexual intercourse at some stage in their lifetime[61,62,63,64,65]: 92% of the adult population report previously having sexual intercourse, with the vast majority (85%) reporting that their most recent sexual contact occurred within a relationship[66,67]. The overall median age for reported initiation of heterosexual sexual activity remained stable at 18 between 2003 and 2010[68]. Research has found that early sexual initiation (at or below 16) is associated with an increased risk of crisis pregnancy, STIs and higher partner numbers[69]. In terms of partner numbers, half of women in Ireland (51%) and almost one-third (29%) of Irish men report one lifetime sexual partner. Six percent of heterosexual women and one-quarter of heterosexual men in Ireland report having ten or more lifetime sexual partners.

61 Layte, R., McGee, H., Quail, A., Rundle, K., Cousins, G., Donnelly, C., Mulcahy, F. and Conroy, R. (2006). *The Irish Study of Sexual Health and Relationships: Main Report*. Crisis Pregnancy Agency and the Department of Health and Children: Dublin.

62 McBride, O., Morgan, K. and McGee, H., (2012). *Irish Contraception and Crisis Pregnancy Study 2010: A Survey of the General Population, Crisis Pregnancy Programme Report 24*. HSE Crisis Pregnancy Programme: Dublin.

63 Rundle, K., Leigh, C., McGee, H. and Layte, R., (2004). *Irish Contraception and Crisis Pregnancy Study: A Survey of the General Population*. Crisis Pregnancy Agency: Dublin.

64 Ipsos MRBI and Department of Health. (2016). *Healthy Ireland Survey 2016 Summary of Findings*. Department of Health: Dublin. Retrieved from: https://health.gov.ie/wp-content/uploads/2016/10/Healthy-Ireland-Survey-2016-Summary-Findings.pdf

65 Ipsos MRBI and Department of Health. (2015). *Healthy Ireland Survey 2015 Summary of Findings*.

66 Ipsos MRBI and Department of Health. (2016). Healthy Ireland Survey 2016 Summary of Findings.

67 Ipsos MRBI and Department of Health. (2015). *Healthy Ireland Survey 2015 Summary of Findings*.

68 McBride, O., Morgan, K. and McGee, H., (2012). Irish Contraception and Crisis Pregnancy Study 2010: A Survey of the General Population, Crisis Pregnancy Programme Report 24.

69 Rundle, K., Layte, R. and McGee, H. (2008). I*rish Study of Sexual Health and Relationships Sub-Report 1: Learning About Sex and First Sexual Experiences*. Crisis Pregnancy Agency and Department of Health and Children: Dublin.

Young People (aged 15-24)

Early sexual initiation, at aged 16 years or younger, is more likely to be reported by younger adults, with the proportion remaining relatively stable for men at 39% in 2003 and 37% in 2010 but increasing for women from 21% to 26% over the same period.[70]

The Growing Up in Ireland[71] study found that among the 17/18-year olds cohort 33% reported they were having sexual intercourse, while 40% reported having oral sex. 17-18-year-old females were more likely than males to report having had sexual intercourse with one person (55% compared to 48%) and less likely to have had four or more sexual partners (14% compared to 23%). Females also reported feeling less pressured (either a little or a lot) to have sex when compared to male respondents (13% compared to 22%). Females were however more likely to fear losing a partner if they did not have sex with them when compared to males (8% versus 3%). The study found a higher level of sexual activity among young people from socially disadvantaged backgrounds.

Over-50s

While reported frequency of sexual activity declines with increasing age, the longitudinal study on ageing in Ireland finds that the majority (59%) of the Irish population over-50 report sexual activity within the previous 12 months[72].

This sexual activity is strongly linked to relationship status (married or cohabiting) as well as being positively associated with self-reported good health, higher quality of life and positive perceptions of ageing. Older people report a lower median number of lifetime partners than their younger counterparts, as well as lower levels of overlapping sexual partners[73].

Migrant Women

A 2010 ICCP (Irish Contraception and Crisis Pregnancy) study found that migrant women's (from Poland and Nigeria, and aged 18 to 34 years) sexual behaviour generally mirrored that of the indigenous population, with the vast majority reporting experience of sex[74]. In contrast a qualitative study of the views of Chinese, Polish and Muslim women in Ireland found that, although these migrant women shared many perspectives with Irish women in how they feel about sex, fertility and motherhood, some specific attitudes linked to cultural differences were different. For example, some migrant women believed that their culture prevented them from talking openly about sex and sexual health and that sexual behaviour can affect a young woman's reputation and that of her wider community[75].

There is a dearth of information relating to sexual behaviour among sex workers, women with disabilities or prisoners.

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70 McBride, O., Morgan, K. and McGee, H., (2012). *Irish Contraception and Crisis Pregnancy Study 2010: A Survey of the General Population*, Crisis Pregnancy Programme Report 24.

71 Growing Up in Ireland Study Team (2016) *Key Findings: Child Cohort at 17/18 years No. 4 Risky Health Behaviours and Sexual Activity.* ESRI/TCD/DCYA: Dublin. Retrieved from: https://www.esri.ie/system/files/media/file-uploads/2016-11/SUSTAT59.pdf

72 Orr, J., McGarrigle, C. and Kenny, R. (2017). *The Irish Longitudinal Study on Ageing in Sexual Activity in the Over 50s Population in Ireland*. Trinity College, Dublin: Dublin.

73 Layte, R., McGee, H., Quail, A., Rundle, K., Cousins, G., Donnelly, C., Mulcahy, F. and Conroy, R. (2006). *The Irish Study of Sexual Health and Relationships: Main Report.*

74 McBride, O., Morgan, K. and McGee, H., (2012). *Irish Contraception and Crisis Pregnancy Study 2010: A Survey of the General Population, Crisis Pregnancy Programme Report 24.*

75 Conlon, C., O'Connor, J. and Ní Chatháin, S. (2012). *Attitudes to Fertility, Sexual Health and Motherhood Amongst a Sample of Non-Irish National Minority Ethnic Women Living in Ireland, Crisis Pregnancy Programme Report No. 25.* HSE Crisis Pregnancy Programme: Dublin.

STIs and HIV

Data on notifiable infections is reported annually by the Health Protection Surveillance Centre (HPSC) and is gender disaggregated. Statutory notifications of STIs have been increasing steadily since the mid-1990s, with a notable 10% increase between 2015 and 2016[76]. HIV notifications have also increased in recent years[77]. These increases may reflect an increase in testing rates. There are differences in the distribution of certain STI notifications by sex, with a female predominance for chlamydia, genital herpes simplex and trichomoniasis notifications. In 2017, there were 1,780 notifications of chlamydia infection among females aged 20-24 compared to 1,217 among males 20-24. Surveillance data indicates that STIs are concentrated within two specific groups: young people and men who have sex with men (MSM). Most notifications of STIs in 2016 were among young people, with 70% of all notified STIs identified in the under-30s.

STI and HIV Testing

A nationally representative survey in 2006 found that 1.8% of women and 3.4% of men reported having ever been diagnosed with an STI; the proportions were highest among those aged 25 to 34, with rates of 4.8% for males and 3.6% for females[78]. A 2010 nationally representative survey found that 14% of those who reported ever having an STI screen had had an STI diagnosis[79]. Factors associated with a greater likelihood of reporting an STI diagnosis were early sexual initiation and non-use of contraception at first sexual intercourse.

The Healthy Ireland Survey 2018[80] found that 21% of its survey respondents have had a HIV test and 22% have had a STI/STD test during their lifetime.

Women aged 25 to 34 are most likely to have had a test, with 44% having had a STI/STD test during their lifetime, and 39% having had a HIV test during their lifetime, this increase among women may be due in part to the antenatal screening programme for HIV.

Routine opt-out antenatal screening for syphilis, hepatitis B and HIV is recommended for all women booking antenatal care. National antenatal HIV screening began in 1999. In 2016 the HIV test uptake rate was 99.8% and the overall prevalence of newly diagnosed HIV was 0.2%.

2.2.3.2 Women's reproductive health

Reproductive health affects both women and men, but it is women who carry the burden of reproductive ill health, linked to their biological status, but also because of a wider social, economic and political disadvantage. On a more positive note, the increased medical surveillance of women during their reproductive years (including the use of hormonal contraceptives) means women's chronic illnesses tend to get picked up earlier, with increased metabolic pressure that pregnancy puts on one's body means that a tendency to chronic disease, may be picked up in pregnancy before it becomes entrenched. For example, blood pressure screening during pregnancy, or before the prescribing of hormonal contraception, is likely to identify problems early; similarly, identification of gestational diabetes during pregnancy may point to a higher risk of type 2 diabetes later in life. This tends to result in action being taken earlier and may be a contributory factor to higher female life expectancy. Key elements of reproductive health for women include access to affordable and accessible contraception, maternity entitlements, the ongoing development of women-centred maternity care, family formation (including the regulation and public provision of assisted human

76 Health Protection Surveillance Centre. (2017). *Sexually Transmitted Infections (STIs) in Ireland, 2016*. HPSC: Dublin.

77 Health Protection Surveillance Centre. (2017). *HIV in Ireland, 2016*. HPSC: Dublin.

78 McGee, H., Rundle, K., Donnelly, C. and Layte, R. (2008). *The Irish Study of Sexual Health and Relationships Sub Report 2: Sexual Health Challenges and Related Service Provision*. Crisis Pregnancy Agency and the Department of Health and Children: Dublin.

79 McBride, O., Morgan, K. and McGee, H., (2012). *Irish Contraception and Crisis Pregnancy Study 2010: A Survey of the General Population, Crisis Pregnancy Programme Report 24*.

80 Ipsos MRBI and Department of Health. (2018). *Healthy Ireland Survey 2018 Summary of Findings*.

reproduction), and prevention of infertility. There is also a need for the provision of menopause services. In its work, Public Health England has identified six pillars of reproductive health. See Table 2.5 for details.

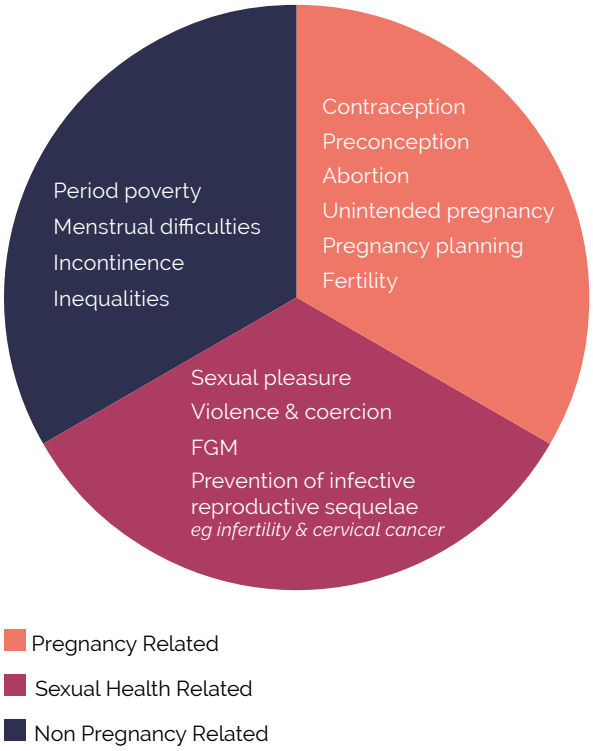
Table 2.5 Six pillars of reproductive health

— *Positive Approach:* The opportunity for reproductive health and access to reproductive healthcare, to be free from stigma and embarrassment.
— *Knowledge and resilience:* The ability to make informed choices and exercise freedom of expression in all aspects of reproductive health.
— *Free from violence and coercion:* The ability to form enjoyable relationships whilst not fearing or experiencing any form of power imbalance or intimidation.
— *Proportionate universalism:* The ability to optimise reproductive health, and social and psychological well-being through support and care that is proportionate to need.
— *User-centered:* The ability to participate effectively and at every level in decisions that affect reproductive lives.
— *Wider determinants:* The opportunity to experience good reproductive health free from the wider factors (such as education and social deprivation) that directly and indirectly impact on reproductive well-being, and the ability to access reproductive healthcare when needed.

Source: Public Health England (2018) A consensus statement: reproductive health is a public health issue.

While a lot of effort goes into improving healthcare for women and their babies during the crucial period of pregnancy and childbirth, the greater proportion of women's lives exists outside these events. Reproductive wellbeing for the non-pregnant woman is also important with the non-pregnancy related aspects of reproductive health often overlooked (e.g. heavy menstrual bleeding, infertility and menopause), compared with the short and intense healthcare needs of a pregnancy. For this Mann and Stephenson (2018)[81] in their work outline a three-pronged approach to reproductive health. See Figure 2.2 for details.

Figure 2.2 A three-pronged approach to reproductive health[82]



2.2.3.3 Women's maternal health (before and after pregnancy)

The TCD Maternal health And Maternal Morbidity in Ireland (MAMMI) study has found that serious aspects of women's health during and after pregnancy remain almost completely hidden for various reasons (e.g. this could include sciatica or hiatus hernia towards the end of pregnancy that doesn't entirely resolve subsequently). They go on to report that most of conditions identified are preventable or treatable, yet women are not being asked about them during the first three months postpartum, a time at which they are in regular contact with healthcare professionals. See Table 2.6 for details.

81 Mann, S. & Stephenson, J. (2018). *Reproductive health and wellbeing - addressing unmet needs*. British Medical Association. Retrieved from: https://bma.org.uk

82 *Ibid.*

Table 2.6 Health problems during and after pregnancy[83]

Health Problem	Prevalence at 3 months postpartum	Number of GPs who did NOT ask mother directly about the problem or condition
Pelvic Girdle Pain	One in three	Almost two thirds
Sexual Health Problems	Half experienced painful sex, one quarter had not resumed having sex	Eight out of ten
Anxiety	28% (self-reported) experienced some anxiety, and 12% experienced anxiety occasionally or often	Half
Depression	18% experienced depression at some time since giving birth	Half
Leaking urine	Almost 60% of women leaked some amount of urine since giving birth	Three quarters
Anal incontinence	12%	Three quarters

Source: Begley, C., Daly, D., Clarke, M., (2013). The Silent Morbidities: Early Results of the MAMMI study. Trinity College Dublin, Queen's University Belfast, Health Research Board. Retrieved from: http://www.mammi.ie/downloads/findings/3.pdf

Crisis pregnancy in Ireland

Crisis pregnancy is defined in Irish legislation as *'a pregnancy which is neither planned nor desired by the woman concerned and which represents a personal crisis for her'*. This definition is understood to include the experiences of women for whom a planned pregnancy develops into a crisis over time due to a change in circumstances[84]. The reasons why a pregnancy is considered a crisis can in some cases be linked to the age of the woman involved and the point in her life at which she becomes pregnant. Research has found that a woman who becomes pregnant unexpectedly must consider how that pregnancy will impact on other dimensions of her life, including her personal relationships, job, education, health and financial situation. The most common reason given for a pregnancy being a crisis is that the pregnancy was not planned[85]. Research during the recent recession found that employment and financial factors featured more strongly for women experiencing a crisis pregnancy, which reflected the impact that the socio-economic environment can have on a woman's personal circumstances[86]. Medical complications during pregnancy are also an important reason for considering a pregnancy a crisis[87].

83 Begley, C., Daly, D., Clarke, M., (2013). *The Silent Morbidities: Early Results of the MAMMI study.* Trinity College Dublin, Queen's University Belfast, Health Research Board. Retrieved from: http://www.mammi.ie/downloads/findings/3.pdf

84 Irish Statute Book (2001) Crisis Pregnancy Agency (Establishment) Order, S.I. No. 446/2001. Ireland.

85 McBride, O., Morgan, K. and McGee, H., (2012). *Irish Contraception and Crisis Pregnancy Study 2010: A Survey of the General Population, Crisis Pregnancy Programme Report 24.*

86 *Ibid.*

87 Russell, H., Watson, D. and Banks, J. (2001). *Pregnancy at Work: A National Survey.* SHCPP: Dublin. Retrieved from: https://www.ihrec.ie/download/pdf/pregnancy_at_work_a_national_survey.pdf

Prevalence of crisis pregnancy

Approximately one in three women (35%) and one in five men (21%) surveyed in 2010 with experience of pregnancy reported having experienced a crisis pregnancy[88]. The proportion has increased for women (28%) and remained stable since 2003 for men (22%)[89]. In 2010, over 65% of women and men with experience of crisis pregnancy reported that they were in a steady relationship, cohabiting, engaged or married at the time a crisis pregnancy occurred[90].

Groups identified as being at a particularly high risk for experiencing a crisis pregnancy include:

— *Young adults (18–25):* The average age for experiencing a crisis pregnancy is 24 for women and 23 for men – this finding has remained stable over time; 44% of pregnancies among women aged 18 to 25 are perceived by the individuals involved as a crisis[91].

— *Young people who have first sex before the age of 17:* These young people are less likely to use contraception and are 70% more likely to experience a crisis pregnancy and three times more likely to experience abortion later in life[92].

— *Older, married women (over the period 2003 and 2010[93],[94]):* This may be related to the financial crisis in the intervening years. A crisis pregnancy in this age group is more likely to be due to the fact that the woman sees her family as complete or has given birth recently. Research finds contraception use is becoming less consistent for both women and men in this age group[95].

Teenage pregnancy

Not all teenage pregnancies are interpreted as a crisis by the young people involved. However, traditionally, the teenage birth rate and abortion rate were used as indicators of crisis pregnancy. The teenage birth rate, as defined by the number of births to females aged under-20 in relation to females aged 15 to 19 per 1,000 population, declined in Ireland from 20 births per 1,000 in 2001 to 7.8 births per 1,000 in 2016. There was a total of 1,098 births to teenagers in 2016 compared with 3,087 in 2001, representing a 64% decrease in the number of births to teenagers over the 15-year period[96].

Causes of crisis pregnancy

Causes of crisis pregnancy include the non-use of contraception, with almost half of the women who reported experiencing a crisis pregnancy indicating that contraception was not used at the time of conception. The main reasons given for the none use of contraception, were that '*sex was not planned*' (32%), that they '*took a chance*' (30%), or that '*alcohol and drugs were used at the time of conception*' (20%)[97]. Other reasons for crisis pregnancy were: the '*failure of contraception*', with 31% of women and 40% of men not knowing why contraception had failed[98]; problems with condom use (19% of women and 15% of men) and contraceptive pill failure (20% of women and 12% of men).

88 McBride, O., Morgan, K. and McGee, H., (2012). *Irish Contraception and Crisis Pregnancy Study 2010: A Survey of the General Population, Crisis Pregnancy Programme Report 24.*

89 *Ibid.*

90 *Ibid.*

91 *Ibid*

92 Rundle, K., Layte, R. and McGee, H. (2008). *Irish Study of Sexual Health and Relationships Sub-Report 1: Learning About Sex and First Sexual Experiences.*

93 *Ibid.*

94 Bourke, A., Kelleher, C., Boduszek, D. and Morgan, K. (2015). Factors Associated with Crisis Pregnancies in Ireland: Findings from Three Nationally Representative Sexual Health Surveys. *Reproductive Health.* 12: 14.

95 McBride, O., Morgan, K. and McGee, H., (2012). *Irish Contraception and Crisis Pregnancy Study 2010: A Survey of the General Population, Crisis Pregnancy Programme Report 24.*

96 Health Service Executive. (2017, 31 May). *64% Decrease in the Number of Births to Teenagers over 15 Year Period.* [Press Release]. Retrieved from: https://www.sexualwellbeing.ie/about/media/press-releases/decrease-teen-births-2016.pdf

97 McBride, O., Morgan, K. and McGee, H., (2012). *Irish Contraception and Crisis Pregnancy Study 2010: A Survey of the General Population, Crisis Pregnancy Programme Report 24.*

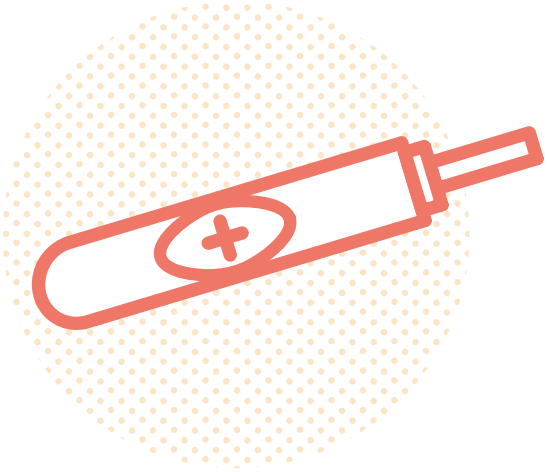
98 *Ibid.*

Crisis pregnancy responses

Parenting is by far the most common outcome for women who experience a crisis pregnancy.

Research finds that when asked about their most recent crisis pregnancy, just under three-quarters of women chose to parent; among men, 66% chose to parent[99].

Adoption while it was once a common response for women experiencing a crisis pregnancy in Ireland this is no longer the case, with the number of babies placed for adoption having decreased significantly in recent decades and continuing to fall on an annual basis. Research has found that just 1% of women and men chose adoption following their most recent crisis pregnancy[100]. Thirty children were placed for non-family adoptions in 2016, compared with 88 in 2004, 99 in 2002 and 1,005 in 1976[101]. Abortion is another possible crisis pregnancy response with 24% of women and 32% of men with experience of crisis pregnancy reporting that their most recent crisis pregnancy had ended in an abortion[102].



Abortion services

Until 2019, abortion was illegal in Ireland under almost all circumstances. Yet, abortion was still a service accessed by Irish women, with women travelling from Ireland to other countries to access services and in more recent years, women ordering abortion pills online to take at home.

Prior to 2019, the thirteenth and fourteenth amendments to the Constitution Act 1992 protected the provision of information on all options available to a woman experiencing a crisis pregnancy, including abortion services outside the state, and protected an individual's right to travel outside Ireland to avail of abortion services[103],[104]. Women travelling to another jurisdiction for an abortion tend to choose England, Wales or the Netherlands to access abortion services. Research found that the majority of women travelling from Ireland for an abortion travelled to England or Wales. In 2016, 3,265 women gave Irish addresses at UK abortion services, representing a rate of 3.2 per 1,000 women[105]. There has been a gradual decline in women availing of abortion services in the UK since 2001, when there were 6,673 abortions to women giving Irish addresses in UK abortion clinics, representing a rate of 7.5 per 1,000 women. The Netherlands has emerged as the only other jurisdiction to which women from Ireland have travelled to for abortion procedures in any significant numbers. The Ministry of Health in the Netherlands has collated data on women providing Irish addresses in Dutch abortion clinics since 2010. In 2015, 34 women were recorded to have provided Irish addresses in abortion clinics in the Netherlands[106]. The figures have significantly declined since their peak in 2006, when the number was 461.

99 *Ibid.*

100 *Ibid.*

101 The Adoption Authority of Ireland. (2017). *The Adoption Authority of Ireland Annual Report 2016.* The Adoption Authority Ireland: Dublin.

102 McBride, O., Morgan, K. and McGee, H., (2012). *Irish Contraception and Crisis Pregnancy Study 2010: A Survey of the General Population, Crisis Pregnancy Programme Report 24.*

103 Irish Statute Book (1992) Thirteenth Amendment of the Constitution Act 1992. Ireland.

104 Irish Statute Book (1992) Fourteenth Amendment of the Constitution Act 1992. Ireland

105 Department of Health (UK). (2017). *Abortion Statistics, England and Wales: 2016 Summary Information from the Abortion Notifications Returned to the Chief Medical Officers of England and Wales.* Department of Health: London.

106 Ministerie van Volksgezondheid, (2017) 'Welzijn en Sport, Netherlands, Women Providing Irish Addresses in Dutch Abortion Clinics Since 2010'. Personal communication to M. O'Brien by email, 30 January 2017.

The legal restrictions on abortion disproportionately impacted on women who were already marginalised and disadvantaged: those with little or no income, women with care responsibilities, minors in state care, women with disabilities, women with a pre-existing illness, women experiencing domestic or sexual violence, asylum seekers and women who were undocumented. The need to travel also precluded doctors in Ireland providing proper care – or even referrals – for their patients. This meant that women with pre-existing health problems who required abortion had to travel without important medical records.

Research about the experiences of women who have taken an abortion pill in Ireland found that 94.7% say they successfully ended their pregnancy without surgical intervention.

The study reported on 1,000 women from Ireland who reported taking an abortion pill and who followed up with the online service. Many women reported being afraid to tell a healthcare professional that they have taken the abortion pill for fear of a negative reaction or that they will be reported to the authorities[107]. Women who did seek follow-up medical care reported a variety of experiences with healthcare professionals in Ireland, including encountering hostile attitudes and being provided with inadequate information[108].

Following the removal of the 8th Amendment to the Constitution and the enactment of the Health (Regulation of the Termination of Pregnancy) Act 2018, abortion services have been provided in Ireland since 1st January 2019. Abortion is now available in certain circumstances[109]:

— In early pregnancy, up to 12 weeks
— If there is a risk to life or health of the pregnant woman
— If there is risk to life or health in any emergency
— Any condition likely to lead to the death of the foetus

To comply with the certification requirements of the law, there must be at least three days between a woman's first consultation and having the abortion. Abortions over 12 weeks of pregnancy in the case of risk to life or health or likely death of the foetus must be certified by two clinicians. A HSE review process is available for the pregnant person in cases where the clinician(s) does not certify the abortion.

The abortion service is provided by the HSE as a free service for those who normally live in the Republic of Ireland. It is provided through GPs or family planning services which have signed up to provide the service, and in maternity units and hospitals. Women from Northern Ireland can access this service but must pay for their care. In May 2019 the SHCPP commissioned a research piece which will generate qualitative data to develop an in-depth understanding of the experiences of women who have accessed unplanned pregnancy support services and abortion services since the Regulation of Termination of Pregnancy Act 2018 was implemented on January 1st 2019.

Abortions can be provided medically (taking medication to end the pregnancy) or surgically (a procedure to remove the pregnancy from the womb by a doctor using a suction method). For abortions in early pregnancy, medical abortions up to nine weeks of pregnancy generally take place with a doctor in the community; while medical abortions between nine and 12 weeks take place in a hospital setting. Hospitals will also provide for circumstances where there is a risk to life or health of the pregnant person, or where there is a condition likely to lead to the death of the foetus before or shortly after birth.

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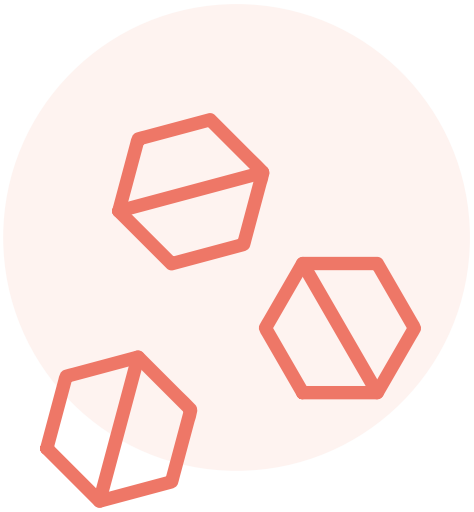
107 Aiken, A., Digol, I., Trussell, J. and Gomperts, R. (2017) 'Self Reported Outcomes and Adverse Events After Medical Abortion Through Online Telemedicine: Population Based Study in the Republic of Ireland and Northern Ireland.' *BMJ Research.*

108 Aiken, A. (2017). 'Oireachtas Debate: International Developments in the Provision of Health Care Services in the Area of Termination of Pregnancies'. Lyndon B Johnson School of Public Affairs and World Health Organization. Houses of the Oireachtas: Dublin.

109 Health Service Executive. (2018). *Your guide to medical abortion.* Retrieved from: https://www2.hse.ie/file-library/unplanned-pregnancy/guide-to-medical-abortion.pdf

Information, support and counselling for women experiencing an unplanned pregnancy are provided by the HSE's *My Options* service on 1800 828 010 or on myoptions.ie. If a person decides to have a termination, 'My Options' will provide details of the doctors (with the consent of the doctors) providing termination of pregnancy services in their locality. 'My Options' provides signposting, referrals as appropriate and information for any pregnancy related queries. This includes supporting those who opt to continue their pregnancy and for people who will not meet legislative requirements in Ireland but may need support to travel abroad for abortion services.



Research about the experiences of women who have taken an abortion pill in Ireland finds that 94.7% say they successfully ended their pregnancy without surgical intervention. The study reports on 1,000 women from the island of Ireland who reported taking an abortion pill and who followed up with the online service. Ninety-three women reported experiencing a symptom for which they were advised by the online service to seek medical advice and 87 followed up on this advice. Seven women reported receiving a blood transfusion and 26 reported receiving antibiotics. The author of the report concludes that fear of the consequences of taking an abortion pill can discourage women from accessing medical services following the taking of an abortion pill. Many women report being afraid to tell a healthcare professional that they have taken the abortion pill for fear of a negative reaction or that they will be reported to the authorities[110]. Women who did seek follow-up medical care reported a variety of experiences with healthcare professionals in Ireland, including encountering hostile attitudes and being provided with inadequate information[111].

110 Aiken, A., Digol, I., Trussell, J. and Gomperts, R. (2017) 'Self Reported Outcomes and Adverse Events After Medical Abortion Through Online Telemedicine: Population Based Study in the Republic of Ireland and Northern Ireland.'

111 Aiken, A. (2017). 'Oireachtas Debate: International Developments in the Provision of Health Care Services in the Area of Termination of Pregnancies'.

2.3 Women's health in Ireland at different life stages

Women's health needs and risks vary depending on their life stage. Table 2.7 summarises some the key health needs and risks for women at various stages.

Table 2.7 Women's key health needs and risks at different life stages

Health behaviours and chronic disease	
Young Women (Approx. 12-24 years)	— Women aged under-25 are more likely to **smoke** than men of the same age: 21% and 18% respectively[112] — The **drinking** behaviour of young women – and the fact that it replicates that of young men more closely than that among older groups of the population – warrants particular attention, given the increased health risks of drinking at this level[113].
Adulthood (Approx. 25-49 years)	— The rate of **binge drinking** at least once a week among Irish women aged 18 and over was 6.8% in 2014, the highest rate in the EU and more than double the EU average rate of 2.6%.[114]
Healthy Ageing (Approx. 50-65 years)	— Women make up a greater proportion of deaths from **cardiovascular disease**, yet rates of hospitalisation from men with heart disease and heart attacks are nearly double that of women[115]. — **Breast cancer** is the most common cancer for women, accounting for 30% of all cancer diagnoses. **Lung cancer** is the second most prevalent cancer for women at 11%. Lung cancer is the leading cause of cancer death for women[116]. — Irish **respiratory death rates** are high by comparison with the EU15 average, especially for women[117]. — 1 in 2 women over 50 will develop a fracture due to **osteoporosis** in their lifetime[118].
Older Women Approx. 65 years +	— Although women have a higher life expectancy than men, women spend many more years than men living with **age related ill-health and disability.**[119] — **Traveller women** have a **life expectancy** more than 10 years lower than the general population.120

112 Ipsos MRBI and Department of Health. (2016). *Healthy Ireland Survey 2016 Summary of Findings.*

113 Ipsos MRBI and Department of Health. (2017). *Healthy Irela*nd *Survey 2017 Summary of Findings.*

114 CSO. (2016). *Women and Men in Ireland 2016.* Retrieved from: https://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2016/health/ and http://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2016/introduction/

115 Women's Health Council. (2002). *Women and Cardiovascular Health.* Department of Health. Retrieved from: http://health.gov.ie/wp-content/uploads/2014/03/women_cardiovascular.pdf

116 National Cancer Registry Ireland. (2017). *Cancer in Ireland 1994-2016 - With Estimates For 2015-2017: Annual Report Of the National Cancer Registry.* Retrieved from: https://www.ncri.ie/sites/ncri/files/pubs/NCRReport_2017_summary.pdf

117 Jennings, S.M. (2014). *Preventing chronic disease: defining the problem – Report from the Prevention of Chronic Diseases Programme.*

118 Osteoporosis Ireland. (2018). *About* Osteoporosis. Retrieved from: http://www.irishosteoporosis.ie/?/about_osteoporosis/

119 Department of Health. (2016). *Health in Ireland Key Trends 2016.* Retrieved from: https://health.gov.ie/wp-content/uploads/2016/12/Health-in-Ireland-Key-Trends-2016.pdf

120 All Ireland Traveller Health Study Team. (2010). *Our Geels, All* Irelan*d Traveller Health Study.* UCD

Mental health and well being	
Women undertake the majority of **unpaid care work** in Ireland. In 2016, 98% of those looking after the home/ family were women.[121]	
Young Women (Approx. 12-24 years)	— Young women (15-24 years) were the group with the highest percentage of negative mental health (17%)[122]. — Adolescent girls and young women report a **higher degree of mental health distress** than boys and young men. A higher percentage (24%) also engages in self-harm compared to males (16%)[123]. — One in every 131 girls (15-19 years) presented to hospital in 2016 as a consequence of **self-harm**[124] .
Adulthood (Approx. 25-49 years)	— 16% of pregnant women in Ireland are at probable risk of **depression during their pregnancy**. With the second highest birth rate in Europe, this means that each year over 11,000 pregnant women could be experiencing, or at risk of depression[125]. — 62.7% of **Traveller women** disclosed that their **mental health** was not good enough for one or more days in the last 30 days; this was compared to 19.9% of General Medical Services (GMS) female cardholders[126].
Healthy Ageing (Approx. 50-65 years)	**Caring responsibilities** can have a negative impact on mental and physical health, leading to exhaustion, depression, injury and greater vulnerability to illness. Women (aged 50-69) within the 'sandwich generation' make an important contribution to supporting two generations, their children and their parents, and this has an impact on their self-reported physical and mental health. The ageing population and the increasing demands on the middle generation for both financial and informal care may lead to an increasing negative impact on women's health.
Older Women Approx. 65 years +	— The incidence of **dementia** is substantially higher amongst women than men in Ireland (lifetime risk of one in six, compared with nearly one in eleven for men).[127] — Rates of **depression** have been consistently shown to be higher in older women than in older men[128].

121 CSO. (2016). *Women and Men in Ireland 2016.*

122 Ipsos MRBI and Department of Health. (2016). *Healthy Ireland Survey 2016 Summary of Findings.*

123 Dooley, B., Fitzgerald, A., (2012) *My World Survey: National Survey of Youth Mental Health in Ireland.* UCD School of Psychology and Headstrong. Retrieved at: https://www.jigsaw.ie/content/images/News___Events_/Research/MWS_Full_Report_PDF.pdf

124 Griffin, E., Dillon, CB., Arensman, E., Corcoran O., Williamson, E., Perry, IJ. (2017). *National Self-Harm Registry Ireland Annual Report 2016.* Cork: National Suicide Research Foundation. Retrieved from: https://www.nsrf.ie/wp-content/uploads/reports/NSRF%20National%20Self-Harm%20Registry%20Ireland%202016.pdf

125 Kennedy, Y. (2016, 3 November) *Rates of depression are high amongst pregnant women in Ireland.* [Press Release]. Retrieved from: https://www.tcd.ie/news_events/articles/rates-of-depression-are-high-amongst-pregnant-women-in-ireland/7341

126 All Ireland Traveller Health Study Team. (2010). *Our Gee*ls, A*ll Ireland Traveller Health Study.* UCD

127 Gantly, D. (2016) 'ASI highlights double impact of dementia on women'. *Irish Medical Times.* Retrieved from: https://www.imt.ie/news/asi-highlights-double-impact-of-dementia-on-women-10-03-2016/

128 O'Regan, C., Cronin, H., and Kenny, R.A. (2016) *Mental Health and Cognitive Function.* TILDA: Irish Longitudinal Study on Ageing. Retrieved from: http://tilda.tcd.ie/publications/reports/pdf/w1-key-findings-report/Chapter6.pdf

Reproductive and sexual health	
Young Women (Approx. 12-24 years)	— *2010 Irish Contraception and* ***Crisis Pregnancy*** *Study* identified the cost of **contraception** as a significant access barrier for young people[129]. Women's access to contraceptives can be hindered by the cost of the GP visit and prescription costs. — A recent survey of 1,100 Irish girls aged 12-19 years found that nearly half (50%) of girls aged 12-19 years have experienced issues around affordability of **sanitary products**[130].
Adulthood (Approx. 25-49 years)	— In 2016, there were 63,897 births in Ireland, a rate of 13.7 per 1000 population, the highest **birth rate** in Europe[131]. — Some mothers experience health problems, sometimes caused by **pregnancy** or an event that happens during or after the baby's birth. Some common health problems include; **incontinence**, pregnancy-related pelvic girdle pain (PPGP), **perinatal depression**, and postpartum sexual health issues[132]. — 24% of **Roma women** had not accessed health services while pregnant and their first point of access was to give birth[133]. — More than a third of women (23,000) attending antenatal services in Ireland in 2016, did not receive a **foetal anomaly ultrasound**[134]**.** — 81,093 women of reproductive age (15-49), live with **disabilities** in Ireland[135]. Women with disabilities using maternity services report **issues with accessibility**, related to the location and models of care, difficulties in transport and moving around the physical environment[136]. — 16% of pregnant women attending maternity services across Ireland are at probable risk of **depression** during their pregnancy[137].
Healthy Ageing (Approx. 50-65 years)	— There is a **higher incidence of cervical cancer** in more deprived populations, with age-standardised rates about 120% higher in the most deprived compared with the least deprived fifth of the Irish population.[138] — During **menopause** women can experience hot flushes**, anxiety**, depression, **memory problems**, and sexual dysfunction.[139]
Older Women Approx. 65 years +	Up to three times as many women than men are affected by **urinary incontinence**, which has a negative impact on mood, quality of life, and social participation[140].

129 McBride, O., Morgan, K. and McGee, H., (2012). *Irish Contraception and Crisis Pregnancy Study 2010: A Survey of the General Population, Crisis Pregnancy Programme Report 24.*

130 Plan International. (2018). *We Need to Talk. Period: Lifting the Barriers to Girls' Education.* Retrieved from: https://www.plan.ie/we-need-to-talk-period/

131 CSO. (2016). *Vital Statistics, Yearly summary.* Retrieved from: https://www.cso.ie/en/releasesandpublications/ep/p-vsys/vitalstatisticsyearlysummary2016/

132 Begley, C., et al (2013). *The Silent Morbidities: Early Results of the MAMMI study.*

133 Pavee Point. (2018). *Roma in Ireland, a National Needs Assessment.* Retrieved from: http://www.paveepoint.ie/wp-content/uploads/2015/04/RNA-PDF.pdf

134 Kenny, L. (2017) Institute of Obstetricians and Gynaecologists evidence to Oireachtas, Joint Committee on Health. 16th February 2017. National Maternity Strategy: Discussion (Resumed).

135 CSO. (2011). *Persons with a Disability.* Retrieved from: https://www.cso.ie/px/pxeirestat/Statire/SelectVarVal/Define.asp?maintable=CD801&PLanguage=0

136 National Disability Authority. (2009). *Women with Disabilities: Barriers and Facilitators to Accessing Services During Pregnancy, Childbirth and Early Motherhood.* University of Dublin, Trinity College Dublin, School of Nursing and Midwifery. Retrieved from: https://nursing-midwifery.tcd.ie/assets/publications/pdf/nda-literature-review.pdf

137 Kennedy, Y. (2016, 3 November) *Rates of depression are high amongst pregnant women in Ireland* [Press Release]. REDEEM Research Group, TCD and National Obstetrics Services. Retrieved from: https://www.tcd.ie/news_events/articles/rates-of-depression-are-high-amongst-pregnant-women-in-ireland/

138 National Cancer Registry Ireland. (2016). *Cancer inequalities in Ireland by deprivation, urban/rural status and age: a National Cancer Registry report.* National Cancer Registry. Retrieved from: https://www.ncri.ie/sites/ncri/files/pubs/cancer-inequality-report-summary-2016.pdf

139 Marie Keating Foundation. (2018). *Information on Menopause.* Retrieved from: http://www.mariekeating.ie/cancer-information/brca/the-menopause-hrt/

140 McGarrigle,C., Donoghue, O., Scarlett, S.,and Kenny, R.A. (2016). *Health and Wellbeing: Active Ageing for Older Adults in Ireland Evidence.* The Irish Longitudinal Study on Ageing. Retrieved from: https://tilda.tcd.ie/publications/reports/pdf/w3-key-findings-report/TILDA%20Wave%203%20Key%20Findings%20report.pdf

2.4 Women's lifestyle behaviours

Lifestyle behaviours, including smoking, diet and physical activity can have a significant impact on a woman's health.

2.4.1 Smoking prevalence[141]

Smoking rates are dropping in both females and males. The overall population incidence has decreased from 23% in 2015 to 20% in 2018, moreover, the decrease from the 1980s, when rates were around 35%, is very significant. According to the most recent Healthy Ireland surveys the rates are 17% for women and 22% for men (this compared with rates of 21% women and 24% of men in 2015). Notwithstanding these reductions, a lot of work still needs to be done in order to achieve the national goal of a tobacco free society (i.e. smoking rates of <5%) and to reduce the damage smoking can do, both to women's health and specifically in pregnancy. Within the *National Strategy for Women and Girls* there are a number of specific actions designed to address smoking rates in women and girls generally (Action 2.14) and to address female smoking and drinking levels in the context of the *National Maternity Strategy*[142] (Actions 2.15-2.16).

Female smoking rates are highest among those aged 25-34. Women more likely to smoke in disadvantaged areas than in affluent areas. Smoking rates among women aged 55-64 are almost four times higher in more disadvantaged areas than in more affluent areas[143], see Table 2.8 for details. Non-manual/skilled workers (21%) are more likely to smoke than those categorised as professional/managerial & technical workers (11%). Women (10%) are more likely than men (2%) to have made an attempt to quit smoking due to advice from a health professional. The most tobacco-dependent population sub-group have been identified as single people aged 35-54, who are engaged in home duties and who left school without a Leaving Certificate[144].

Table 2.8 Percentage of women who smoke (by age and deprivation)

Age	15-24	25-34	35-44	45-54	55-64	65-74	75+
Women in Deprived areas	21	30	27	29	31	13	12
Women in Affluent areas	15	22	13	9	8	8	4

Source: Ipsos MRBI and Department of Health. (2018). Healthy Ireland Survey 2018 Summary of Findings. p.24

2.4.2 Consumption of alcohol[145]

Women generally drink less, and drink significantly less frequently than men (72% of women drank compared with 78% men in the last 12 months and of that 48% of women and 62% of men drink at least once a week). Older drinkers are more likely to drink more frequently, while female binge drinking drops sharply with age (compared with male binge drinking). Binge drinking is defined as six or more standard drinks on a drinking occasion. Women from more disadvantaged areas are more likely to binge drink on a typical drinking occasion than those from more affluent areas, see Table 2.9 for details.

141 Ipsos MRBI and Department of Health. (2018). *Healthy Ireland Survey 2018 Summary of Findings.*
142 Department of Health (2016) *The National Maternity Strategy 2016-2026: Creating a Better Future Together.*
143 *Ibid.*
144 *Ibid*, p.24-5.
145 Ipsos MRBI and Department of Health. (2018). *Healthy Ireland Survey 2018 Summary of Findings.*

Table 2.9 Percentage of women who binge drink (by age and deprivation)

Age	15-24	25-34	35-44	45-54	55-64	65-74	75+
Women in Deprived areas	25	37	18	18	5	8	2
Women in Affluent areas	21	20	9	9	8	1	<0.5

Source: Ipsos MRBI and Department of Health. (2018). Healthy Ireland Survey 2018 Summary of Findings. p.25

Particular concerns for women and girls in relation to alcohol consumption include: the breast cancer risks in relation to underage drinking for young girls; alcohol as a risk factor for breast cancer for women[146]; and the risk of Foetal Alcohol Syndrome and recommendations in relation to alcohol free pregnancy[147].

2.4.3 Drug misuse[148]

Illicit drug use has become more common in the adult population in Ireland. Cannabis is the most commonly used drug followed by MDMA/ecstasy and cocaine. Illicit drug use is more common among males and younger age groups. Figures from a Northern Ireland study show that approximately three in ten adults report use of illicit drugs in 2014-2015, while one in eight females between 15 and 24 reported having used an illegal drug in the previous 12 months (compared with one in four males)[149].

2.4.4 Diet and nutrition[150]

Diet can have an impact upon the risk of chronic disease, including cancers and cardiovascular disease. The prevalence of diets rich in fat and excess sugars, and low in fibre and fresh fruit and vegetables combined with inactive lifestyles, have resulted in greater prevalence of obesity in many countries. The number of people who are obese and overweight is increasing in both sexes in Ireland[151].

Using the Metabolic Risk Classification of waist measurements, 45% of women were found to have a substantially increased level of risk of premature death due to obesity compared with men (27%).

Almost a third (30%) of young people in Ireland were found to be overweight or obese, with 27% of young women overweight and 9% of young women categorised as obese. The proportion of women consuming at least one type of unhealthy food is highest among women aged 75 and over (42%). People in more disadvantaged areas have higher levels of consumption (36%) of at least one or more unhealthy foods a day compared with 32% of people in more affluent areas. Women (6%) are less likely than men (11%) to drink sugar sweetened drinks at least once a day. Women are more likely (43%) than men (30%) to consume five or more portions of fruit and vegetables a day. Consumption of fruit and vegetables is lower among those aged 75 and older (25%) and those aged between 15 and 24 (27%). Women are also at risk of developing gestational diabetes in pregnancy and developing Type 2 diabetes in the following 5-10 years.

146 Guerra Guerrero, V., Fazzi Baez, A., Cofré González, C.G., Miño González, C.G. (2017). 'Modifiable risk factors for breast cancer: an obligation for health professionals.' *Rev Panam Salud Publica.* 41:e80. Retrieved from: http://iris.paho.org/xmlui/handle/123456789/34054

147 Department of Health (2016) *The National Maternity Strategy 2016-2026: Creating a Better Future Together.*

148 European Monitoring Centre for Drugs and Drug Addiction (2018) *Ireland Drug Report 2018.* Retrieved from: http://www.emcdda.europa.eu/system/files/publications/11313/ireland-cdr-2018-with-numbers.pdf

149 NACDA, Department of Health, Ipsos. (2017). *Prevalence of Drug use and Gambling in Ireland and Drug Use in Northern Ireland.* Retrieved from: https://health.gov.ie/wp-content/uploads/2016/11/Bulletin-1.pdf

150 Ipsos MRBI and Department of Health. (2018). *Healthy Ireland Survey 2018 Summary of Findings.* Department of Health: Dublin. Retrieved from: https://health.gov.ie/wp-content/uploads/2018/10/Healthy-Ireland-Survey-2018.pdf

151 Morgan, K., McGee, H., Watson, D., Perry, I., Barry, M. (2008) *SLAN 2007: Survey of Lifestyle, Attitudes & Nutrition in Ireland: Main Report.* Dublin: Department of Health and Children. Retrieved from: https://epubs.rcsi.ie/cgi/viewcontent.cgi?article=1002&context=psycholrep

2.4.5 Folic acid

At present, Ireland has the highest rate of babies born with spina bifida in the EU. Taking a daily folic acid supplement can potentially prevent two thirds of Neural Tube Defects (NTDs) such as spina bifida from occurring. It is therefore recommended that all women of childbearing age (who are sexually active and who could become pregnant - even if taking contraception - as approximately 50% of pregnancies are unplanned) take a 400µg daily folic acid supplement daily.

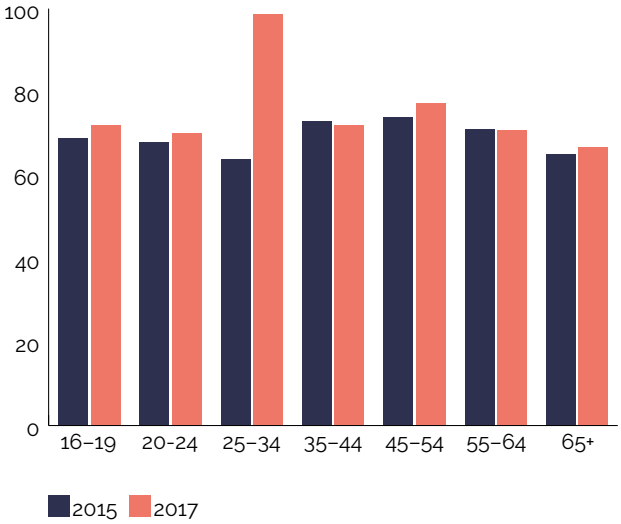
According to the Healthy Ireland Survey 2016 'fewer than 1 in 10 (9%) of women take a folic acid supplement' with just '18% of women aged 25 to 34 taking a folic acid supplement and just 5% of those younger taking the supplement' (p 19).

2.4.6 Physical exercise (including participation in sports)

Nationally, the participation rates of teens and young women in sport are much lower than that of men and boys. This compares with women of over 45 who are more likely to participate in sport than men over 45 (ISM 2017). The percentage of women and men who are classified as highly active (meeting the national physical activity guidelines of half an hour per day of moderate to vigorous physical activity) shows a similar pattern, with younger men outperforming women up to age 25, but the reverse gender gap opens up after age 35, with women outperforming men. This would suggest that possible areas of enhanced gender related focus for physical activity, of relevance to the WHAP, would be teenage girls and young women.

Nationally, recreational walking is the most popular form of physical activity with almost 2.5 million (66.2%) people walking for recreation each week. Females are more likely than males to take regular walks for recreation (71.1% and 61.2% respectively). See Figure 2.3 for details of the percentage of women who participate in recreational walking by age. Those with higher levels of education are more likely to go for regular walks than those with lower levels of education.[152]

Figure 2.3 Percentage of women who participate in recreational walking by age



Source: Irish Sports Monitor 2017 (p.27)

43% of the population regularly participate in sport[153] – either actively or socially – at the same level as in 2015. 4.5% less women than men participate in sport but the gender difference is decreasing (the difference was 15.7% in 2007). Younger women are more likely to play sport than older women, with an increasing number of women aged 35 and over participating between 2015 and 2017. See Table 2.10 for details of the 10 most popular sports that women participate in and Figure 2.4 for details of levels of women's participation in sport by age.

152 Ipsos MRBI. (2018). *Irish Sports Monitor: Annual Report 2017*. Retrieved from: https://www.sportireland.ie/Research/Irish%20Sports%20Monitor%202017%20-%20Half%20Year%20Report/Irish%20Sports%20Monitor%202017.pdf

153 Sport is defined in the Sport Ireland Act "All forms of physical activity which, through casual or regular participation aim at expressing or improving physical fitness and mental well-being and at forming social relationships."

Table 2.10 Changes in women's % participation rates in various sporting activities (2017 v 2015)

Sport/activity	2017	2015
Exercise	13.5	12.9
Swimming	9.8	8.6
Running	5.5	6.9
Dancing	4.3	4.2
Yoga	3.4	2.4
Cycling	3.0	3.3
Pilates	2.2	1.9
Weights	1.3	1.4
Gaelic Football	1.2	0.8
Golf	1.2	0.9
Camogie	0.6	0.5
Soccer	0.5	1.2

Source: Ipsos MRBI. (2018). Irish Sports Monitor: Annual Report 2017. Retrieved from: https://www.sportireland.ie/Research/Irish%20Sports%20Monitor%202017%20-%20Half%20Year%20Report/Irish%20Sports%20Monitor%202017.pdf p18

Figure 2.4 Women's participation in sport by age

Source: Irish Sports Monitor 2017 (p.18)

2.5 Violence against women

'Violence against women is an umbrella term used to describe any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women. As well as domestic violence and abuse, it also includes (but is not limited to) rape and sexual abuse, crimes against women, and based on notions of 'honour,' forced marriage, forced prostitution and trafficking, female genital mutilation (FGM) and sexual harassment'[154] (p 15).

Health problems that have been linked to violence against women include depression, emotional distress and suicidality, as well as injuries, pain and long-term health conditions.[155] Health problems for women linked to sexual violence include sexually transmitted infections or diseases, vaginal bleeding, urinary tract infection, miscarriage and neonatal death.[156] Mental health impacts of rape include suicidality, flashbacks, anxiety, depression and panic attacks.[157]

Understanding the exact scale of violence against women is difficult due to systemic underreporting and definitional issues. What is known is that young women and girls are more likely than boys to experience sexual abuse, physical abuse or neglect.[158]

154 Westmarland, N., & Bows, H., (2018). 'Tackling violence against women - meeting unmet needs. In BMA (2018) Addressing unmet needs in women's health'. *Journal of Interpersonal Violence*. 28(17).

155 World Health Organisation. (2012). *Intimate partner violence.* Retrieved from: http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf

156 *Ibid.*

157 Westmarland, N., & Bows, H., (2018). 'Tackling violence against women - meeting unmet needs'. In BMA (2018) Addressing unmet needs in women's health'. *Journal of Interpersonal Violence*. 28(17): 3265-3282.

158 Women's Health and Equality Consortium. (2011). *Why women's health?* Retrieved from: https://www.whec.org.uk/wpcontent/uploads/downloads/2011/11/WhyWomensHealth11.pdf

What research exists in an Irish context suggests that almost 50% of women in Ireland have experienced a least one form of sexual harassment, while one in four (equivalent to 400,000 Irish women) has experienced physical and/or sexual violence since the age of 15.[159]

Almost half (47%) of those who disclosed experiences of sexual violence in the 2002 *Sexual Abuse and Violence in Ireland* (SAVI) study[160] reported that they had never previously disclosed that abuse to others[161]. Physical and/or sexual violence also occur between family members and between same sex couples. Official national data identified that one in seven women in Ireland compared to one in 16 men experience severe domestic violence, with women more than twice as likely as men to have experienced severe physical abuse and seven times more likely to have experienced sexual abuse than men.[162] In contrast, Women's Aid suggest that that up to one in four women are subjected to domestic violence, while annually an average of 10 women die violently in Ireland (with one in every two femicide victims killed by a current or former male intimate partner)[163].

Worryingly, just one in five Irish victims of physical or sexual abuse have been found to report this abuse to legal and medical services and/or An Gárda Síochána, while just the one in ten women avail of services such as victims support or refuges suggesting that there are a lot of women who have been subject to domestic/gender-based violence who have unmet needs for assistance. The health care system is often the route through which victims seek to access supports[164] .

The type of health supports needed to support women who have/who are experiencing violence depends on the recency of the violence and abuse, with different responses needed for someone who is at immediate risk or who has sustained life threatening injuries compared with someone who has experienced years of abuse as a child or adult. To date, more attention has been directed to acute needs rather than chronic conditions. Responding to the complex acute needs arising from violence requires a multi-disciplinary and multi-agency approach. Responding to non-recent/historic violence and abuse is only in its infancy. The issue of violence against older women appears to have been subsumed under the category of elder abuse, which can be perpetrated inside or outside the family.

2.6 Women, health and disadvantage

The 2010 Marmot Review[165] into health inequalities in England found systematic gender differences in a range of health outcomes. So, although women live longer than men, they spend a greater proportion of their life in poor health and are 'more likely to come into contact with health services – mainly in their reproductive years'.

2.6.1 Key social determinants of health

There is an incontrovertible relationship between poverty, social inclusion and health inequalities. Gender and income (or the lack of it) is key social determinants of health. See Table 2.11 for details.

159 Fundamental Rights Agency. (2014). *Report on violence against women across the EU: abuse at home, work, in public and online.*

160 McGee H., Garavan, R., deBarra, M., Byrne J., Conroy R. (2002). *The SAVI Report. Sexual Abuse and Violence in Ireland. A national study of Irish experiences, beliefs and attitudes concerning sexual violence.* Dublin: Liffey Press.

161 *Ibid.*

162 Watson, D. and Parsons, S. (2005) *Domestic Abuse of Women and Men in Ireland: Report on the National Study of Domestic Abuse.* Dublin: National Crime Council and ESRI.

163 Women's Aid. (2018). Femicide Watch 2017. Republic of Ireland. Retrieved from: https://www.womensaid.ie/download/pdf/womens_aid_femicide_watch_2017.pdf

164 McGee H., Garavan, R., deBarra, M., Byrne J., Conroy R. (2002). *The SAVI Report. Sexual Abuse and Violence in Ireland. A national study of Irish experiences, beliefs and attitudes concerning sexual violence.*

165 Marmot Review. (2010). *Fair Society, Healthy Lives- Strategic review of health Inequalities in England post 2010.*

Table 2.11 Some key social determinants of health

Social Determinant	Impact
Gender	In addition to biological differences, fundamental social differences exist in the way women and men are treated and the assets and resilience they possess. In all societies, these gender relations affect health to varying degrees
Income and income distribution	Income provides direct and rapid access to the range of health services as well as indirect access to education, food, housing, recreational activities, and other societal resources (including private health insurance).
Education	Educational disadvantage can limit access to employment, raising the risk of poverty and its adverse impact on health.
Unemployment and job security	Unemployment has been found[166,167,168] to damage both physical and mental health. It can also trigger other problems that have negative impacts including marital breakdown (it increases the risk by 70%) and problem drinking. A direct correlation has also been found in an Irish context between unemployment and increased risk of suicide for men in particular (NSRF, 2008).
Housing	According to the WHO (2011) the health effects of poor-quality housing environments include the following: — 2-12% pop. effected by radon will develop lung cancer — 6-15% people using solid fuels will be affected by chronic obstructive pulmonary disease, acute lower respiratory infections and lung cancer.
Location	Prevalence rates for diseases such as diabetes, cancer, migraine/severe headaches and depression have been found to be lower in living environments with green space within a one-kilometre radius, with mental health thought to be particularly affected by the amount of local green space[169].
Food Insecurity	Food poverty (which refers to the inability to acquire or eat an adequate quality or sufficient quantity of food in socially acceptable ways) clearly contributes to health inequalities.

Source: Walsh, K (2014) Health Inequalities in Ireland in a Cancer Context (unpublished paper for the Irish Cancer Society)

166 Watkin, S. (1985). 'Recession and Health - a Literature Review'. *Health Policy Implications of Unemployment*. World Health Organization Regional Office for Europe, Copenhagen.

167 Morrell, S., Taylor, R., Quine, S., Kerr, C., & Western, J. (1994). 'A Cohort Study of Unemployment as a Cause of Psychological Disturbance in Australian Youth'. *Social Science and Medicine*. 38.11:1553-1564.

168 Barnes M., Mansour A., Tomaszewski, W., & Oroyemi, P. (2009). *Social Impacts of Recession: The Impact of Job Loss and Job Insecurity on Social Disad*vantage. The Social Exclusion Task Force: Cabinet Office UK.

169 Maas, J., Verheij, R.A, de Vries, S, Spreeuwenberg, P., Schellevis, F.G. & Groenewegen, P. P. (2009) 'Morbidity is related to a green living environment.' *Journal of Epidemiology and* Community Health. 63: 967–97.

Social determinants (including gender and socio-economic status) contribute to health inequalities because their effects on health are not distributed equally across society. They can influence health both directly and indirectly. They also operate at different levels. Structural issues, such as socioeconomic policies or income inequality, are often termed 'upstream' factors. While 'downstream'/lifestyle factors like smoking or stress operate at an individual level – and can be influenced by upstream factors. It is the case therefore that efforts to address inequalities in health must address the distribution of the social determinants of health. It requires going beyond the immediate causes of disease and placing a stronger focus on upstream factors, or the fundamental 'causes of causes' (WHO, 2008).

The exact pathways from social determinants to health inequalities are not yet fully understood. What is clear is the way in which socio-economic or material factors such as government social spending and the distribution of income and other resources in society influence the social and built environment, which in turn influence and interact with the health and well-being of the individuals and communities who live and work in these places.

As this interaction feeds into psychosocial factors such as stress, isolation, social relationships and social support as well as behavioural and lifestyle factors, such as smoking, diet and exercise. Ultimately, all these factors are inter-related and influence health as follows:

— Women in more deprived areas are less likely to rate their health as good or very good[170],[171];

— Women in more deprived areas are more likely to have a long-term health problem;

— Those in more deprived areas are also more likely to smoke and binge drink, while women living in more deprived areas are more likely than those in affluent areas to continue smoking and binge drinking into their 50s[172]; and

— High stress levels stress can also be linked to the impact of poverty, financial strain, social exclusion, discrimination or inequality, as can behavioural factors such as cigarette use[173]; or poor diet (a healthy diet being difficult to achieve on a low income).

See Figure 2.5 for an illustration of the health issues and social determinants affecting women across the life course.

170 Ipsos MRBI and Department of Health. (2018). *Healthy Ireland Survey 2018 Summary of Findings*, p. 23.

171 The gap between the self-rated health of women from deprived and from affluent areas emerges from the 35 to 44 age group onwards. This gap is widest among those aged 55 to 74.

172 Ipsos MRBI and Department of Health. (2018). *Healthy Ireland Survey 2018 Summary of Findings*

173 Graham, H. (2009). 'Introduction: the challenge of health inequalities.' *Understanding Health Inequalities*, 2nd edition. Maidenhead: Open University Press.

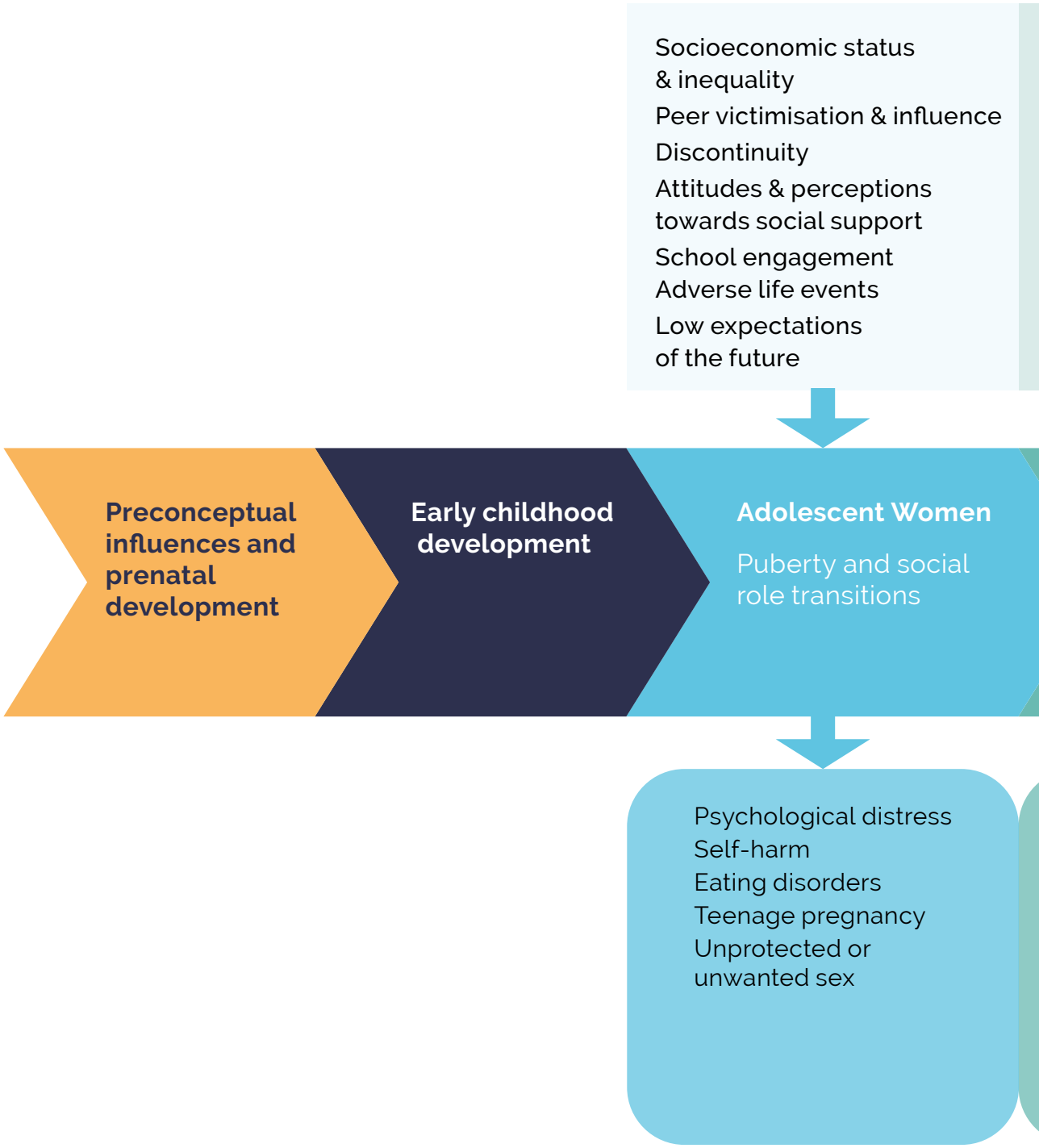
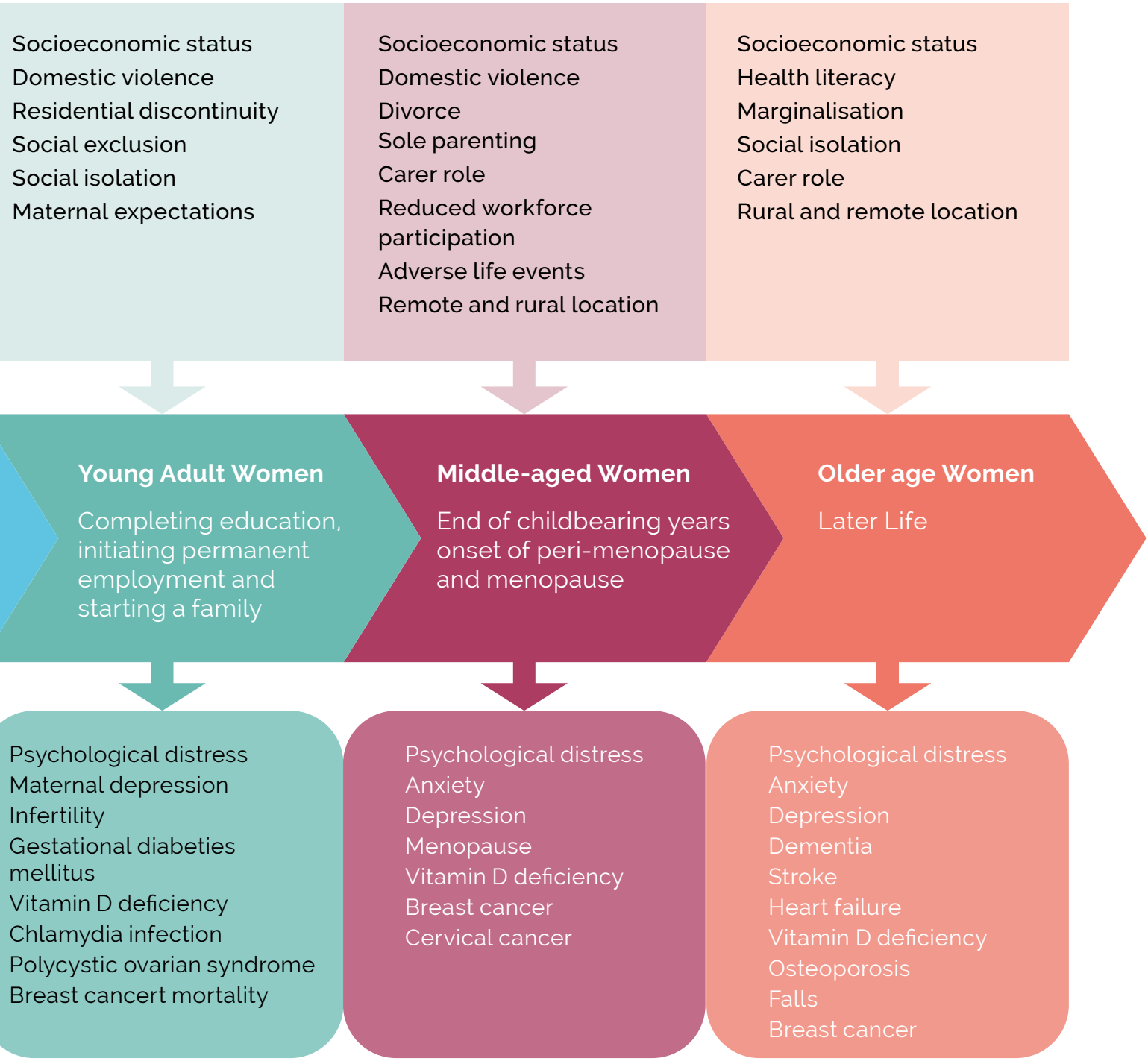

Socioeconomic status & inequality
Peer victimisation & influence
Discontinuity
Attitudes & perceptions towards social support
School engagement
Adverse life events
Low expectations of the future
Preconceptual influences and prenatal development
Early childhood development
Adolescent Women
Puberty and social role transitions
Psychological distress
Self-harm
Eating disorders
Teenage pregnancy
Unprotected or unwanted sex

Figure 2.5 Health issues and social determinants affecting women across the life course



Steel, et al. (2013) Women's health in NSW – a life course approach: a rapid review. (p5)[174]

174 Steel, A., Frawley, J., Dobson, A., Jackson, C., Lucke, J., Tooth, L., Brown, W., Byle, J., Mishra, G. (2013) *Women's health in NSW – a life course approach: a rapid review.* University of Queensland, Centre of Research Excellence in Women's Mental Health in the 21st Century. Retrieved from: https://www.saxinstitute.org.au/wp-content/uploads/Womens-health-in-NSW2.pdf

2.6.2 Structural inequalities

The structural inequalities women face, which have the potential of negatively impact on their health, include the fact that women are more likely to:

— Be poor[175];

— Parent alone[176];

— Be the main provider of unpaid care work[177];

— Be in precarious employment earning low wages[178]; and

— Be at risk of domestic or sexual violence.

Income (and a lack of it) is important both for itself and for the access it provides to other social determinants of health such as education, food, housing, recreational activities, and other societal resources (including private health insurance). Women in less well-off socio-economic groups have consistently been shown to be at the greatest disadvantage with regard to many aspects of health. The majority of those with a medical card are women, who have primary or no education, are not employed, and are more likely to rate health as lower than other groups. In contrast those with private health insurance are more likely men, who have education, who are in the workforce, and rate their health as excellent or very good[179]. The variation among individuals and groups due to income is often referred to as the 'social gradient.' This gradient is more obvious in some locations than others, with health progressively better the higher the socioeconomic position of people and communities. In more affluent counties for example where high levels of overall population health exist, the average can mask significant health differentials between those on low and high incomes.[180].

2.7 Priority groups of women

Being part of a socially or economically disadvantaged group may mean there are barriers to healthcare access, including lack of affordable health services, or access to female doctors. Discrimination and prejudice such as racism, and homophobia may also prevent women accessing health services. Women from deprived areas and marginalised social groups in particular are likely to experience multiple disadvantages within the health service.

2.7.1 Traveller and Roma women

Traveller and Roma women experience stark health inequalities due to structural inequalities linked to the social determinants of health, including poor accommodation conditions, poverty, illiteracy and discrimination[181]. See Table 2.12 for details.

Traveller women have identified significant barriers to health services, including: discrimination and racism (both at individual and institutional levels); lack of trust with healthcare providers; lack of culturally-appropriate service provision; and limited engagement from service providers with Travellers and Traveller organisations.

Roma women also experience significant structural barriers to accessing primary health care due to lack of sufficient income, high cost of health care and lack of interpretation and translation services. The Primary Health Care Traveller Projects, which have been so effective at increasing access to health information and services for the Traveller community, are staffed by a predominantly female workforce who receive less than the minimum wage and have precarious working conditions.

175 EAPN (No Date). *Consistent Poverty Rates*. Retrieved from: http://www.eapn.ie/eapn/training/consistent-poverty-rates

176 CSO. (2017, 27 July). '*Census 2016 Results: Profile 4 Households and Families - Number of families increases to 1,218,370*'. [Press Release]. Retrieved from: https://www.cso.ie/en/csolatestnews/pressreleases/2017pressreleases/pressstatementcensus2016resultsprofile4-householdsandfamilies/

177 CSO. (2017). *Census 2016 Profile 9 - Health, Disability and Carers.* Retrieved from: https://www.cso.ie/en/csolatestnews/presspages/2017/census2016profile9-healthdisabilityandcarers/

178 National Women's Council of Ireland. (2019). *Women and Employment*. Retrieved from: https://www.nwci.ie/discover/what_we_do/womens_economic_independence/women_and_employment

179 Department of Health. (2016). *Health in Ireland Key Trends 2016.*

180 Mikkonen, J. and Raphael, D. (2010) 'Social Determinants of Health: The Canadian Facts.' York University School of Health Policy and Management, Toronto. Retrieved from: http:/thecanadianfacts.org.

181 Department of Justice and Equality. (2017). *National Traveller and Roma Inclusion Strategy 2017-21.*

Table 2.12 Traveller and Roma women's health	
Life expectancy	Traveller women's life expectancy is ten years lower than for women in the general population[182]. Traveller women have a life expectancy of 70.1 compared to the national average of 81.6. According to the ESRI[183] there is a steeper increase in poor health with age for Travellers, particularly in the 34-64 age range, than in the general community.
Mental health	Traveller women experience mental health difficulties at higher rates than women in the general population.[184] The suicide rate for Traveller women is five times higher than women in the general population.[185] 63% of Traveller women disclosed that their mental health was not good for one or more days in the last 30 days; this was compared to 20% of female medical cardholders.[186] 60% of Roma women report more than 14 days of the previous month when their mental health was not good[187].
Infant mortality	Infant mortality is 3.6 times higher among Travellers than among the general population[188].
Violence against women	Domestic violence is an issue within the Traveller community, as it is in the general population. Traveller women account for the largest group in admissions to domestic violence refuges, with 49% of refuge admissions being Travellers and 57% of Traveller women recorded as repeat admissions.[189]
Health access and screening	31.5% of Roma women do not have a GP. 44.6% of Roma women don't have a medical card (often due to problems proving where they live). 84% of Roma women have experienced discrimination in health services, compared to 53% of Roma men.[190]
Imprisonment	Minority groups are often over-represented in prison. Reasons proposed for overrepresentation include socio-economic factors, alcohol and other drug misuse and mental health problems[191]. Traveller women are at least 18 times more likely to be imprisoned than women in the general population.[192]
Traveller Women as Healthcare Providers	The All Ireland Traveller Health Study highlighted that 83% of Travellers received their public health information through the work of Primary Health Care Traveller Projects (PHCTP) and Traveller organisations, principally from Traveller women who have been trained as health advocates and who liaise with health professionals.[193]

182 Pavee Point (2017) *Shadow Report to CEDAW Committee*. Retrieved from: http://www.paveepoint.ie/wpcontent/uploads/2015/04/Pavee-Point-NTWF-2017-Joint-Shadow-Report-to-CEDAW-Committee-19012017.pdf

183 Watson, D., Kenny, O., McGinnity, F. (2017) *A Social Portrait of Travellers in Ireland*. Dublin: ESRI. Retrieved from: https://www.esri.ie/system/files?file=media/file-uploads/2017-01/RS56.pdf

184 Pavee Point Presentation 'Our Geels: Mental Health and Suicide'. Presentation to the World Congress on Women's Mental Health, Dublin March 2017. Retrieved from: http://www.paveepoint.ie/wp-content/uploads/2015/04/PP_MissieMaryBrigidCollins_WCWMH.pdf

185 *Ibid.*

186 All Ireland Traveller Health Study Team. (2010). *Our Geels, All Ireland Traveller Health Study.*

187 Pavee Point (2017) *Shadow Report* to *CEDAW Committee.*

188 Department of Justice and Equality. (2017). *National Traveller and Roma Inclusion Strategy 2017-21.*

189 Pavee Point & Traveller Women's Forum (2017) Irish Traveller and Roma Women Joint Shadow Report: A Response to Ireland's Consolidated Sixth & Seventh Periodic Report to the UN Committee on the Elimination of Discrimination Against Women. http://www.paveepoint.ie/wp-content/uploads/2015/04/Pavee-Point-NTWF-2017-Joint-Shadow-Report-to-CEDAWCommittee-19012017.pdf

190 Pavee Point (2017) *Shadow Report to CEDAW Committee.*

191 All Ireland Traveller Health Study Team. (2010). *Our Geels, All Ireland Traveller Health Study.*

192 *Ibid.*

193 *Ibid.*

2.7.2 Women who are homeless

There has been a feminisation of homelessness in Ireland during the current housing crisis. In August 2018 women made up 42% [194] of the national adult homeless population (rising to 44% in Dublin). This increase has been attributed to the rising numbers in family homelessness, the majority of which are lone parent, female-headed households.[195] Women often enter homelessness with a history of domestic violence, trauma, and/or time spent in hospital, prison or other institutional settings. For many of these women it is a temporary never-to-be-repeated situation, the minority are however not so lucky and can get trapped in homelessness, cycling between services[196].

An Irish study in 2015, Homelessness, An Unhealthy State[197], reported that almost 50% of women experiencing homelessness classified their health as 'poor' or 'fair' and 90% had at least one diagnosed mental or physical health problem.

The concept of complex multiple needs is often used to describe the situation where an individual (in this case a woman) who is homeless will present to services with more than one serious problem. See Table 2.13 for a definition of complex needs.

In certain circumstances, a crisis pregnancy can contribute to women becoming homeless. The HSE Sexual Health & Crisis Pregnancy Programme has provided grant assistance for the provision of supported accommodation services for pregnant women, or lone mothers with young children who are homeless. A 2010 review for the HSE[198] of this supported accommodation found that the women using the services attached most value to having a safe and affordable home, access to affordable childcare, transport so they could access education, training and employment, and a society that did not judge them as *'bad mothers'.*

Table 2.13 A definition of complex needs

Complex needs as where a person who is homeless present with three or more of the following:
Mental health problems
Problematic use of various substances
Personality disorders
Offending behaviours
Vulnerability because of age
Borderline learning difficulties
Disability
Physical health problems
Challenging behaviours

Source: All Party Parliamentary Group on Complex Needs and Dual Diagnosis. (2014). Complex Needs and Dual Diagnosis Factsheet.[199]

These overlapping needs in relation to health, life skills and housing can exacerbate one another, while meeting the breadth and complexity of these needs is clearly a challenge.

194 Department of Housing, Planning and Local Government. (August 2018). *Homelessness Report August 2018.* Retrieved from: https://www.housing.gov.ie/sites/default/files/publications/files/homeless_report_-_august_2018.pdf

195 Mayock, P & Bretherton, J. (2017). Women's Homelessness in Europe. Palgrave: MacMillan

196 Walsh, K (2015) *Women and Homelessness – A Resource Guide.* Simon Communities of Ireland.

197 O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A., O'Carroll, A. (2015) *Homelessness: An Unhealthy State - Health status, risk behaviours and service utilisation among homeless people in two Irish cities.* Dublin: Partnership for Health Equity. Retrieved from: https://www.drugsandalcohol.ie/24541/1/Homelessness.pdf

198 Lennon, L., O'Connor, H., OCS Consulting. (2010) *2010 Review of Supported Accommodation Services for Women During and After Pregnancy.* Dublin: HSE Crisis Pregnancy Programme. Retrieved from: https://www.sexualwellbeing.ie/for-professionals/research/research-reports/2010-review-of-supported-accommodation-services-for-women-during-and-after-pregnancy1.pdf

199 All Party Parliamentary Group on Complex Needs and Dual Diagnosis. (2014). *Complex Needs and Dual Diagnosis Factsheet.* Retrieved from: https://www.turning-point.co.uk/_cache_1d62/content/appg_factsheet_1_-_june_2014-5090910000019641.pdf

2.7.3 Migrant women

Table 2.14 Health recommendations in the McMahon report	
1	The HSE initiative to exempt residents from prescription charges, which the Working Group welcomes, be implemented as soon as possible.
2	A health promotion initiative be targeted at residents of Direct Provision centres to inform them about access to breast screening, cervical checks, and bowel and diabetic screening services free of charge.
3	Immediately undertake a review of services for persons in the system experiencing a crisis pregnancy, with a view to a protocol being agreed to guide State agencies and NGOs supporting such persons. Particular attention should be paid to addressing the needs of the individual in the context of the legislative framework. Issues relating to travel documents, financial assistance, confidentiality, and access to information and support services should be addressed.
4	The RIA Sexual and Gender-based Violence Policy be rolled out as soon as possible and accompanied by an awareness-raising and training plan.
5	An initiative be put in place to facilitate access by persons in the system to information and services concerning sexual and reproductive health and family planning.
6	An adequately trained and resourced interpreting service be put in place where demand exists. Interpreters dealing with persons in the system should be sensitivity trained, especially when interpreting the disclosure of needs, experiences and values of vulnerable groups. General Practitioners should be encouraged to offer interpreting services to this client group.
7	All centre staff should be provided with mental health awareness training by the HSE or designated NGOs. This training should cater for recognition of mental health issues and assist staff in alerting appropriate services, while ensuring the safety and wellbeing of the individual and all those who work and live in the centre.
8	Sensitivity training on issues that impact on vulnerable groups should be provided to all relevant Direct Provision staff.
9	Information leaflets, posters, talks and confidential contact details be provided in every centre and kept up to date to target vulnerable groups and promote dignity. Issues to be identified include e.g. FGM, torture, HIV, mental health, LGBT, disability, religion, domestic violence, human trafficking, exploitation, prostitution and older people's needs.
10	Residents be able to access appropriate transport provision or financial assistance to ensure attendance at medical appointments and safe return to the centre.
11	The HSE National Operational Plan to include an account of progress on the implementation of the health-related recommendations made by the Working Group that are adopted by Government.

Source: MacMahon, B et al (2015) Working Group to Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers

The double discrimination experienced by women as a result of their gender and ethnicity has an impact on all aspects of their lives, including on health[200]. Immigration status is an important factor in determining use of health services in Ireland. Undocumented migrants, those seeking asylum and those who have refugee status often experience poor access to health services.[201]

Exclusion from health services means that undocumented women face delayed access to screening, treatment and care, limited access to contraception and heightened levels of discrimination and gender-based violence, all of which damages women's health and perpetuates health inequities.[202]

Reception and Integration Agency figures for October 2018[203] show 6,405 people resident in Direct Provision, of which 2,626 were female (of all ages). The 2015 McMahon report on Direct Provision and the Protection Process[204] made a series of eleven recommendations in relation to enhancing access to health services and support for those living in Direct Provision. See Table 2.14 for details.

2.7.4 Women with disabilities

Almost 50% of women with disabilities in Ireland are at risk of poverty or social exclusion.[205] Labour participation rates for people with disabilities are extremely low, with only three out of 10 adults with a disability of a working age having a job.[206] Women with disabilities are less likely to be employed, with family caring responsibilities a key reason for their lower rates of employment.[207]

Women with disabilities have lower uptake of health promotion and health screening services than women in general.

Rates of screening for both cervical and breast cancer are lower among women with disabilities than the general population and especially low for women with severe and profound intellectual disability.[208]

According to Inclusion Ireland[209], women with disabilities experience inequality in accessing sexual health services and in their right to enjoy relationships on an equal basis with others. Due to a legacy of institutionalisation and segregation, women and girls have been deprived of information and education on sexuality and family planning. Internationally,

200 Health Service Executive. (2007). *Intercultural Health Strategy.* Retrieved from: https://www.hse.ie/eng/services/publications/socialinclusion/national-intercultural-health-strategy-2007---2012.pdf

201 AkiDwa, Dorus Luimni and HSE. (2012). *Migrant Women's Awareness, Experiences and Perceptions of Health Services in Limerick.* Retrieved from: http://dorasluimni.org/wp-content/uploads/2017/07/healthmapping.pdf

202 World Health Organisation. (2016). *Migrant women's health issues: addressing barriers to access health care for migrant women with irregular status.* Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0017/330092/6-Migrant-womens-health-issues-irregular-status.pdf?ua=1

203 Reception and Integration Agency Department of Justice and Equality. (2018). *Monthly Report October 2018.* Department of Justice and Equality. Retrieved from: http://www.ria.gov.ie/en/RIA/October%202018%20monthly%20report%20updated%20.pdf/Files/October%202018%20monthly%20report%20updated%20.pdf

204 Department of Justice and Equality (2015, 30 June). *Government publishes Working Group report on Direct Provision and the Protection Process.* [Press Release]. Retrieved from: http://www.justice.ie/en/JELR/Pages/PR15000389

205 European Institute for Gender Equality. (2016). *Poverty, gender and intersecting inequalities in the EU Review of the implementation of Area A: Women and Poverty of the Beijing Platform for Action.* Brussels: EIGE

206 CSO. (2011). *Persons with a Disability.* Retrieved from: https://www.cso.ie/px/pxeirestat/Statire/SelectVarVal/Define.asp?maintable=CD801&PLanguage=0

207 Watson, D. & Nolan, B. (2011). *The Social Portrait of People with Disabilities in Ireland 2011. A report by the Department of Social Protection and the ESRI.* Dublin: DSP.

208 Burke, E., McCallion, E., McCarron, M. (Eds.) (2014). *Advancing years, Different challenges: Wave 2 IDS-TILDA: findings on the ageing of people with an intellectual disability: an intellectual disability supplement to the Irish Longitudinal Study on Ageing.* Dublin: Trinity College Dublin. Retrieved from: https://www.tcd.ie/tcaid/assets/pdf/Wave_2_Report_October_2014.pdf

209 Inclusion Ireland. (2015). *Submission to the Department of Justice and Equality - On a new National Women's Strategy 2017-2020.* Retrieved from: http://www.inclusionireland.ie/sites/default/files/attach/basic-page/1110/submission-womens-strategy.pdf

a systematic review of evidence by the WHO[210] shows that children and adults with disabilities are more likely to experience violence than their non-disabled peers and those with intellectual disabilities are most at risk.

2.7.5 Women who are carers

There were 70,459 people in receipt of caring-related social welfare payments in 2016[211], while significantly higher number of individuals identified themselves as carers with Census 2016 (see **Appendix 1 Table A.20** for details). Women undertake the majority of unpaid care work.[212] Caring responsibilities can have a negative impact on mental and physical health, leading to exhaustion, depression, injury and greater vulnerability to illness generally. Families are heavily reliant on grandparents for childcare. A similar proportion of women and men provide care but women do so for significantly longer hours.

2.7.6 LGBTQI+ women

Principles[213] and standards[214] exist in relation to the provision of health care and supports for LGBTQI+ (lesbian, gay, bisexual, transgender, queer and intersex) individuals. Notwithstanding, LGBTQI+ women experience barriers in accessing health and social services due to a lack of understanding of their specific needs and a lack of targeted service promotion. Furthermore, research has also demonstrated that LGBTQI+ people are less likely to engage with health interventions and screening programmes if it is not explicit that they are welcome to access the service.[215]

There is also a broad issue of access to health services for the LGBTQI+ community. These barriers generally occur due to the consequences of a complex interaction of environmental, social, cultural and political factors. Research into the causes of health barriers inequalities for LGBTQI+ people identified a number of causes including: heteronormativity[216]; hetero-sexism[217]; minority stress[218;219]; victimisation[220]; institutional discrimination[221]; and stigma[222;223]. Challenges and difficulties identified[224] for LGBTQI+ groups

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210 Hughes K., Bellis M., Jones L, Wood S, Bates G, Eckley L, McCoy E, Mikton C, Shakespeare T, Officer A. (2012). 'Prevalence and risk of violence against adults. Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies.' *The Lancet.* 379(9826):1621-9. Retrieved from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61851-5/fulltext

211 CSO. (2016). *Women and Men in Ireland 2016.*

212 *Ibid.*

213 The Yogyakarta Principles. (2006). The Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity. Retrieved from: http://yogyakartaprinciples.org/wp-content/uploads/2016/08/principles_en.pdf

214 World Professional Association for Transgender Health. (2011). 'Standards of Care for the Health of Transexual, Transgender, and Gender Nonconforming People, Version 7'. *International Journal of Transgenderism.* 13(4):165-232

215 Brooks, H., Llewellyn, C.D., Nadarzynski, T., Pelloso, FC., De Souza Guilherme F., Polllard, A., Jones, CJ. (2018) 'Sexual orientation disclosure in health care: a systematic review'. *British Journal of General Practice.* 668:e187-e196

216 Heteronormativity: Is a set of beliefs and practices that gender is an absolute and unquestionable binary, therefore describing and reinforcing heterosexuality as a norm. It implies that people's gender and sex characteristics are by nature and should always be aligned, and therefore heterosexuality is the only conceivable sexuality and the only way of being 'normal'.

217 Heterosexism is a set of discriminatory attitudes, bias and behaviours relying on gender as a binary to favour heterosexuality and heterosexual relationships

218 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.* Dublin: GLEN and BeLong To Youth Service. Retrieved from: https://www.hse.ie/eng/services/publications/mentalhealth/suporting-lgbt-lives.pdf

219 Minority stress arises where stigma, prejudice and discrimination create a hostile environment where people are subject to stressful social exchange.

220 Victimisation takes place where one person treats another less favourably based on a range of factors such as gender identity, sexual orientation, sex characteristics, sex, disability etc.

221 Institutional discrimination occurs where laws and policies in the public domain sustain inequalities, e.g. the prohibition of same-sex marriage, or where laws do not protect against discrimination based on sexual orientation, gender identity and sex characteristics.

222 Stigma is a perceived negative attribute that causes someone to devalue or think less of the whole person.

223 Health4LGBTI. (2017). *State of the Art Synthesis Report (SSR).* Retrieved from: https://ec.europa.eu/health/sites/health/files/social_determinants/docs/stateofart_report_en.pdf

224 Pinto, N. (2014) *Consultations with ILAG-Europe's Members on the needs, priorities, challenges and good practices in the field of health.* ILGA- Europe

getting involved in health and access to health provision include:

- Antagonism and lack of cooperation from health authorities, organisations and professionals, and from governmental agencies with responsibilities in this field;
- Lack of resources;
- Interrelation with the work of other actors on health;
- Diversity of issues within LGBTQI+ health, and specificities of different groups;
- The broad scope of LGBTQI+ health;
- Lack of involvement of LGBTQI+ communities in health activities and difficulties in reaching out to specific subgroups within LGBTI community;

In 2009, the HSE published an overview of health and social service provision and support for LGBTQI+ people in Ireland.[225]

The report highlighted particular health issues experienced by lesbian and bisexual women as including:

- Higher incidences of cardio-vascular disease, polycystic ovarian syndrome, ovarian cancer and possibly breast cancer;
- Lower use of gynaecological services;
- Low awareness of STIs spread by woman-to-woman sex;
- Barriers to accessing assisted human reproduction (AHR) services.

The study also found that members of the transgender community face a lack of essential health services – surgeons, postoperative care, endocrinologists, psychiatrists, therapists, and a designated gender specialist – and are more likely to experience isolation, fear, stigma, physical violence and family rejection contributing to depression, anxiety, self-harm, suicide and substance misuse.

See Table 2.15 for some of the specific health issues for LGBTQI+ individuals.

Each LGBTQI+ group also has particular health needs. See Table 2.16 for details.

225 HSE LGBT Health sub-committee (2009) *LGBT Health: Towards Meeting the Health Care Needs of Lesbian, Gay, Bisexual and Transgender People.* Dublin: HSE. Retrieved from: https://www.hse.ie/eng/services/publications/topics/sexual/lgbt-health.pdf

Table 2.15 Health issues for LGBTQI+ individuals	
Physical Health	Higher incidences of obesity and eating disorders are to be found among the LGBTQI+ population, raising the risk for diabetes and heart disease, among other weight related ailments. Members of the LGBTQI+ community are typically more likely to be smokers[226]. The National Drug and Alcohol Strategy 2017 to 2025 identifies LGBTQI+ individuals as a group with complex needs, and the strategy calls for targeted harm-reduction, education and prevention measures for drugs and alcohol abuse that are tailored towards higher risk groups.[227]
Mental Health	LBTQI+ groups are at significantly higher risk of experiencing mental health problems compared to the heterosexual population. These problems can be linked to the discrimination and marginalisation experienced by LGBTQI+ people, and are not inherent to sexual orientations, gender identities or sex characteristics. [228] LGBTQI+ people have higher rates of risk behaviours (drinking, smoking and drug use) that are linked to discrimination. LGBTQI+ individuals are more likely to report mental health difficulties than the non-LGBTI+ population and are proportionately more likely to access mental health services than heterosexuals[229]. Nearly one in four LGBTQI+ people have either severe or extremely severe anxiety levels, with one in five LGBTQI+ people suffering from severe or extremely severe depression. Similar trends are found in terms of self-harm[230].
Sexual Health	LGBTQI+ Ireland survey respondents identified sexual health promotion as too narrow and heteronormative. The level and quality of sexual health services available around the country varies. Not everyone is aware of the different options open to them (e.g. PrEP and PEP). The costs associated with some of these treatments can also act as a barrier to their use.
Mortality	Lesbian women have greater all-cause mortality than heterosexual people[231]. LGBTQI+ individuals have a higher risk of certain cancers, are less likely to attend for routine screening and more likely to present with more advanced disease.

226 Higgins, A., Doyle, L., Downes, C., Murphy, R., Sharek, D., DeVries, J., Begley, T., McCann, E., Sheerin, F., Smyth, S. (2016). *The LGBT Ireland Report: National Study of the Mental Health and Wellbeing of Lesbian, Gay, Bisexual, Transgender and Intersex People in Ireland.* Dublin: GLEN & BeLonG To Youth Service. Retrieved from: http://belongto.org/wp-content/uploads/2018/05/LGBT-Ireland-Full-Reportpdf.pdf

227 Department of Health, Healthy Ireland. (2017). *Reducing Harm, Supporting Recovery: A Health-Led Response to Drug and Alcohol Use in Ireland 2017-2025.* Retrieved from: https://health.gov.ie/wp-content/uploads/2017/07/Reducing-Harm-Supporting-Recovery-2017-2025.pdf

228 Gonzales, G., Przedworski, J. and Henning-Smith, C. (2016). 'Comparison of health and health risk factors between lesbian, gay, and bisexual adults and heterosexual adults in the United States'. *JAMA Internal Medicine.* 176(9):1344-51. Retrieved form: https://www.ncbi.nlm.nih.gov/pubmed/27367843

229 Fay, V. (2016). *Lesbian, Gay, Bisexual and Trans (LGBT) Young People's Health in the UK: A literature review with a focus on needs, barriers and practice.* Proud Trust. Retrieved from: https://www.theproudtrust.org/wp-content/uploads/download-manager-files/LGBT-Young-Peoples-Health-Research(1).pdf

230 Higgins, A., Doyle, L., Downes, C., Murphy, R., Sharek, D., DeVries, J., Begley, T., McCann, E., Sheerin, F., Smyth, S. (2016). *The LGBT Ireland Report: National Study of the Mental Health and Wellbeing of Lesbian, Gay, Bisexual, Transgender and Intersex People in Ireland.*

231 Cochran, S., Bjorkenstam, C., and Mays, V. (2016). 'Sexual orientation and all-cause mortality among US adults aged 18 to 59 years, 2001-2011.' Am J Public Health. 106: 918– 920.

Table 2.16 Health issues for specific LBTQI+ groups of women[232]	
Lesbian women	Specific health needs include sexual and cervical health, reproductive health, mental health, substance use, weight discrepancies etc.
Bisexual women	Specific health needs include aspects of general/physical health (cancer), mental health, and substance (mis) use including stress with limited research specifically focusing on health issue relating to bi-sexual people.
Trans women	Specific health needs include general health, mental health, depression, suicidal ideation and suicide attempts, substance mis-use, as well as the impact of transitioning on mental health. Specific barrier facing transgender individuals include inappropriate or prejudicial treatment from healthcare staff. This treatment includes using inappropriate pronouns, using and displaying old names in front of other patients, offering inappropriate services, providing inaccurate advice and refusing service provision[233].
Intersex individuals	Specific health needs include assigned sex, impact of surgery, ethical accountability, mental health, and accessing specialist services.

2.7.7 Women who offend

Women who commit crime comprise a relatively small yet increasing group within the criminal justice system in Ireland. International research suggests that women offenders are likely to be poor, have limited education and are either unemployed or in low skilled employment. Many experience accommodation problems[234], often resulting in homelessness, and serious problems of addiction and/or mental health often feature. In 2013, the Probation Service worked on a daily basis with almost 1,300 women offenders in the community, either assessing or supervising them on a range of probation type orders, community service or post release supervision. In 2013, 14% or 1 in 7 new referrals to the Probation Service are for women offenders (1,206 new referrals). On any day there are around 150 women in custody. 2,151 women were committed to prison in 2012 which is almost 15% of all committals. In comparison 2,326 women were committed to prison in 2013 which accounted for 18% of all committals. While there are currently 133 spaces for female prisoners, both female prisons regularly run above capacity with an average female population of 152 in custody in 2012.

Most women who offend pose a low risk to society; however they generally have high support and health needs[235].

232 Health4LGBTI. (2017). *State of the Art Synthesis Report (SSR).*

233 Santiago McBride, R. (2011). *Healthcare Issues for Transgender People Living in Northern Ireland.* Institute for Conflict Research. Retrieved from: http://www.hscbusiness.hscni.net/pdf/Healthcare_Issues_for_Transgender_People_in_Northern_Ireland_-_Ex_Summary_-_JULY_2011.pdf

234 Mayock, P. and Sheridan, S. (2012) *Women's 'Journeys' to Homelessness: Key Findings from a Biographical Study of Homeless Women in Ireland. Women and Homelessness in Ireland, Research Paper 1.* Dublin: School of Social Work and Social Policy and Children's Research Centre, Trinity College Dublin.

235 Irish Prison Service and the Probation Service. (2014). *Joint Probation Service – Irish Prison Service Strategy 2014 – 2016: An Effective Response to Women Who Offend.* Retrieved from: http://www.irishprisons.ie/images/pdf/women_strat_2014.pdf

2.7.8 Women involved in prostitution

The profile and associated health needs of women involved in prostitution has changed significantly over the last 10-15 years (Sweeney, 2015)[236]. Those health services which were provided for women in prostitution traditionally centred on sexual health and addiction. However, women working in prostitution are not a homogenous group and how women in prostitution will interact with health services may differ depending on their context, for example whether they are a victim of trafficking, a migrant woman or a transgender woman.

If health services are to meet the different health needs of women, working indoors and working on the street then health services must consider and understand the differences between the needs of these groups of women[237].

Prostitution impacts negatively on the physical, sexual and reproductive and emotional and mental health of women. Health risks can include frequent viral illness, STDs, vaginal infections, back aches, sleeplessness, depression, general physical conditions including headache and stomach ache, eating disorders, cervical cancer, infertility, hepatitis, rape and sexual assault with related injuries such as fissures; traumatic brain injury from physical assaults; symptoms of post-traumatic stress disorder and suicidal ideation.

Women in prostitution are also known to be at far higher risk of violence and murder compared to the general population, with women continually needing to be hypervigilant about their safety[238]. Women in prostitution may also have other chronic health problems linked to complex socioeconomic backgrounds and lifestyle factors[239] that may have initially led them into prostitution[240].

Women in prostitution in 2019 are also primarily a highly mobile group, involved in largely indoor focused activity that involves foreign nationals and touring populations (with far smaller numbers involved in on-street prostitution in larger cities)[241]. Among some of the most recent data available is the Immigrant Council of Ireland 2009 study[242], it estimated that at that time there was a minimum of 1,000 women involved in indoor prostitution in Ireland (representing 51 different nationalities and ranging in age from 18 to 58 years (with evidence that girls as young as 16 years are involved).

This study estimated that just 3-13% of the women involved in indoor prostitution were Irish, while the majority were migrant women. It also estimated at that time that, 41% were 'touring escorts' moving and/or being moved by criminal gangs around Ireland and internationally. The profile of clients attending the HSE Women's Health Project (WHP) [243] in 2017 supports this overview, although it does only reflect those women accessing its service. (See Table 2.17 for details).

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236 Sweeney, L-A. (2015). *The psychosocial experiences of women involved in prostitution: an exploratory study.* PhD in Health Promotion, National University of Ireland, Galway. Retrieved from: https://aran.library.nuigalway.ie/xmlui/bitstream/handle/10379/4970/Leigh-Ann%20Sweeney%20PhD.pdf?sequence=1

237 Jeal N, Salisbury C. (2007). 'Health needs and service use of parlour-based prostitutes compared with street-based prostitutes: a cross-sectional survey.' *BJOG.* 114:875–881.

238 Farley, M. (2004) '"Bad for the Body, Bad for the Heart" Prostitution Harms Women Even if Legalized or Decriminalized'. *Violence Against Women*, 10 (10):1087-1125.

239 Mastrocola E. L., Taylor A. K., & Chew-Graham, C. (2015). Access to healthcare for long-term conditions in women involved in street-based prostitution: a qualitative study. *BMC Family Practice* 16:118. Retrieved from: https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-015-0331-9

240 Kurtz, S.P., Surratt, H.L., Kiley, M.C., Inciardi, J.A. (2005) 'Barriers to health and social services for street-based sex workers'. *J Health Care Poor Underserved.* 16(2):345-61. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/15937397

241 In 2017 20% of the individual supported by Ruhama were involved is on-street prostitution in Dublin. Ruhama. (2017). *Ruhama Annual Report 2017.* Retrieved from: https://www.ruhama.ie/assets/Press-Releases/Ruhama-2017-Annual-Report

242 Kelleher Associates, O'Connor, M., and Pillinger, J. (2009) *Globalisation, Sex Trafficking and Prostitution: The Experiences of Migrant Women in Ireland.* Immigrant Council of Ireland. Dublin 2. Retrieved from: https://www.immigrantcouncil.ie/sites/default/files/2017-09/AT%202009%20Globalisation%2C%20Sex%20trafficking%20%26%20Prostitution%20Report%20SUMMARY.pdf

243 The WHP (HSE) was established in 1991 to respond to the health needs and the harm experienced by women in prostitution. Since 2003, it has worked with trafficked women Current clinic time are Tuesday 2-4pm by appointment, Wednesday 2-4pm and Thursday 6-8pm.

Table 2.17 Profile of Clients attending the HSE WHP Clinic in 2017		
Total attendees		**205**
New Attendees (including 63 new internationals)		64
Nationalities	Irish	11
	UK	3
	International	191
Opiate dependent		3
On/off street	Indoor	192
	Outdoor	2
	N/A as Victim of Trafficking	11

Source: Latham, L . (2018). Presentation on Anti-Human Trafficking Team & Women's Health Service in Ireland. Given at the 18th Alliance OSCE Conference against Trafficking in Persons conference entitled Everyone Has a Role: How to Make a Difference Together, in Vienna, 23-24 April 2018. Retrieved from: https://www.osce.org/secretariat/382177?download=true

The current diverse, dispersed and highly mobile nature of prostitution means that for many women involved in prostitution their health needs are increasingly determined by their psychosocial experiences and location.

Among the key barriers identified by Sweeney (2015) in relation to women in prostitution in Ireland accessing health services, included: a fear of being identified due to concern about the reaction of traffickers/pimps and the fear of experiencing stigma from service providers; limited information on where they could go due to their constant movement around the country; and the limited nature of services available to them, given that many local agencies do not provide a service for women involved in prostitution.

For women who are controlled and held in prostitution by criminal gangs, they are likely to have no control over where they stay, or opportunity to link with local services. For those women who are independent – a minority of those in prostitution – lack of reliable income and vigilance about attacks by buyers or criminal gangs means they may have to continue to work while ill.

Currently, only one HSE facility, the Women's Health Project situated in Dublin is available to women involved in prostitution. Other organisations supporting women in prostitution include Ruhama and the Immigrant Council of Ireland both of which are also Dublin-based. In other parts of the country, AIDs West, Cork Sexual Health Service, Cork Sexual Violence Centre, GOSSH (Limerick) and Doras Luimní work with women in prostitution in a health capacity. Key health needs[244] for women in prostitution have been identified as including:

1. The provision of basic health and support services available nationwide to include specialised sexual health clinic in all major cities (as provided by the WHP (HSE) for the greater Dublin area).
2. Culturally appropriate training for health care practitioners give them the skills to identify the health needs of women from other countries in prostitution in Ireland.
3. Research on the long-term impact of prostitution on women's mental and physical health and the mortality rate of women in prostitution

244 Kelleher Associates, O'Connor, M., and Pillinger, J. (2009) *Globalisation, Sex Trafficking and Prostitution: The Experiences of Migrant Women in Ireland.*

2.7.9 Women and trafficking

Prostitution and trafficking are not the same but are inherently intertwined as women are trafficked primarily for the purpose of sexual exploitation. The clandestine nature of human trafficking makes it difficult to measure accurately. The Department of Justice and Equality's Anti-Human Trafficking Unit (AHTU) gathers information from a number of sources to create two distinct datasets of a) potential victims[245] and b) suspected victims[246]. The data that is available, relates to suspected victims of trafficking only, see Table 2.18 for details.

Table 2.18 Total suspected adult trafficking (including for labour and sex trafficking) victims by year and gender

Year	Age	Female	Male	Trans	Total
2013	Adult	26	2	-	28
2014	Adult	26	8	-	34
2015	Adult	35	19	1	55
2016	Adult	38	36	-	74
2017	Adult	42	30	-	72 (includes 31 sex trafficking victims)
Totals		167	95	1	263

Source: Dept of Justice and Equality (2018) Trafficking in Human Beings in Ireland, Annual Report 2017 p 5.

Nationally, three dedicated State units[247] focus directly on human trafficking supported by 2016 *Second National Action Plan to Prevent and Combat Human Trafficking in Ireland*. From a health perspective the HSE Anti-Human Trafficking Team (AHTT) deliver an individual care plan for each victim of human trafficking under the national action plan. The HSE team then assesses and plans care with the individual according to their particular needs and within the limitation of the existing policies. Ruhama [248] also provides education and training support, housing support, counselling, outreach, advocacy and specialist casework support to victims of sex trafficking.

The health problems affecting victims of trafficking are a result of number of factors including stress, deprivation of food and sleep, hazards related to being trafficked to various locations and across borders, physical violence and sexual violence[249]. It is also the case that because women who are trafficked generally do not have access to health care, by the time they reach a clinician it is likely that health problems are well advanced[250]. These women are at particularly high risk for acquiring multiple sexually transmitted infections and the sequelae of multiple forced and unsafe abortions[251]. Physical abuse and torture also often occur, while psychological violence results in high rates of posttraumatic stress disorder, depression, suicidal ideation, drug addiction, etc[252].

Importantly, health care providers are often the only professionals to interact with individuals who have been trafficked, or who are still under the control of traffickers, pimps or criminal gangs, as women may attend for STI testing, pregnancy and/or abortion services. Health care providers must therefore be aware of this possibility and prepared to identify, treat, and assist such individuals as part of their regular clinical practice. One study found that 28% of

245 A "potential victim" refers to a person encountered by non-State groups, who they believe may be a victim of trafficking. These persons may, or may not, be referred to An Garda Síochána for identification and entry to the system of State supports known as the National Referral Mechanism (NRM).

246 A "suspected victim" refers to a person that meets a reasonable grounds threshold and is therefore considered a victim of human trafficking by An Garda Síochána.

247 The Department of Justice and Equality's Anti-Human Trafficking Unit (AHTU), the Human Trafficking Investigation & Co-Ordination Unit (HTICU) which is part of the Garda National Protective Services Bureau (GNPSB) and the HSE Anti-Human Trafficking Team (AHTT).

248 In 2017, Ruhama provided support to 109 victims of sex trafficking, originating from 26 different nations. Ruhama. (2017). *Ruhama Annual Report 2017.*

249 Dovydaitis, T. (2010). 'Human Trafficking: The Role of the Health Care Provider'. *J Midwifery Women's Health.* 55(5): 462–467. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3125713/

250 Barrows, J., Finger, R. (2008). 'Human trafficking and the healthcare professional'. *South Med J.* 101:521–4.

251 Cwikel, J., Chudakov, B., Paikin, M., Agmon, K., Belmaker, RH. (2004) 'Trafficked female sex workers awaiting deportation: Comparison with brothel workers'. *Arch Womens Ment Health.* 7:243– 9.

252 Dovydaitis, T. (2010). 'Human Trafficking: The Role of the Health Care Provider'.

trafficked women saw a health care professional while still in control of traffickers[253]. This represents a serious missed opportunity for intervention.

Women who are trafficked clearly have multiple needs which demands a complex response involving multiple agencies including medical and health care, welfare, sexual health services, rape crisis centres, and in many cases, interpreting services. Concerns also particularly exist regarding the lack of appropriate accommodation for particularly traumatised victims of sexual abuse. Currently, potential or suspected victims of trafficking – who have specific safety needs (from their traffickers) and health needs – are provided with the same accommodation and ancillary services as those provided to newly arrived asylum seekers, namely direct provision reception centres, arranged by the Reception and Integration Agency.

Concerns exist in relation to the appropriateness of this accommodation for particularly traumatised victims of sexual abuse/trafficking[254].

2.7.10 Other groups

Other groups of women whose health needs need to be explored and addressed within the WHAP include female lone parent families, women involved in substance misuse as well as women working in health care. As is the case for all these priority groups of women (including those discussed in section 2.7 above), there is a need for further research to identify their health needs, health outcomes and engagement with health services. Within the health services there are a number of programmes designed to support women (e.g. Women in Leadership) that could be explored and built upon within the WHAP.

253 *Ibid.*

254 Kelleher Associates, O'Connor, M., and Pillinger, J. (2009) *Globalisation, Sex Trafficking and Prostitution: The Experiences of Migrant Women in Ireland.*

Section 3 – Women's Engagement with the Health Service

3.1 Overview of national and international literature on women's engagement with health services (service use, service needs)

3.1.1 International literature on women's engagement with health services

At an international level, global efforts to advance women's health are being progressed through the adoption of the 2030 Agenda Sustainable Development and taken forward through the Sustainable Development Goals[255] and the global strategy for women, children and adolescents' health. Goal 3 '*Good Health and well-being*' of the UN Sustainable Development Goals in particular is focused on ensuring healthy lives and promoting the well-being at all ages. This goal recognises *'access to good health and wellbeing as a human right for all men and women'*. Goal 5 in contrast is focused on achieving gender equality and empowering women.

The recognition of women's health and the link between gender and health can be traced back to the early 1970's. Alvarez-Dardet and Vives-Cases[256] in their work recognise three main waves in the development of clear gender and health links. The first wave was the "visibility and legitimatisation" of gender issues and women's health as objects of scientific study and possible policy action; the second involved acceptance of gender as a genuine health determinant; and the third, final wave in this political process of creating true gender policies included the Beijing Conference held in 1995, together with the work of the WHO's Commission on Social Determinants of Health, with gender now recognised as one of the most important social determinants of health.

At a European level, Health 2020[257] – the umbrella policy framework for health and well-being in the WHO European Region was adopted by the 53 Member States in September 2012. This policy acknowledges gender as a determinant of health alongside other social and environmental determinants, and includes gender mainstreaming as a mechanism to achieve gender equity. It in turn fed into the development of the 2016 *Strategy on women's health and well-being in the WHO European Region.*[258] This 2016 Strategy acknowledges gender is a determinant of health, alongside social and environmental determinants, and identifies gender mainstreaming as a mechanism to achieve gender equity. The Strategy focuses on the determinants of women's health, without necessarily making comparisons between women and men.

Gender inequalities and possible areas of focus:[259,260]

- From 2000 to 2012, life expectancy has improved for women across the European Region, but with fewer years lived without disability or activity restriction.

255 United Nations. (2015). *Sustainable Development Goals.* Retrieved from: https://sustainabledevelopment.un.org/?menu=1300

256 Avarez-Dardet, C., and Vives-Cases, C. (2012) 'Three waves of gender and health.' *Eurohealth incorporating Euro Observer.* (18)2:4-8. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0007/169531/Eurohealth-Vol-18-No-2.pdf

257 World Health Organisation. (2012). *Health 2020: the European policy for health and well-being.* Retrieved from: http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/about-health-2020

258 World Health Organisation Europe. (2016). *Strategy on women's health and well-being in the WHO European Region.* Copenhagen: WHO. http://www.euro.who.int/en/health-topics/health-determinants/gender/publications/2016/strategy-on-womens-health-and-well-being-in-the-who-european-region-2016

259 This review of services is focused on the WHO European Region as the region that is most relevant to the Irish context.

260 WHO (2016) *Strategy on women's health and well-being in the WHO European Region* .

— Women see themselves as less healthy than men and report more illness.

— Women forego care for financial reasons.

— Equal access to health services has not been achieved for rural, minority, migrant, refugee or asylum-seeking women, or for women in detention.[261]

— Physical health conditions dominate in early life, while depressive and anxiety disorders develop among young women moving into adult life. In older age lower back pain, ischaemic heart disease and cancers are more prevalent.[262]

— There is a marked decline in subjective well-being among girls during adolescent years.[263]

— Gender inequalities in employment, quality of work and job segregation continue to exert a negative influence on health.

— Gender stereotypes have consequences for women's health in terms of self-confidence and well-being in particular; concerns about physical appearance may cause girls and young women to develop eating disorders and other mental illnesses, such as depression and anxiety[264].

— Stereotypes and sexism pave the way for certain forms of oppression, such as sexual harassment and gender-based violence.[265]

— Gender stereotypes affect health systems responses, such as in under- and over-diagnosis of certain conditions.[266]

— Violence against women persists in all countries and among all population groups.

— Recent studies show that social media has been associated with serious health effects among young women as a result of activities such as cyberbullying.[267]

— Women's increasing exposure to risk factors for non-communicable diseases (NCDs) increases the risk of developing diseases and disabilities earlier in life. More than 50% of women in the European Region are overweight, with higher prevalence of obesity among women with lower levels of education than is the case for men. In addition, adolescent girls have reduced physical activity and, in many countries, are catching up with males in their use of tobacco and alcohol, abetted by the tobacco and alcohol industries through marketing that specifically targets young people.[268] It should be noted that Ireland has stringent restrictions on alcohol marketing and the marketing of tobacco products is not permitted. Ireland is also the first country in Europe to introduce standardized packaging for all tobacco products (not just cigarettes and roll-your-own).

— Major depressive disorders are the main cause of disease among adolescent girls and women across the Region, and dementia and Alzheimer's disease are main causes of ill health among older women in western European countries.[269] The impact of socioeconomic inequalities has a huge influence on women's mental health both as patients and informal providers of care. Treatment gaps experienced by young women affected by depression and anxiety disorders

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261 Economic and Social Council. (2014). *Beijing + 20 regional review of progress: regional synthesis*. Geneva: United Nations Economic Commission for Europe. 2014 (ECE/AC.28/2014/3; Retrieved from: https://www.unece.org/fileadmin/DAM/Gender/documents/Beijing%2B15/ECE.AC.28.2014.3.E.pdf

262 World Health Organisation. (2015). *Beyond the mortality advantage: investigating women's health in Europe*. Copenhagen: WHO Regional Office for Europe. Retrieved from: http://www.euro.who.int/en/health-topics/health-determinants/gender/publications/2015/beyond-the-mortality-advantage.-investigating-womens-health-in-europe

263 Gavin, A., Keane, E., Callaghan, M., Molcho, M., Kelly, C, and Nic Gabhainn, S. (2015) *The Irish Health Behaviour in School-aged Children (HBSC) Study 2014*. Galway: NUIG and Department of Health. Retrieved from: https://health.gov.ie/wp-content/uploads/2015/12/HBSC2014web2.pdf

264 World Health Organisation. (2015). *Beyond the mortality advantage: investigating women's health in Europe.*

265 European Commission. (2015). *Forum on the future of gender equality in the European Union: report.* Retrieved from: http://ec.europa.eu/justice/events/future-of-gender-equality-2015/index_en.htm

266 Govender, K., Penn-Kekana, L. (2008). 'Gender biases and discrimination: a review of health care interpersonal interactions'. *Glob Public Health*. 3(S1):90–103. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/19288345

267 World Health Organisation. (2015). *Beyond the mortality advantage: investigating women's health in Europe.*

268 *Ibid.*

269 *Ibid.*

upon reaching maturity need particular attention given the high prevalence of these conditions.

— Differences between women and men in sensitivity to toxic substances, combined with gender division of labour, may increase the exposure and vulnerability of girls and women to chemicals and pollution.

— In areas where domestic heating are met by burning solid fuels (e.g. wood) on open fires women and young children who spend a significant amount of time indoors at home are disproportionally exposed to high levels of household air pollution, which includes a range of health-damaging pollutants such as fine particles and carbon monoxide.[270] It is estimated that 117,200 deaths per year in the European Region are attributable to household air pollution.

— Women are over-represented as care providers in the formal and informal sectors. Women are also over-represented as care recipients among those aged 65 and over in institutions and at home. Formal care alternatives in many countries are few and may be inaccessible, unaffordable and/or of low quality. This puts pressure on women of all ages, for whom the expectation of providing intergenerational support is high.[271]

— The links between migration, female-headed households, feminization of poverty in rural areas and access to health services need to be better explored. In particular, the specific health needs of migrant women and women left behind by migrant partners should be addressed.

The needs of health services (meeting the health needs of women):[272]

— Health care providers are often ill equipped to understand and address the causes and manifestations of practices such as gender biased sex selection and female genital mutilation; it is therefore crucial to increase their knowledge, competences and skills in detecting and preventing these practices without further discriminating against or stigmatizing women.

— Women's risk of contracting NCDs may be increased by health system biases: while cardiovascular disease is the major cause of death for women in the European Region, it is still perceived as a men's health issue. The risk to women is often underestimated owing to the perception that they are physiologically protected against it. While women are indeed at lower risk during their fertile years, protection fades after menopause, when risk increases. Assessment and management of cardiovascular risk in women often ignores factors that are particularly important, such as diabetes, obesity, physical inactivity and smoking.

— Despite increased inclusion of women in clinical trials, participation is especially low in studies in which safety, safe dosage range and side effects are determined. This results in a lack of awareness among health care professionals about the importance of sex-specific differences in disease manifestation and response to treatment throughout the life-course, which can cause problems in diagnosis and treatment, including delays in diagnosing women in the early stages of coronary disease because the symptoms seem atypical.

— Services need to be aware that women are also 1.5 times more likely than men to develop adverse reactions to prescription drugs.

— The internationalization of long-term care has brought growing staff migration, mostly involving women.

— Developments of women only services as well as the implementation of gender-specific approaches in routine care are underway and need to be evaluated, amended and expanded. Training as well as research requirements are numerous and urgent.[273]

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270 World Health Organisation. (2014). *Burden of disease from household air pollution for 2012*. Geneva. Retrieved from: http://www.who.int/phe/health_topics/outdoorair/databases/HAP_BoD_results_March2014.pdf?ua=1

271 World Health Organisation. (2015). *Beyond the mortality advantage: investigating women's health in Europe*.

272 *Ibid.*

273 Amering, M. (2017) 'The needs of women users of mental health services and their families'. *European Psychiatry*. 41(Supplement):8-9. Retrieved from: https://www.europsy-journal.com/article/S0924-9338(17)30082-2/abstract

Barriers to accessing services

International research has found that some barriers to care are gender specific. According to the WHO[274], some of the key sociocultural factors that prevent women and girls benefiting from quality health services and attaining the best possible level of health include:

— Unequal power relationships between men and women;

— An exclusive focus on women's reproductive roles; and

— Potential or actual experience of physical, sexual and emotional violence.

Poverty can also be an important barrier to positive health outcomes for both men and women, but it tends to disproportionality impact women and girls' health.

3.1.2 National literature on women's engagement with health services

In Ireland (just as in other jurisdictions) health care utilisation depends on many factors that relate both to the health care system and to the characteristics of individual patients. In a time of social and economic transition, characterised by increased life expectancy, population ageing, changing expectations and the re-structuring of health services, it is important to be able to disentangle the complex patterns and drivers of health service use[275].

Ireland also has a complex set of entitlements to health care. At the end of Sept 2018, 1,578,015 individuals (approx. 33% of the 2016 Census of population) had a medical card, while 500,234 individuals (approx. 10.5% of the 2016 Census of population) had a GP visit card.[276] This means that 67% of the population were paying some level of out of pocket costs for primary and secondary care services with '*the price faced by users a strong determinant of health care utilisation*' (Introduction Section).[277] According to Ma and Nolan (2017)[278] this '*use of direct out-of-pocket payments to finance general practitioner (GP) care by the majority is unusual in a European context*'.

Research using the Irish sample of the EU-Statistics on Income and Living Conditions survey (EU-SILC) found that almost four per cent of survey respondents reported an unmet need for medical care.

Overall, women, lower income groups, those with poorer health status and those without a medical card or private insurance were more likely to report an unmet healthcare need.

The majority of those reporting an unmet need noted that their unmet healthcare need was due to affordability issues (59 per cent) or waiting lists (25 per cent).[279] The review estimated that unmet need due to cost was likely to reflect the high out-of-pocket cost for primary care; while unmet need due to waiting lists reflected the relatively long waits for hospital care in the public system.

Data on individual's engagement with the health service is collected in a variety of ways. The largest national, continuous data source on utilisation of health services is however the Hospital In-Patient Enquiry (HIPE). Unfortunately, this has not been examined from the point of view of gender differentials in utilisation patterns. This lack of this type of examination acts as a barrier to understanding women's use of health services and is a limitation in relation to the development of good Irish health research.

274 World Health Organisation. (2008). *Women's Health*. Retrieved from: https://www.who.int/topics/womens_health/en/

275 McNamara, A., Normand, C., and Whelan, B. (2013) *Patterns and Determinants of Health Care Utilisation in Ireland*. The Irish Longitudinal Study on Ageing, TCD, Dublin. Retrieved from: https://tilda.tcd.ie/publications/reports/pdf/Report_HealthcareUtilisation.pdf

276 Department of Health. (2018). *Health in Ireland Key Trends 2018*. Retrieved from: https://health.gov.ie/wp-content/uploads/2018/12/Key-Health-Trends-2018.pdf

277 McNamara, A., Normand, C., and Whelan, B. (2013) *Patterns and Determinants of Health Care Utilisation in Ireland*.

278 Ma, Y., and Nolan, A. (2017). 'Public Healthcare Entitlements and Healthcare Utilisation among the Older Population in Ireland.' *Health Economics*. 11:1412-1428 Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/27696689

279 Connolly, S. and Wren, M.A. (2017) 'Unmet healthcare needs in Ireland: Analysis using the EU-SILC survey'. *Health Policy*. 121(4):434-441. Retrieved from: https://www.esri.ie/system/files?file=media/file-uploads/2017-06/RB20170301.pdf

GP Visits[280]

Nationally, the Healthy Ireland Survey 2018 found that women (79%) are more likely to have visited a GP than men (68%) with an average of 3.8 visits per person among all aged 15 and older. This average includes those who have not visited a GP. Older age groups are more likely to have visited a GP than those who are younger (94% of those aged 75 and older; 64% of those aged 15 to 24). Individuals with a full medical card or indeed a GP visit card are more likely to visit their GP than those without a card. According to the Healthy Ireland 2018 survey, those with a full medical card visited their GP an average of 6.2 times in the previous 12 months compared with 3.6 visits for those with a GP visit card and 2.4 visits for those with neither card (p. 21).

Those aged 75 and older have on average 6.4 visits per year, compared with an average of 2.5 visits for those aged 15 to 24. 8% of those surveyed have used a GP out-of-hours service during the last 12 months. TILDA found little difference in utilisation between the over 50's male and female participants in its study. Earlier work also did not find consistent gender differences in patterns of utilisation of health services, other than that women who had recently had a birth caused female utilisation rates to be sharply higher than men's in the mid-adult age ranges.

Little difference exists between women from deprived areas and women from affluent areas in relation to GP visits. See Table 3.1 for details.

Hospital admissions/Emergency Departments

The Healthy Ireland Survey 2018 found that 12% of those surveyed had been admitted to hospital in the past 12 months, 9% to a public hospital and 3% to a private hospital with women (12%) marginally more likely to be admitted than men (11%). Among those aged under 45, women are more likely to be admitted to hospital than men (12% and 7% respectively). Usage of Emergency Departments in public hospitals is highest among those aged 15 to 24 and 75 and older (14% and 13% respectively). Lifetime visits to emergency Departments are higher among men (75%) than women (66%).

Visits to a Dentist

According to the 2018 Healthy Ireland Survey, women are more likely than men to have visited a dentist in the past 12 months (53% and 42% respectively).

Prescriptions

39% of those surveyed as part of the 2017 Healthy Ireland Survey were prescribed an antibiotic in the past 12 months, with prescriptions more prevalent among women (44%) than men (33%). Women in all age groups were found to be more likely to be prescribed an antibiotic than men. The gap was widest among those aged 75 and older (women: 56%, men: 40%).

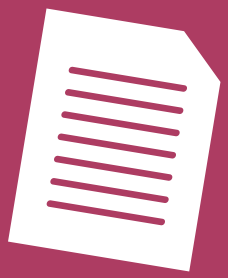
Table 3.1 Proportion of women visiting a GP in the past 12 months (by age and deprivation)

Age	15-24	25-34	35-44	45-54	55-64	65-74	75+
Women from Deprived areas	72	77	71	75	82	91	96
Women from Affluent areas	70	74	73	76	79	91	96

Source: Ipsos MRBI and Department of Health. (2018). Healthy Ireland Survey 2018 Summary of Findings. Department of Health: Dublin. Retrieved from: https://health.gov.ie/wp-content/uploads/2018/10/Healthy-Ireland-Survey-2018.pdf p 22

280 Ipsos MRBI and Department of Health. (2018). *Healthy Ireland Survey 2018 Summary of Findings.*

Section 4 - Health Policies and Services Relevant to Women's Health



4.1 Relevant international women-specific health policies, services and initiatives

At international level, the UN's *Global Strategy For Women's, Children's And Adolescents' Health 2016-2030* aims to achieve the highest attainable standard of health for all women, children and adolescents, transform the future and ensure that every new-born, mother and child not only survives, but thrives.

At European level, the World Health Organisation (WHO) has devised the *Strategy on women's health and well-being in the WHO European Region* [281]. The strategy has four areas for action:

- Strengthening governance for women's health and well-being, with women at the centre;
- Eliminating discriminatory values, norms and practices that affect the health and well-being of girls and women;
- Tackling the impact of gender and social, economic, cultural and environmental determinants on women's health and well-being; and
- Improving health system responses to women's health and well-being.

It is guided by the principles of:

- A human rights-based approach to women's health;
- The recognition that women are not a homogenous group; and
- The adoption of a whole of government approach to promoting gender equality.

4.2 Current women-specific health policies, services and initiatives in Ireland

There are a small number of women specific health policies, services and initiatives in Ireland. See Table 4.1 for an overview of some of these policies and initiatives. These include:

Table 4.1 Women-specific health policies, services and initiatives

1.	*The National Maternity Strategy 2016-2026 Creating a Better Future Together*[282]
2.	*The General Scheme of the Assisted Human Reproduction (AHR) Bill 2017*[283] (this has a specific focus within it on women)
3.	*Breastfeeding in a Healthy Ireland: Health Service Breastfeeding Action Plan 2016-2020*[284]
4.	The *HSE Women's Health Project* operates sexual health clinic services and outreach support to women/trans women involved in sex industry[285].

281 World Health Organisation Europe. (2016). *Strategy on women's health and well-being in the WHO European Region.*

282 Department of Health (2016) *The National Maternity Strategy 2016-2026: Creating a Better Future Together.*

283 Department of Health, Healthy Ireland. (2017). *General Scheme of the Assisted Human Reproduction (AHR) Bill 2017.*

284 Health Service Executive, Healthy Ireland, Breasfeeding.ie. (2016). *Breastfeeding in a Healthy Ireland: Health Service Breastfeeding Action Plan 2016-2020.*

285 Health Service Executive. (2017). *Women's Health Project.* Retrieved from: https://www.hse.ie/eng/services/list/5/sexhealth/whp/

1 – The National Maternity Strategy 2016-2026: Creating a Better Future Together[286]

This strategy produced by the Department of Health in 2016, which is the first of its kind, endorses a health and wellbeing approach which seeks to support and empower mothers and families to improve their own health and wellbeing as a strategic priority, in addition to access to safe, high quality woman centred maternity care, and facilitation of a woman's choice of care pathway.

Implementation of the Strategy is led by the *HSE National Women and Infants Health Programme* (NWIHP). NWIHP developed a detailed Implementation Plan in 2017 with 77 Actions under the four strategic priorities. The Implementation of the plan is overseen by the National Director of the NWIHP and a steering group. A maternity forum has been created to engage with partners in the voluntary / community sector. The *National Strategy for Women and Girls* supports the implementation of the *National Maternity Strategy 2016-2026*[287] in Action 2.19.

2 – The General Scheme of the Assisted Human Reproduction (AHR) Bill 2017[288]

This bill seeks to provide for legal regulation of AHR services to safeguard the interests of women, couples, children and healthcare professionals. The development of this regulatory framework will also support the state to fulfil its commitment to provide publicly-funded access to AHR.

3 – Breastfeeding in a Healthy Ireland: Health Service Breastfeeding Action Plan 2016-2020[289]

The promotion, support and protection of breastfeeding is a key element of the *HSE Healthy Childhood Policy Priority Programme* and the *Nurture – Infant Health and Wellbeing Programme*. This Plan sets out the priority areas to be addressed over the next five years to improve breastfeeding supports, to enable more mothers in Ireland to breastfeed and to improve health outcomes for mothers and children in Ireland.

The Action plan outlines the actions needed to enhance breastfeeding rates and provide skilled support to mothers, through maternity services, hospitals, primary care services and in partnership with voluntary breastfeeding organisations and other stakeholders.

4 – HSE Women's Health Project

This project is run by the HSE Women's Health Service (WHS) and the Anti-Human Trafficking Team (AHTT) is a statutory service. The WHS operates sexual health clinic services and outreach support to women/trans women involved in sex industry while the AHTT has responsibility for care planning for both female/male victims of trafficking in all areas of exploitation.

286 Department of Health (2016) *The National Maternity Strategy 2016-2026: Creating a Better Future Together.*

287 *Ibid.*

288 Department of Health, Healthy Ireland. (2017). *General Scheme of the Assisted Human Reproduction (AHR) Bill 2017.* Retrieved from: https://health.gov.ie/wp-content/uploads/2017/10/AHR-general-scheme-with-cover.pdf

289 Health Service Executive, Healthy Ireland, Breasfeeding.ie. (2016). *Breastfeeding in a Healthy Ireland: Health Service Breastfeeding Action Plan 2016-2020.* Retrieved from: https://www.hse.ie/eng/about/who/healthwellbeing/healthy-ireland/publications/breastfeeding-in-a-healthy-ireland.pdf

4.3 Health policies, services and initiatives that are relevant to women

There are a much larger number of health policies that while they do not have a specific gender focus are very pertinent to meeting the health needs of women. See Table 4.2 for details.

Table 4.2 Health policies, services and initiatives that are relevant to women

1. *Connecting for Life- Ireland's National Strategy to Reduce Suicide 2015-2020*[290]
2. *Healthy Ireland Framework*[291]
3. *National Cancer Strategy 2017 – 2026*[292] (This has a specific focus within it on women)
4. *National Sexual Health Strategy (2015-2020)*[293]
5. *Obesity Policy and Action Plan: A Healthy Weight for Ireland (2016- 2025)*[294]
6. *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025*[295]
7. *Sláintecare Implementation Strategy 2018*[296]
8. *The Irish National Dementia Strategy*[297]
9. *Tobacco Free Ireland (2013 - 2025)*[298]

1 – Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015-2020[299]

Connecting for Life is Ireland's national strategy to reduce suicide 2015-2020. It sets out a vision of an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing. The strategy follows on from *Reach Out: National Strategy for Action on Suicide Prevention 2005-2014*. *Connecting for Life* emphasises different policy approaches aimed at:

- Improving the Overall Health and Wellbeing of the Population;
- Reaching Individuals and Groups Vulnerable to Suicide; and
- Providing Targeted Treatment and Programmes for Groups Most Vulnerable.

The strategy identifies the priority demographic cohorts, in terms of vulnerability to suicide, as middle-aged men and women, young people and economically disadvantaged people. There are no actions specific to women, but sex/gender are included in annual indicators for principal outcomes.[300]

290 Department of Health, Healthy Ireland, National Office of Suicide *Prevention, HSE. (2015). Connecting for Life: Ireland's National Strategy to* Reduce Suicide 2015-2020.

291 *Government of Ireland. (2013). Healthy Ireland – a framework* for improved health and *wellbeing.*

292 *Department of Health.* (2017). National Cancer Strategy (2017-2025).

293 Department of Health, Healthy Ireland. (2015). National Sexual Health Strategy (2015-2020). Retrieved from: https://health.gov.ie/wp-content/uploads/2015/10/National-Sexual-Health-Strategy.pdf

294 Department of Health, Healthy Ireland. (2016). Obesity Policy and Action Plan: A Healthy Weight for Ireland (2016- 2025). Retrieved from: https://health.gov.ie/wp-content/uploads/2016/09/A-Healthy-Weight-for-Ireland-Obesity-Policy-and-Action-Plan-2016-2025.pdf

295 Department of Health, Healthy Ireland. (2017). *Reducing Harm, Supporting Recovery: A Health-Led Response to* Drug *and Alcohol Use in Ireland 2017-2025.*

296 Department of Health. (2018). *Sláintecare Implementation Strategy.* Government of Ireland. Retrieved from: https://www.gov.ie/en/campaigns/slaintecare-implementation-strategy/

297 Department of Health (2014). *Irish National* Dementia Strategy. Retrieved from: https://health.gov.ie/wp-content/uploads/2014/12/30115-National-Dementia-Strategy-Eng.pdf

298 Department of Health, Healthy Ireland. (2013). *Tobacco Free Ireland (2013-2025).* Retrieved from: https://health.gov.ie/wp-content/uploads/2014/03/TobaccoFreeIreland.pdf

299 Department of Health, Healthy Ireland, National Office of Suicide Prevention, HSE. (2015). *Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015-2020.*

300 These indicators include standardised annual incidence of intentional self-harm deaths ('definite suicide') and standardised annual A&E self-harm rates: Proportion of persons readmitted to A&E following self-harm in subsequent 12 months overall and Proportion of persons admitted to A&E following self-harm who have had previous such admissions (all of these are provided in overall terms and by each of the following comparison groups: gender, age group, socio-economic status.

2 – Healthy Ireland Framework[301]

Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025 which was launched in 2013 sets out the vision for a country where all people can enjoy health & wellbeing and that wellbeing is valued, supported and the responsibility of all. It has a whole-of-government and whole-of-society approach to improving health and wellbeing, with a focus on prevention, reducing health inequalities and keeping people healthier for longer. It also seeks to address the many social and environmental determinants that can impact on health and wellbeing, such as education and employment. The Framework is an "umbrella" policy, covering a range of other subsequently published policies, structures and initiatives as follows. See Table 4.3 for details.

Table 4.3 Health policies under the Healthy Ireland Framework that are relevant to women

A Healthy Weight for Ireland; Obesity Policy and Action Plan, 2016-2025[302]
Get Ireland Active! National Physical Activity Plan for Ireland, 2016-2020[303]
National Sexual Health Strategy, 2015-2020[304]
Healthy Ireland Fund[305]
Healthy Ireland Survey[306]
National Nutrition Standards for the School Meals Scheme[307]
Healthy Workplace Framework[308]
Healthy Ireland Outcomes Framework[309]
Warmth and Wellbeing pilot scheme[310]
Healthy Cities and Counties[311]
Healthy Campuses
Public information campaigns; Healthy Ireland Campaign 2018[312], *START campaign*[313].

301 Government of Ireland. (2013). *Healthy Ireland – a framework for improved health and wellbeing.*

302 Department of Health, Healthy Ireland. (2016) Obesity Policy and Action Plan: A Healthy Weight for Ireland (2016- 2025).

303 Department of Health, Department of Transport, Tourism and Sport, Healthy Ireland. (2015). *Get Ireland Active! National Physical Activity Plan for Ireland, 2016-2020.* Retrieved from: https://www.getirelandactive.ie/Professionals/National-PA-Plan.pdf

304 Department of Health, Healthy Ireland. (2015). *National Sexual Health S*trategy (2015-2020).

305 Department of Health, Healthy Ireland. Healthy Ireland Fund. https://www.pobal.ie/programmes/healthy-ireland-fund/

306 Department of Health, Healthy Ireland. (2014). Healthy Ireland Survey. Retrieved from: https://www.gov.ie/en/collection/231c02-healthy-ireland-survey-wave/

307 Department of Health, Department of Education and Skills, Department of Employment Affairs and Social Protection. (2017). *National Nutrition Standards for the School Mea*ls Scheme. Retrieved from: https://www.welfare.ie/en/downloads/NutritionalStandardsForSchoolMeals.pdf

308 Department of Health, Healthy Ireland. (2019). Healthy *W*orkplace Framework. Retrieved from: https://www.gov.ie/en/publication/445a4a-healthy-workplace-framework/

309 Healthy Ireland. (2018). *Healthy Ireland Outcome*s Framework 2018. Retrieved from: https://health.gov.ie/wp-content/uploads/2018/12/Healthy-Ireland-Outcomes-Framework-2018.pdf

310 Department of Communications, Climate Action and Environment, Department of Health, HSE. (2011). *Warmth and W*ellbeing Pilot Scheme. SEAI. https://www.seai.ie/grants/home-energy-grants/free-upgrades-for-eligible-homes/warmth-and-wellbeing/

311 Department of Health, Healthy Ireland. (2019). *Healthy Counties and Cities.* Retrieved from: https://www.gov.ie/en/publication/d4fa22-healthy-counties-and-cities/

312 Department of Healthy (2018) *Healthy Ireland Campaign.* Retrieved from: https://www.gov.ie/en/campaigns/healthy-ireland/?referrer=/

313 Department of Health, Safefood. (2019). *START Campaign.* Retrieved from: https://www.safefood.eu/START/Welcome.aspx

The vision of a Healthy Ireland, is a place '*where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued, and supported at every level of society and is everyone's responsibility*' (p 5)[314]. It will achieve its vision by increasing the proportion of people who are healthy at all stages of life; reducing health inequalities; protecting from threats to health and wellbeing and creating environments to support a healthy Ireland. The Framework recognises the impact of social determinants of health and inequities in health. Particular risks to health for women including higher prevalence of smoking and self-harm, inactivity and weight gain were identified.

Healthy Ireland in the Health Services National Implementation Plan (HSE, 2015)[315] identified policy priority areas including:

- Tobacco Control;
- Healthy Eating and Active Living (HEAL);
- Sexual Health;
- Mental Health and Wellbeing;
- Alcohol;
- Healthy Childhood; and
- Positive Ageing.

3 – National Cancer Strategy 2017 – 2026[316]

The *National Cancer Strategy 2017 – 2026* seeks to meet the needs of cancer patients in Ireland over the next decade. It also seeks to reduce the incidence of cancer through preventative measures and improve outcomes by providing screening and assisting in early diagnosis. In addition, it outlines actions in relation to provision of optimal care; maximising patient involvement and quality of life; enabling and ensuring change through governance, workforce planning; and measuring performance, quality & outcomes. It has a focus on the specific needs of women dealing with cancer and the cancers that particularly affect women.

Women specific objectives/actions within the plan include: Ensuring that Rapid Access Clinic and Symptomatic Breast Disease Clinic targets are met; Maintaining target uptake rate for BreastCheck; and Achieving target coverage for Cervical Check.

4 – National Sexual Health Strategy (2015-2020)

The *National Sexual Health Strategy 2015-2020*[317] takes a life-course approach. It aims to improve sexual health and wellbeing and reduce negative sexual health outcomes by ensuring that everyone living in Ireland has access to high quality sexual health information, education and services throughout their lives.

The Strategy is set out under three overarching goals:

- Goal 1 – Sexual health promotion, education and prevention: Everyone living in Ireland will receive comprehensive and age-appropriate sexual health education and/or information and will have access to appropriate prevention and promotion services;

314 Government of Ireland. (2013). *Healthy Ireland – a framework for improved health and wellbeing.*

315 Health Service Executive, Healthy Ireland. (2015). *Healthy Ireland in the Health Services National Implementation Plan 2015 – 2017.* Retrieved from: https://www.hse.ie/eng/about/who/healthwellbeing/healthy-ireland/healthy-ireland-in-the-health-services-implementation-plan-2015-2017.pdf

316 Department of Health. (2017). *National Cancer Strategy (2017-2025).*

317 Department of Health, Healthy Ireland. (2015). *National Sexual Health Strategy (2015-2020).*

— Goal 2 – Sexual health services: Equitable, accessible and high-quality sexual health services that are targeted and tailored to need, will be available to everyone;

— Goal 3 – Sexual health intelligence: Robust and high-quality sexual health information will be generated to underpin policy, practice, service planning and strategic monitoring.

Women specific actions within the Strategy relate to the HPV vaccine and crisis pregnancy as follows:

— Provide accessible crisis pregnancy supports, STI/HIV testing and other supports and counselling for all sexually active adults (Action 3.14);

— Maintain and promote the HPV vaccination programme for adolescent girls in line with national immunisation guidelines (Action 3.24);

— Assess the effectiveness (including cost effectiveness) of extending the HPV vaccine to other groups and develop appropriate guidelines (Action 3.25);

— Continue to build on the existing evidence base to understand emerging trends relating to crisis pregnancy and sexual health and undertake new research initiatives to address knowledge gaps. (Action 5.1);

— Systematically monitor crisis pregnancy indicators and emergent trends related to crisis pregnancy nationally and internationally (Action 5.12).

Interestingly, no reference is made to menopause within this Strategy despite the fact that this is intimately linked to the sexual health of women as they age.

5 – Obesity Policy and Action Plan: A Healthy Weight for Ireland[318]

The *Obesity Policy and Action Plan: A Healthy Weight for Ireland 2016- 2025* sets out 10 Steps forward to achieving a healthy weight for Ireland. Plan implementation is supported by a number of cross-sectoral Implementation Groups including representatives of a range of relevant Government Departments and agencies, and academia. Specific actions for women and girls include: review and implement the HSE–ICGP weight management algorithms for children and adults and their healthy weight management guidelines before, during and after pregnancy (Step Action 6.6); implementation and monitoring of the forthcoming breastfeeding action plan (implementation will require investment in whole-time equivalents, Action 6.11); and the development of programmes to improve healthy eating for mothers, preconception, and for infants and children up to two years across acute and primary care settings in addition to enhanced training, provision of supports to mothers (Action 9.3).

318 Department of Health, Healthy Ireland. (2016). *Obesity Policy and Action Plan: A Healthy Weight for Ireland (2016- 2025).*

6 – Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025[319]

This strategy sets out the Government's response to addressing the harm caused by substance misuse in our society over the next eight years. It identifies a set of key actions to be delivered between 2017 and 2020, and provides an opportunity for the development of further actions from 2021 to 2024 to address needs that may emerge later on in the lifetime of the strategy. It does not examine the issue of harm from a gendered perspective. Women specific actions within the plan include: expanding addiction services for pregnant and postnatal women (2.1.20); responding to the needs of women who are using drugs and/or alcohol in a harmful manner (2.1.21); and improve the range of problem substance use services and rehabilitation supports for people with high support needs who are homeless (2.1.25) in line with *Rebuilding Ireland* (the development and provision of gender and culturally specific step down services, particularly housing, for women and their children progressing from residential rehabilitation treatment who are at risk of discharge into homelessness is sub-action 2 of Action 2.1.25).

7 – Sláintecare[320]

Sláintecare is a vision for a new health service in Ireland detailed in the report from the Oireachtas Committee on the Future of Healthcare published on 30 May 2017.

It is the first time there has been political consensus on a health reform plan for the next ten years and cross-party support on delivering a universal health system in Ireland[321].

See Table 4.4 for details of the main elements of *Sláintecare*.

Table 4.4 Main elements of Sláintecare

Entitlement for all Irish residents to all health and social care.
No charge to access GP, primary or hospital care and reduced charges for drugs.
Care provided at the lowest level of complexity, often outside of hospital, in an integrated way.
eHealth as a key tool for developing a universal health system and integrated care.
Strong focus on public health and health promotion.
Waiting times guarantees with a maximum: (4 hour wait time for Emergency Departments, 10 days for a diagnostics test, 10 weeks for an outpatient appointment & 12 weeks for an inpatient procedure).
Private care phased out of public hospitals.
Significant expansion of access to diagnostics in the community.
Earlier and better access to mental health services.
An expanded workforce including allied health professionals, nurses and doctors. The importance of addressing recruitment and retention issues of all healthcare staff and the development of integrated workforce planning is emphasised in the report.
A new HSE Board, to be established promptly.
Accountability and clinical governance, to be legislated for.
A National Health Fund set up to ring-fence funding for a transitional fund and expansion of entitlements.

The report details specific costings for the expansion of entitlements and system development and timelines for implementation, recommending the establishment of an Implementation Office to drive the reform. It is for a ten-year period but many of the key actions will be implemented during the first six years. The plan specifically highlighted the under-resourcing of community mental health services and reliance on medication over psychological and counselling services.

319 Department of Health, Healthy Ireland. (2017). *Reducing Harm, Supporting Recovery: A Health-Led Response to Drug and Alcohol Use in Ireland 2017-2025*.

320 Department of Health. (2018). *Sláintecare Implementation Strategy*.

321 Centre for Health Policy and Management, Trinity College Dublin. (2017). Sláintecare – a pathway to universal healthcare in Ireland. Retrieved from: https://www.tcd.ie/medicine/health_policy_management/assets/pdf/policy-brief-on-the-slaintecare-report-19122017.pdf

If implemented, Sláintecare will develop single-tier access to healthcare services, based on need not ability to pay. A greater proportion of the Health Budget would be spent on mental health services, with significant investment in the community supports and therapeutic interventions sought by women.

NWCI make the case that the *Sláintecare* universal care package for women should include '*entitlement to maternity services, contraception, and infertility services. Additional resources must be available for GPs, women's healthcare providers and Obstetricians through the Maternity & Infant Scheme for the provision of abortion care.*'[322]

8 – The Irish National Dementia Strategy[323]

This strategy was produced by the Department of Health in 2014. The aim of the Strategy is to improve dementia care so that people with dementia can live well for as long as possible, can ultimately die with comfort and dignity, and can have services and supports delivered in the best way possible. The strategy is developed using a population-based approach with no reference to the gender dimensions of dementia, despite the fact that women are more likely to suffer with dementia later in life.[324] This is something that could be addressed in the WHAP.

9 – Tobacco Free Ireland[325]

The *Tobacco Free Ireland (TFI) Policy* was developed by the Department of Health in 2013. This government strategy (2013 - 2025) has a number of cross governmental actions which are based on the six national standards:

- Monitoring of tobacco use and prevention policies;
- Protecting people from second-hand smoke;
- Offering help to people who want to quit;
- Warning of the dangers of tobacco;
- Enforcing bans on advertising, promotion and sponsorship;
- Raising taxes on tobacco.

Tobacco Free Ireland seeks to de-normalise tobacco within Irish society, reduce initiation rates, assist smokers to quit, protect non-smokers, especially children, from the effects of second-hand smoke, by building a stable policy and legislative framework. The Tobacco Free Ireland Programme was one of the first priority area programmes to be established. The main aim of the new programme is to take responsibility for and systematically drive policy priorities in the area of tobacco control. The policy contains the following specific actions: '*Undertake targeted approaches for specific groups, particularly young people, lower socioeconomic groups, pregnant and post-partum women and patients with cardiac and respiratory disorders*' (9.9). This also includes provision for '*Specialist smoking cessation staff trained to deal with specific groups. Referral pathways to support these groups via a "one-stop" model being developed'.*

4.4 Other policies that are relevant to the health of women

There are a variety of other policies and strategies that impact on women's health and well-being.

See Table 4.5 for details.

322 National Women's Council of Ireland. (2018). *Pre-Budget Submission 2019: Investing in Women's Futures.* Retrieved from: https://www.nwci.ie/images/uploads/NWCI_PBS_2019-FINAL.pdf

323 Department of Health (2014). *Irish National Dementia Strategy.*

324 Kumar, P., Jethwa, R., Roycroft, G., Wilson, R. (Eds). (2016). *Growing older in the UK.* London: British Medical Association. Retrieved from: https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/ healthy-ageing, p.4-5

325 Department of Health, Healthy Ireland. (2013). *Tobacco Free Ireland (2013-2025).*

Table 4.5 Other policies and strategies that impact on women's health and well-being

1. *National Strategy for Women and Girls 2017-2020: creating a better society for all*[326]
2. *Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People (2014-2020)*[327]
3. *First 5 Strategy: A Whole-of-Government Strategy for Babies, Young Children and their Families 2019-2028*[328]
4. *National Action Plan on Bullying*[329]
5. *National Carers' Strategy - Recognised, Supported, Empowered*[330]
6. *National Disability Inclusion Strategy (2017-2021)*[331]
7. *National Physical Activity Plan for Ireland: Get Ireland Active*[332]
8. *National Sports Policy (2018-2027)*[333]
9. *National Traveller and Roma Inclusion Strategy (2017-2021)*[334]
10. *Positive Ageing- Starts Now! The National Positive Ageing Strategy*[335]
11. *Second National Action Plan to Prevent and Combat Trafficking in Human Beings in Ireland*[336]

1 – The National Strategy for Women and Girls 2017-2020: creating a better society for all[337]

The current *National Strategy for Women and Girls 2017-2020: creating a better society for all* was launched by the Department of Justice and Equality in April 2017. It has 6 high level objectives. Objective Two of the Strategy is focused on Advancing the Physical and Mental Health and Wellbeing of Women and Girls, while Objective 5 is focused on combating violence against women.

The outcome areas of this National Strategy actions 2.2 – 2.29 include physical activity; social & emotional wellbeing; smoking; drug and alcohol use; breastfeeding; nutrition; mental health; sexual health; maternity care and inclusion. Current and on-going national strategies, action plans and programmes are supported. There are also actions addressing the health needs of target population groups through existing and forthcoming strategies, including older women; Traveller & Roma women; women & girls affected by FGM; LGBTQI+ people; and women with disabilities.

Action 2.1 commits the Department of Health, HSE and the National Women's Council of Ireland (NWCI) to develop a *Women's Health Action Plan* (WHAP):

326 Department of Justice and Equality. (2017). National Strategy for Women and Girls 2017-2020: creating a better society for all. Retrieved from: http://justice.ie/en/JELR/National_Strategy_for_Women_and_Girls_2017_-_2020.pdf/Files/National_Strategy_for_Women_and_Girls_2017_-_2020.pdf

327 Department of Children and Youth Affairs. (2014). *Better Outcomes, Brighter Futures: The National P*olicy Framework for Children and Young People (2014-2020). Dublin: The Stationary Office Retrieved from: https://www.dcya.gov.ie/documents/cypp_framework/BetterOutcomesBetterFutureReport.pdf

328 Government of Ireland. (2018). *First 5 Strategy: A Whole-of-Government Strategy for Babies, Young Children and their Fam*ilies 2019-2028. Retrieved from: https://www.dcya.gov.ie/documents/earlyyears/19112018_4966_DCYA_EarlyYears_Booklet_A4_v22_WEB.pdf

329 Department of Education and Skills. (2013). National Action Plan on Bullying. Retrieved from: https://www.education.ie/en/Publications/Education-Reports/Action-Plan-On-Bullying-2013.pdf

330 Department of Health. (2012). *National Carers' Strategy* - Recognised, Supported, Empowered. Retrieved from: http://familycarers.ie/wp-content/uploads/2016/01/The-National-Carers-Strategy.pdf

331 Department of Justice and Equality. (2017). *Nat*ional Disability Inclusion Strategy (2017-2021). Retrieved from: http://www.justice.ie/en/JELR/dept-justice-ndi-inclusion-stratgey-booklet.pdf/Files/dept-justice-ndi-inclusion-stratgey-booklet.pdf

332 Department of Health, Department of Transport, Tourism and Sport, Healthy Ireland. (2015). *Get Ireland Active! National Physical Activity Plan for* Ireland, 2016-2020. Retrieved from: https://www.getirelandactive.ie/Professionals/National-PA-Plan.pdf

333 Department of Transport, Tourism and Sport. (2017). National Sports Policy (2018-2027). Retrieved from: http://www.dttas.ie/sites/default/files/publications/sport/english/national-sports-policy-2018-2027/national-sports-policy-2018.pdf

334 Department of Justice and Equality. (2017). *National Traveller and Roma Inclusion Strategy 2017-21*. Retrieved from: http://www.justice.ie/en/JELR/National%20Traveller%20and%20Roma%20Inclusion%20Strategy,%202017-2021.pdf/Files/National%20Traveller%20and%20Roma%20Inclusion%20Strategy,%202017-2021.pdf

335 Department of Health. (2013). Positive Ageing- Starts Now! The National Positive Ageing Strategy. Retrieved from: https://health.gov.ie/wp-content/uploads/2014/03/National_Positive_Ageing_Strategy_English.pdf

336 Department of Justice and Equality. (2016). *Second National Action Plan to Prevent and Combat Trafficking in Human Beings in Ireland.* Retrieved from: http://www.justice.ie/en/JELR/2nd_National_Action_Plan_to_Prevent_and_Combat_Human_Trafficking_in_Ireland.pdf/Files/2nd_National_Action_Plan_to_Prevent_and_Combat_Human_Trafficking_in_Ireland.pdf

337 Department of Justice and Equality. (2017). *National Strategy for Women and Girls 2017-2020: creating a better society for all.*

'Strengthen the partnership work with the National Women's Council of Ireland in identifying and implementing key actions to address the particular physical and mental health needs of women and girls in order to advance the integration of their needs into existing and emerging health strategies, policies and programmes through an action plan for women's health'.

This new plan will only be the second Women's specific health plan. The previous plan *The Plan for Women's Health (1997-1999)* published in 1997, set out four main objectives for the health services in relation to women:

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

This plan was supported by the establishment of the Women's Health Council, as the relevant statutory advisory body. The Women's Health Council was integrated into the Department of Health and Children in 2009. It was particularly important in terms of its recognition that there are major demographic variations in health status particularly related to gender, age, and social class. The four objectives can all be seen to remain relevant to the current women's health agenda.

2 – Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People (2014-2020)[338]

Better Outcomes Brighter Futures: The national policy framework for children and young people 2014-2020 (DYCA, 2014) is a whole-of-Government approach to deliver on Transformational Goals and National Outcomes for children and young people. The policy framework provides commitment to advancing child health and supports. In relation to early years, it focuses on early healthy development prioritising under-2-year-olds, and commits to strengthening prenatal and antenatal supports, addressing maternal health and wellbeing, and raising breastfeeding rates in line with international norms. The Strategy contains actions and indicators in relation to: breastfeeding (Aim 1.1. Action 1); Mortality rates (by cause and age) (Aim 1.1. Action 6); Teenage Pregnancy (Aim 1.3 Action 12); and Positive Self-Perception (Aim 2.2 Action 21).

3 – First 5 Strategy: A Whole-of-Government Strategy for Babies, Young Children and their Families 2019-2028[339]

This strategy designed to support babies, young children and their families in the first five years of their life was launched in Autumn 2018. The strategy which will be operational for 10 years will provide:

- A broader range of options for parents to balance working and caring
- A new model of parenting support
- New developments in child health, including a dedicated child health workforce
- Reform of the Early Learning and Care (ELC) system, including a new funding model
- A package of measures to tackle early childhood poverty

Actions specific to women within the plan particularly relate to pregnant women and all women of reproductive age as follows:

338 Department of Children and Youth Affairs. (2014). *Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People (2014-2020)*

339 Government of Ireland. (2018). *First 5 Strategy: A Whole-of-Government Strategy for Babies, Young Children and their Families 2019-2028.*

— Continue progress towards the breastfeeding target rate set out in the *National Breastfeeding Action Plan* (i.e. annual 2% increase in breastfeeding duration rates over the period 2016– 2021). To meet this target, continue to support mothers to breastfeed through the PHN service, implement standardised breastfeeding policies and provide clinical specialist posts in both primary care and maternity hospitals as per the key actions of the National Breastfeeding Action Plan. Extensions to this target will be considered at the end of year three review of First 5 in 2021.

— Enhance weaning support to parents through the *National Healthy Childhood Programme*.

— Provide access to comprehensive family planning and reproductive healthcare services, including information and advice for people considering pregnancy and carry out a national information campaign to promote the importance of pre-conception health.

— Develop mechanisms to improve folic acid intake among all women of reproductive ages.

— Review the content and scope of Maternity and Infant Care Scheme, standardise the six-week post-natal check-up for the mother and the six-week check of the baby (as part of the Newborn Clinical Examination) and consider extending coverage of this Scheme to include to a pre-conception consultation and beyond six-week post-natal check-up of the mother.

— As resources allow, make the antenatal visit by the Public Health Nurse more widely available to expectant mothers in line with need.

— Increase the use of antenatal care in the first trimester, particularly among vulnerable groups.

— Increase uptake of vaccinations during pregnancy by promoting the influenza vaccine during pregnancy, raising awareness of the importance of the pertussis vaccine during pregnancy and exploring mechanisms to effect administration of the vaccine.

4 – National Action Plan on Bullying[340]

This Plan details all grounds for harassment under the Equal Status Acts should be listed in anti-bullying policies i.e. gender (including transgender), civil status, family status, sexual orientation, religion, age, disability, race and membership of the Traveller community.

5– National Carers' Strategy - Recognised, Supported, Empowered[341]

This strategy was published by the Department of Health in 2017. It sets the strategic direction for future policies, services and supports provided by Government Departments and agencies for carers. It details:

— Guiding Principles;

— Goals and Objectives Addressing Priority Areas (Income Support, Health, Information, Respite, Housing, Transport, Training, Employment, Children and Young People With Caring Responsibilities); and

— A Roadmap for Implementation containing 42 Actions to be achieved on a cost-neutral basis in the short to medium term.

In its profile of Irish Carers, the strategy identifies 64% of carers as women but does not contain actions specifically targeted at female carers.

6 – National Disability Inclusion Strategy (2017–2021)[342]

This strategy produced by the Department of Justice and Equality takes a whole of government approach to proving the lives of people with disabilities both in a practical sense, and also in creating the best possible opportunities for people with disabilities to fulfil their potential.

The Strategy comprises the following eight themes

— Equality and Choice

— Joined up policies and public services

— Education

340 Department of Education and Skills. (2013). *National Action Plan on Bullying*

341 Department of Health. (2012). *National Carers' Strategy - Recognised, Supported, Empowered*

342 Department of Justice and Equality. (2017). *National Disability Inclusion Strategy (2017-2021).*

— Employment

— Health and Wellbeing

— Person centered disability services

— Living in the community

— Transport and access to places

There are nine actions within the health and wellbeing section plan, with one specific reference to women with disabilities as follows: '*We will proof all new Government policies and programmes against their potential impact on women with disabilities. As a first step, consideration will be given to whether a new Impact Assessment should be developed to support this action, or whether the current (separate) Disability and Gender Impact Assessments are sufficient.*' See Table 4.6 for details of the nine actions.

Table 4.6 Health and well-being actions from the National Disability Strategy
We will continue to coordinate the implementation of the *Healthy Ireland Framework*
We will invest in the development of early intervention services which specifically target the mental health needs of infants, young children and their families.
We will develop the intellectual disability and mental health service capacity as set out in *A Vision for Change.*
We will examine the need to establish statutory, national advocacy services for children and adults with mental health difficulties in hospitals, day centres, training centres, clinics, and throughout the community, building on existing services.
We will ensure through targeted measures that health services provide care on an equal basis to people with mental health difficulties.
We will amend legislation under the review of the Mental Health Act 2001 to deal in a more complete and comprehensive manner with the operation of advance healthcare directives in the area of mental health in the longer term.
We will continue to develop services. In common with previous years, the *Health Service Executive's Service Plan 2017* emphasises recovery as central to quality, evidence–based and person-centered services.
We will further develop the capacity of mainstream Health Service Executive funded services to provide accessible services and information to people with disabilities.
We will develop policy advice for consideration by relevant Government Departments based on international research, to guide the development and implementation of a national programme for vocational rehabilitation, with due regard to the neuro-rehabilitation strategy and other medical rehabilitation programmes as appropriate.

7 – National Physical Activity Plan for Ireland: Get Ireland Active[343]

Get Ireland Active the *National Physical Activity Plan* includes eight actions areas, including a focus on getting children and young people more active. Plan implementation is supported by a number of cross-sectoral Implementation Groups including representatives of a range of relevant Government Departments and agencies, and academia. This plan does not contain any women specific actions but women specific actions are identified as an important element in the more recent National Sports Policy (see bullet 8 below), with co-ordinated implementation of both policies.

8 – National Sports Policy (2018-2017)[344]

'*Addressing women's participation at all levels in sport*' is identified as an '*important element*' of this policy. The policy also considers the issue of women in leadership positions including as National Governing Body Board members and CEOs. Actions with the plan that are specifically relevant to women's health include:

— The elimination of the active sport participation gradient between men and women. (This is a key performance indicator)

— The setting of gender diversity targets and development of equality action plans by National Governing Bodies with support provided for dedicated leadership training programmes for women including governance-related and technical training (coaching, refereeing and team management). Sport Ireland will monitor their progress in delivering on these and report annually. If sufficient progress is not being made, it will engage further with all stakeholders on the matter (Action 32).

This Policy also references a number of actions in the *National Strategy for Women and Girls* relating to enhancing women's visibility and participation (2.5, 3.5-3.7, 4.4) in sport. The Federation of Irish Sport's 20@20 *If she can't see it, she can't be it* campaign also supports women's participation in sport.

9 – National Traveller and Roma Inclusion Strategy (2017-2021)[345]

This strategy, launched by the Department of Justice and Equality in June 2017, contains 149 actions. Action 72 is focused on supporting '*Roma women to access maternal health services in a timely and appropriate manner*'. Other actions (97, 98 ,99 and 100) focus on supporting Traveller and Roma women to tackle disadvantage, while several actions (105, 107 and 108) are focused on removing the barriers that prevent Traveller and Roma women accessing domestic violence supports when they are needed. Specific actions include:

'Acknowledging the results of the National Roma Needs Assessment for Roma in Ireland, the HSE will support Roma women to access maternal health services in a timely and appropriate manner' (Action 72) and the action that 'All relevant Departments will resource the development and implementation of local Traveller and Roma women's forums/groups to provide support in health, education, training, employment and accommodation issues' (Action 99).

343 Department of Health, Department of Transport, Tourism and Sport, Healthy Ireland. (2015). *Get Ireland Active! National Physical Activity Plan for Ireland, 2016-2020.*

344 Department of Transport, Tourism and Sport. (2017). *National Sports Policy (2018-2027).*

345 Department of Justice and Equality. (2017). *National Traveller and Roma Inclusion Strategy 2017-21*

10 – Positive Ageing - Starts Now! The National Positive Aging Strategy (2013)[346]

The *National Positive Ageing Strategy* was published in April 2013. It is a high-level document outlining Ireland's vision for ageing and older people and the national goals and objectives required to promote positive ageing. The strategy has four goals. Goal 2 has a specific health focus to *'Support people as they age to maintain, improve or manage their physical and mental health and wellbeing'* (P19). This goal is underpinned by three objectives as follows (p20):

- Prevent and reduce disability, chronic disease and premature mortality as people age by supporting the development and implementation of policies to reduce associated lifestyle factors.
- Promote the development and delivery of a continuum of high-quality care services and supports that are responsive to the changing needs and preferences of people as they age and at end of life.
- Recognise and support the role of carers by implementing the *National Carers' Strategy* (2012).

The Strategy makes a reference to the *'differing needs of older women and men, in terms of life expectancy, employment, physical and mental health and caring roles and responsibilities are key considerations'* (p13) but does not expand on these differences to any great extent. It does however note that in relation to elder abuse 60% of the referrals were women and that some of the commitments in *Future Health: A Strategic Framework for Reform of the Health Service 2012-2015* are relevant to improving access to health services for older people, including Breast Check screening for 65-69-year-old women from 2014.

11 – Second National Action Plan to Prevent and Combat Trafficking in Human Beings in Ireland[347]

This plan produced by the Department of Justice and Equality in 2016 identifies seven goals as follows (p33):

- Prevent trafficking in human beings.
- Identify, assist, protect and support victims of trafficking in human beings. Ensure an effective criminal justice response.
- Ensure that Ireland's response to human trafficking complies with the requirements of a human rights-based approach and is gender-sensitive.
- Ensure effective co-ordination and co-operation between key actors, both nationally and internationally.
- Increase the level of knowledge of emerging trends in the trafficking of human beings.
- Continue to ensure an effective response to child trafficking.

The plan outlines 65 actions to combat this crime, primarily affecting women and young girls. It identifies that over the period 2009-2015 75% of trafficking victims were female.

346 Department of Health. (2013). *Positive Ageing- Starts Now! The National Positive Ageing Strategy*

347 Department of Justice and Equality. (2016). *Second National Action Plan to Prevent and Combat Trafficking in Human Beings in Ireland.*

4.5 Assessment of how Ireland's current health policy framework takes into account women's specific health needs

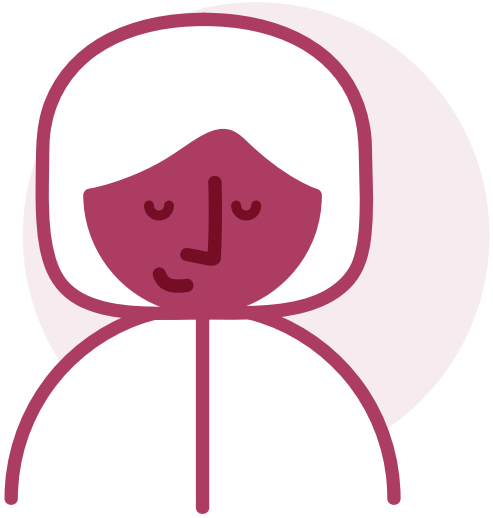
There are a variety of strategies and plans relating to, or incorporating women's health that government departments, the HSE, other state agencies and partners are committed to and many of these are referred to in the *National Strategy for Women and Girls 2017-2020.*

With the exception of the few strategies (The National Maternity Strategy 2016–2026, the National Cancer Strategy 2017–2026, the General Scheme of the Assisted Human Reproduction (AHR) Bill 2017 and the Heath Service Breastfeeding Action Plan 2016-2020) most national health strategies focus on a population health and/or life-cycle approach, without a specific focus on the needs of women. Development of an overarching Women's Health Action Plan can support integration of a gender focus into all health policy development.

Within the HSE, women's health is currently addressed through acute hospital and primary care services; through mental health, social inclusion and older people's services; through specific strategies and plans; and the policy priority programmes. There are few staff nationally or indeed at CHO levels with a specific remit for women's health and Scally (2018)[348] suggests that there needs to be *'an exploration of how women's health issues can be given more structured and consistent attention'* (p.21).

The HSE has recently launched domestic, sexual and gender-based training programme[349] to support front-line staff to provide a responsive service to women experiencing violence, including guidance on brief interventions, child protection and referral to social work services.

In relation to violence against women, Ireland ratified the Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention) in March 2019[350]. Countries who ratify the treaty are obligated to protect and support victims of such violence, this includes establishing services such as refuge, medical services, and counselling[351]. In order to ratify the Convention, Ireland had to introduce a suite of new laws to tackle different forms of violence against women, including domestic violence and psychological violence.



348 Scally, G. (2018). *Scoping Inquiry into the CervicalCheck Screening Programme.* Retrieved from: http://scallyreview.ie/wp-content/uploads/2018/09/Scoping-Inquiry-into-CervicalCheck-Final-Report.pdf

349 Health Service Executive, Sonas. (2019). *National Domestic, Sexual and Gender-Based Violence Training Resource Manual.* HSE. Retrieved from: https://www.hse.ie/eng/about/who/primarycare/socialinclusion/other-areas/domestic-violence/dsgbv-training-resource-manual.pdf

350 National Women's Council of Ireland. (2019, 8 March). 'Ratification of the Istanbul Convention marks a momentous International Women's Day' [Press Release]. Retrieved from: https://www.nwci.ie/learn/article/ratification_of_the_istanbul_convention_marks_a_momentous_international_wom

351 Council of Europe. (2011). *Convention on preventing and combating violence against women and domestic violence.* Retrieved from: https://www.coe.int/fr/web/conventions/full-list/-/conventions/rms/0900001680084 82e

4.6 Models of practice in relation to Women's Health Policy

4.6.1 The WHO's Strategy on Women's health and wellbeing in the WHO European Region

The WHO launched its strategy on *Women's Health and Well-being in the European Region in 2016* based on a detailed and extensive review of the evidence, guidance from the governing bodies, feedback from technical experts, results of an online consultation with Member States, face-to-face consultations in countries and feedback from WHO regions for health and healthy cities networks.

The Strategy is underpinned by the values of the European policy framework for health and well-being, *Health 2020*, which clearly recognises gender as a determinant of health, alongside social and environmental determinants, and which identifies gender inequality as an important issues and gender mainstreaming as a key mechanism to achieve gender equity. The Strategy identifies four priority areas for action in line with Health 2020, and provides guidance to optimize investment in girls' and women's health, including by refining existing national policies and strategies to make them more consistent with current evidence and more responsive to women's health and well-being across the life-course.

The mission of the Strategy is to 'inspire governments and stakeholders to work towards improving the health and well-being of women and girls beyond maternal and child health, ensuring that policies and health systems are gender-responsive and based on a life-course approach.'

The Strategy has employed a number of useful guiding principles which have potential for wider replication as follows:

1. The Strategy has a human rights approach which means that women's rights and the right to health are integral to all priorities and actions. This also includes ending discrimination against women and girls in all forms by ensuring women's equal access to, and equal opportunities in, political and public life, education, health and economic resources. It is also designed to promote the systematic application of human rights standards, including the United Nations Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child.
2. The Strategy is equity driven, recognising that women are not a homogenous group. This means that consideration must be given to how gender intersects with other axes of social inequalities, such as ethnicity and place of residence, and the unequal distribution of social determinants of health such as income, education and employment.
3. The gender-responsive focus of the Strategy reflects the need to adopt whole-of-government policies promoting gender equality and health policies that consider gender norms, values and inequalities, along with measures taken to actively reduce their harmful effects.
4. The life-course approach to women's health used within the Strategy is useful in that it recognises that sex and gender combine with social and environmental determinants of health to influence how health risks and benefits accumulate through life. It not only recognizes that women's health is important for ensuring a better start in life for their children and providing care for their families, but seeks to achieve better health for girls and women in their own right, regardless of their status as mothers or as future mothers and carers.
5. Intersectoral action is central to the Strategy. So that as well as strengthening the role of the health sector in improving women's health, the Strategy identifies key areas for collaboration with other sectors, such as education, social protection, the labour market, the environment and civil society. This approach is necessary to ensure equal access to economic resources and to value unpaid care through the provision of public services.

6. Ensuring effective participation of women is the final crucial principal. The Strategy recognises that 'Women are powerful actors for change' and 'supports their leadership of, and participation in, decision-making'. The Strategy acknowledges that to be consistent with the guiding principle of a human rights-based approach, participation must be genuine, transparent and representative, and should employ mechanisms for securing the involvement of all girls and women, including those who are excluded.

4.6.2 Australia's Women's Health Policies

Australia has a both a national federal women's health policy and a series of state (there are six states in Australia. Each state has its own state constitution, which divides the state's government into the same divisions of legislature, executive, and judiciary as the federal government) level women's (health) strategies (*Queensland Women's Strategy 2016-21*, has a specific section within it on Women's health and wellbeing[352] while the Western Australia's women's health strategy is exclusively focused on health[353]), frameworks[354], priorities[355] and reviews[356]. Australian Women's Health Policy also benefits from the data generated by the *Australian Longitudinal Study on Women's Health* which began in 1996[357].

The *National Women's Health Policy* launched in 2010 was designed by the federal Commonwealth government to provide a 20-year guide, seeks '*to continue to improve the health and wellbeing of all women in Australia, especially those at greatest risk for poor health*'. This policy built on the first policy which was published in 1989. The 2010 policy interestingly adopts a dual priority approach that recognises the importance of:

a) Addressing immediate and future health challenges by maintaining and developing health services and prevention programs to treat and avoid disease through targeting health issues that will have the greatest impact over the next two decades.

b) Addressing the fundamental ways in which society is structured which impacts on women's health and wellbeing. This will involve addressing health inequities through broader reforms addressing the social determinants of health.

The policy[358] identifies four priority health issues as follows:

1. Prevention of chronic diseases through the control of risk factors; targeting chronic disease such as cardiovascular disease, diabetes and cancer, as well as risk factors such as obesity, nutrition, physical inactivity, alcohol and tobacco consumption. The policy also encourages a clearer understanding of the context of women's lives, including the barriers that prevent women taking up healthier lifestyle behaviours.
2. Mental health and wellbeing; targeting anxiety, depression and suicide.
3. Sexual and reproductive health; targeting access to information and services relating to sexual health, reproductive health, safe sex practices, screening and maternal health. The importance of the health of mothers prior to conception, during pregnancy and in the

352 Queensland Government (2016). *Queensland Women's Strategy 2016-21.* Retrieved from: https://www.csyw.qld.gov.au/resources/campaign/womens-strategy/queensland-womens-strategy.pdf

353 Government of Western Australia. (2013). *Western Australia's women's health strategy.* Retrieved from: https://www.fwhc.org.au/wp-content/uploads/2017/12/wa-womens-health-strategy-2013-17.pdf

354 New South Wales Government. (2013). *New South Wales Framework for Women's Health 2013.* Retrieved from: https://www.health.nsw.gov.au/women/Publications/womens-health-framework-2013.pdf

355 Victorian Women's Health Sevices. (2015). *Priorities for Victorian women's health 2015–2019.* Retrieved from: https://womenshealthvic.com.au/resources/WHV_Publications/Position-Paper_2015.03.12_Priorities-for-Victorian-womens-health-2015-2019_(Fulltext-PDF).pdf

356 Steel, A., Frawley, J., Dobson, A., Jackson, C., Lucke, J., Tooth, L., Brown, W., Byle, J., Mishra, G. (2013) *Women's health in NSW – a life course approach: a rapid review.* University of Queensland, Centre of Research Excellence in Women's Mental Health in the 21st Century. Retrieved from: https://www.saxinstitute.org.au/wp-content/uploads/Womens-health-in-NSW2.pdf

357 University of Newcastle and The University of Queensland. (1996). *Australian Longitudinal Study on Women's Health.* Retrieved from: https://www.alswh.org.au

358 Government of Australia. (2010). *National Women's Health Policy.* Retrieved from: http://www.health.gov.au/internet/main/publishing.nsf/Content/3BC776B3C331D5EECA257BF0001A8D46/$File/NWHP.pdf

post-natal period can have a profound and long-term effect on their own health and that of their children.

4. Healthy ageing; targeting musculo-skeletal conditions, disability and dementia. The policy highlights that the social, economic and environmental conditions under which women live and age can affect their experience of old age.

The policy also identifies five policy goals. These goals are intended to highlight ways that gender inequality and health inequities (between women and men, and between differing groups of women) can be addressed. The policy goals are to:

1. Highlight the significance of gender as a key determinant of women's health and wellbeing;
2. Acknowledge that women's health needs differ according to their life stage;
3. Prioritise the needs of women with the highest risk of poor health;
4. Ensure the health system is responsive to all women, with a clear focus on illness prevention and health promotion; and
5. Support effective and collaborative research, data collection, monitoring, evaluation and knowledge transfer to advance the evidence base on women's health.

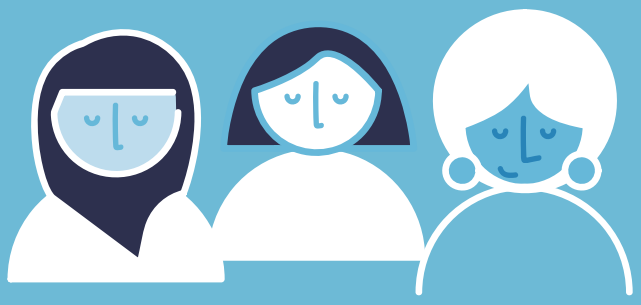
The policy recognises that there is an opportunity to ensure that these goals are reflected in the health reform process, to develop a health system that is more responsive to the needs of Australian women. The policy is not underpinned by a social determinants framework[359] but some of the more recently produced state level strategies are.

Of the state level documents just the *Western Australian Women's Health Strategy (2013-2017)* is aligned to and builds on the national strategy while focusing specially on the needs of women and what women are experiencing in Western Australia. The *NWS Health Framework for Women's Health 2013*[360] (developed by the New South Wales Ministry of Health) in contrast does not reference the national strategy. In Victoria, the *2015 Priorities for Victorian Women's' Health* (developed by a coalition of Victorian Women's health services) makes very limited reference to national policies. The Women's Health in NSW report is a review of the issues.

359 Australian Women's Health Network. (2016). *The Australian Women's Health Charter.* Retrieved from: http://awhn.org.au/wp-content/uploads/2016/05/AWHN-Australian-Womens-Health-Charter.pdf

360 New South Wales Government. (2013). *New South Wales Framework for Women's Health 2013.* Retrieved from: https://www.health.nsw.gov.au/women/Publications/womens-health-framework-2013.pdf

Section 5 — Conclusions



The key conclusions arising from this evidence review are as follows:

5.1 Women in Ireland

Women (aged 18 and over) make up over 38% of the total Irish population. Although still relatively young by EU standards, the proportion of people aged 65 and over (female and male) in Ireland is growing rapidly, with many people now living longer and healthier lives. Women are living longer with more healthy life years that ever before. These improvements are largely due to lower mortality rates and better survival from conditions such as heart disease and cancer affecting older age groups. With the proportion of women in older age groups increasing, the number of women in child bearing age groups has declined. The likely result of which is a steady reduction in the number of births, even if Ireland continues to experience fertility rates that are higher that most EU countries. This demographic transformation provides both opportunities and challenges for women, for their health and for health care providers.

The notion of what is family in Ireland has changed radically since the 1980's. Now just over two fifths of Irish women are married (with or without children), while one third are single women, one in ten women are the head of a one parent households, while just less than one in ten women are part of cohabiting couples.

Significantly, about 45% women (820,251 individuals) live with one or more usually resident never married children (of any age) suggesting that a significant proportion of women continue to have an important role to play particularly in relation to the health of children and in many cases their partners. Women also make up three fifths of carers nationally.

In 2019, over 15% of the population come from other ethnic backgrounds, the largest minority group are other white backgrounds. Female Irish Travellers make up 0.7% of the female population. Minority ethnic groups are however not spread evenly across the country, with the Dublin region the most ethnically diverse region and the Border region the least diverse. In contrast the region with the highest percentage of female Travellers is the Midlands.

Over the period 1991-2016 there has been a significant change in the economic status of women linked to the fact that Irish women are better educated than ever before. More recently the employment rate for women in Ireland has risen from 59.1% in 2006 to 61.4% in 2016[361].

5.2 Women's Health in Ireland

The understanding that women's health is affected by a wide range of factors, including: the conditions in which women are born, grow, live, work and age; whether or not a woman has sufficient income, adequate housing, and social or community bonds and support; as well as a woman's individual behaviour, diet and lifestyle, is critical to ensuring that health services can meet the changing needs of the diversity of women across the life stages.

361 CSO. (2016). *Women and Men in Ireland 2016.*

Statistically women in Ireland have a higher life expectancy than men, and rate their health as better than men, notwithstanding women often report more illness and distress. A distinct health gradient exists between women from disadvantaged/poorer backgrounds and women from more affluent backgrounds with health generally improving with income. Particular social groups (defined by ethnicity, gender or geography for example) tend to be more affected by these inequalities than other groups, suggesting that measures will need to be targeted at these groups in order to address these inequalities. Significantly, women tend to be more pro-active about their health, suggesting that health promotion campaigns targeted at women can be effective.

5.3 Women's Health Concerns and Needs

It is important to recognise that women's health needs and risks vary depending on their life stage, that health services need to seek to meet women's needs at these different stages.

Women's chronic disease: Key causes of mortality for Irish women relate to respiratory issues. There is also a high incidence of both allergic respiratory disorders (rhinitis, asthma) and of genetic respiratory disease in Ireland. Lung cancer is the leading cause of cancer deaths for women, while cancers of the uterus and ovary are also common cancers in women.

Again health gradients exist in relation to the risk of cancer, with women in areas with the lowest education levels at significantly higher risk of cervical cancer than those in areas with higher educational attainment.

Among the most common cancers represented among the surviving (prevalent) cancer patient population are: breast cancer (23% of all cancer survivors), colorectal cancer (12%) and skin melanoma (7%). National cancer screening programmes of specific relevance to women are BreastCheck and CervicalCheck. The Scally Report has identified a number of failings in relation to the operation of CervicalCheck and implementation of these recommendations is being progressed, with an implementation plan published by the Department of Health in December 2018[362]. A review of this implementation plan by Dr Gabriel Scally in March 2019 found that this plan '*is a comprehensive response to the original report, and that it represents a very substantial body of work for the Department of Health, the HSE and the National Cancer Registry'*.[363] The development of the WHAP is explicitly referenced in the implementation report.

Women's mental health: Because women have different life experiences and socio-economic realities to men, the mental health symptoms they present with, are also often different, as are their pathways into services, and their treatment needs. Statistically more women than men report mental health problems, linked to this more women than men engage in self-harm. Women are also more likely to attempt suicide (with men more likely to die by suicide). Hospitalisation rates are somewhat lower for women than men for a variety of diagnoses. Marginalised women are disproportionately impacted by poor mental health. Many women's preferred interventions are talking therapies/counselling, while women report that mental health services generally tend to rely more on medication.

Issues also exist in relation to perinatal mental health with a perinatal mental health service clinical pathway needing to continue to be rolled out and resourced across maternity hospitals nationwide.

362 Department of Health, Health Service Executive. (2018). *Implementation Plan for the Scoping Inquiry into CervicalCheck Issues.* Retrieved from: https://health.gov.ie/wp-content/uploads/2018/12/Implementation-Plan-for-Recommendations-of-the-Scoping-Inquiry.pdf

363 MerrionStreet.ie (2019, 22 March). *Minister for Health Publishes Review of Implementation Plan by Dr. Gabriel Scally.* [Press Release]. Retrieved from: https://merrionstreet.ie/en/NewsRoom/Releases/Minister_for_Health_Publishes_Review_of_Implementation_Plan_by_Dr_Gabriel_Scally.html

Women's sexual health: This review has found that younger women are more likely to use contraception and have more sexual partners than older women. Notwithstanding, older women remain sexually active into their 60s and 70s, with or without a partner.

This indicates that women need to be able to easily access sexual health related services throughout the life course.

Women's' reproductive health: Key elements of reproductive health for women include access to affordable and accessible contraception, access to abortion services, maternity entitlements, the ongoing development of women-centred maternity care, family formation (including the regulation and public provision of assisted human reproduction), treatment of health issues following pregnancy and the prevention of infertility. Reproductive wellbeing for non-pregnant woman is also important with more attention needing to be given to meeting these needs (e.g. the provision of menstrual health and menopause services).

Given that Ireland has the highest rate of babies born with spina bifida in the EU, work also needs to continue to encourage women to take a folic acid supplement.

Women's lifestyle behaviours: The positive news is that smoking rates are dropping, although a lot of work still needs to be done particularly with younger women and with women living in disadvantaged areas. Concerns also continue to exist for women in relation to alcohol consumption, linked to alcohol as a risk factor for breast cancer for women; the risk of Foetal Alcohol Syndrome and recommendations in relation to alcohol free pregnancy. Illicit drug use is most common among younger women, with cannabis the most commonly used drug followed by MDMA/ecstasy and cocaine. Women make up a growing number of clients of specialised drug treatment centres. Women have a significantly higher risk of premature death due to obesity compared with men. Older women (>75 years) are the group most likely to consume unhealthy food, while women living in disadvantaged areas are more likely to consume unhealthy food than women in affluent areas. Women are also at risk of developing gestational diabetes in pregnancy and developing Type 2 diabetes in the following 5-10 years. Clearly, work needs to continue to help and support women in relation to tackling obesity. Work also needs to continue in relation to raising the activity levels of women, as the health impacts of their inactivity could be significant if inactivity persists as women age. In this context walking is the most popular and accessible form of physical exercise for women from all backgrounds and work needs to be done to encourage women and younger women in particular to participate in more physical activities.

Women and gender-based violence: Statistically women are very significantly more likely and more vulnerable to experiencing gender-based violence throughout their life time. This includes domestic violence and abuse, it also includes rape and sexual abuse, crimes against women based on notions of 'honour', forced marriage, forced prostitution and trafficking, female genital mutilation and sexual harassment. A whole series of health problems can be linked to violence against women including depression, emotional distress and suicidality as well as injuries, pain and long-term health conditions, sexually transmitted infections or diseases, miscarriage and neonatal death. Mental health impacts of rape include suicidality, flashbacks, anxiety, depression and panic attacks. Estimating the exact scale of this violence against women is however difficult due to definitional and underreporting issues. The recent ratification of the Istanbul Convention[364] and the proposal to undertake a new SAVI II report[365] are both very welcome in this context. Key also is putting in place the necessary acute and long-term health and others supports for women who have/who are experiencing violence, based on the recognition that different responses are needed for individuals at immediate risk/in the immediate aftermath and for individuals who experienced abuse as a child

364 Department of Justice and Equality. (2019, 8 March). *Minister Flanagan announces ratification of the Istanbul Convention by Ireland on International Women's Day.* [Press Release]. Retrieved from: http://www.justice.ie/en/JELR/Pages/PR19000066

365 Department of Justice and Equality. (2019, 10 January). *Department of Justice and Equality and the Central Statistics Office sign Memorandum of Understanding on the Undertaking of a National Sexual Violence Prevalence Study.* [Press Release]. Retrieved from: http://www.justice.ie/en/JELR/Pages/PR19000007

or adult. The separation of the issue of violence against older women and inclusion under the category of elder abuse is also something that needs to be re-examined.

Women, health and disadvantage: The general structural inequalities which women face which have the potential to negatively impact on their health include the facts that women are more likely to: Be poor (have a medical card); Parent alone; Be the main provider of unpaid care work; Be in precarious or part time employment earning low/ lower wages and be at risk of gender-based violence.

Women from disadvantaged and minority backgrounds face even more inequalities that in turn can negatively affect these women's health to varying degrees.

At its simplest this is because women with access to larger incomes can pay to rapidly access health services as well as other societal resources including education, food, housing, recreational activities etc. The variation among individuals and groups due to income is often referred to as the 'social gradient', while the relationship between poverty, social inclusion and health inequalities is now incontrovertible.

Groups of women who experience multiple disadvantage within the health service and who need particular targeted interventions to overcome this level of multiple disadvantage include: Women from disadvantaged areas; Traveller and Roma women; Women who are homeless; Migrant women; Women with disabilities; Women who are carers; LBTQI+ women; Women who offend; Women involved in prostitution; and Women who are trafficked. Each of these groups has particular health needs and some of the common barriers that face these groups and that need to be tackled include: Lack of easy access to affordable health services; Inability to access female doctors as well as discrimination and prejudice including racism and homophobia. A key element in the provision of health services to these disadvantaged groups include the training of health staff to understand the diversity of needs and challenges faced by these different groups.

5.4 Women's engagement with the Health Services

Internationally, the Sustainable Development Goals are being used to advance women's health globally, while at European level both Health 2020 and the 2016 Strategy on women's health and well-being in the WHO European Region acknowledge gender as a determinant of health, and identify gender mainstreaming as a mechanism to achieve gender equity. Possible areas of focus for the new *Women's Health Action Plan* arising from these perspectives include:

— The need to provide equal access to health services for all women (recognising that gender inequalities in employment, education, quality of work, etc. have a negative influence on health).

— The need to address the various health conditions that arise at the different life stages of women.

— Recognition that gender stereotypes have consequences for women's health in terms of self-confidence and well-being, with concerns about physical appearance having the potential to cause young women in particular to develop eating disorders and other mental illnesses, such as depression and anxiety.

— Violence against women persists across all population groups.

— Women's increasing exposure to risk factors (including substance misuse, obesity, lack of physical exercise) increases the risk of developing diseases and disabilities earlier in life.

— Major depressive disorders are the main cause of disease among women and dementia and Alzheimer's disease are main causes of ill health among older women in western Europe

— The impact of socioeconomic inequalities has a huge influence on women's mental health both as patients and informal providers of care.

— In areas where domestic heating needs are met by burning solid fuels (e.g. wood) on open fires women who spend a significant amount of time indoors at home are disproportionally

exposed to high levels of household air pollution, which includes a range of health-damaging pollutants.

— Women are overrepresented as care providers in the formal and informal sectors.

— Women are also overrepresented as care recipients among those aged 65 and over in institutions and at home.

— Gender specific barriers that need to be addressed in order to support to women access health services include: poverty; unequal power relationships between men and women; an exclusive focus on women's reproductive roles; as well as potential or actual experience of physical, sexual and emotional violence.

Nationally, there are a number of issues in relation to women's engagement with health services. The first is the nature and extent of health care services available, the second is women's ability to access and uptake these services and the third concern, the characteristics and health needs of individual/groups of women. All three of these issues need to be explored and addressed within the WHAP.

Challenges that will need to be addressed in this context include the existence of the number of significant data gaps linked to a lack of sex disaggregated data and gender analysis of service users. For example, the largest national, continuous data source on utilisation of health services the Hospital In-Patient Enquiry (HIPE) has not been examined from the point of view of gender differentials in utilisation patterns.

GP's provide the key gateway to access health services for women and women are more likely to visit their GP than men, suggesting that the GP has a critical role in relation to identifying the gender specific needs of women and of signposting women to the services they need.

5.5 Health policies and services relevant to women's health

Internationally and at EU level, the key policies the WHAP needs to connect with and be informed by are the UN's *Global Strategy For Women's, Children's And Adolescents' Health 2016-2030* and the WHO *Strategy on women's health and well-being in the WHO European Region*. The WHO strategy has four key areas for action: 1) Strengthening governance for women's health and well-being, with women at the centre; 2) Eliminating discriminatory values, norms and practices that affect the health and well-being of girls and women; 3) Tackling the impact of gender and social, economic, cultural and environmental determinants on women's health and well-being; and 4) Improving health system responses to women's health and well-being. These four action areas could usefully be applied in the Irish WHAP.

Nationally, Ireland has three women specific health policies (and one dedicated Dublin based women health project focusing on the needs of women involved in prostitution). It is striking that the three policies focus on the reproductive role of women, rather than the general health of women. There a much larger number of health policies (at least nine) that while they do not have a specific gender focus are relevant to meeting the health needs of women and connections will need to be made to these in the WHAP, most of these strategies have been prepared using a population or life-cycle approach. This review also identifies a number of other key policies and strategies that have an impact on women's health and well-being that it will be important for the WHAP to reference and make connections with.

5.6 Models of practice in relation to Women's Health Policy

The review found that the WHO has a dedicated strategy on Women's Health and Well-being in the European Region. The Strategy has six guiding principles all of which are relevant for the Irish WHAP as follows;

1. The application of human rights approach which means that women's rights and the right to health are integral to all priorities and actions.
2. The Strategy is equity driven, recognising that women are not a homogenous group.
3. The gender-responsive focus of the Strategy reflects the need to adopt whole-of-government approach to promoting gender equality.
4. The application of life-course approach to women's health.
5. Making intersectoral action central to the Strategy.
6. Making the participation of women central to all stages of the strategy from development to implementation.

Australia in contrast has both a federal women's health policy and a series of state level women's health strategies. It also benefits from data generated by a national Longitudinal Study on Women's Health. Both of these models of practice can provide useful learning for the WHAP both in terms of how the plans were developed and in terms of how women were invited to participate in the plan development and implementation.

5.7 In conclusion

The evidence provided in this review confirms the need for a national women's health action plan which will facilitate and provide an enhanced response to the health inequalities experienced by women. The review has documented the significant health needs of women spanning all categories of health from healthy lifestyles to chronic disease to mental health. In addition, the review identified how particular groups of women, including women with disabilities and LGBTQI+ women, are experiencing particular health inequalities and barriers to care.

The evidence presented identifies key areas for consideration as part of the WHAP development process, including through consultation with women:

— Changing health needs of women throughout the life cycle;

— Women's health behaviours and lifestyles, within the context of women's lives and responsibilities;

— Specific mental health needs and presentations of women;

— Reproductive and sexual healthcare needs of women at all stages of life;

— Health supports needed for women who have/are experiencing violence;

— Services for diseases predominantly affecting women;

— Barriers to healthcare and poor health outcomes experienced by women who are socially or economically disadvantaged; and

— The application and use of gender mainstreaming approaches with health services.

Appendix 1 – Women in Ireland

Table A.1 Number of females by age band (1991 - 2016)						
Ages	**1991**	**1996**	**2002**	**2006**	**2011**	**2016**
0 - 4	133,179	121,654	135,590	147,696	174,253	161,784
5 - 9	155,157	137,608	128,200	140,341	156,733	174,091
10 - 14	169,400	158,710	139,594	133,368	147,415	156,098
15 - 19	163,618	165,586	152,775	142,016	138,757	147,908
20 - 24	130,093	144,211	163,042	169,709	150,595	136,052
25 - 64	791,679	861,456	1,004,992	1,124,716	1,255,721	1,290,774
65+	229,175	236,630	246,846	260,831	292,079	340,730
All ages	1,772,301	1,825,855	1,971,039	2,118,677	2,315,553	2,407,437

Source: CSO Census 2016

Table A.2 Proportion of females by age band, 1991 – 2016						
Age band	**1991**	**1996**	**2002**	**2006**	**2011**	**2016**
0 - 4	7.5%	6.7%	6.9%	7.0%	7.5%	6.7%
5 - 9	8.8%	7.5%	6.5%	6.6%	6.8%	7.2%
10 - 14	9.6%	8.7%	7.1%	6.3%	6.4%	6.5%
15 - 19	9.2%	9.1%	7.8%	6.7%	6.0%	6.1%
20 - 24	7.3%	7.9%	8.3%	8.0%	6.5%	5.7%
25 - 64	44.7%	47.2%	51.0%	53.1%	54.2%	53.6%
65+	12.9%	13.0%	12.5%	12.3%	12.6%	14.2%

Source: CSO Census 2016

Table A.3 Change in proportion of females by age band, 1991 – 2016	
Age band	**1991 - 2016**
0 - 4	-0.8%
5 - 9	-1.5%
10 - 14	-3.1%
15 - 19	-3.1%
20 - 24	-1.7%
25 - 64	+8.9%
65+	+1.2%

Source: CSO Census 2016

Table A.4 Distribution of females by region and age, 2016							
Census Region	**Total female population**	**Females under 18 years**	**% of under 18 years**	**Females between 18-64 years**	**% aged 18-64**	**Females over 65 years**	**% over 65 years**
ROI	2,407,437	581,717	24.2%	1,484,990	61.7%	340,730	14.2%
Dublin	688,988	149,099	21.6%	447,972	65.0%	91,917	13.3%
South-West	348,845	82,546	23.7%	213,460	61.2%	52,839	15.1%
Mid-East	347,746	94,321	27.1%	212,535	61.1%	40,890	11.8%
Mid-West	237,476	58,058	24.4%	142,611	60.1%	36,807	15.5%
West	228,022	54,788	24.0%	137,463	60.3%	35,771	15.7%
South-East	212,691	53,214	25.0%	127,549	60.0%	31,928	15.0%
Border	197,686	50,480	25.5%	116,145	58.8%	31,061	15.7%
Midlands	145,983	39,211	26.9%	87,255	59.8%	19,517	13.4%

Source: CSO Census 2016

Table A.5 Number and percentage of females by county and age (Census, 2016)							
Census County	**Total female population**	**Females under 18 years**	**% under 18 years**	**Females between 18-64 years**	**% 18-64 years**	**Females over 65 years**	**% over 65 years**
Dublin City	282,284	48,262	17.1	192,946	68.4	41,076	14.6
Cork County	210,258	54,945	26.1	126,664	60.2	28,649	13.6
Fingal	150,780	40,844	27.1	95,405	63.3	14,531	9.6
South Dublin	142,490	36,616	25.7	89,245	62.6	16,629	11.7
Dún Laoghaire-Rathdown	113,434	23,377	20.6	70,376	62.0	19,681	17.4
Kildare	111,958	30,449	27.2	69,962	62.5	11,547	10.3
Meath	98,268	27,959	28.5	59,426	60.5	10,883	11.1
Limerick City and County	97,559	22,984	23.6	59,890	61.4	14,685	15.1
Galway County	89,527	23,408	26.1	52,734	58.9	13,385	15.0
Donegal	80,170	20,412	25.5	46,858	58.4	12,900	16.1
Tipperary	79,885	19,895	24.9	47,104	59.0	12,886	16.1
Wexford	76,000	19,060	25.1	45,383	59.7	11,557	15.2
Kerry	74,652	17,021	22.8	44,515	59.6	13,116	17.6
Wicklow	72,269	18,656	25.8	43,862	60.7	9,751	13.5
Mayo	65,460	15,683	24.0	37,979	58.0	11,798	18.0
Louth	65,251	17,257	26.4	39,285	60.2	8,709	13.3
Cork City	63,935	10,580	16.5	42,281	66.1	11,074	17.3
Clare	60,032	15,179	25.3	35,617	59.3	9,236	15.4
Waterford City and County	58,525	14,349	24.5	34,995	59.8	9,181	15.7
Kilkenny	49,699	12,523	25.2	29,852	60.1	7,324	14.7
Westmeath	44,688	11,660	26.1	27,011	60.4	6,017	13.5
Laois	41,886	11,862	28.3	25,148	60.0	4,876	11.6
Galway City	40,868	7,689	18.8	28,175	68.9	5,004	12.2
Offaly	39,123	10,262	26.2	23,258	59.4	5,603	14.3
Cavan	37,846	10,349	27.3	22,190	58.6	5,307	14.0
Sligo	33,170	7,694	23.2	19,907	60.0	5,569	16.8
Roscommon	32,167	8,008	24.9	18,575	57.7	5,584	17.4
Monaghan	30,520	8,015	26.3	17,989	58.9	4,516	14.8
Carlow	28,467	7,282	25.6	17,319	60.8	3,866	13.6
Longford	20,286	5,427	26.8	11,838	58.4	3,021	14.9
Leitrim	15,980	4,010	25.1	9,201	57.6	2,769	17.3

Source: CSO Census 2016

Table A.6 Females over 18 years by marital status					
	Single	**Married (incl. same sex civil partnership)**	**Separated**	**Divorced**	**Widowed**
Number	654,917	895,037	66,563	60,586	148,617
Proportion	35.9%	49.0%	3.6%	3.3%	8.1%

Source: CSO Census 2016

Table A.7 Persons over 65 living alone in a private household, 2016		
	Persons living alone in private households	**Percentage of persons living alone in private households**
Both sexes	156,799	26.7%
Female	97,636	31.5%
Male	59,163	21.3%

Source: CSO Census 2016

Table A.8 Ethnic background of female population usually resident in the state, 2016		
Ethnic group	**Number**	**Proportion**
All ethnic or cultural backgrounds	2,369,461	100.0%
White Irish	1,951,406	82.4%
White Irish Traveller	15,610	0.7%
Any other White background	226,200	9.5%
Black or Black Irish - African	29,600	1.2%
Black or Black Irish - any other Black background	3,315	0.1%
Asian or Asian Irish - Chinese	10,427	0.4%
Asian or Asian Irish - any other Asian background	38,660	1.6%
Other including mixed background	35,181	1.5%
Not stated	59,062	2.5%

Source: CSO Census 2016

Table A.9 Ethnic background of female population usually resident in the state by region, 2016									
Region	**State**	**Border**	**Dublin**	**Mid-East**	**Midlands**	**Mid-West**	**South-East**	**South-West**	**West**
White Irish	82.4%	86.7%	76.1%	84.2%	83.7%	85.9%	86.4%	84.1%	83.7%
White Irish Traveller	0.7%	0.5%	0.4%	0.5%	1.3%	0.8%	0.8%	0.5%	1.4%
Any other White background	9.5%	8.0%	11.5%	8.9%	8.8%	7.9%	8.1%	9.6%	9.4%
Black	1.4%	0.6%	2.2%	1.6%	1.5%	0.7%	0.7%	1.0%	1.0%
Asian	2.1%	1.1%	3.8%	1.7%	1.4%	1.5%	1.1%	1.5%	1.3%
Other including mixed background	1.5%	0.9%	2.2%	1.3%	1.2%	1.1%	1.0%	1.3%	1.3%
Not stated	2.5%	2.1%	3.8%	1.8%	2.1%	2.1%	1.8%	2.1%	1.9%

Source: CSO Census 2016

Table A.10 The 10 counties with the highest proportion of population made up of Irish Travellers		
County	**All ethnic or cultural backgrounds**	**White Irish Traveller**
Longford	20253	2.5%
Galway City	37901	2.1%
Galway County	88387	1.5%
Offaly	39090	1.2%
Westmeath	44290	1.1%
Wexford	75257	1.1%
Mayo	64165	1.0%
Limerick City and County	96222	0.9%
Laois	41832	0.9%
Carlow	28323	0.9%

Source: CSO Census 2016

Table A.11 Irish Traveller population by broad age bands, 2016			
	State	**Irish Travellers**	**General population**
0 - 24 years	8,816	56.5%	24.2%
25 - 64 years	6,313	40.4%	61.7%
65 years and over	481	3.1%	14.2%

Source: CSO Census 2016

Table A.12 Females usually resident and present in the state by nationality		
Nationality	**Number**	**Proportion**
Irish	2,066,874	87.2%
Polish	60,655	2.6%
UK	50,389	2.1%
Other EU28	24,833	1.0%
Lithuanian	19,633	0.8%
Other Asian	19,094	0.8%
Romanian	14,096	0.6%
Latvian	11,345	0.5%
African	10,630	0.4%
Brazilian	7,267	0.3%
Spanish	7,235	0.3%
German	6,539	0.3%
American (US)	6,109	0.3%
French	5,795	0.2%
Other nationalities	5,713	0.2%
Other European	5,538	0.2%
Italian	5,297	0.2%
Indian	4,229	0.2%
Not stated, including no nationality	34,200	1.4%

Source: CSO Census 2016

Table A.13 Females aged 15 and over by highest education completed					
	No formal/ Primary	Secondary	Third level non degree	Degree or higher	Other (including not stated)
State	9.5%	26.7%	15.6%	25.7%	22.5%
Dublin	8.9%	23.4%	12.9%	29.8%	25.0%
South-West	8.7%	27.4%	16.4%	25.5%	22.0%
Mid-East	8.8%	27.5%	17.1%	25.1%	21.5%
Mid-West	9.5%	29.6%	16.4%	22.6%	22.0%
West	9.5%	26.6%	15.6%	26.5%	21.7%
South-East	10.6%	30.0%	17.5%	21.9%	20.0%
Border	12.7%	27.0%	17.1%	22.1%	21.1%
Midlands	10.5%	29.5%	16.9%	21.0%	22.0%

Source: CSO Census 2016

Table A.14 Females aged 15 and over by economic status, 2016												
	1991	%	1996	%	2002	%	2006	%	2011	%	2016	%
Persons at work	405,132	30.8	504,589	35.8	678,334	43.3	822,808	48.5	852,819	46.4	929,967	48.5
Unemployed looking for first regular job	66,538	5.1	69,065	4.9	59,088	3.8	72,823	4.3	150,516	8.2	126,466	6.6
Student or pupil	142,992	10.9	172,682	12.3	184,619	11.8	184,958	10.9	207,635	11.3	216,074	11.3
Looking after home/ family	592,771	45.1	549,077	39.0	417,633	26.6	370,300	21.8	321,878	17.5	284,809	14.9
Retired	77,431	5.9	84,309	6.0	143,973	9.2	171,407	10.1	219,985	12.0	270,171	14.1
Unable to work due to permanent sickness or disability	28,792	2.2	27,526	2.0	63,132	4.0	67,820	4.0	77,491	4.2	79,952	4.
Others not in labour force	909	0.1	635	0.0	20,876	1.3	7,156	0.4	6,828	0.4	8,025	0.4%

Source: CSO Census 2016

Table A.15 Females ages 15-64 by education level and employment rate (Q2 2009 – Q2 2017)									
	2009 Q2	2010 Q2	2011 Q2	2012 Q2	2013 Q2	2014 Q2	2015 Q2	2016 Q2	2017 Q2
Primary	30	27	26	26	24	24	24	26	25
Upper secondary	62	60	58	58	57	59	58	60	60
Third level	78	78	77	77	77	78	79	79	81

Source: CSO Census 2016

Table A.16 Unemployed females aged 15 and over by ethnic group, 2016		
	All persons aged 15 years and over	**Unemployed - Looking or recently having lost or given up previous job**
White Irish Traveller	9653	37.0%
Black or Black Irish-African	18226	20.5%
Black or Black Irish – any other Black background	2223	13.4%
Other including mixed background	24305	13.1%
Asian or Asian Irish – any other Asian background	27542	11.1%
Any other White background	188753	10.6%
Asian or Asian Irish - Chinese	8220	8.4%
All ethnic or cultural backgrounds	1879591	6.6%
Not stated	46537	6.5%
White Irish	1554132	5.6%

Source: CSO Census 2016

Table A.17 Female population by general health and broad age band, 2016												
	Very good	**%**	**Good**	**%**	**Fair**	**%**	**Bad**	**%**	**Very Bad**	**%**	**Not stated**	**%**
All ages	1,426,423	59.3	666,152	27.7	198,591	8.2	32,753	1.4	7,187	0.3	76,331	3.2
0 - 24	622,635	80.2	109,116	14.1	12,985	1.7	1,470	0.2	394	0.1	29,333	3.8
25 - 64	618,014	59.7	310,156	30.0	64,879	6.3	10,293	1.0	1,888	0.2	29,142	2.8
65 +	79,108	23.2	146,709	43.1	85,160	25.0	14,624	4.3	3,619	1.1	11,510	3.4

Source: CSO Census 2016

Table A.18 Female population by type of disability	
	% of total female population
Total persons with a disability	13.8%
Other disability, including chronic illness	6.8%
A condition that substantially limits one or more basic physical activities	6.2%
Difficulty in participating in other activities	5.3%
Difficulty in working or attending school/college	4.5%
Difficulty in going outside home alone	4.5%
Difficulty in dressing, bathing or getting around inside the home	3.3%
Difficulty in learning, remembering or concentrating	3.0%
Psychological or emotional condition	2.7%
Deafness or a serious hearing impairment	2.0%
Blindness or a serious vision impairment	1.2%
An intellectual disability	1.1%

Source: CSO Census 2016

Table A.19 Percentage of the female population with a disability by region, 2016	
State	13.8%
Border	13.8%
Midland	14.0%
West	13.4%
Dublin	13.7%
Mid-East	12.8%
Mid-West	14.6%
South-East	14.4%
South-West	14.1%

Source: CSO Census 2016

Table A.20 Female carers by age		
Age band	**Number**	**Proportion**
0-24 years	6,945	5.9%
25-64 years	94,483	80.0%
65+years	16,723	14.2%
Total	118,151	

Source: CSO Census 2016

Table A.21 Hours of unpaid care provided by female carers (aged 15 and over)[366]		
Hours unpaid care	**Number of carers**	**Proportion by hours**
1-14 hours unpaid help per week	47,838	41.2%
15-28 hours unpaid help per week	19,223	16.5%
29-42 hours unpaid help per week	8,897	7.7%
43-84 hours unpaid help per week	9,317	8.0%
85-167 hours unpaid help per week	5,838	5.0%
168 hours unpaid help per week	11,889	10.2%
Not stated - hours unpaid help per week	13,224	11.4%

Source: CSO Census 2016

Table A.22 Live Births, Birth Rate and Total Fertility Rate, Ireland and EU28 (2008-2017)												% Change	
		2008	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2008-2017**	**2016-2017**
Number of live births		75,173	75,554	75,174	74,033	71,674	68,954	67,295	65,536	63,841	62,053	-17.5	-2.8
Birth rate (per 1,000 population)		16.8	16.7	16.5	16.2	15.6	15.0	14.6	14.0	13.5	12.9	-23.2	-4.4
Total fertility rate	Ireland	2.07	2.06	2.06	2.02	1.98	1.93	1.90	1.86	1.81	1.80	-13.0	-0.60
	EU28	1.61	1.61	1.62	1.59	1.59	1.55	1.58	1.57	1.60	n/a	-0.60	1.90

Source: Various CSO Vital Statistics Releases

366 This excludes the 1,925 female carers under the age of 15 years of age. These females account for 1.63% of total female carers.

Table A.23 Life expectancy by aged and gender (1996, 2006 and 2016)					
	Life expectancy at age	**1996**	**2006**	**2016**	**% Change 1996-2016**
Female	0	78.7	81.7	83.6	6.2
	1	78.2	80.9	82.8	5.9
	40	39.9	42.6	44.3	11.0
	65	17.4	19.9	21.1	21.3
	75	10.3	12.0	13.1	27.2
Male	0	73.1	76.9	79.9	9.3
	1	72.6	76.2	79.2	9.1
	40	35.2	38.5	41.0	16.5
	65	13.9	16.6	18.6	33.8
	75	8.1	9.7	11.2	38.3

Source: Department of Health. (2018). Health in Ireland Key Trends 2018. Retrieved from: https://health.gov.ie/wp-content/uploads/2018/12/Key-Health-Trends-2018.pdf

Table A.24 Female Population by urban and rural area (Census, 2016)					
	State	**Aggregate Town Area**	**Aggregate Rural Area**	**% Aggregate Town Area**	**% Aggregate Rural Area**
2016	2,407,437	1,527,054	880,383	63.4%	36.6%
2011	2,315,553	1,457,722	857,831	63.0%	37.0%

Source: Department of Health, 2019

Appendix 2 – Summary of Wider Determinants of Women's Health

Source: Department of Health, 2019

Socio-Economic Factors

— The gender pay gap was 14% in Ireland in 2017 (this gap is relatively low by international standards, but has risen by 2% since 2012)[367].

— The pay gap between men and childless women is lower; American data suggests that never-married women earn 96% of what men earn[368].

— Women who do reach positions of seniority have proportionately less children, or other dependents[369,370,371].

— It has been found that the average earnings of men increase with fatherhood (the so-called fatherhood premium), while the wages of mothers decrease (the motherhood penalty)[372].

— A British study has found that men with children can earn as much as 21% more than childless men, while working mothers typically suffer a 15% pay penalty[373].

— Some of the difference may be accounted for by fathers working longer hours and mothers cutting time at work to attend to caring responsibilities associated with parenthood,[374,375,376].

— American data suggests that the motherhood penalty has been reducing for high earning women, but that the fatherhood premium is showing steady increases[377].

— To further exacerbate inequality, the motherhood penalty is at its worst for low earning women, while the fatherhood premium is largest for the highest earning men[378].

— In Ireland, the employment rate for men is approximately 10% higher for men than for women. Moreover, only 47.8% of lone parents work, as opposed to 70.2% of adults in two

367 Gartland, F. (2017, 19 October). Gender pay gap is widening in Ireland, CSO figures show. *The Irish Times*. Retrieved from: https://www.irishtimes.com/news/social-affairs/gender-pay-gap-is-widening-in-ireland-cso-figures-show-1.3260896

368 WGN. (2016, 27 April). *TUC study finds significant wage gap between working fathers and childless men*. Retrieved from: https://www.wgn.co.uk/news/tuc-study-finds-significant-wage-gap-working-fathers-childless-men/

369 Cain Miller, C. (2016, 6 September). The Motherhood Penalty vs. the Fatherhood Bonus. *The New York Times*. Retrieved from: https://www.nytimes.com/2014/09/07/upshot/a-child-helps-your-career-if-youre-a-man.html; Budig, J. (2014). *The Fatherhood Bonus and The Motherhood Penalty: Parenthood and the Gender Gap in Pay.* Third Way. Retrieved from: https://www.thirdway.org/report/the-fatherhood-bonus-and-the-motherhood-penalty-parenthood-and-the-gender-gap-in-pay

370 CSO. (2017, 27 July). *Census 2016 Results: Profile 4 Households and Families - Number of families increases to 1,218,370*. [Press Release]. Retrieved from: https://www.cso.ie/en/csolatestnews/pressreleases/2017pressreleases/pressstatementcensus2016resultsprofile4-householdsandfamilies/

371 CSO. (2016). *Employment*. Retrieved from: https://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2016/employment/

372 WGN. (2016, 27 April). *TUC study finds significant wage gap between working fathers and childless men*. Retrieved from: https://www.wgn.co.uk/news/tuc-study-finds-significant-wage-gap-working-fathers-childless-men/

373 *Ibid.*

374 Budig, M. J., & Hodges, M. J. (2010). 'Differences in Disadvantage: Variation in the Motherhood Penalty across White Women's Earnings Distribution'. *American Sociological Review*, 75(5), 705–728. Retrieved from: https://doi.org/10.1177/0003122410381593

375 The Economist. (2017). 'The Gender Pay Gap.' *The Economist*. Retrieved from: https://www.economist.com/international/2017/10/07/the-gender-pay-gap

376 Weeden, K.A., Cha, Y., Bucca, M. (2016). Long Work Hours, Part-Time Work, and Trends in the Gender Gap in Pay, the Motherhood Wage Penalty, and the Fatherhood Wage Premium. The Russell Sage Foundation Journal of the Social Sciences. 2(4):71-102. Retrieved from: https://www.rsfjournal.org/content/2/4/71

377 Budig, M. J., & Hodges, M. J. (2010). 'Differences in Disadvantage: Variation in the Motherhood Penalty across White Women's Earnings Distribution'.

378 *Ibid.*

parent families, and 86% of lone parents are female[379].

— Meanwhile, 76.6% of those in receipt of the means tested Carer's Allowance, which limits engagement in employment, training or education to a maximum of 15 hours per week, are women[380].

— It is clear, therefore, that the burden of caring for dependents, whether they be children, people living with disabilities, or frail older adults, rests disproportionately with women, who as a consequence, have lower rates of engagement with the labour market and therefore lower incomes.

— This is relevant to women's experience of the health services as the burden of engaging with health services on behalf of others disproportionately falls on women, in addition to their personal engagement with health services to meet their own needs.

— Women also have higher rates of part time work and are proportionately less well represented in senior positions that are better remunerated and are more likely to have security of tenure[381].

— Women with caring responsibilities and female parents in particular, therefore operate at a significant economic disadvantage, with the greatest inequalities experienced by those least able to bear them.

— Socio-economically disadvantaged cohorts also have a higher burden of ill-health and disability[382].

— Many women have reduced access to resources that in the current two-tier system may deepen this inequality.

— Moreover, sudden sickness or accidents affecting family members are likely to adversely affect women's employment and earning power more than men's. In such circumstances, long waiting lists are likely to impact more on women than on men, and more so on those who cannot afford access to private care.

— Interestingly, although women may be disproportionately impacted as parents or next-of-kin of the patient, and not as the patient themselves, this is not captured in health outcome statistics or in lifetime health outcomes such as women's own NCD risk factors or life expectancy data.

— Additionally, the burden that caring responsibilities and consequent loss of economic power places on women is, however, not without health consequences for disadvantaged women. For example, the 2018 Healthy Ireland Survey identified the population most likely to smoke as single people engaged in home duties aged 35-54, who left home without a Leaving Certificate. 73% of this cohort smoked, in comparison to the national average of 20% (and the female average of 17%)[383].

Maternal Health Factors

— 81% of women in Ireland have a child or children by the ages of 40-44[384].

— This life event can have short, medium and long-term health impacts.

— "Normal" pregnancies can include all sorts of adverse and discomfort-inducing side effects such as "morning" sickness that occurs in 75% of all pregnancies and can often last well beyond the morning and also, well beyond the first trimester[385].

— Other adverse, but unfortunately common outcomes of pregnancy can include loosening

379 CSO. (2017, 27 July). '*Census 2016 Results: Profile 4 Households and Families - Number of families increases to 1,218,370*'.

380 *Ibid.*

381 Weeden, K.A., Cha, Y., Bucca, M. (2016). Long Work Hours, Part-Time Work, and Trends in the Gender Gap in Pay, the Motherhood Wage Penalty, and the Fatherhood Wage Premium.

382 Government of Ireland. (2013). *Healthy Ireland – a framework for improved health and wellbeing.*

383 Ipsos MRBI and Department of Health. (2018). *Healthy Ireland Survey 2018 Summary of Findings.*

384 OECD Family Database, OECD Social Policy Division: Directorate of Employment, Labour and Social Affairs. (2018). *Childlessness.* Retrieved from: http://www.oecd.org/els/family/SF_2-5-Childlessness.pdf

385 Pregnancy Statistics.org (2011). *Morning Sickness Statistics.* Retrieved from: http://www.pregnancystatistics.org/content/morning-sickness-statistics.html

of ligaments causing sciatica and symphysis pubis, chronic reflux and indigestion and a variety of other digestive and urinary outcomes that occur within expected parameters and are not considered unhealthy in that they don't impact adversely on the outcomes of the pregnancy.

— "Morning" sickness is in fact significantly linked to fewer miscarriages and better pregnancy outcomes in terms of fewer low weight babies[386].

— More abnormal (but unfortunately, common enough) outcomes include hyperemesis gravidarum (up to 2% of pregnancies)[387], pre-eclampsia (3% of pregnancies)[388], miscarriage (more than 1/5 of pregnancies, usually first trimester)[389], placenta praevia (0.15% of pregnancies)[390] and many others that can have long term adverse health consequences for both mother and baby.

— This is without listing the possible adverse outcomes of the birth process itself.

— Caesarian sections are performed in 19-38% of births (rates vary by hospital)[391], and necessitate longer post-partum recovery times.

— Vaginal births can result in significant tearing, the necessity for episiotomies and a resulting degree of post-delivery incontinence in a significant minority of women; faecal incontinence peaks at 6.4% of women 6 weeks post-partum[392] while the figure for urinary incontinence at 6 weeks post-partum is 11.4%[393].

— Post-partum/post-natal depression is difficult to quantify unless severe, but may be common in a significant minority of women (estimated at about 10-20%)[394].

— Breastfeeding is rightly recommended for a wide variety of very significant health benefits to the baby, as well as a reduction in breast cancer risk for younger mothers. However, if practiced exclusively as recommended, it places the burden of sleepless nights firmly on post-partum women; sleep deprivation may increase risk of postnatal depression[395].

— In summary, even normal reproductive processes can result in significant feelings of being unwell in a majority of women at various points in the life-cycle. Given that many of these symptoms occur within the so-called "normal" range, it is possible that these issues are, on occasion, not treated with sufficient compassion by some elements of the health service. Moreover, these can result in significant absences from work in addition to maternity leave, thereby impacting on lifetime earnings, pensions and career progression and reinforcing socio-economic factors summarised above.

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393 Burgio, KL., Zyczynski, H., Locher, JL., Richter, HE., Redden, DT., Wright, KC. (2003). 'Urinary incontinence in the 12-month postpartum period.' *Obstet Gynecol.* 102(6):1291-8. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/14662217

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Sexual Health and Reproductive Factors

— Even normal reproductive processes in women who choose not to have children can impact on quality of life in a way that is not experienced by men and may not receive sufficient attention from health services.

— Women require medical supervision when using hormonal contraception on a long-term basis. This may actually lead to better health outcomes as other health issues may be picked up earlier with more frequent visits to the doctor. However, hormonal contraception currently comes at a significant financial cost for those not covered by medical or GP visit cards. A Departmental committee on contraception is currently seeking to explore avenues to reducing or eliminating these cost barriers.

— A recent Oireachtas motion on period poverty (passed by both Houses) seeks to address the annual cost of periods for those with limited means. The cost has been estimated at over €132-208 per woman per annum, with period poverty impacting significantly on teenage girls in particular[396].

— A recent survey of 1,100 Irish girls aged 12-19 years undertaken by Plan International, an NGO that advances children's rights and equality for girls, found that nearly half (50%) of girls aged 12-19 years have experienced issues around affordability of sanitary products, and approximately 10% of the young women who participated in the survey said they were forced to use a "less suitable sanitary product" because of the high monthly cost involved[397].

— 61% of girls have missed school because of their period (often related to pain)[398].

— Moreover, nearly 60% of young women and girls said school does not inform them adequately about periods, with six out of ten young women reporting feeling shame and embarrassment about their period and more than 80% not feeling comfortable talking about their periods with their father or a teacher[28].

— Periods adversely impact the ability to participate in sport; notably, the participation rates for Irish teenage girls are significantly worse than those for teenage boys[399].

— Endometriosis affects an estimated 10% of women during their reproductive years and can cause significant pain and disability on a monthly basis. Moreover, if sufficiently severe, scars and adhesions can result in enduring symptoms post-menopausally[400].

— Menopause, while a "normal" part of the lifecycle, similarly results in significant feelings of being unwell (e.g. hot flushes, dizziness, forgetfulness, fatigue), and is linked to chronic pain and the emergence of a number of chronic conditions, including fibromyalgia[401].

Domestic, sexual and gender-based violence

— COSC estimates suggest that 15% cent of women and 6% of men have experienced severe levels of abuse from a partner[402].

— The burden of domestic, sexual and gender-based violence (DSGBV) is therefore borne disproportionately (but not exclusively) by women.

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398 Nauert, R. (2019). *Menopause Symptoms Linked to Chronic Pain.* Retrieved from: https://psychcentral.com/news/2019/04/05/menopause-symptoms-linked-to-chronic-pain/143500.html

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400 Endometriosis-uk.org. (2011). *Endometriosis Facts and Figures.* Retrieved from: https://www.endometriosis-uk.org/endometriosis-facts-and-figures

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402 COSC The National Office for the Prevention of Domestic, Sexual and Gender-based Violence. (2003). *National Study of Domestic Abuse.* Retrieved from: http://www.cosc.ie/en/COSC/Pages/WP08000146

— Violence is a matter for the criminal justice system, the Department of Justice and An Garda Siochána, however, treatment of victims is carried out by the health services.

— As the recent SATU Policy Review evidence collection highlighted these services have been under-invested and under-managed systemically for a long time.

Health and wellbeing of women aged 50 and older

Several chronic conditions are particularly prevalent for women aged 50 and older: osteoporosis (29%); arthritis (46%); cataracts (17%); and pain (41%).

— The burden of osteoporosis and arthritis is greater for women aged 75 and older: 38% have osteoporosis and 61% have arthritis, and this increases the risk of disability and low physical activity levels.

— The prevalence of cataracts for women aged 50+ is 17 % and the prevalence of cataracts among women aged 50-64 years old has increased from 4% in 2009 to 6% in 2017.

— Rates of disability, frailty, falls and recurrent falls and low physical activity are also higher for women aged 50 and older.

— 20% of women aged 75+ living at home in the community have limitations with activities of daily living (ADL): dressing, bathing, or getting around inside the home.

— Frailty is a risk factor for single and recurrent falls, fear of falling and disability, and frailty negatively impacts on mental health and cognition. Frailty is not inevitable and can be avoided, delayed and reversed with timely and appropriate interventions.

— Frailty disproportionately affects women (25% for women and 13% for men).

— Between 2009 and 2017 for the over 50s age group the prevalence of frailty among women increased at a greater rate (9%) compared with men (3%).

— Among the 50+ age group falls causing injury are more common for women (13%) compared to men (7%) and the prevalence of falls has been found to increase from the age of 40 for women[403].

— For the 75+ age group a significantly higher proportion of women report low levels of physical activity: 31% of women report walking the recommended 150 minutes per week compared to 45% of men.

Data is from the Irish Longitudinal Study on Ageing (TILDA) Wave 4, 2017[404].

403 Peeters , G., van Schoor, N.M., Cooper, R., Tooth, L., Kenny, R.A. (2018). 'Should prevention of falls start earlier? Co-ordinated analyses of harmonised data on falls in middle-aged adults across four population-based cohort studies'. *PLOS One*. Retrieved from: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0201989

404 TILDA (2017), *The Irish Longitudinal Study on Ageing: Wellbeing and Health in Ireland's over 50s 2009-2016.* Retrieved from: https://tilda.tcd.ie/publications/reports/pdf/w4-key-findings-report/TILDA-Wave4-Key-Findings-report.pdf

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