

Developing a Policy for  
**Women's Health**

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*A Discussion Document*

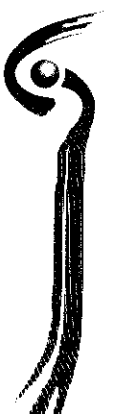


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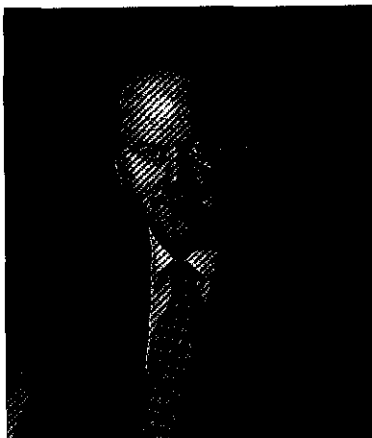


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## FOREWORD BY MICHAEL NOONAN T.D., MINISTER FOR HEALTH



It is my responsibility as Minister for Health to promote the health of the people of this country. I will in the near future publish a national policy for health promotion which will provide guidance for the health services and all agencies whose responsibilities influence public health. Within this broad policy framework, the health needs of women require special attention.

*There are a number of reasons why the health of women deserves special attention. Women, because of their reproductive role, are exposed to special risks during pregnancy and childbirth. Some women are called upon to play many roles simultaneously, such as wife, mother, income earner and carer of an elderly parent which may take a heavy toll on their health. The majority of women in this country are economically dependent, either on their husbands, partners or on the state, and many may not be in a position to make the most healthy choices for their lives.*

Women are far too often the victims of gender based violence, both as children and adults, and this abuse may damage their physical and psychological health. Although women now live longer than men, these extra years are not necessarily active years. Many women in advanced old age experience extended periods of dependency during their last years. For these reasons, we need to examine how we organise health services for women. Since women rely on good public health and social services to maintain their health, the health services should be aware of women's vulnerability to ill health and should actively work to promote their health.

**A Government of Renewal**, the policy document of the Government, makes a commitment to publish a plan for the development of health services for women. This **Discussion Document** is an important step towards defining the shape of a women's health



A Policy for  
Women's Health





## DEFINING THE ISSUES

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A policy for women's health must encompass a spectrum of health issues from those which are unique to women through those which impact more on them than men, to those which affect them differently to men. Health issues which are unique to women are those concerned with *maternity and gynaecology*. Issues which impact more on women than men include long term nursing care, as women over 75 outnumber men by a ratio of two to one. Issues which affect women differently to men include the prevention of alcohol abuse and of infection by sexually

transmitted diseases. There are also groups of disadvantaged women who for differing reasons may experience a concentration of health and social problems or who find access to health services difficult. Women's health issues also include the consultation of women by health agencies, the participation of women at all levels in the health services, the representation of women in decision making in the health services and the contribution this country can play in promoting women's health in the developing world.





The Health of  
Irish Women

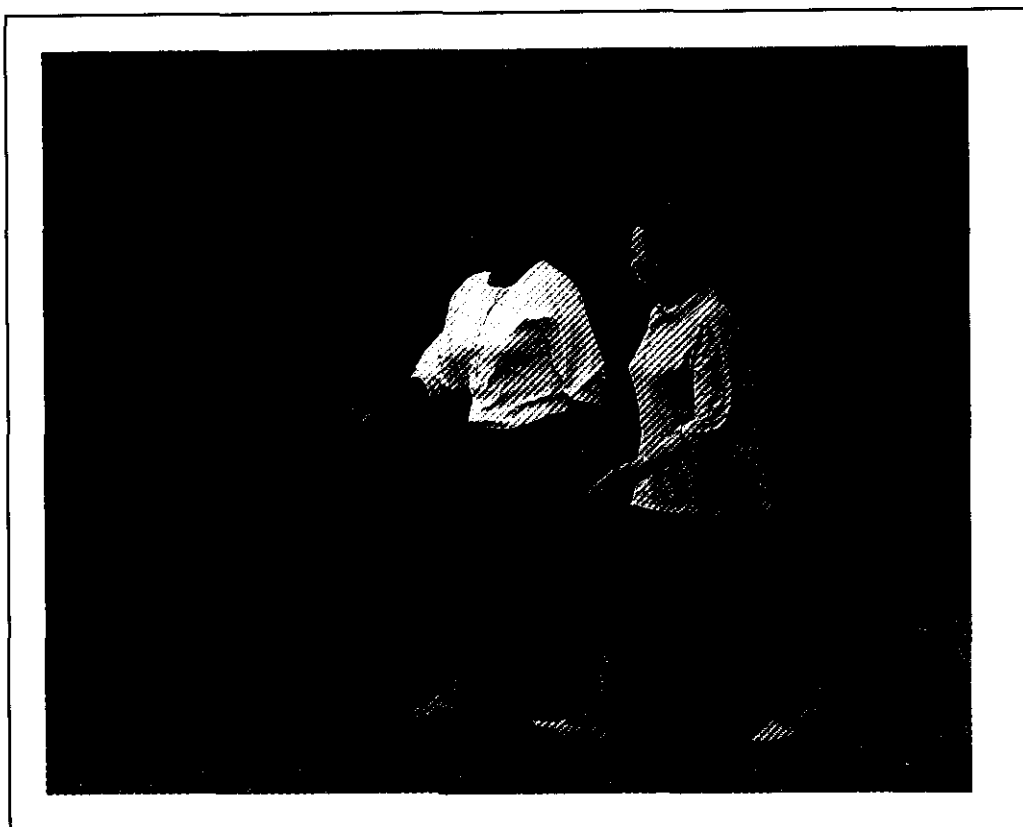






TABLE 1 CAUSES OF DEATH IN IRISH MEN AND WOMEN, 1993

Cause of Death	Male	Female
<b>Malignant Neoplasms of:</b>		
Breast	-	647
Trachea, Bronchus & Lung	1087	509
Colon	395	316
Ovary	-	206
Stomach	267	178
Leukaemia	149	102
Skin	52	50
Cervix	-	74
Other	2165	1341
<b>Total</b>	<b>4115</b>	<b>3423</b>
Disease of Circulatory System	2857	3562
Ischaemic Heart Disease	4594	3208
Pneumonia, Bronchitis, Emphysema & Asthma	1115	1220
Injury & Poisoning	935	437
Other Causes	3167	3023
<b>Total Deaths in 1993</b>	<b>16,783</b>	<b>14,873</b>

Source: Vital Statistics - Fourth Quarter and Yearly Summary, 1993 CSO



**TABLE 3 CAUSES OF DEATH IN MEN IN IRELAND AND THE EU**

**AGE STANDARDISED DEATH RATES PER 100,000, 1991**

SDR/100,000 Men	All Ages		0 - 64 years	
	Irl	EU	Irl	EU
Diseases of the Circulatory System	523.4	(402.7)	132.2	(93.3)
Ischaemic Heart Disease	330.4	(180.1)	100.7	(53.5)
Cerebrovascular Diseases	84.5	(97.9)	12.5	(15.2)
Cancer of Digestive Organs and Peritoneum	89.6	(85.8)	32.4	(31.8)
Trachea/Bronchus/Lung Cancer	68.2	(76.8)	24.0	(33.3)
Bronchitis/Emphysema/Asthma	22.1	(27.4)	4.1	(4.5)
Motor Vehicle Accidents	17.3	(21.6)	-	-
External Causes of Injury and Poisoning	61.00	(69.2)	-	-

Source: World Health Statistics HFA 1994

Age standardised rates (SDR) for men from diseases of the circulatory system and ischaemic heart disease have been declining but are still considerably higher than the EU average (Table 3). SDRs for men from cancer of the trachea, bronchus or lung have been decreasing since 1987 and are now below the EU average. However, the SDRs for women are continuing to

rise for these cancers (Table 2). In cancer of the digestive organs and peritoneum, SDRs for men are closer to the EU male average than Irish women are to the EU female average. Cerebrovascular disease death rates have dropped below the EU average for men. However, premature mortality rates for women are still above the EU female average (Table 2).

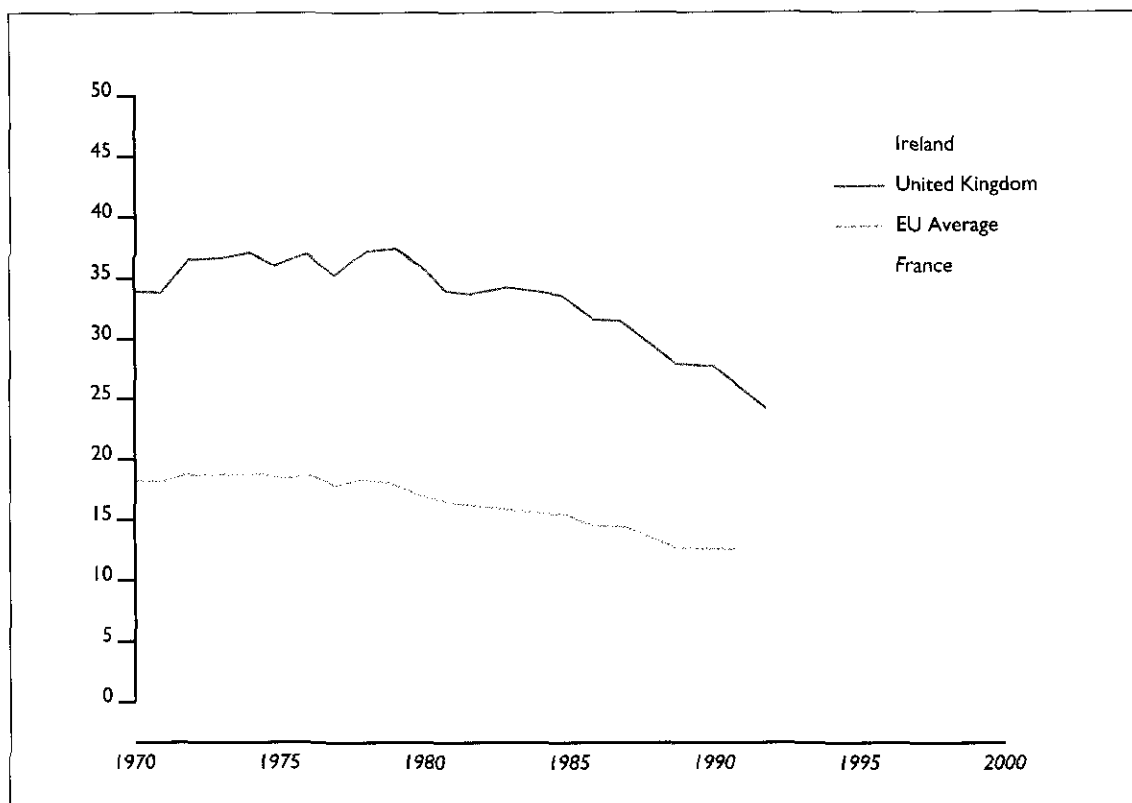


## CARDIOVASCULAR DISEASE

The **Health Strategy** identifies smoking as the cause of about 30 per cent of cardiovascular deaths internationally. Cardiovascular disease is also influenced significantly by factors such as diet and

blood cholesterol level. Other risk factors include hypertension, high alcohol consumption and lack of physical exercise.

**FIGURE 1 FEMALE MORTALITY FROM ISCHAEMIC HEART DISEASE 0-64 YEARS**



Age Standardised Death Rates per 100,000 Females. Source: World Health Statistics HFA 1994

Heart disease and circulatory disorders accounted for almost one quarter of deaths in women under 65 years in 1990. Mortality from ischaemic heart disease in Irish women is

amongst the highest of any of the countries of the European Union and is currently 70 per cent above the EU average (Figure 1).

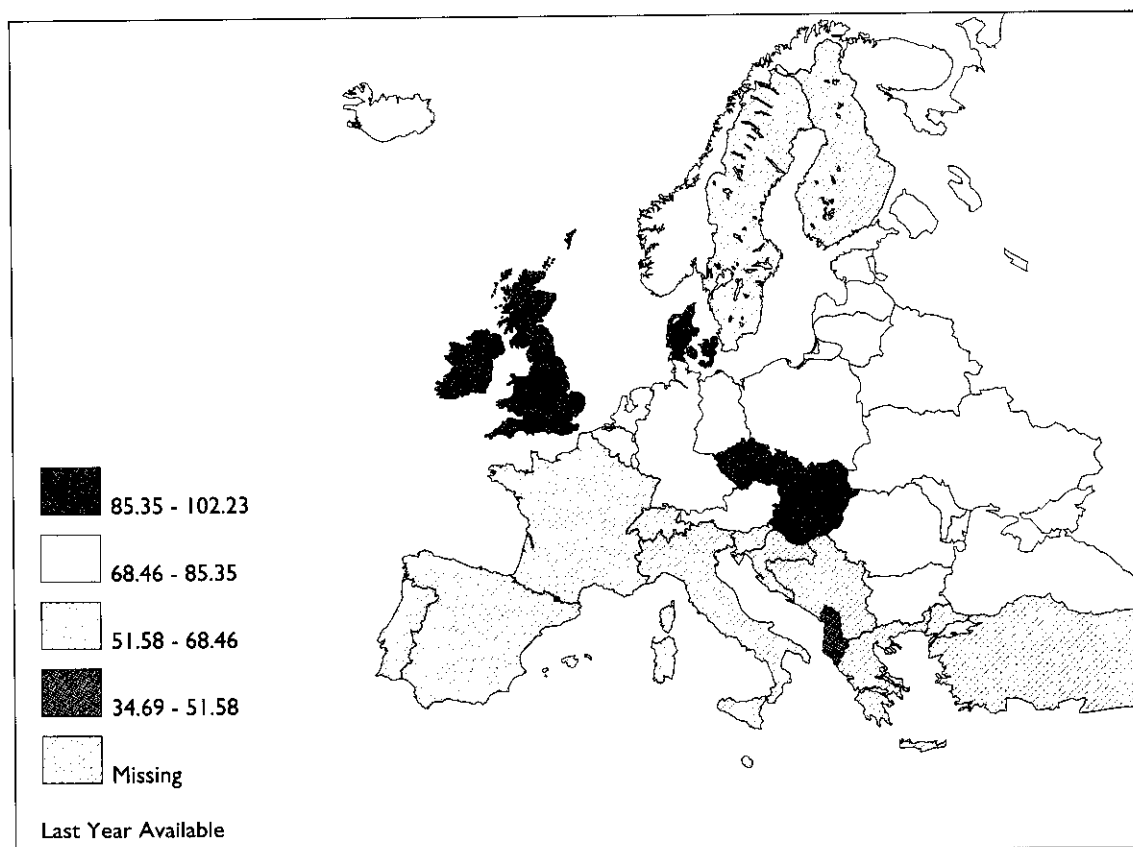


## CANCER

The Health Strategy states that smoking is a critical risk factor in the incidence of cancer. It is a major causative factor in almost 90 per cent of the 1,500 deaths from lung cancer which occur in Ireland each year. It is also known to increase the risk of cancers of the mouth, throat, oesophagus, bladder and

kidneys. Studies have also suggested that consumption of animal fat is positively related to the risk of cancer and that increased fibre consumptions may reduce this risk. Over-exposure to sunlight is an increasing cause of skin cancers.

**FIGURE 2 FEMALE MORTALITY FROM MALIGNANT NEOPLASMS 0-64 YEARS**



Age Standardised Death Rates 1991. Source: World Health HFA 1994

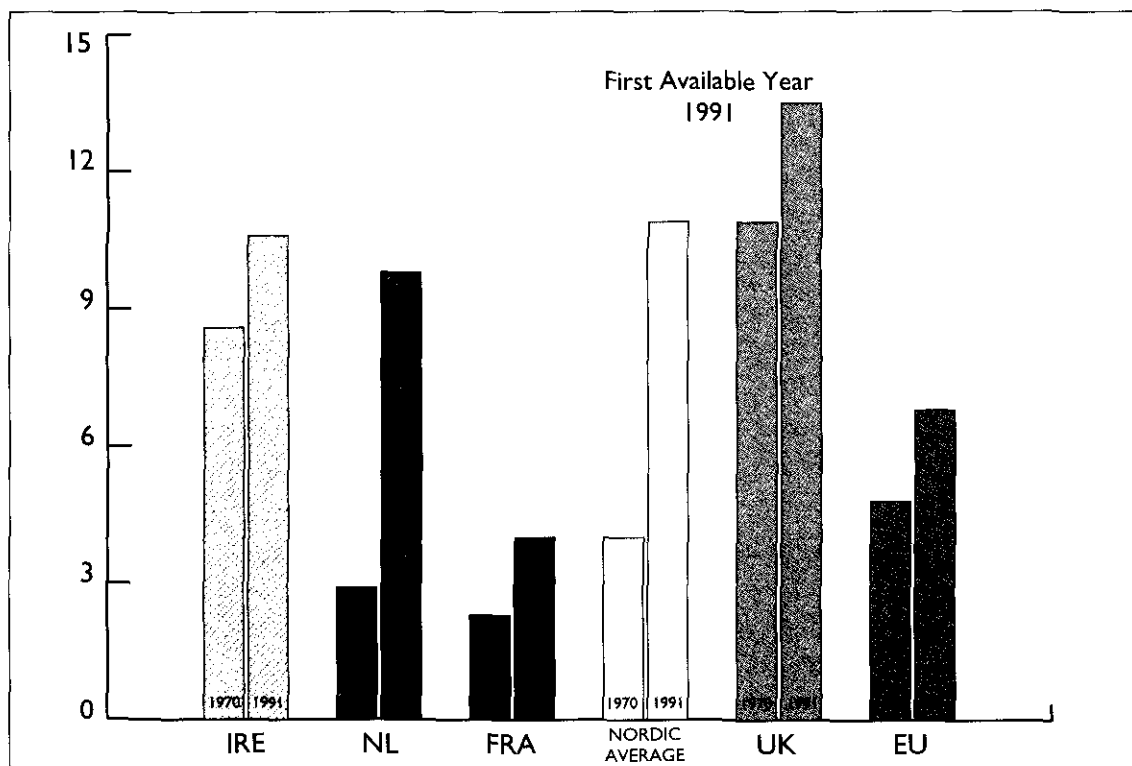


## LUNG CANCER

Total deaths from lung cancer increased steadily until they peaked in 1987. In 1993, 509 women died from lung cancer and associated cancers of the trachea and bronchus<sup>(2)</sup>. This accounted for 14.8 per cent of all cancer deaths. Since women started smoking heavily about twenty to thirty years later than men, lung cancer rates in women are continuing to rise whereas in men they are beginning to fall. In Ireland the ratio of male to female deaths for lung cancer is now less than

2.5:1 whereas in 1970 it was 4:1. In 1994 Ireland ranked fifth highest for deaths from lung cancer in women in selected European countries, with men ranking tenth highest<sup>(3)</sup>. In some countries lung cancer has overtaken breast cancer as a cause of mortality among women. Although the standardised mortality rate for females is lower than in the United Kingdom, it compares unfavourably with the EU average (Figure 3).

**FIGURE 3 FEMALE MORTALITY FROM CANCER OF THE TRACHEA/LUNG/BRONCHUS 0-64 YEARS**



Age Standardised Death Rates for 100,000 females 1970-1991. Source: World Health Statistics HFA 1994



incidence among women aged 50 approaches 2 per 1000 women per year and the disease is the single commonest cause of death among women aged 40-50, accounting for about a fifth of all deaths in this age group. <sup>(6)</sup>

Incidence and prevalence rates are not yet ascertainable in Ireland. However the Mater Foundation screening programme for a defined population has reported a prevalence rate of 7.9 per 1000 which is high by comparison with other European countries and an incidence rate of 1.5/1,000 women which is higher than in the United Kingdom.

Women most at risk of breast cancer are likely to be aged fifty or over; to have a family history of breast cancer and to have had a previous cancer episode in a breast. Five to ten per cent of breast cancer is due to an inherited predisposition which manifests in women in their thirties and forties and also appears in successive generations. In addition the genes BRCA1 and BRCA2 predispose to ovarian cancer. The risk of breast cancer is higher for women living in western developed countries. The occurrence of menarche less than 11 years, menopause greater than 54 years, previous benign breast disease, nulliparity or first pregnancy after 30 years of age also increase the risk <sup>(6)</sup>. Affluent women have a higher incidence rate of breast cancer but better survival rates than women who are socio-economically deprived <sup>(7)</sup>. Women living in countries with high fat consumption have the

highest rates of breast cancer <sup>(6)</sup>. There is some evidence that alcohol intake as low as 10 gms per day may be an associated risk factor. Breastfeeding is said to have a protective effect. However, both of these factors are still under debate. Prolonged hormone replacement therapy, after 10-15 years of use has also shown an increased risk of breast cancer. <sup>(6)</sup>

It is not possible to prevent breast cancer at present. However, early detection may prolong life and improves the quality of life of victims of the disease. Studies have shown that approximately 20 to 30 per cent of deaths in women over 50 could be prevented if a mass screening programme was established for women aged 50 to 64. No benefit from mass screening has yet been shown for women aged less than 50 years.



## CANCER OF THE CERVIX

Cancer of the cervix is a relatively uncommon cancer in western developed countries but is common in the under developed world. Approximately 460,000 cases of cervical cancer occur worldwide each year and three quarters of these are in the underdeveloped countries<sup>(6)</sup>. In 1993 cervical cancer accounted for 74 deaths in this country (Table 1). In addition each year there are approximately 25 deaths certified as due to cancer of the uterus unspecified and at least half of these are likely to be due to cancer of the cervix. Cervical cancer accounts for 2 per cent of all cancer deaths in Irish women and an age standardised mortality rate of 3.2 per 100,000 women. Although deaths due to cervical cancer tend to occur more often in older women and are rare in women under 35 years of age, sixty per cent of the deaths in 1993 occurred in women aged less than 65 years<sup>(7)</sup>.

The risks factors for the disease are multifactorial and at present the exact cause of cervical cancer is uncertain. However the human papilloma virus types 16 and 18 are considered to be linked to the subsequent development of cervical cancer. The condition being screened for in cervical screening is the precursor of cervical cancer rather than the disease itself and is asymptomatic. The precursor, known as cervical intraepithelial neoplasia (CIN), usually precedes cervical cancer and can take up to ten years to become invasive. Some cases of CIN will regress if left untreated and because it is not possible to distinguish those

that will progress to cancer, all cases of CIN II and CIN III are recommended for treatment and CIN I is placed under surveillance. Treatment of this condition is almost completely successful in preventing cervical cancer whereas treatment of cancer of the cervix only has an overall five year survival of 57 per cent. While cervical screening is simple, quick and relatively inexpensive, not all women at risk of the disease respond to requests to attend for screening. It has been found that women from the higher socio-economic groups present for screening but women from the lower socio-economic groups may fail to do so<sup>(8)</sup> and may even ignore symptoms of the condition. It is in the main among the latter groups that deaths from cervical cancer occur<sup>(10)</sup>.



## INJURY (ACCIDENTS) AND OSTEOPOROSIS

*The **Health Strategy** welcomes the decreasing trend in accidental deaths which fell by about 30 per cent over the past twenty years.*

Despite a welcome fall in mortality, injury is still a major cause of premature death and disability in Irish women. Accidents account for about 15 per cent of deaths of people under 65 years. Each year approximately 500 women die as a result of injury. Forty per cent of these deaths are to women aged less than sixty years. Injuries and injury deaths, of which fractures are the single major cause, increase with age. Road traffic accidents account for one-fifth of injury deaths and are commoner in younger women. Falls account for over one-third of the deaths and pose a special problem for older women. Osteoporosis can predispose postmenopausal women to fracture of the hip. It is estimated that 12 per cent of women will sustain a hip fracture by the age of 85 years. In a national study one fifth of women claimed not to know the aetiology of this condition and the means of avoidance <sup>(1)</sup>. Osteoporosis can be prevented by exercise, a diet containing calcium, non smoking, low alcohol intake and hormone replacement therapy.

Falls are the major cause of home injuries where forty per cent of all injury deaths take place. Fires and hypothermia are other important causes of injury and death in Irish women. In 1993, sixty six women died as a result of suicide, accounting for eighteen per cent of total suicides <sup>(2)</sup>. Further

attention needs to be given to the causes and prevention of injuries to women. There is a need for increased awareness that safety in general and falls in particular are important health issues for Irish women.

*The **Health Strategy** concludes that given the multi-sectoral approach and concerted action required to achieve a reduction in accidents, the Minister for Health will liaise with the Ministers having responsibility for the relevant agencies so as to agree appropriate mechanisms for co-operation and co-ordination in their accident reduction initiatives.*

**The action programmes to reduce injury and accidents outlined in the Health Strategy will focus nationally and regionally on causes of accidents.**





**TABLE 5 NUMBER OF DISCHARGES BY GENDER OF PERSONS AGED 15 YEARS AND OVER FROM ACUTE GENERAL HOSPITALS IN 1993**

Disease	Number Male	Number Female	% Female	Average length of stay in days Male	Average length of stay in days Female
Digestive System	32702	34673	52	5.1	4.8
Musculoskeletal System & Connective Tissue	23544	22560	50	6.9	9.7
Skin, Subcutaneous Tissue & Breast	14295	19319	56	3.5	4.6
Reproductive System	8272	17841	68	6.7	4.7
Respiratory System	18141	15180	46	10.7	12.5
Nervous System	15365	12323	45	10.7	13.5
Ear, Nose & Throat	10702	8899	45	4.3	3.7
Eye	6906	7530	52	3.9	3.7
Kidney & Urinary Tract	10137	6802	40	6.0	6.8
Pregnancy, Childbirth & The Puerperium	-	6434	100	-	4.0
Hepatobiliary System & Pancreas	3489	5785	62	9.8	8.1
Injury, Poisoning & Toxic Effect of Drugs	4644	4285	48	3.6	4.0
Endocrine, Nutritional & Metabolic	2967	3866	57	7.1	8.8
Blood & Blood Forming Organs	2083	2621	56	6.1	7.0
Mental Diseases & Disorders	1059	1472	58	13.6	27.3
Infectious & Parasitic Diseases	1402	1416	50	9.8	13.9
Other	12404	12637	51		
<b>Total Discharges</b>	<b>196055</b>	<b>206155</b>	<b>51</b>		

Source: Hospital In-patient Enquiry, 1993

Note data from Psychiatric and Maternity Hospitals are not included



Eating disorders commonly known as anorexia nervosa and bulimia occur almost exclusively in females. Up to one per cent of girls in the 13-19 year age group suffer from these eating disorders. In 1994 between 150 and 200 new patients were referred to the psychiatric clinic in St Vincent's Elm Park which provides a specialist service to those suffering from these disorders. There are approximately 220 admissions per annum to all hospitals in the country. The aetiology of the disorder is complex and prognosis is poor with a 20 per cent recovery

rate. A further 20 per cent become chronic and 60 per cent continue to have psychological problems. Mortality is 5 to 10 per cent in the chronic state and is often due to suicide.

**The Health Strategy states that further progress will be made over the next four years in developing services for people with mental illness or infirmity, in appropriate settings such as specialist departments in general hospitals, hostels and day centres in the community.**

## RESEARCH

There is a recognised link between the occurrence of illness and disease and certain socio-economic groups. However, there is a scarcity of data relating to illnesses in women by socio-economic group in this country. The Institute of Women's Health at the National Maternity Hospital commissioned a major study of women's health needs which, when published, will provide vital information on some aspects of women's health. The Institute has kindly allowed some of the results of the research to be used in this **Discussion Document** and are referred to

below. Comprehensive information on women's health is essential to the development of a women's health policy that addresses the real health needs of women.

**The Health Strategy announced that a comprehensive data base will be developed to identify needs, monitor ongoing programmes as well as target achievements. Within this data base particular attention will be paid to identifying and addressing particular health problems pertaining to women.**



Eligibility  
of Women for  
Health Services





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There is confusion in relation to entitlement to some health and personal social services provided by health boards in the community. Such services include home nursing for non-medical card holders, home help services, meals on wheels, laundry services, day care services, transport to out-patient or day services. Because these services are used predominantly by older women and because women are the main carers in the home of older people, the confusion about entitlements probably has a greater impact on them than on men. The rules governing entitlement to health and personal social services in the community need to be formalised and

standardised across health boards.

The Health Strategy has promised that national guidelines on eligibility and charges, which will be applied in a uniform manner in all areas, will be introduced in respect of all services where legislative provisions are at present absent. This development will form part of the reform of the framework of the health services and will be underpinned by the new legislation. The new legislation will also update existing provisions governing long-term care for those who are no longer able to look after themselves in the community.



Health Services  
particular  
to Women





Appointment systems are essential and should be arranged in all maternity hospitals. The extent to which women experiencing a normal pregnancy require to be seen in hospital as frequently as at present is also open to question. Closer links between general practitioners and maternity hospitals in antenatal care would reduce unnecessary visits to hospital and time consuming journeys for many women. The **Report of the Second Commission on the Status of Women** points out that many women are not aware of the free maternity and infant scheme whereby all women can avail of free ante and post natal care from their general practitioners, thus avoiding long hours travelling to and waiting in maternity hospitals and units. Wider use of the scheme would also ensure more time available for women who require the specialist care of a maternity unit and would facilitate greater continuity of care by medical and midwifery staff of individual mothers.

*The Maternity and Infant Care Scheme has been reviewed by a working party in the context of the maternity services generally. It is expected that the report will be presented to the Minister soon.*

Maternity services should, as far as possible, be integrated with the other health services women need. The role of the family doctor in the care of pregnant and post partum women should be strengthened in the interest of continuity of care of mother and child.

In 1993 there were 196 domiciliary births, representing 0.4 per cent of births in that year. It is sometimes argued that there should be greater support for home births from the health services. While recognising that mothers who choose to give birth in their own home are entitled to the medical and midwifery care they require, there are good arguments why the health services should discourage home births. The main reason is because the health of the new born child is at greater risk in the home than in a well staffed and equipped maternity unit. The perinatal mortality rate fell from 24 per 1,000 to less than 10 per 1,000 live and still births between 1970 and 1990. Maternal mortality is now below the EU average and is currently 2 per 100,000 live and stillbirths. This improvement can be attributed to good antenatal and perinatal care provided by our hospitals. Many of the criticisms of services which encourage women to give birth at home would be met if the maternity units could further facilitate women giving birth by providing domestic style surroundings, with more choice, the minimum of unnecessary interference as well as early discharge home after birth.

Midwives, as the profession which is responsible for the care of women in normal labour and childbirth, have a particular responsibility to recognise the changing aspirations of women in relation to childbirth and to facilitate an appropriate response to that change.





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- the Health Promotion Unit Budget Plan for 1995 to include provision for the designation of the Unit as a National Breastfeeding Resource Centre;
  - from 1995, all courses for health professionals to incorporate the recommendations on professional training contained in this report;
  - at the 1996 review of the EC Directive on Maternity Leave, this country to support the extension of such leave to 16 weeks;
  - by the year 1997, the social and health education programme in primary and secondary schools to contain a component on breastfeeding;
  - by 1998, the public sector and in particular the health sector, to give a lead in the provision of workplace creche facilities and lactation breaks.
- The implementation of the targets will be monitored by the Health Promotion Unit through feedback from the various agencies involved in the promotion of breastfeeding.**





It is estimated that 63,000 Irish women have had abortions in Britain in the past 23 years. The statistics are based on the numbers of women who attended clinics and gave addresses in Ireland. A crisis pregnancy and the decision to have an abortion do not happen in isolation from other parts of a woman's life. Some women experience significant psychological and emotional trauma following an abortion. Other problems in a woman's life may be magnified by the experience of abortion. In a survey carried out by the Irish Family Planning Association (IFPA) of 193 Irish women who had abortions in Britain, only 15 or 7.8 per cent returned to the IFPA for post-abortion counselling <sup>(15)</sup>. General

practitioners, staff in the mental health services and in the maternity services need to be alert to this problem and provide counselling or arrange for such counselling.

**The Commission on the Status of Women recommended that the Department of Health commission research on the long-term implications for the well being of women who have had abortions, with a view to framing a policy response. The Department will investigate the feasibility of carrying out such a study and if it is found to be feasible, will commission the necessary research.**



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## MENSTRUATION

For most young women, menstruation causes little or no problem. A minority may experience considerable pain and distress associated with the menstrual cycle. The Department of Health has helped to redress an information deficit on menstruation with the publication of **The Gynae Book**. A booklet on menstruation for young girls has also been published by the Health Promotion Unit in conjunction with the Council for the Status of Women. Some hospitals have responded to the problems associated with menstruation by holding separate specialist clinics

with access by referral from general practitioners. This is an innovation which other maternity hospitals and gynaecological departments could adopt. Good liaison with general practitioners will be vital to the effectiveness of the specialist clinics.

*Each health board and voluntary hospital should review the way in which services for young girls with problems associated with menstruation are provided.*



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## GYNAECOLOGY

Women frequently need medical assistance because of complications of their reproductive and urinary systems and related problems. Women require these services throughout their lives but particularly from adolescence to old age. Advice on gynaecological problems is available to women through their family doctor, family planning clinics, with referral to specialist care if necessary. As far as possible, there should be integration and continuity of care for women with gynaecological problems. Similar criticisms to those of the maternity services have been made of the gynaecological services - lack of privacy, long waiting times in out-patient departments and unnecessary intrusion by medical students

during consultations. Although there are 83 obstetrician/gynaecologists employed as consultants in the public health services, only 3 are women. The absence of a significant number of women in this speciality dealing with the most sensitive issue of women's health is a serious shortcoming in the existing services. The first part-time training post in this specialty was advertised for Coombe Women's Hospital/St James's at the end of 1994. Further opportunities for part-time training need to be encouraged.

*Each health board and voluntary hospital should review the organisation of gynaecology services to improve the quality of the service available.*

## URO-GYNAECOLOGY

One in every four women will experience one or more episodes of urinary incontinence during her lifetime and for one in fifteen the problem is such that it will significantly impair her quality of life. Women are frequently reluctant to reveal this problem despite considerable distress. Genuine stress urinary incontinence (GSUI) accounts for approximately 60 per cent of all cases of female incontinence; detrusor instability (DI) and mixed GSUI and DI account for most of the remainder.

Treatment of incontinence is effective in over 85 per cent of cases. In addition approximately one third of women with urinary incontinence will have an additional gynaecological problem; genital prolapse, menstrual dysfunction, pelvic pain, menopausal symptoms, etc. Uro-gynaecology clinics are available in a few hospitals but need to be more widely available.



issues of quality assurance and audit. On the basis of submissions made to the European Union and site visits carried out by experts of the European Breast Cancer Screening Group, the Mater Hospital has been designated as a European Reference Centre (EUREF).

The guidelines followed by the screening programme were those laid down by the Karolinska Clinic, Sweden and addressed the total management of the breast cancer patient. The Karolinska's approach integrates all of the team facilities required for breast cancer screening. It ensures the optimal diagnosis and management of the patient and it helps to eliminate false-positive diagnoses. A false-positive diagnosis is when a woman is identified as possibly having breast cancer following mammography but is subsequently found not to have the disease. False-positive diagnoses give rise to a great deal of anxiety on the part of the women concerned. The Karolinska approach emphasises a three strand approach of clinical palpation, mammography and fine needle aspiration as the way of reducing the number of false-positive diagnoses.

The Mater Foundation Screening Programme has adopted this quality approach and has produced important information regarding the feasibility of a mammographic programme. The report on the Programme has been submitted to the Minister and is currently being evaluated by the Department.

*The Second Commission on the Status of Women recommended that in the medium term there should be a national breast cancer screening programme aimed at enabling women in the high risk group to have access to mammography for screening purposes. The Programme for Government **A Government of Renewal** makes a commitment to the expansion of mass screening for breast cancer on a phased basis for all at-risk women.*

**The Minister made £600,000 available this year to facilitate the phased expansion of a breast cancer screening programme to women aged 50-64 years. The expert advice available to the Minister emphasises the importance of gradually building up the expertise in mass screening for breast cancer to ensure a service of highest quality for the women in the target age group of 50 - 64 years.**

#### **GENETIC SCREENING FOR BREAST CANCER**

Genetic screening of family members at risk of breast cancer can now be undertaken and opens up a largely unexplored area with many controversial issues. There is a need for increased awareness of the potential of genetic screening to identify at risk women and for counselling of those women and their families who chose to avail of this technique. It is unlikely that the needs of such families can be met through the clinical genetic service and therefore it may be necessary to establish a service specifically focused on patients with cancer.



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## CERVICAL CANCER

About 60 - 70 women die each year from cervical cancer. Unlike ovarian cancer, a significant number of these deaths could be prevented if the disease had been detected and treated at the precursory stage. Cervical screening is available to women through their general practitioners, family planning clinics, maternity hospitals and special clinics organised by health boards in some community care areas. It is estimated that 65 per cent of women in Ireland have had a cervical smear at some time <sup>(1)</sup>. Uptake of the service varies significantly by age, employment status, educational experience and geographical location <sup>(1)</sup>.

A smear may be undertaken as a diagnostic or screening service. As a screening service, it is not included as one of the services provided free of charge under the general medical services to women with medical cards by their general practitioners. Although many general practitioners provide this service without charge, it would be preferable if cervical smear testing was provided as part of the general medical services as recommended by the Report of the Second Commission on the Status of Women. Women who are medical card holders could be informed of the availability of the service and encouraged to avail of it at the appropriate intervals. The Department and the health boards could promote the service among women and encourage them to avail of the service either from their general practitioner or family planning clinic at the appropriate interval.

Smears are analysed in a number of hospital laboratories throughout the country. The largest public cytology laboratories are located in St. Luke's Hospital, Dublin, University College Hospital, Galway, Coombe Women's Hospital and Cork Regional Hospital. A total of 154,224 smears were analysed in public and private laboratories for both diagnostic and screening purposes in 1992. The charge for having a smear analysed in a public laboratory was recently removed.

The **Interim Report on Cervical Screening Services (1988)** recommended that the interval between the taking of a smear and the issue of the result should not exceed one month. This recommendation has been endorsed by the **Report of the Second Commission on the Status of Women**. There has been progress on this issue as seventy five per cent of laboratories now report the result of smear tests within four weeks. As agreed in the **Programme for Economic and Social Progress**, the Minister reconvened the expert committee under the chairmanship of the Chief Medical Officer of the Department of Health. The expert committee reviewed all aspects of the cervical screening service. It is generally agreed that opportunistic screening such as the current Irish screening service while being of benefit to the individual is not effective in reducing overall mortality in the population. This can only be achieved by a population screening programme. A major





the trauma of the assault. Multi-disciplinary teams of health professionals in each health board area provide the necessary psychological support services for victims.

**The full implementation of the Child Care Act, 1991 will be a major contribution towards protecting children from abuse. A Government of Renewal, the policy document of the Government, makes a commitment to the rapid implementation of the provisions of the Child Care Act. To this end, substantial additional resources are being provided to develop the infrastructure needed to support the legislation. The full year cost of the various new child care and family support services approved by the Minister during 1993 and 1994 is in the region of £20m. An additional £10m has been provided in 1995 to continue the implementation of the Act. It is expected that funding of a similar amount will be provided in 1996.**

The Report of the Kilkenny Incest Investigation recommended that refuges for victims of domestic violence should be provided by each health board either directly or in association with voluntary agencies. It also recommended that refuges should have access to back up facilities and professional counselling services. The Minister has accepted these recommendations and has indicated that he regards the provision of refuges and other services for victims of domestic violence as an important component of

the network of child care and family support services being developed under the Child Care Act, 1991.

The level of financial support provided by the health boards to women's refuges represents 90 per cent of the total expenditure on such services. The Minister has provided funding to the health boards for additional emergency accommodation for victims of domestic violence in Navan, Castlebar, Wexford and Letterkenny and the appointment of additional social workers and child care workers to provide support to families in difficulty. It is the Minister's intention that further progress will be made towards the improvement of services for victims of domestic violence as part of the full implementation of the Child Care Act, 1991. These initiatives are also in line with the recommendations contained in the **Report of the Second Commission on the Status of Women.**

*The **Health Strategy** proposes to expand the services for women who are victims of rape and domestic violence, and to co-ordinate these services more effectively with other health services. The Minister is committed to the improvement of services for victims of domestic violence as part of the full implementation of the Child Care Act, 1991.*



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## TEENAGE PREGNANCIES

In 1993 there were 2,637 births to women aged less than 20, of which 57 were under 15 years of age <sup>(2)</sup>. While the total number of births to teenagers has been falling, the number of births to single, teenage mothers has been rising. Only 9 per cent of births to teenagers in 1993 were to married women, compared to 60 per cent in 1980. The increase in births to teenage single mothers is a matter for concern. Most teenagers are ill equipped physically, emotionally and financially for motherhood and child rearing. A high proportion of these young mothers come from deprived urban areas. Factors associated with the rising number of such pregnancies are sexual activity without contraception, irresponsible use of alcohol and addiction to other drugs. A multi faceted programme is needed to educate young people, both male and female, in more responsible attitudes to sexual activity and relationships and about the responsibilities of parenting. Priority needs to be given to deprived urban areas in the development of such a programme. The Health Promotion Unit has provided a grant to the Eastern Health Board to develop a pilot programme to reduce teenage pregnancies. The programme has been developed by public health doctors on the staff of the Board, in conjunction with teachers and parents.

A recent report on adolescent reproductive behaviour in Northern Ireland has recommended that programmes aimed specifically at reducing

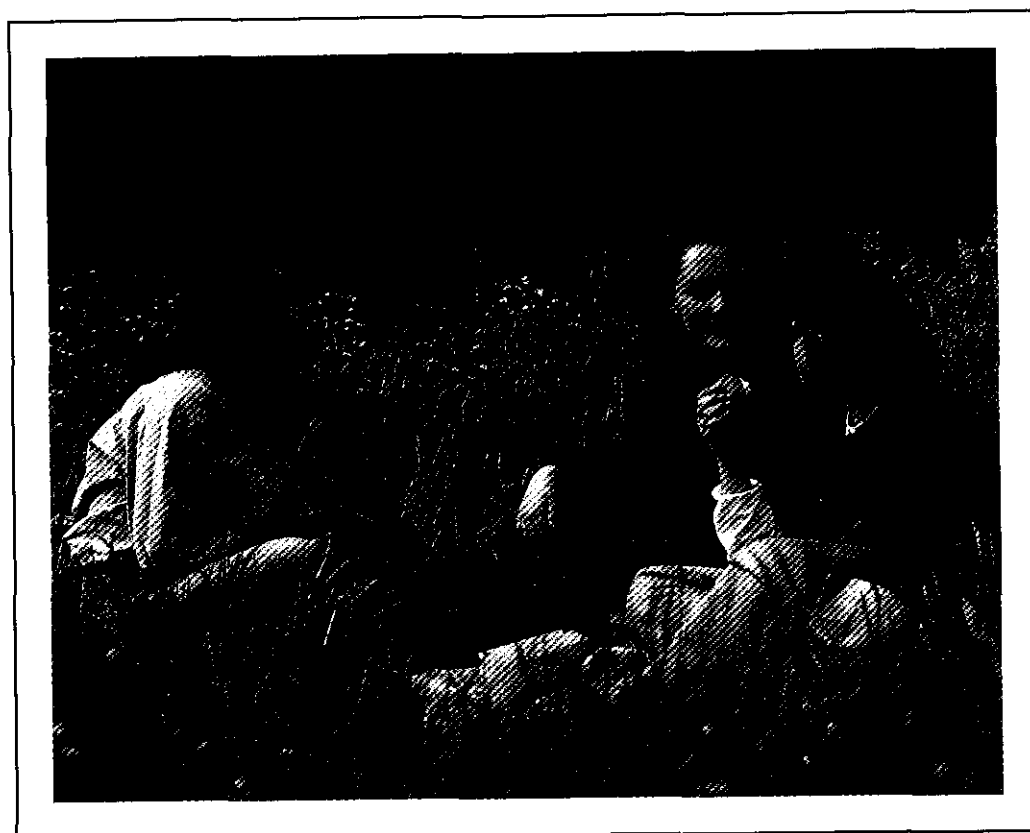
unplanned pregnancies are necessary. It also concluded that the health services should develop guidelines on how best to respond to the needs of teenagers who become pregnant especially those with no partner in evidence. <sup>(16)</sup>

*Under the Health Strategy, there will be a specific policy of targeting resources towards areas or groups with low health status and giving them priority in the development of services. The health boards will be required to identify "health development sectors" in each region on the basis of indicators of health status and social problems, with particular attention to be given to teenage pregnancies.*





Health issues  
which predominantly  
affect Women





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- health boards should ensure that vasectomy services are available;
  - *arrangements for the dissemination of information on family planning should be made by health boards;*
  - *copies of family planning materials, including those available from Health Promotion Unit of the Department of Health, should be made available to the public through sources such as general practitioners, non-governmental organisations, maternity hospitals/units, pharmacies and health board services;*
  - each health board should provide a leaflet which outlines the type and range of family planning services available in its area and details of service-providers or contact phone numbers;
  - the family planning requirements of individuals in deprived and/or at-risk groups, and for those with special needs, should be established by health boards, in consultation with the groups involved and provided in a *manner which is easily understood by the recipients;*
  - health boards should ensure that the family planning needs of persons living in remote areas are adequately met;
  - health boards should devise appropriate arrangements to ensure a co-ordinated

approach to the development and implementation of family planning services.

Health boards have been asked to report to the Department of Health on the specific measures which will be implemented to comply with the guidelines.

**The Minister also announced that a comprehensive family planning service would be available, before the end of 1995, to women entitled to use the General Medical Services.**

The Health Promotion Unit has published a leaflet on methods of family planning. This complements a range of leaflets on specific methods of family planning which have been developed by the Well Woman Centre and a guide to contraception developed by the Irish Family Planning Association, with financial support from the Health Promotion Unit. The Report of the Second Commission on the Status of Women recommended that maternity hospitals, as a condition of public funding, should incorporate a family planning service advising on all legal methods of family planning as part of post maternity care. The Commission also recommended that publicly funded hospitals should, as a condition of funding, provide female sterilisation on referral from a doctor. While such an approach is appropriate to publicly owned and managed hospitals, in a pluralist society the ethical views of the proprietors of voluntary hospitals should also be respected.



## DEVELOPMENTS IN HUMAN REPRODUCTION

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Major developments have taken place in recent years in medical science's ability to control the human reproductive system. In-vitro fertilisation (IVF) and allied techniques are, in particular, a significant advance for the treatment in certain cases of human infertility. In-vitro fertilisation is presently available at the Human Assisted Reproduction Unit at the Rotunda Hospital. This Unit is a limited company separate from the hospital and funded outside of the health services. It is also understood that a privately funded IVF service has commenced in Galway. At present IVF is not covered by the general medical services nor is it covered by Voluntary Health Insurance. There is a strong case for the inclusion of IVF as a health service under the general medical services scheme.

While there is no specific legislation in this country governing in-vitro fertilisation, medical practice is governed by guidelines issued by the Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland and approved by the Medical Council. These guidelines apply only to registered medical practitioners. This country is virtually unique in Western Europe in not having legislation setting down the parameters in which developments in reproductive medicine can take place. While there is no suggestion that any abuses are taking place, it is desirable that issues of vital concern to human reproduction are safeguarded by law in this country.



## WOMEN INFECTED BY HEPATITIS C VIRUS

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The Blood Transfusion Service Board (BTSB) manufactured the product, Human Immunoglobulin - Anti-D, for clinical use in September, 1970 and routine supplies to maternity hospitals and units throughout the country commenced in April, 1971. Anti-D is a product given to prevent Rh Haemolytic Disease in the newborn babies of women who have Rh Negative blood when the baby has Rh Positive blood. Anti-D prevents Rh Haemolytic Disease by blocking the maternal production of antibodies which cross into the foetal blood stream, destroying the foetal red cells. The problem normally arises in relation to a second pregnancy and with increasing severity in subsequent pregnancies. Prior to the development of Anti-D immunoglobulin, it is estimated that over one hundred babies died in Ireland each year as a result of Rh Haemolytic Disease, and a large number of others were affected by conditions such as severe anaemia and brain damage.

Rh Haemolytic Disease is largely preventable by the use of Anti-D and the condition has now been all but eliminated. Anti-D is normally administered to mothers who have Rh Negative blood at the delivery of their first baby, and at the end of each subsequent pregnancy. It may also be administered at certain stages during pregnancy, such as at twenty-eight weeks, but clinical practices vary in this regard. Anti-D may also be given in the case of foetal maternal haemorrhage.

The hepatitis C Virus was first identified in 1989. Prior to that time it was grouped with other unidentified viruses and described as Hepatitis Non A Non B. A sufficiently reliable test for routine screening of blood donors for hepatitis C became available in 1991. This test was introduced in Ireland on 1 October, 1991. Following the discovery of an apparent link between Anti-D and hepatitis C in early 1994 the BTSB discontinued the manufacture of their Anti-D product and substituted WinRho SD, an Anti-D product made by RH Pharmaceuticals Inc., Winnipeg, Canada, for its own product and continued as a supplier of Anti-D to maternity hospitals.

On 21 February, 1994 the BTSB announced the establishment of a National Blood Screening Programme for all women who had received Anti-D immunoglobulin between 1970 and February, 1994. The number of persons who have been screened for hepatitis C under the National Blood Screening Programme is 57,763 as at 16 May, 1995. The number who have tested positive for hepatitis C antibodies as at 16 May, 1995, is 1,220. 505 of these women are positive for hepatitis C virus.

An Expert Group appointed by the Minister for Health reported on 5 April, 1995 on all the circumstances surrounding the infection of Anti-D immunoglobulin.

The National Blood Screening Programme also



Health issues  
which affect  
Women differently  
to Men





women and smoking. One advertisement focused on the harm done to the unborn child by smoking during pregnancy and another highlighted the way in which smoking interferes with personal appearance. These messages addressed to women were developed in consultation with the Council for the Status of Women (CSW) as part of the ongoing liaison between the HPU and the CSW. HPU has also provided financial support to the CSW for the organisation of a seminar on young women and smoking and to the Women's Committee of the Irish Congress of Trade Unions for a leaflet on smoking.

It appears that the reasons why women start smoking and are more reluctant than men to stop smoking are complex. More research is needed on the reasons why women smoke and on the effective strategies to persuade them to stop smoking.

**The Health Strategy proposes a target for the reduction of smoking of at least 1 percentage point per year so that more than 80 per cent of the population aged fifteen years and over will be non-smokers by the year 2000. Specific attention will be paid to reducing smoking among women in the achievement of these targets.**



## WOMEN AND HIV/AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES

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Women who engage in unprotected sex face particular risks of contracting disease. In Ireland the rate of spread of Human Immunodeficiency Virus (HIV) is greater amongst heterosexuals than among other groups such as homosexual men or injecting drug users. Women who have unprotected vaginal intercourse with an infected person are more at risk of contracting HIV than men, as the virus passes more readily from men to women than from women to men. The main sources of HIV infection in women are heterosexual contact with an infected male or the sharing of contaminated injecting equipment by drug abusers.

At the onset of the epidemic in the early 1980s, heterosexual contact was not a major source of spread but as the epidemic has become more prolific, the risk to women has increased. In 1986 there was only one female case of AIDS in Ireland. Now eighty or eighteen per cent of the total AIDS cases are female. The majority of these cases are related to intravenous drug use. Transmission of the virus by injecting drug users is caused by having unprotected sexual intercourse with another person and by sharing needles or injecting equipment which are contaminated. It is apparent therefore that *women are becoming progressively more at risk of infection with HIV*. This pattern is similar to that in the United States and Western Europe. However the impact of HIV/AIDS is not just a matter of numbers. HIV/AIDS affects women,

not only as individuals who may be infected with HIV, but also as providers of health care, educators, wives, mothers, partners and workers.

### HIV POSITIVE MOTHERS

In Ireland 115 babies have been HIV positive at birth. Research being carried out at the Coombe Women's Hospital and Our Lady's Hospital Crumlin has indicated that approximately 30 of these babies remained positive at the end of the *first year of life and 15 of these developed AIDS*. This would seem to indicate a transmission rate from mother to infant of approximately 25 per cent. This is consistent with other Western European research. Research is continuing as it is not known at this stage if the disappearance of maternal antibodies in the majority of babies is permanent or whether they will develop the positive antibodies again.

### PREVENTION

To prevent the sexual spread of HIV infection, abstinence or avoidance of sex other than with a non infected life partner is the safest approach. For sexually active women who are not in a relationship with one faithful partner, a good quality condom, properly used, is the single most effective defence against HIV and the transmission of other sexually transmissible diseases. The female condom, now available in this country, is also a barrier method of contraception which acts by lining the inside of



## MENTAL ILLNESS IN WOMEN

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As discussed earlier, women's experience of mental health is different to men's. In the view of the Commission on the Status of women:

*"There are strong grounds for believing that the incidence of depression among women is a direct consequence of social and environmental factors related to the lesser financial and social status of women, isolation and inadequacies in the built environment."* (29)

There would appear to be considerable scope for promoting mental health in women and preventing some of the illnesses to which they are susceptible. The mental health services are undergoing a major transformation in this country, moving away from a reliance on institutional care to a service based in the general hospital and in the community. The service is developing a more preventive orientation, with earlier intervention. Promoting women's mental health and preventing mental illness in women have not been addressed specifically by the mental health services but there is clearly scope for a more co-ordinated response to these issues. The Commission on the Status of Women recommended that such a strategy be developed, based on research on the most appropriate intervention.

**The Minister will commission research on the factors associated with mental illness in women in this country following consultation with**

**women's health groups and mental health organisations.**

Concern has been expressed that current mental health legislation puts women at a disadvantage in relation to involuntary detention for treatment in psychiatric hospitals. It has been suggested that husbands may initiate detention procedures not so much because their wives need psychiatric care but because of matrimonial disputes. A survey carried out by the Department in 1992 found that slightly more husbands sought involuntary admission of their wives than wives sought for their husbands. In the Green Paper on Mental Health, published in 1992, the Government put forward proposals for new mental health legislation to provide greater safeguards for involuntary patients as required by the European Convention on Human Rights. Extensive consultation took place on the proposals of the Green Paper and the Government will shortly announce its proposals for new mental health legislation in the form of a White Paper. The new legislation will help to ensure that the need for treatment and care is the sole criteria in involuntary admissions to psychiatric hospitals.

**The Government will publish shortly a White Paper on Mental Health Legislation which will outline decisions in relation to the provisions of a new mental health act.**





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for the Improvement of Maternity Services. The Unit has also funded the publication of leaflets by the Arthritis Foundation of Ireland on arthritis, pregnancy and motherhood and on women and arthritis.

The Health Promotion Unit, in conjunction with the Council for the Status of Women, has published an information leaflet on **Stilboestrol (DES)** for the daughters of women who may have been prescribed the drug in the period 1949-1975. The Unit also published a leaflet on DES prepared for general practitioners by the Institute of Obstetricians and Gynaecologists. The leaflet was accompanied by a questionnaire to general practitioners, obstetricians and gynaecologists in an attempt to assess the extent of problems arising from DES in Ireland.

The HPU, in conjunction with the social work department of St James Hospital supported the group, Women's Aid, with the development of **Guidelines for Accident and Emergency Staff in Hospitals on the Identification and Management of Violent Assaults on Women**. The guidelines were published in July 1994.

The HPU, in conjunction with the National Youth Council of Ireland, has conducted two training courses for Youth Officers from every county branch of the Irish Countrywomen's Association (ICA). During the training course, participants were introduced to various methodologies which could be suitable for training young people to make informed and

healthy lifestyle choices particularly in the area of abuse of drugs, both legal and illegal. The ICA has also been involved in the dissemination of *Lifewise*, a community approach to achieving healthier lifestyles which covers nutrition, excessive smoking, alcohol and relaxation.

If those providing health information to women are to do their job effectively, they need accurate, up-to-date information on women's health needs. For this reason, the Health Promotion Unit co-funded a major national survey of women's health needs carried out by the Economic and Social Research Institute for the *National Maternity Hospital* Holles Street. The survey was undertaken by the Hospital in the context of its centenary celebrations in 1994. The results of the survey, when published, should provide valuable information on where useful health information and education interventions might be made in the future.

The HPU public office is open to the public, in person or by phone from 9.30 a.m. to 1 p.m. and from 2 to 5 p.m. each weekday. The effective delivery of the information service at local level depends on the co-operation of health professionals, voluntary organisations and women's groups, in ensuring that the information is accessible to those women who need it.

**The HPU will continue to work closely with women's organisations and professional groups to provide information of high quality on issues relevant to women's health.**



Access to Health  
Services by  
disadvantaged  
Women





## WOMEN IN ADVANCED OLD AGE

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Of those aged 75 years and older, women outnumber men by two to one. Over 90 per cent of those over 75 years of age are living at home and just under 10 per cent need long term nursing care. The objective of health policy towards older people is to maintain them in dignity and independence at home for as long as possible. Services to support older people at home improved in recent years but the rapid increase in the number of those over 75 means that services must continue to expand quickly if they are to meet their objective. Services in need of development are home nursing, home help, day care respite care and transport.

*The **Health Strategy** states that priority will be given over the next four years to strengthening home, community and hospital services to provide much-needed support to elderly people who are ill or dependent, and to assist those who care for them.*

When an elderly woman needs to be in hospital, she should be admitted on the same basis as a younger person. To ensure that older people receive the best possible care in hospital, each general hospital should have a specialist department of medicine of old age. There are now twenty such departments of medicine of old age in general hospitals around the country.

*The **Health Strategy** states that the number of specialist departments of medicine of old age will be increased so that every general hospital either has such a department or has access to one.*

When an older person can no longer be supported at home, care of a high quality should be available in health board homes and hospitals

or in voluntary and private nursing homes. At this stage many older women are very dependent and rely on staff for assistance with all the activities of daily living. The Health (Nursing Homes) Act, 1990 which came into effect in September, 1993 provides a new legal framework for voluntary and private nursing home care in this country. Every home must register with a health board every three years which will help to ensure high standards of care in all nursing homes. Since the introduction of the Act on 1st September, 1993 over 7,000 subventions have been approved. All homes will be obliged to enter into a written contract of care with each resident or the person acting on her behalf. A resident and person concerned with her care may make a formal complaint to a health board about standards of care and the board must investigate the complaint. A **Code of Practice for Nursing Homes** has been prepared in consultation with the main interests involved. The purpose of the Code is to complement the legislation by setting out what is regarded as high quality nursing care. It is hoped that the code will have a wider influence in relation to standards in health board long stay homes and hospitals.

*The **Health Strategy** states that adequate funding will be made available to meet in full the requirements of the Health (Nursing Homes) Act, 1990 by the end of 1996 and that additional places for convalescent care for elderly people, who do not need acute medical care, will be provided. A **Code of Practice for Nursing Homes** will be published shortly.*



## WOMEN IN RURAL AREAS

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*The main problem experienced by women living in remote rural areas in relation to their health is access to health services. They may have to travel long distances for family planning services, ante and post natal care and out patient appointments. The absence of public transport over much of rural Ireland increases the inaccessibility of services. Health boards need to be more aware of the problems which these women may experience and should consider innovative ways of ensuring that women in remote rural areas benefit from services which people in more populated areas take for granted.*

The Commission on the Status of Women recommended that each health board should establish mobile health centres to provide routine treatment to women in rural areas on a regular basis. Provided that there is good liaison between clinics, general practitioners and public health nurses in the area, such clinics could help improve accessibility to services. Other measures which could be considered would be specialist out-patient clinics in health centres and improved co-ordination between hospitals and general practitioners.



## PRISONERS

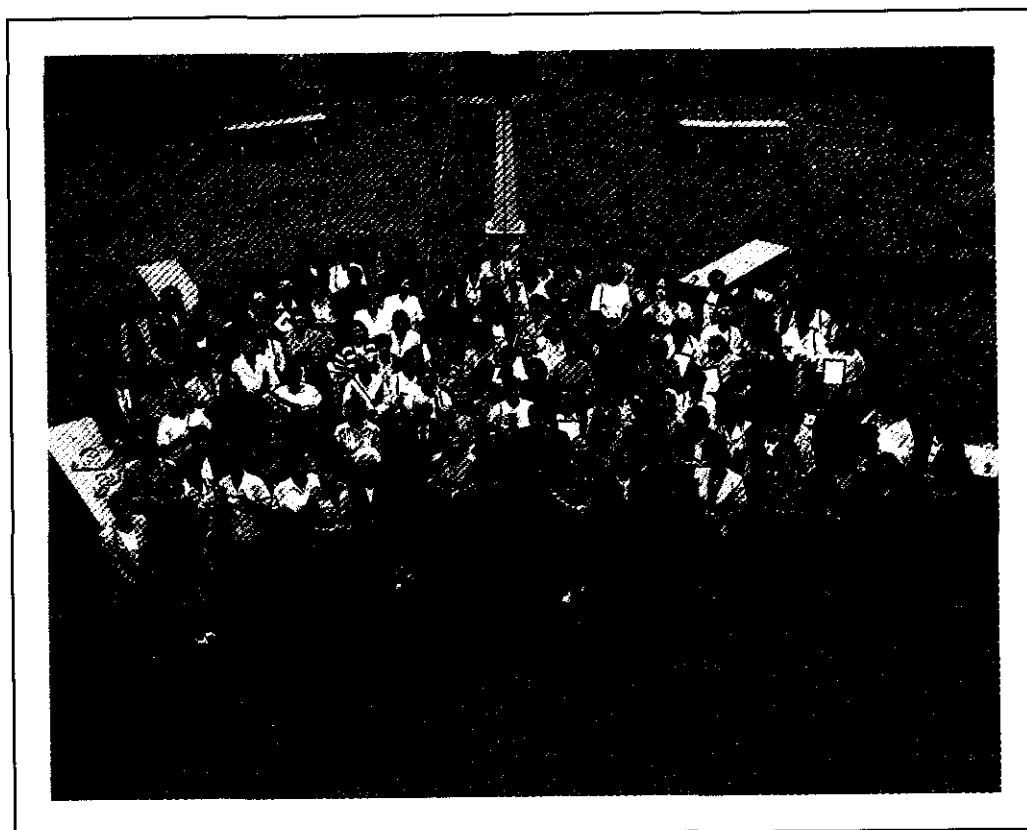
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The average number of female prisoners in a prison on any day is 47. Of these women, approximately 35 are in Mountjoy prison and 10 in Limerick prison. The age of these prisoners ranges from 18 to 24 years. Most female prisoners are imprisoned for drug-related offences. It is important, therefore, that liaison be developed between prisons and the relevant health boards regarding admissions and discharges of drug misusing prisoners. A satellite clinic could be set up in prisons to monitor and

record the admission of drug addicts into prisons and to supply these prisoners with methadone and clean needles when required. Counselling should be available to women prisoners who are HIV positive. Counselling should also be made available to female prisoners who have been the victims of physical/sexual abuse. Mental health care for female prisoners should be improved by closer liaison between the prison authorities and the health boards.



Consultation and  
Representation of  
Women in the  
Health Services





The absence of women at senior level means that it is left to interest or pressure groups to articulate a perspective on health services that should inform the system from within.

The Commission on the Status of Women addressed the issue of how to improve the representation of women in the health services. It recommended that the Department, health boards and hospitals should adopt programmes with specific targets and strategies.

Personnel policy in the health service already emphasises the need for each health agency to observe the principles of equality in its employment and personnel practices. The objective is to ensure that all staff, irrespective of gender, have an equal opportunity to develop their potential and to advancement on the basis of merit. Positive measures taken include improvements in recruitment practice and the provision of flexible working arrangements and career breaks. Reference is now made to the employer's commitment to equal opportunities when advertising health service posts. The latest information shows that some 4,000 employees, mostly women, are job-sharing and 1,350 are on career breaks.

However, if health agencies wish to be regarded as progressive employers, further change will need to take place in a number of areas. The recent report **Barriers to Women's Promotion in the Midland and Mid-Western Health Boards** offers a perspective from the viewpoint of female employees which suggests that the main

obstacles relate to organisational procedures such as training, interviews and promotional paths and organisational culture. The report suggests that the particular issues raised are not peculiar to the Midland and Mid-Western Health Boards and provides a valuable input to the review of policy and procedures in all health agencies.

As a further step towards developing a broadly based approach in the health service to the achievement of equality of opportunity, health agencies are currently reviewing their employment practices. When completed, the Department and agencies will consider what further joint action may be appropriate to complement the measures adopted by each health service employer

The Commission recommended that health boards, hospitals and professional bodies should pursue a more flexible approach to job sharing posts and part-time work to facilitate women who are managing domestic and occupational commitments. It also recommended that interview boards for medical and nursing posts in the health services should include 40 per cent representation of women. These are issues which will be addressed in the review of current practices referred to above.

*The **Health Strategy** states that one of the objectives of government policy is a greater participation by women in the organisation of the health services, both in the more senior positions and at the representative levels.*



Women's Health  
in the  
Underdeveloped  
World







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## COUNTRIES OF CENTRAL AND EASTERN EUROPE

Many countries in Central and Eastern Europe have undergone dramatic political and economic changes in the past few years. In some countries the health of women has been adversely affected by the changes. The political and economic situation in some of the countries has stabilised, but they are still faced with serious health problems.

The EUROHEALTH programme of the World Health Organisation was established to focus specifically on health as a vital part of the social and economic development of Central and Eastern Europe. EUROHEALTH is the common framework intended to assist individual countries during successive phases of change. There is a role for Ireland to play in the EUROHEALTH programme, particularly in helping to improve women's health services. In recognition of this, the Department of Health made a direct financial contribution to the EUROHEALTH programme in 1994.

Women in the former Yugoslavia have experienced particular problems arising from the civil war. The Government, through the Department of Foreign Affairs, has already funded services for victims of rape in Croatia and Bosnia-Herzegovina, principally by supporting the training of counsellors to work with rape victims. A delegation from the Dublin Rape Crisis Centre has made three visits to Zagreb in Croatia to make contact with organisations working directly with refugees. They selected ten women to

attend a two week intensive training course in rape counselling at the Dublin Rape Crisis Centre which took place in Dublin in June 1993.

Representatives of the centre have also evaluated the level of skill transfer from those who attended the training course to the local situation and assessed the future needs of the local organisations in terms of training and supervision. Further assistance should be provided from the Emergency Humanitarian Assistance Fund to continue and expand this service.



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mothers for more individual care and for greater involvement in decision making about their care. The Minister proposes to establish a group to monitor developments in maternity services and to advise him of priorities for further enhancement.

Priority also needs to be given to expanding the range of services available to women who are **victims of domestic violence and rape**. These services should be coordinated better with other health board services.

**Traveller women** have major health problems and experience particular difficulty in gaining access to appropriate services and in receiving continuity of care. A special programme is needed to ensure that Traveller women receive ante and post natal care, family planning and genetic counselling if required.

There is a need to increase the proportion of women who are **members of health bodies** and to strengthen the commitment to **equal opportunity programmes** in organisations funded from the Department of Health vote.

Improving the health of women in the **developing world** and in Eastern Europe should become a more explicit objective of Irish aid and action in bi-lateral and multi-lateral aid programmes, in support for third world agencies and in international fora.

**Research** is needed on many aspects of women's health in this country. In particular, research should be commissioned on the health of women by socio-economic status, the factors which precipitate mental illness in women and the reasons why Irish women seek abortions abroad.

*The priorities identified above are suggested for the purpose of focussing discussion in the consultative process which will follow the publication of this Discussion Document.*



Towards  
a Plan for  
Women's Health





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## TOWARDS A PLAN FOR WOMEN'S HEALTH

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This document has been prepared for discussion by all those interested in improving the health of women in this country. The Minister invites comments on its contents and proposals. The Council for the Status of Women has agreed to assist with the co-ordination of the consultation at national, regional and local level. It is proposed to organise conferences, seminars and workshops to facilitate debate on the document and involvement by as many women as possible. Following consultation on the document, the Minister will prepare a national plan for women's

health which will be published by the Government and implemented over a defined period.

Submissions on the **Discussion Document** may also be sent to the following address:

The Secretary  
Department of Health  
Hawkins House  
Dublin 2







## PRIORITIES FOR THE DEVELOPMENT OF WOMEN'S HEALTH SERVICES

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Many issues have been raised in this Discussion Document in relation to women's health which need attention. Is it possible to prioritise these issues by reference to their relative importance to promoting the health of women in Ireland? Reducing premature morbidity and increasing the life expectancy of women must be a primary goal of any policy for women's health. Within the limitations of current information on women's health, it appears that the single greatest cause of premature death and preventable illness among Irish women is cigarette **smoking**. Smoking is a contributory factor to thousands of deaths of women each year and to much of their morbidity. A reduction in smoking among Irish women would do more to prolong the life and improve the health of women than any other public health measure. For this reason the priority in promoting health for women should be to persuade as many women as possible to stop smoking and prevent as many girls as possible from taking up the habit.

Screening for **breast and cervical cancer** has a smaller contribution to make to reducing premature mortality and morbidity among Irish women. Deaths from breast cancer among women over 50 years of age could be reduced by about 30 per cent by a well organised breast screening programme. The Government is committed to the phased expansion of screening for breast cancer in women between the ages of 50 and 64 years to cover the whole country.

This phased expansion will take place, subject to the limitations of ensuring appropriate expertise in all aspects of breast cancer screening.

The organisation of services available to women with cancer is being reviewed by an expert group established by the Minister for Health to review cancer services generally.

About 60 per cent of deaths from cervical cancer in women of all ages could be prevented by a similar screening programme for cervical cancer. There are major difficulties about establishing a screening programme, not least the absence of a population register of women who might be called for screening. A working party has reported to the Minister on the feasibility of establishing a national screening programme for cervical cancer. There are steps, however, that could be taken immediately to improve access by women to cervical screening as currently provided. Cervical screening could be provided without charge to women covered by the General Medical Services. Women in the age groups 30 to 50 who are covered by medical cards could be invited to avail of a smear test at the recommended intervals. Women not covered by a medical card could be encouraged to have a smear test at the recommended interval.

Another priority in improving health services for women is the transformation of the **maternity services** to respond to the expectations of



## WOMEN'S HEALTH IN THE UNDERDEVELOPED WORLD

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The health problems of women in this country are relatively easily remedied by comparison with those of women in the underdeveloped world. Many third world women still die unnecessarily in childbirth or lose children to preventable diseases. Their life expectancy may be as much as 25 years lower than that of Irish women. Heavy physical work, poverty, prolonged and repeated child bearing contribute to the relatively short and difficult lives that many of these women lead.

Agencies which are working to improve the lives of people in the third world increasingly recognise the importance of improving women's health and through them, the health of their families. Many Irish doctors, nurses and other health service staff have or are working with agencies throughout the third world to improve the health of women and their families. This country has also provided training opportunities, particularly through the missionary orders, for young people from third world countries to train as doctors, nurses, and paramedics and to put their skills to good use in their countries of origin.

Because of the high standard of our health services, the strong links that exist with many third world countries and the generosity of the Irish in helping people of the third world, this country could play a greater role in assisting to improve the health of women in the third world. It is already a fundamental principle of official Irish aid that sustainable development is possible only

when adequate attention is paid to the particular role of women in development and to environmental issues. Because of this, careful attention is taken to ensure that the recognition of the contribution of women is an integral part of the rural development projects which receive assistance. These include projects where the role of women is crucial to their success - such as the provision of clean water and sanitation, and the development of primary health care. In 1990 Irish Aid established a Primary Health Care project in Sudan which included maternal/child health care. In 1993 a cervical cytology screening project commenced in Lesotho.

In the Government's bi-lateral aid programme, in assistance to third world agencies, in the multi-lateral aid programme of the European Community, in the forum of the World Health Organisation, measures to improve women's health in the developing world could be given a greater priority. Those Irish people with first hand knowledge of improving health services for women in the developing world have an important contribution to make to this process.





## CONSULTATION AND REPRESENTATION OF WOMEN IN THE HEALTH SERVICES

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There has been little consultation of women in the health services about issues of concern to them. Women's views on services have been made known through public representatives, women's groups and professionals but there is scope for more direct involvement of women at all levels of the health services. Consultation on this document will provide an opportunity for women to influence the shape of a policy specifically designed to address issues of most concern to them. Every agency providing services to women should consider ways in which users and representative groups could be consulted on a routine basis. For example, maternity hospitals and units might consider organising a user's committee whose members would be mainly women who recently used the services of the hospital/unit. Opinion surveys of users or potential users would also help to give greater feedback to health board and hospital management about the quality of services available and the shortcomings which need to be addressed.

Women are under-represented in positions of responsibility in the health services. Of 243 members of the eight health boards in February 1995 only 31 or 13 per cent were women. Of 358 members of the boards of 27 other bodies under the aegis of the Minister for Health, only 115 or 32 per cent were women. While there has been an attempt by successive Ministers of Health to increase the representation of women in the boards of health boards, the actual level of

representation is still far short of the 40 per cent target to which the Government committed itself in 1992. The position is complicated as the members of many bodies in the health services are elected or nominated by other representative or professional bodies, such as county councils and the medical profession. The need to encourage these bodies to put forward more women candidates was recognised in July, 1993 when the Minister wrote to approximately 50 nominating bodies or organisations regarding the Government decision in relation to the appointment of women to state boards and requested them to take this decision into account when submitting nominations for the Minister's consideration.

Women are under-represented at medical consultant and senior management level. Of 1183 consultant medical practitioners in post on the 1 January, 1995 only 19.5 per cent were women. The most up-to-date information available shows that just three of the most senior management posts in the health boards are held by women. However, at senior management level in the nursing and paramedical categories, the balance is in favour of women; 74 per cent of senior nursing posts and just over 60 per cent of senior paramedical posts are held by women.

With such a dearth of women at senior management and consultant medical practitioner level in the health service it is difficult to convince women that their interests are being taken into account in the planning and delivery of services.



## PROSTITUTES

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Women prostitutes are at great risk of infection from the HIV virus, syphilis, gonorrhoea and other sexually transmitted diseases. For their health, the health of any children they may have and the community, it is important that these women have access to health services that are targeted to their needs and way of life.

The Eastern Health Board has developed a clinic in Baggot St Hospital to improve the availability of health services to these women. The Women's Health Project commenced in 1991. It targets women engaged in prostitution and provides a health service specific to the needs of these women. The services available include information, advice and counselling, liaison and referral, education and support. Specific medical facilities comprise sexual health advice, cervical smears, HIV testing and family planning advice. The services are provided through a combination of outreach and a drop-in clinic. The Women's Health Project has also formed an association with RUHAMA, a voluntary organisation established by the Good Shepherd congregation of religious sisters. The Eastern Health Board provided funding of £20,000 to RUHAMA in 1994 to assist with its befriending and enabling service.

The report entitled **The Health Needs of Women Working in Prostitution in the Republic of Ireland** <sup>(21)</sup> jointly sponsored by the Eastern Health Board and EUROPAP under the Europe Against AIDS Programme presents an

overview of female prostitution in Ireland in 1994. Health services which are available to women working in prostitution with particular reference to HIV prevention measures are essential. The study concluded that there are major discrepancies between the private and public life of prostitutes and consequently serious health risks for all concerned. Adequate and appropriate service provision contributes to creating a positive sense of self and therefore a holistic approach needs to be taken to the needs of women in prostitution in terms of their health, both sexual and general.

*Health boards, which have not done so already, should develop out-reach services for prostitutes to encourage them to avail of health services. Special clinics, on the model of the Baggot St clinic, should be considered by other boards where the numbers of prostitutes justifies such a service.*



## TRAVELLER WOMEN

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There are approximately 9,000 Traveller women in Ireland. At birth a female Traveller can expect to live almost 12 years less than Irish women generally. Life expectancy at birth is 9.9 years less for male travellers than males generally. The difference in life expectancy between Travellers and the rest of the community persists for both sexes up to age 65 and is more marked at all ages in female travellers. Travellers are only now reaching the life expectancy that settled Irish people achieved in the 1940s. The stillbirth rate for Travellers in 1987 was 19.1 per 1,000 total births, compared to the national figure of 6.9. The perinatal mortality rate for Travellers in 1987 was 28.3 per 1,000 total births compared to the national figure of 9.9. The infant mortality rate for Travellers in 1987 was 18.1 per 1,000 live births, compared to the national figure of 7.8.

Travellers of all ages have very high mortality rates compared to the Irish population. Because of the high proportion who are unhoused and the practice of marrying close blood relations, it is likely that some of these high rates are more important than others in terms of identifying causes of mortality. The high standardised mortality rates for accidents among unhoused Travellers offers scope for preventive action of an educational nature. The prevalence of metabolic disorders and congenital problems in Traveller children is partly explained by the practice of Travellers marrying within their own community. The higher mortality rates in female Travellers for practically all causes of death may

be partly explained by prolonged and repeated pregnancies and the difficulties of raising large families in the conditions associated with the Traveller way of life.

A precondition for reducing premature mortality and unnecessary morbidity among Traveller women is an improvement in their accommodation. Houses should be provided for those Travellers who wish to live in a house. Serviced sites should be provided for those who wish to retain the traditional Traveller way of life. Health boards should ensure that health services are provided to Traveller women and children, with a special emphasis on maternal and child health.

The Eastern Health Board has a mobile health clinic for Travellers which has had considerable success in giving Traveller women greater access to ante and post natal care, health education and vaccination for their children. A peer led initiative on women's health between the Eastern Health Board and the Dublin Traveller's Education and Development Group is currently being piloted in Finglas.

*The **Health Strategy** states that a special programme will be implemented to address the particular health needs of the travelling community. Such a programme will address the health needs of Traveller women, in particular access to ante and post natal care, family planning and genetic counselling.*



## WOMEN WITH DISABILITIES

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The health services have an important role to play in the lives of disabled women. For disabled women to lead independent lives, easy access to rehabilitation and other health services is vital. The health services provide disabled women with the specialist medical care they need but they should also provide practical assistance so that disabled women can achieve and maintain independent living. There is also a need to create increased public awareness and understanding of the challenges and difficulties confronting women

with long-term disabilities. The role of the health services in relation to people with disabilities is currently being examined by a review body established by the Minister for Health. The particular problems of women's disabilities will be examined by this group.

*The **Health Strategy** states that services for people with a physical or sensory handicap will be further developed on the basis of locally assessed need.*







## WOMEN'S DENTAL HEALTH

The level of oral and dental health of girls is as good as, and in some cases exceeds, the level of that of males. The dental health of women aged sixteen and over is not so good. Women tend to lose their natural teeth much faster than men and tend to have less natural teeth compared with men of the same age. Tooth loss in women is not so much a direct result of pregnancy but is associated with reduced accessibility by poorer women to dental care. Women in middle-age may also have teeth removed for cosmetic rather than health reasons.

Action has been taken to improve dental services for women. For example, the Department of Social Welfare's Treatment Benefits Scheme has been extended to cover dependent spouses of insured workers, most of whom are women. The policy agreement of the parties in Government

**A Government of Renewal** includes a commitment that the Dental Action Plan announced in the **Health Strategy** will be implemented over four years. In the implementation of the Plan, it is proposed to discriminate positively in favour of the oral health of women covered by medical cards and to give their dental needs a high priority for health board dental services. Both of these measures should ensure that more women, particularly poorer women, have increased access to publicly funded dental services. Improved access should result in higher levels of oral and dental health and reduced tooth loss among women.

**The Dental Action Plan announced in the Health Strategy will be implemented over four years. The implementation of the Plan will discriminate positively in favour of the oral health of women.**



## HEALTH INFORMATION FOR WOMEN

Health is a major determining factor of personal and social wellbeing. Users of the health services should have clear information on their rights and their choices in relation to these services. People today are better informed about health issues. Newspapers, television, radio and women's magazines in particular, contribute to this new awareness. People are also more aware of the role of lifestyles in determining health. All this information may not always help a person when it comes to making contact with the health services. It is often a time when people are confused and feeling vulnerable. They can be overwhelmed by the complexity of the services and their entitlement to them.

An **Information Guide to our Health Services** launched in 1993 provides the information which health service users need. It assists people:

- to find out what category they fit into for eligibility purposes;
- to understand the range of health services available to them;
- to make an informed choice based on the options available.

The Guide provides information on services for particular groups - including women, children, the elderly and people with disabilities. It also gives details of the various community drugs schemes and other benefits available.

Information is an important component in the empowerment of women to take care of their

own health and to interact with the appropriate health services. As well as needing information on lifestyle factors applicable to both sexes such as the effects of smoking, exercise and nutrition, women also need information on issues specific to their reproductive cycle. As already mentioned in this Discussion Document, the Health Promotion Unit has available without charge a range of publications on these issues - the **Gynae Booklet**, the **Menopause Booklet**, the **Hysterectomy Booklet**, leaflets on **Cystitis**, **Menstruation** and **Folic Acid** and leaflets on **Family Planning**. The Unit works closely with women's organisations in the provision of information. It provided financial support to Family Planning Services Ltd for the development of a video on the menopause launched in 1993. An Irish Menopause Society has been established with the objectives of educating health professionals and advancing research on the issue. To coincide with the launch of the Association, a booklet entitled **The Menopause: A Guide for Primary Care** has been published with financial support from Health Promotion Unit. The Unit also grant aided a seminar on the menopause jointly organised by the Council for the Status of Women and the Well Woman Centre and funded the publication of a booklet on **Endometriosis** by the Endometriosis Society. The Unit funds the printing of a booklet on miscarriage by the Tipperary Childbirth Research Trust and has funded the printing and reprinting of the **Consumer Guide to the Maternity Services in Ireland** published by the Association



the vagina. The effectiveness of the female condom in the fight against HIV/AIDS and other sexually transmitted diseases has not yet been documented. It has been shown that contraceptive methods that do not depend on partner's consent, such as oral contraceptives, are most effective for protecting against pregnancy, but the use of oral contraceptives (the pill) or spermicides does not protect women from infection with HIV or other sexually transmitted diseases. To prevent the spread of HIV by injecting drug users the injecting of drugs should be avoided but if this is not possible clean needles should be used. Needle exchange programmes are operated by the Eastern Health Board. The Health Promotion Unit, as part of the National AIDS Prevention Strategy, has directed television and radio advertisements at women. Messages specifically aimed at women have been placed in the toilet areas of women's clinics.

The Commission on the Status of Women recommended that an age appropriate programme to prevent the spread of AIDS be taught in schools, within the context of sex and relationship education. At present AIDS education resource materials developed jointly by the Departments of Health and Education are available to all second level schools. As part of the dissemination process, training has been offered to two teachers from each school. Consideration is currently being given to the development of materials appropriate for

younger age groups. The location of health education topics generally in the curriculum is under review in the context of the White Paper on Education and the Minister for Education's circular on Relationships and Sex Education.

**The Health Strategy states that the Department of Health will implement a four-strand strategy on AIDS based upon surveillance, prevention, care and management and anti-discrimination. The Department, through the Health Promotion Unit, will continue to develop its preventive strategy aimed at women to reduce the spread of HIV/AIDS. Health boards will place greater emphasis in their health education programmes aimed at young people on the particular dangers to which women are exposed in relation to HIV. Health boards will also develop their services, including fostering and adoption, to support the small number of children of HIV mothers.**



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## ALCOHOL

About 70 per cent of Irish women drink alcohol. Alcohol is a problem for a minority of women drinkers. Misuse of alcohol is harmful to both men and women but holds special dangers for women. Women are generally smaller and have proportionately less water in their bodies than men. Alcohol is distributed in body fluids and is therefore more concentrated in a woman's system. A number of investigations have suggested that women may be more susceptible to the toxic effects of alcohol than men. Following a standard oral dose of alcohol, their blood-alcohol values are significantly higher than men's. Tissue ethanol concentrations are also correspondingly higher in women, and it is reasonable to suppose that over a period of time this may result in earlier or more severe tissue damage. Women who drink heavily develop fatty liver, hepatitis, cirrhosis of the liver, obesity, anaemia, malnutrition and gastrointestinal haemorrhage faster than men.

A study of Irish women admitted to seven treatment centres for alcohol-related problems in the late 1980s showed that they had many of the characteristics found among similar women elsewhere. They tended to drink alone, use other drugs - predominantly tranquillisers and sleeping pills and to have a relatively high level of attempted suicide.

In addition to risks to her own health, a pregnant woman who drinks excessively also puts her unborn child's health at risk. Babies born to

mothers with a severe drink problem can be found to have certain physical and mental abnormalities known as foetal alcohol syndrome.

*The **Health Strategy** target for alcohol consumption is to promote moderation in the consumption of alcohol and to reduce the risks to physical, mental and family health that can arise from alcohol misuse.*

**A National Alcohol Policy will be published by the Minister in the near future. This policy was formulated following an intensive consultation process with relevant interest groups. The policy will address economic, social, cultural, legislative and educational factors in relation to alcohol use and misuse, as well as advertising.**



## DRUG DEPENDENCE

### SMOKING

Statistics for the year to the end of June, 1993 show that 28 per cent of people aged 15 years and over smoke, of which 31 per cent are men and 26 per cent are women <sup>(18)</sup>. This compares with a prevalence of 43 per cent in the early 1970s - 49 per cent among men and 37 per cent among women. Preliminary analysis of recent surveys of smoking behaviour among second level school pupils suggests that the prevalence of smoking among young people, including young girls, may have plateaued and may even be declining among the younger teenage groups. Further analysis is required to confirm this trend. In any event, given the effects of smoking on health, smoking levels are still unacceptably high.

Lung cancer death rates among Irish women have been increasing since the 1950s and are showing little evidence of decline. The level of smoking among adult women and continued uptake by young women are causes of concern. Women as well as men are susceptible to the main tobacco-related illnesses - heart disease, cancers (especially lung cancer) and chronic bronchitis. In Scotland and the United States, lung cancer has overtaken breast cancer as the leading type of cancer death among women. Women also run added risks specific to their sex. Women who smoke and use oral contraceptives are 5 to 10 times more likely to develop heart disease than those who use the pill and do not smoke. Smoking during pregnancy increases the risk of having a low birthweight baby which in turn is

associated with increased perinatal illness and death. Smoking causes women to have a natural menopause 1-2 years early. On a cosmetic level, smoking increases the tendency of the skin to wrinkle.

Given these negative effects of smoking the question naturally arises as to why smoking has decreased more slowly among adult women than among men and why young women continue to take up the habit. One reason may be the targeting by tobacco companies of women through advertising. A survey conducted in thirteen European countries by the British Medical Association of seventy one of the most widely read women's magazines, found that over two-thirds carried advertisements for cigarettes and only 5 had voluntarily decided not to accept cigarette advertising <sup>(19)</sup>. The fact that most popular journals circulate in countries other than those in which they are published means that tobacco advertising is an issue that can only be tackled effectively at a European level. A European Commission proposal for a ban on tobacco advertising throughout the Union has been discussed at the Council of Ministers. Because of the strength of opposition to the proposal, it remains on the table. Member States are currently discussing other methods of reducing tobacco consumption.

The anti-smoking campaign organised by the Health Promotion Unit (HPU) in 1991 in the mass media specifically addressed the issue of



includes a Secondary Testing Programme whereby any woman who tested positive for hepatitis C antibodies but negative for the hepatitis C virus are being re-tested for viral presence up to six times. This is to ensure, as far as possible, a reliable virus result. Mindful that the virus may be intermittently present in the woman, the test for viral presence is further supported by liver enzyme tests and other tests.

The BTSB is aware that some of those who tested positive for hepatitis C had donated blood in the past. A Targeted Look back Programme to identify recipients of these donations is underway at present.

A comprehensive counselling programme was put in place by the BTSB for persons who received the Anti-D product. Treatment for those who test positive for hepatitis C is being provided at six designated hospitals. The treatment initially involves an out-patient visit which may be followed by a short admission for clinical investigation and follow up treatment, if required. Over 500 women have attended at the special out-patient clinics. Treatment including prescribed medication is being provided by the public hospital service free of charge.

The services put in place for persons who have tested positive for hepatitis C under the National Blood Screening Programme will be available for as long as they are required. The needs of those who have been diagnosed as positive will be

monitored and re-assessed on an ongoing basis to ensure that the necessary support services are provided to meet their needs.

The policy document- a Government of Renewal - included a commitment to fair compensation for women infected by the hepatitis C virus from Anti-D. The Government announced on 5 April 1995 that it had decided to establish, as a matter of urgency, a Tribunal which will assess compensation on an ex-gratia basis in respect of Anti-D recipients who are infected with hepatitis C antibodies/virus and the partners and children of these women who are also infected with hepatitis C antibodies/virus.

*A review of the operations of the Blood Transfusion Service Board was undertaken by consultants appointed by the Minister for Health. The Minister published their report in May 1995. The recommendations of this report and of the Report of an Expert Group on the hepatitis C problem published earlier this year, together with changes made in the management and organisation of the BTSB, will facilitate the necessary re-organisation of the BTSB so that it can play its essential role in the health services.*



## GENETIC COUNSELLING

A genetic disorder is any medical disorder which is due to a defect in a gene or group of genes. In many cases the risks of inheriting the gene involved can be accurately specified and the family provided with genetic counselling. It is also possible to identify those family members who are not carriers and so are not at risk of passing on the disorder. It is generally accepted internationally that about 5 per cent of people have genetic disorders or congenital malformations at birth or will manifest a genetic disorder in later life.

In December 1988 a committee was set up to examine the need for a medical genetics service in Ireland and to recommend how such a service should be organised. This committee recommended that a major medical genetics centre should be established in Our Lady's Hospital for Sick Children in Dublin and that smaller medical genetic centres be provided in

Cork and Galway. They recommended that this service should be developed on a phased basis commencing in Dublin.

Following acceptance of the recommendations of this report, a major medical genetics counselling centre was established at Our Lady's Hospital for Sick Children, Crumlin. Funds totalling £610,000 have been provided since 1992 towards the establishment of the service which has included provision of necessary accommodation, recruitment of specialist staff including a consultant medical geneticist, laboratory and other support staff. The counselling and advice being provided is non-directive.

**It is intended that genetic counselling services will be established in Cork and Galway as resources permit.**



## SUPPORTING THE CARERS

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Women are over represented among those providing informal care to dependent people at home. A study commissioned by the National Council for the Elderly found that women outnumbered men as carers for dependent older people by a factor of nearly 5 to 1.<sup>(17)</sup> As well as being the main carers in the home of the dependent elderly, women are also the main informal carers of those with a mental or physical handicap and those with a mental illness. Until recent times, the carer received little official recognition and less support from the health services in their demanding roles. Thanks to the work of the National Council for the Elderly, the Soroptomists (Ireland), the National Association for the Mentally Handicapped of Ireland, the Irish Wheelchair Association, the Carers Association, the Alzheimer Society and others, attention has been focused on the difficulties facing many carers and their need for recognition, financial support and practical help. The Report of the Working Group on Services for the Elderly - **The Years Ahead** - recognised the contribution of the carer to the support of the dependent elderly and made recommendations to increase the amount of practical help available to them. Of particular value to carers are respite care, home nursing, home help, day care and transport to services. A significant amount of the additional funding made available by Government in recent years to expand services for the elderly has been used to develop these services. However, more needs to be done to keep pace with the rapid

expansion of the elderly population.

Parents, most often women, caring for a son or a daughter with a mental handicap can experience some of the greatest hardships known to any family. The problems are particularly acute for older parents who themselves may be in poor health. The provision of day and residential places in the past decade has not kept pace with an unprecedented rise of 25 per cent in the population of people with a moderate severe or profound mental handicap. The Report of the Working Party on services for people with a mental handicap, **Needs and Abilities**, sketched the problem to be tackled and the principles which should be followed. Considerable progress has been made in improving services for those with a mental handicap and their carers in the past few years. Since 1990, over £40 million has been invested in services for people with a mental handicap and their families. This additional funding has provided almost 1,000 residential places, over 2,000 day places, home support services for thousands of families and a strengthening of many other services for people with a mental handicap.

**In the policy agreement, A Government of Renewal, the Government is committed to building on the improvement in services for people with a mental handicap and their carers in future years, to eliminate waiting lists and to maximise the quality of life and right of participation of every citizen with a mental handicap.**





## FAMILY PLANNING

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The control of fertility is, historically, one of the most important developments for the health, well-being and liberation of women. The sharp decline of the birth rate in recent years, and in particular, the fall in the size of completed families, indicates the extent to which women are controlling their fertility. The Commission on the Status of Women considered that choice in family planning methods was a key factor in enabling women to have control over important decisions in their lives. Legislation in this country has been slow to recognise the right of couples to a method of family planning of their choice. In 1993, the Health (Family Planning)(Amendment) Act removed condoms from the scope of legislation which controlled medical contraceptives. The wider availability of condoms should make access to one method of family planning easier for some couples.

In a study of women's health needs in Ireland in 1994, two thirds of those surveyed reported that they were sexually active. It is estimated that 31 per cent of those who are sexually active do not use any form of family planning. Condoms are the most frequently used method of family planning (22 per cent), followed by the combined pill (17 per cent), with the natural method in third place (14 per cent). The method of family planning used by sexually active women varied significantly by age, level of education, employment status and geographical location <sup>(1)</sup>.

*The Health Strategy states that an accessible and comprehensive family planning service will be*

*developed in each health board area on a phased basis by the end of 1995.*

In March 1995, the Minister issued **Guidelines on Family Planning Policy** to health boards. In summary these guidelines advise that:

- each health board should ensure that an equitable, accessible and comprehensive family planning service is provided in its area;
- the role of the general practitioner in providing family planning services is to be developed and strengthened;
- a broadly based programme, involving family planning clinics provided by the health board and/or other service-providers, is to be developed to ensure that services are within easy reach and that choice of service-provider is available;
- the family planning service in each health board maternity hospital or unit should be evaluated to determine the extent to which current needs are being met;
- sterilisation operations for family planning purposes are a matter for decision by the woman concerned in conjunction with her medical practitioner. Where sterilisation is not available at a particular hospital, a woman has the right to ask her doctor to refer her to a hospital where the procedure is available and the health board should make the appropriate arrangements;



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## MOTHERS IN NEED OF SUPPORT

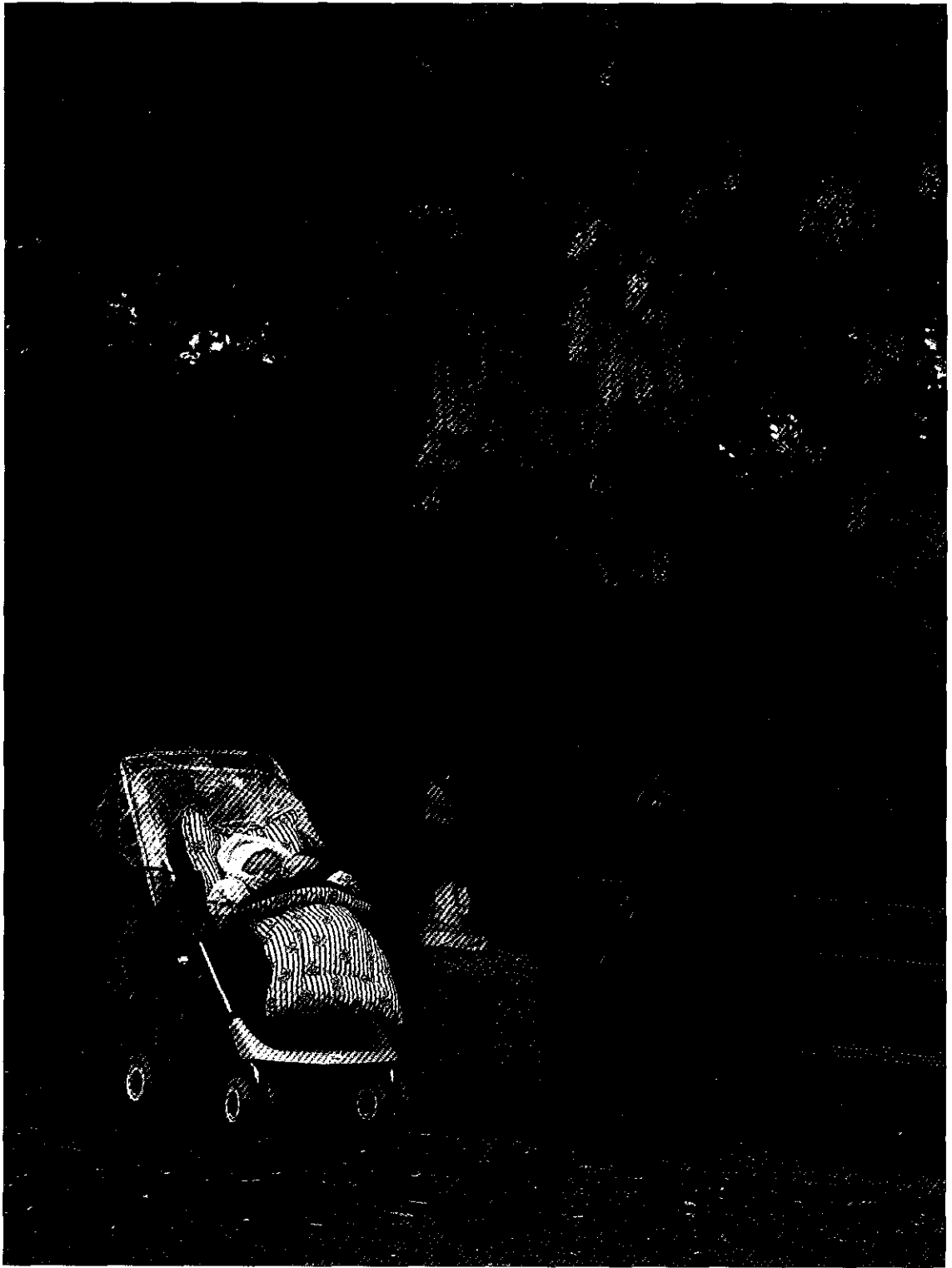
Young mothers, both single and married, may experience particular difficulties in child rearing in areas of economic and social deprivation. They may not have the family or financial resources to assist with the difficulties of rearing young children. A Community Mothers Programme, organised by staff of the Eastern Health Board, assists first and second time parents with infants up to one years of age or two years in special circumstances. The programme aims to empower parents, usually the mother, to develop their latent skills and to build confidence and self-esteem, so that they can tackle their problems in their own way.

The programme is named after the corps of experienced mothers who are the key resource of the programme. These mothers, who have successfully reared children in these areas are recruited as Community Mothers to give support and encouragement to parents in the rearing of their children, emphasising health care, nutritional improvement and overall development. The Community Mothers are trained, monitored and guided by nurses with expertise in family development. The parents are visited in their own homes by a Community Mother once a month for the first twelve to eighteen months of the infant's life. The parents are acknowledged as the experts in the care of their child and the key agents for change and are supported while they achieve their own goals for their children. A behavioural approach is used in which parents

are encouraged to undertake tasks. Other significant outcomes are parent and child groups, ante-natal visiting, support for breastfeeding mothers and developmental initiatives with the Travelling community.

Many of the Community Mothers have benefited from their involvement in the programme through self-development and increased self-esteem. A number have found full time employment and others have become involved in community endeavours and adult education such as personal development courses.

*The Community Mothers Programme has been evaluated and is achieving its objective of enhancing the parenting skills of mothers living in disadvantaged areas of Dublin. Health boards should develop ways of assisting inexperienced mothers in disadvantaged areas, on the model of the Community Mothers Programme.*





## VIOLENCE AGAINST WOMEN AND CHILDREN

The extent of rape, sexual abuse and violence against women and their children in our society has come to the forefront of public attention in recent years. As far as violence against women is concerned, the role of the health services has been to support refuges for women (and children) subject to violence in the home and centres providing crisis support and counselling. The work of Rape Crisis Centres has focussed attention on the trauma of rape and child sexual abuse and the need to support the victims. There is increasing recognition in the health services of the complementary role of the work of the Rape Crisis Centres in Dublin, Cork, Galway, Limerick, Clonmel, Waterford, Kilkenny, Athlone, Castlebar and Tralee with that of the statutory health services in providing a comprehensive service for victims of rape and sexual abuse.

In the past the Rape Crisis Centres were funded from a number of different sources, with funding uncertain from year to year. Following a Government decision in July 1991 funding for the Centres is being channelled through the health boards. Funding in 1995 for the Rape Crisis Centres amounted to £907,000, or £250,000 more than in 1994. The funding of these centres has been made as secure as the budgetary cycle of Government finances permits. Funding has also been provided to the health boards without a rape counselling service to develop one directly or by an arrangement with a voluntary organisation.

*Each health board should ensure that there is sufficient liaison between the board's services, the rape crises centres and voluntary organisations that provide counselling for rape and/or sexual abuse victims in each area.*

Specialist investigation and treatment services for adult victims of rape or sexual abuse are available at the Sexual Assault Treatment Unit, Rotunda Hospital, Dublin. The unit provides facilities for the examination and treatment of victims of sexual assault and rape and for the collection and processing of forensic evidence. This service is designed primarily to meet the needs of the population within the greater Dublin region but is available, where necessary, to persons resident in other parts of the country.

In the case of child and adolescent victims of sexual assault and rape, investigation facilities are in operation at specialist units located in the Children's Hospital, Temple Street, Our Lady's Hospital for Sick Children, Crumlin, St. Finbarr's Hospital, Cork, and Ardkeen Hospital, Waterford. In the other health board areas assessment services are provided on a community basis.

Following medical assessment and treatment in the immediate aftermath of sexual assault and rape, victims, including those who become pregnant as a result of rape, are referred to support services, both statutory and voluntary, for on-going counselling and support to deal with



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difficulty in the way of establishing such a programme is the absence of a population register of women to ensure that women of the right age are called for screening at the right time.

A debate about the feasibility of establishing a national screening programme need not prevent immediate improvement in access by women to cervical smear tests. Since women in lower incomes are less likely to seek smear tests, screening at the appropriate interval should be provided to all women covered by the general medical services, as recommended by the Commission on the Status of Women. Women

who are not covered by a medical card should be encouraged to seek screening at the same intervals as women in the general medical services, by arrangement with their own doctor or clinic. More information is needed to inform women of the benefits of cervical screening, of the ages within which screening is most effective and of the intervals at which screening should take place.

**In line with the approach indicated in the Health Strategy the Minister proposes to reorganise screening for cervical cancer taking account of the expert group's recommendations.**



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## DIAGNOSIS AND TREATMENT

At present in Ireland, mammography is used largely as a diagnostic tool for symptomatic or concerned women and, in some cases, for women at particular risk of developing the disease. The diagnostic mammography services, including the training of doctors, radiographers and the provision of equipment have been steadily developing in Ireland over the last number of years. Mammography services, on a referral basis, are available to women at sixteen general hospitals throughout the country. There are now a sufficient number of mammography units in the country to meet the diagnostic needs of Irish women. A number of hospitals have also developed breast clinics. These are centres of excellence which specialise in the treatment of all aspects of breast disease. A quality assurance programme and clinical audit should be an integral part of both the diagnostic mammography service and the breast clinics.

Concern has been expressed by such bodies as the Council for the Status of Women, the Irish Cancer Society and the Irish Countrywomen's Association about the difficulties women may experience in gaining access to treatment for breast cancer. They have also expressed concern about deficiencies in aspects of rehabilitation, such as communication with and counselling for patients and the provision of temporary prostheses. The Association of Surgeons with a Special Interest in Cancer have indicated that they will shortly produce a protocol for breast

cancer treatment and management. Continuing professional education is required for all involved in the early detection, treatment and rehabilitation of breast cancer. The concept of the breast clinic is another positive step in the direction of the provision of optimum services for breast diseases. Referral to breast clinics should be by a general practitioner with an agreed protocol for urgent referrals. A rapid diagnostic service, multi-professional expertise comprising surgery, radiology, cytopathology, oncology and nurse specialist in breast care is recommended for these clinics and would also facilitate 'same day' diagnosis. Training requirements, quality assurance and clinical audit should be an integral part of the programme.

**The Minister is currently developing a Cancer Strategy which will examine the organisation of services to detect and treat cancer, the adequacy of rehabilitation services and the provision of palliative care. The cancer strategy is expected to be finalised before the end of the year.**



## BREAST CANCER

### EARLY DETECTION

It is not possible at present to prevent breast cancer occurring since the causes are not well understood. The current strategy is to detect breast cancer at an early stage by self examination of the breast, clinical examination and mammography. The Health Promotion Unit, in association with the Irish Cancer Society and the Irish Countrywomen's Association, has organised a number of successful seminars on breast cancer awareness for women throughout the country. Much research has been undertaken into the effectiveness of screening in detecting early breast cancers and consequent early treatment. It is estimated that approximately 20 - 30 per cent of deaths from breast cancer in women over 50 could be prevented if a mass screening programme was established for women between the ages of 50 - 64. Benefit to women younger than 50 years has not yet been proven. There is, therefore, no sound scientific evidence to support mammography screening for women under 50 years.

A population register and the proper organisation of screening is crucial to its success in reducing mortality. This means that all eligible women must be recruited to screening, mammography must be performed by experienced personnel and the clinical follow up of women who are referred for further investigation following screening must be undertaken by experienced clinicians. Success of a breast cancer screening programme depends

on absolute quality assurance in the following disciplines; radiography, radiology, medical physics, cytology and histology, surgery and epidemiology. Screening for breast cancer requires considerable resources in terms of finance and skilled personnel.

A pilot programme of breast cancer screening is currently being undertaken by the Mater Foundation. This programme was established in 1989 and is part of a network of pilot studies on breast cancer screening currently underway within the European Union. The study is being carried out in a defined catchment area in North Dublin and Cavan/Monaghan, representing urban and rural populations. The study population is 35,000 women aged 50-64, equally divided between the urban and rural areas. The control population is 34,000 women in the same age group, resident in the former Southern Tumour Registry area. A mobile unit is being used to facilitate women being called for screening.

The objectives of the study are:

- (i) to evaluate the impact of mammographic screening on morbidity and mortality from breast cancer in Irish women and
- (ii) to address the feasibility and potential value of a national breast screening programme.

The Programme, which has now completed its second round of screening, has addressed the



## MENOPAUSE

The menopause marks the end of a women's reproductive life. The average age of women reaching the menopause is 50 years. Each woman experiences the menopause in a different way. A balanced diet and exercise can reduce unpleasant effects of the menopause. Some women will require medical treatment such as hormone replacement therapy.

The booklet produced by the Health Promotion Unit of the Department of Health on the menopause has helped to make information on this important phase of a woman's life more widely available. The Irish Menopause Society has also launched a booklet for health professionals and its publication is funded by the Health Promotion Unit. The Unit has also provided funding to Family Planning Services Ltd for the development of a video on the menopause which was launched in 1993. Information and advice on the menopause is also available from

the Well Woman Centres in Dublin. Two maternity hospitals in Dublin provide specialist clinics with referral from general practitioners. However, information and advice on the menopause may be difficult to come by for some women. It is estimated that close to 20 per cent of women do not know or do not have enough information on the menopause <sup>(1)</sup>. General practitioners, family planning clinics and health board services have a vital role to play in informing women of the normal and abnormal factors associated with the menopause and where they can go for advice and counselling if necessary.

*Each health board and voluntary hospital should review the way in which services for women with problems associated with the menopause are provided.*





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## MISCARRIAGE AND STILLBIRTH

The loss of a child through miscarriage or stillbirth is a traumatic experience and is a cause of considerable grief and loss to the parents of the child. The practices in our hospitals in dealing with these tragic events have changed considerably in recent years as a result of a growing awareness of the pain and sense of loss suffered by mothers who experience either a miscarriage or a stillbirth. In particular the need of the parents to grieve the loss of their child should be recognised and also that society should recognise the existence of the child which has been lost. These needs will require to be addressed at two levels.

In the case of mothers who have experienced a miscarriage or stillbirth, it is important that hospitals recognise and provide for both the physical and psychological needs of the parents in coping with the loss of their child. Such care should provide for:

- separate accommodation for mothers who have experienced miscarriage or stillbirth;
- full and appropriate counselling for the parents;
- choice of the parents to see, hold and, if they so wish, to name the child and that they be provided with an appropriate memento including where possible a photograph of the child.

A formal state register of stillbirths was established in early 1995. The legislation provides for the retrospective registration of stillbirths on a voluntary basis, so that it will be possible for parents to register any such births which occur in the interim, as well as stillbirths which have already occurred.



## ABORTION

Under Article 40.3.3 of Bunreacht na hEireann, the State is obliged to protect the life of the unborn, with equal respect for the life of the mother. Abortion is unlawful in this State under the Offences Against the Person Act, 1861, unless it is necessary to protect the life of the mother. This position was reaffirmed by the Supreme Court in the judgement of the X case in 1992. The Government has recently appointed an expert group to review aspects of the Constitution, including Art. 40.3.3, in the light of changes in society since the Constitution came into force and to recommend any changes necessary. The Regulation of Information (Services outside the State for Termination of Pregnancies) Act, 1995, which was recently enacted following confirmation of its constitutionality by the Supreme Court, specifies the conditions under which certain information about pregnancy termination services outside the State may be made available in the State. One of the main objectives of this Act is to ensure that any doctors or advice agencies who provide abortion information to pregnant women do so only in the context of full counselling on all the available options, without any advocacy or promotion of abortion.

It is estimated that between 4,000 and 5,000 Irish women have abortions in Britain each year. The majority of women who go to Britain for abortions do not consult with any medical professional, be it family doctor or advice agency

prior to travelling. A study of Irish women who had abortions in Britain in 1991 found that of a sample of 53 women, 4 were referred by pregnancy advice agencies and 5 were referred by a general practitioner, not necessarily the woman's own general practitioner. The remainder relied on friends, family, acquaintances and magazines for information and made the necessary arrangements themselves <sup>(14)</sup>.

This information is a cause of concern as it suggests that the majority of Irish women do not receive counselling prior to travelling. Research in Ireland and abroad shows that, having received counselling a considerable number of women decide against abortion. In the Irish context the percentage of women who decide against abortion after receiving full counselling is in the region of 14 to 25 per cent <sup>(14)</sup>.

**In line with the commitment given in the policy agreement for A Government of Renewal, to put in place research, education and counselling with the objective of minimising the circumstances in which such high numbers of women seek to have abortions, the Minister has provided funding for agencies engaged in counselling women with crisis pregnancies. Research agencies have also been invited by the Department of Health to submit proposals to study the factors which contribute to the incidence of unwanted pregnancy and those factors which result in the option of abortion.**



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## BREASTFEEDING

Breastfeeding is regarded as the most desirable method of infant feeding from both a physical health point of view in strengthening the infant's immunity to illness and from a psychological point of view in providing opportunities for developing a strong mother/infant bond. Currently about one-third of mothers are breastfeeding their babies at the time of leaving hospital and this percentage has remained virtually the same since 1980. This country has one of the lowest levels of breastfeeding of any country in the EU. The Health Promotion Unit has two publications which encourage mothers to breastfeed and provide relevant information to them - **The Book of the Child** and **Food and Babies**, an infant feeding handbook. The Health Promotion Unit also provides some financial assistance for education and materials for voluntary groups promoting breastfeeding.

Mothers are currently leaving maternity hospitals after a few days, often at a crucial time in their breastfeeding experience. Primary care personnel such as general practitioners and public health nurses already have heavy workloads and often do not provide the support necessary for a mother to breastfeed. It is estimated that only about 11 per cent of mothers are breastfeeding at 3 months.

To develop a co-ordinated approach to the issue, the Minister for Health in mid 1992 established a National Committee to promote breastfeeding. This Committee comprised

representatives of relevant parties - midwives, public health nurses, obstetricians, paediatricians, general practitioners, voluntary organisations and health educators. The Committee developed **A National Breastfeeding Policy for Ireland** which was launched by the Minister for Health in August, 1994. The policy has the following medium and long-term targets:

- an overall breastfeeding initiation rate of 35 per cent by 1996 and 50 per cent by the year 2000;
- a breastfeeding initiation rate of 20 per cent among lower socio-economic groups by 1996 and 30 per cent by the year 2000;
- a breastfeeding rate of 30 per cent at 4 months by the year 2000.

In order to achieve these targets, the Report recommended that the following be put in place:

- all maternity hospitals and units to have a breastfeeding policy and a lactation team in place by early 1995;
- by early 1995, the national structures necessary for Ireland's participation in the Baby Friendly Initiative, should be in place;
- all Community Care Areas to have identified a Breastfeeding Resource Person by early 1995;



**The Guidelines for Midwives** drawn up by An Bord Altranais, the professional body of nursing, have been criticised on the grounds that they are insufficient to monitor and deal with domiciliary midwifery.

*The role of midwives in domiciliary midwifery is currently being examined by the Department of Health in the context of a review of the Nurses Act, 1985.*

The presence of student doctors and midwives can give rise to difficulties for some women and their partners during labour. However, the good standards of obstetrical services available in Ireland are to a large extent the result of the excellent education and training student midwives and doctors receive. The presence of student doctors and midwives during labour should be handled sensitively and discussed with women and their partners in advance. Each woman should be told that she has a right to refuse to participate in the teaching of medical or midwifery students.

*The **Health Strategy** recommends that the health services should make maternity services more responsive to the needs of mothers who now seek more individual care and a greater involvement in decision-making about their care.*

*The **Report of the Second Commission on the Status of Women** recommended that the Department of Health should put in place a*

*mechanism to monitor its recommendations in the maternity services.*

**In view of the importance of the maternity services to the health and well-being of women, the Minister proposes to establish a task force, representative of the maternity hospitals and units, women's health groups and the professions to monitor the implementation of the recommendations of the Commission's Report and to advise him on priorities for improvement. The task force will be asked to complete its work within two years.**



## HEALTH SERVICES PARTICULAR TO WOMEN

### CHILDBIRTH

Fertility patterns are changing rapidly in Ireland. The birth rate has been falling rapidly, from 21.8 births per 1,000 population in 1980 to 13.9 births in 1993. The total number of births in the same period has fallen from 74,064 to below 50,000. In 1993 the total period fertility rate fell to 1.93 which is below the population replacement level for the first time. The Central Statistics Office has predicted a further decline to 1.5 by 2006. The number of births outside marriage continues to rise and reached 9,664 or 19.4 per cent of all births in 1993. The average age of Irish mothers at first birth is 28.2 years which is older than that of other EU countries.

Among the most important services which are exclusively used by women are those relating to childbirth. The maternity services in this country are of a high standard with regard to protecting the lives and health of mothers and new born infants. An antenatal and postnatal service is available without charge to all women from general practitioners and maternity hospitals. The overwhelming majority of the 49,500 births per annum take place in maternity hospitals, staffed by consultant obstetricians, paediatricians and midwives. New or improved maternity accommodation has been provided in many hospitals in recent years throughout the country.

In a national study close to 31 per cent of mothers are estimated to have attended antenatal classes in preparation for childbirth <sup>(11)</sup>. During antenatal visits 96 per cent of mothers

felt that they had enough time with the midwife and 78 per cent with the doctor. Eighty three per cent of mothers felt that they had enough privacy during the antenatal visit. Sixty two per cent attended the same doctor/midwife during visits, although 70 per cent would have preferred to see the same midwife or doctor at each visit <sup>(11)</sup>.

The maternity services have been criticised for a number of reasons. Concern has been expressed about the lack of respect for the experience of giving birth, the poor continuity in medical and midwifery care for public patients, the absence of appointment systems in out-patient departments of maternity hospitals, the lack of choice for women as regards accommodation, birthing positions, pain control, unnecessary procedures, visiting times and choice of companion during labour. As women have fewer children, they attach greater importance to the unique experience of childbirth for themselves and their partners. The vast majority of births are normal and without the complications which require medical intervention. There is a clear need for maternity hospitals to respect the unique experience of childbirth for each mother and father by giving parents as much choice as possible and by simulating a domestic environment for those with a normal labour and delivery.

The extent to which women have to queue in public out patient departments in maternity hospitals could be tackled in a number of ways.





## ELIGIBILITY OF WOMEN FOR HEALTH SERVICES

The entire population is entitled by law to in-patient services in public hospitals, at no charge to those covered by medical cards and at small charges to the rest of the population. All women are entitled to avail of the maternity and infant scheme which provides ante-natal, hospital and post natal care for mothers and babies without charge. Eligibility for general medical services, including general practitioner care, prescribed medicines, and domiciliary nursing, is determined in law by a person's income and his or her health

needs and those of any dependants. A woman may hold a medical card in her own right or may be included on the medical card of her husband. The rules for eligibility do not discriminate against women. However, this does not imply that women are not at a disadvantage in gaining access to some health services.

Table 7 below shows the breakdown of persons covered by medical card by gender in December 1993. Fifty four per cent of those covered were female.

**TABLE 7 NUMBER OF PERSONS COVERED BY MEDICAL CARDS  
BY GENDER AND AGE GROUP, 1993**

Age	Male	Female	% Female
Under 5 yrs	43,990	42,589	49
5 - 15 yrs	131,320	125,402	49
16 - 44 yrs	192,470	221,944	54
45 - 64 yrs	102,079	116,339	53
65 yrs +	116,522	181,966	61
Total	586,381	688,240	54



## SUMMARY

The life expectancy of Irish women at birth is one of the lowest of any member state of the European Union. For women aged forty, Ireland has the lowest life expectancy of any EU member state. The main causes of death among Irish women under 65 years of age are cardiovascular disease, cancer, especially of the breast, lung, trachea and bronchus, and accidents. Although deaths from ischaemic heart disease have reduced considerably over the last 20 years in the under 65 year age group, they are still remarkably higher than the EU average. Risk factors such as smoking, hypertension, high fat diet and overall sedentary life style can usually be modified considerably. Almost all deaths from cancer of the lung, trachea and bronchus, which are increasing in women, could be prevented or postponed if women did not smoke. The most common diagnoses among women treated in hospital are diseases of the digestive system, musculoskeletal system and connective tissue, skin, subcutaneous tissue and breast. The number of women discharged was higher than for men and the average length of stay for females was longer than for males. A higher prevalence of depression and cancer has been reported among female general practice attenders than among men. Women in the lower socio-economic groups are more likely to be admitted to psychiatric hospitals, have a higher prevalence of chronic conditions within the general practice setting and to develop cervical cancer than women in the higher socio-economic groups.

About one per cent of young women suffer from an eating disorder. Information is scarce on women's health by socio-economic group. There is an urgent need to find out the status of women's health generally, to assess the effect of socio-economic factors on their health and to monitor women's health over time.

**The Health Strategy puts forward targets for the reduction of preventable mortality from cardiovascular disease and cancer. Action programmes will focus on six key areas:- smoking, alcohol, nutrition and diet, exercise, cholesterol and blood pressure, and causes of accidents. A comprehensive data base will be developed to provide detailed information on smoking and alcohol consumption, use of drugs, diet and nutrition, level of fitness and stress. Such a data base is essential if plans and programmes are to be targeted effectively. The data base will pay particular attention to the health needs of women.**





## MENTAL ILLNESS

The most common psychiatric disorders among women requiring treatment in a psychiatric hospital are depression, schizophrenia, mania and alcohol disorders. Table 6 gives a breakdown of the diagnoses of persons admitted to psychiatric hospitals and units in 1993 by gender. It shows that while fewer women were treated in hospital for mental illness than men, women were more frequently admitted for depression, mania and neuroses. The highest rates of admission were

among women in the unskilled manual and the non-manual socio-economic groups <sup>(13)</sup>.

General practitioners also see patients with psychiatric illness but the volume of such illness treated is not comprehensively documented. Depression, however, has been reported as three times more prevalent in females within the primary care setting <sup>(12)</sup>.

**TABLE 6 ADMISSIONS TO PSYCHIATRIC HOSPITALS AND UNITS  
IN 1993 BY GENDER AND DIAGNOSIS**

Diagnosis	Male	Female
Organic Psychosis	397	333
Schizophrenia	3,257	2,363
Other Psychosis	147	127
Depressive Disorders	3,141	4,688
Mania	1,099	1,397
Neuroses	606	967
Personality Disorders	792	722
Alcoholic Disorders	4,405	1,313
Drug Dependence	220	161
Mental Handicap	272	180
Unspecified	161	187
<b>All Diagnosis</b>	<b>14,567</b>	<b>12,438</b>

Source: Activities of Irish Psychiatric Hospitals and Units 1993, HRB



## OTHER DISEASES IN WOMEN

Many of the diseases which cause ill health and death are common to men and women. However the pattern of many diseases varies between the sexes, and some diseases affect only women, such as diseases relating to the female genital tract. The main source of information about the morbidity of women in this country at present comes from the Hospital In-patient Enquiry. Table 5 gives a breakdown of data on discharges by diagnosis of persons discharged from acute general hospitals in 1993. The number of females discharged was higher than males. The average length of stay for females was 7.3 days compared to 6.8 for males. The table shows that the most common diagnoses among women treated in hospital were diseases of the digestive system, musculoskeletal system and connective tissue, skin, subcutaneous tissue and breast.

Information on morbidity in women who are not admitted to hospital is not generally available. A Dublin study on prevalence of morbidity among general practitioner attenders revealed that males had about twice the prevalence of coronary heart disease and stroke of women attenders, whereas females had three times the prevalence of depression and twice the prevalence of cancer. The study also demonstrated that the mean annual consultation rate of middle aged women from Dublin was higher than that of the male patients with 3.6 consultations per year compared with 3 consultations by men, but that this did not appear to be due to a higher prevalence of chronic conditions. This study also indicated a social class gradient in chronic conditions, with the prevalence increasing in the lower socio-economic groups for both men and women.<sup>(12)</sup>



## CANCER OF THE SKIN

Cancer of the skin accounted for 102 deaths in Ireland in 1993 and 50 of those were in women. There are two types of skin cancer, non melanoma skin cancer (NMSC) and malignant melanoma. NMSC is the most common occurring malignancy in white skinned populations. Both genetic and environmental factors such as exposure to ultra violet radiation increase the risk of skin cancer. NMSC occurs on parts of the body exposed to the sun. A person's type of skin as well as the cumulative exposure to ultra violet radiation are considered to be risk factors. It occurs mostly in those aged more than 60 years. This cancer is slow growing and curable in the early stages. In contrast, malignant melanoma is a rare cancer and is much more serious. There is concern that it is on the increase. It caused 41 female deaths in 1993 and appears to be commoner in women. It occurs in the pigmented cells of the skin, is more likely to

occur in those who have pale skin, blue eyes, fair/red hair and a history of sunburn particularly during childhood. Prevention of skin cancer can be achieved by a vigilant approach to sun exposure and artificial forms of ultra violet radiation. Early detection of skin cancer can save lives.

*The medium-term target of the Health Strategy is to reduce the death rate from cancer in the under 65 age group by 15 per cent in the next ten years.*

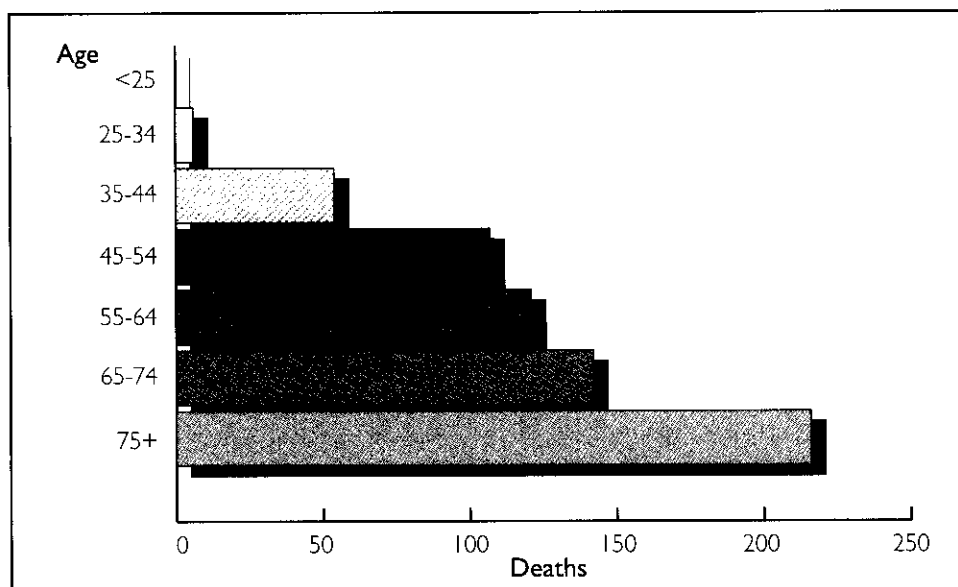
*This compares with the reduction of about 7 per cent which has been achieved over the last twenty years.*

**The action programmes to reduce cancer outlined in the Health Strategy document will focus nationally and regionally on smoking, alcohol and nutrition and diet.**





**FIGURE 5 BREAST CANCER DEATHS IRELAND 1993**



#### CANCER OF THE LARGE BOWEL

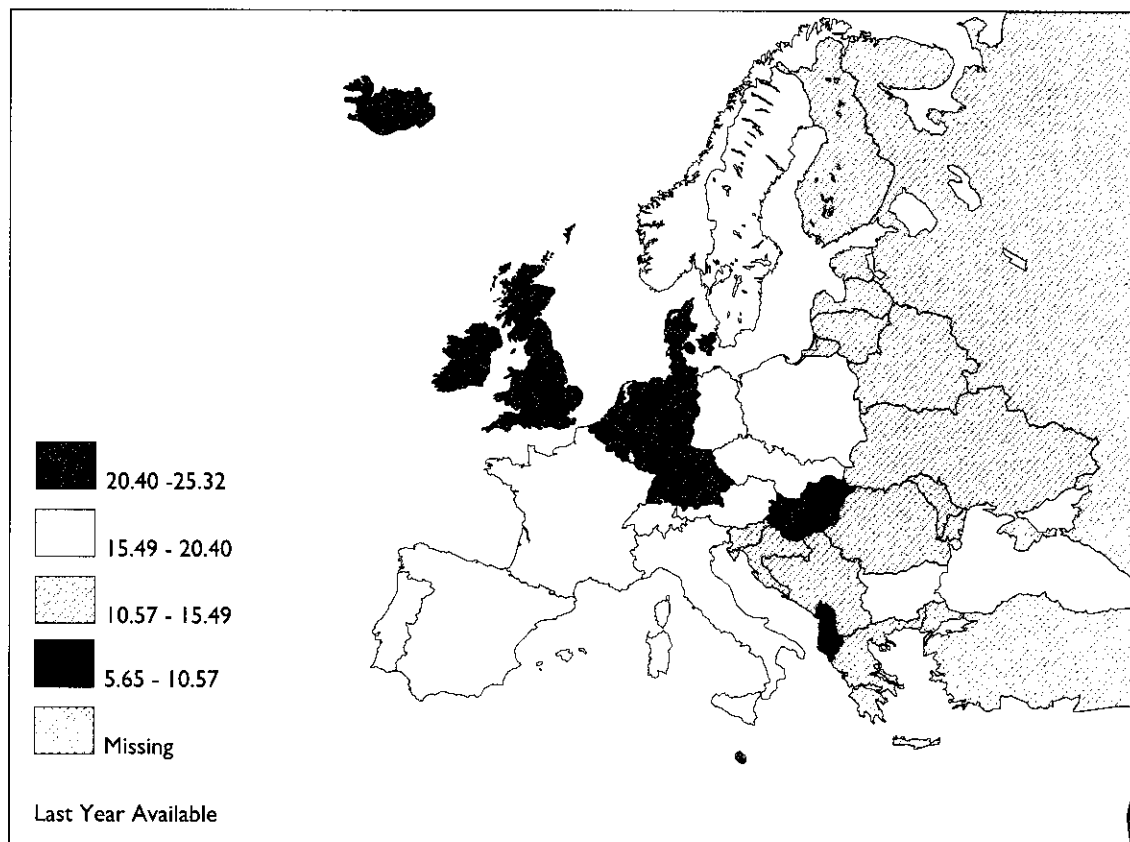
Cancer of the large bowel accounted for 945 deaths in 1993 in Ireland, 400 of which occurred in women<sup>(2)</sup>. In the most recently available figures Ireland ranked second highest in the EU for female and third highest for male death rates from large bowel cancer. The causes of large bowel cancer are not clear but diet is believed to play an important role. Populations in countries with high levels of fat consumption are at greatest risk and high levels of dietary fibre are believed to protect by accelerating the transit time of the bowel contents. As in many other cancers where it is likely that diet is associated with the development of the disease it is only

possible to recommend broad guidelines, sometimes known as the prudent diet. Because of poor prognosis when the tumour has spread beyond the wall of the bowel, there has been considerable interest in early detection through screening. At present, however, there is no recommended population based screening method for the detection of the cancer of the large bowel. Experts involved in the Europe against Cancer Programme have stated that on the basis of the results of existing studies mass screening for colorectal cancer should not be carried out and further research is necessary.<sup>(8)</sup>



## BREAST CANCER

FIGURE 4 FEMALE MORTALITY FROM BREAST CANCER 0-64 YEARS



Age Standardised Death Rates, 1991. Source: World Health Statistics HFA 1994

Breast cancer is the commonest cause of mortality from malignancy in women in Ireland. Of the 3,423 deaths of women from cancer in 1993, 647 deaths or 18.9 per cent, were caused by breast cancer. One hundred and sixty one of these deaths were of women under 55 years.

Breast cancer accounts for about 10 per cent of the deaths of women aged under 65. Among the countries of the EU, Ireland ranks fourth highest for deaths from breast cancer<sup>(5)</sup>

There are approximately 570,000 new cases of breast cancer in the world each year. The



Cancer accounts for approximately twenty per cent of deaths in women in Ireland. In 1993, 3,423 or twenty three per cent of deaths resulted from cancer<sup>(2)</sup>. While there has been a decrease in mortality generally in Ireland, cancer mortality has increased. In 1994 Irish women ranked third of selected European countries in

relation to cancer death rates (Table 4) whereas Irish men ranked ninth highest. The cancers which account for the largest numbers of deaths in Ireland are cancers of the lung, large bowel and stomach in both sexes and cancer of the breast in women.

**TABLE 4 MORTALITY FROM CANCER IN SELECTED EUROPEAN COUNTRIES.**

<b>Age standardised death rate per 100,000 women</b>	
Denmark	203.7
Scotland	200.8
<b>Ireland</b>	<b>184.1</b>
England & Wales	180.7
N. Ireland	174.9
Germany	163.6
Belgium	159.8
Netherlands	162.3
Italy	144.8
France	128.9
Portugal	125.6
Spain	118.3
Greece	110.5

Age standardised death rate per 100,000 women. Source: World Health Statistics Annual, 1993



The premature mortality rate from ischaemic heart disease is still unacceptably high at 20.8 per 100,000 women compared to an EU average of 12.7 per 100,000 women (Table 2). Rates have, however, been declining with an acceleration in the rate of decrease in the late 1980s. The gap between Ireland and the EU is narrowing. Mortality rates from stroke have also been declining steadily.

Mortality rates associated with coronary artery bypass surgery are higher in women than in men, though fewer women have such surgery. There is an emerging trend in developed countries that the highest incidence of myocardial infarction and of admission to coronary care units is occurring among elderly women. To some extent this reflects the larger numbers of women than men in the elderly population.

Research is continuing into potential risk factors for cardiovascular disease <sup>(3)</sup> but it is known that high blood pressure, smoking, obesity and a sedentary life style can predispose a person to the disease. In a national survey carried out by the Irish Heart Foundation, 98 per cent of women reported that their blood pressure had been checked at some time. One in five men and one in four women aged 50-69 years had been treated for raised blood pressure. Nearly 33 per cent of women had a cholesterol check. Twenty nine per cent of women were current smokers. Smoking was lowest in women in the non-manual classes (21 per cent) and

substantially higher in women in the lower socio-economic groups (36 per cent). Nearly 28 per cent of women were overweight and a further 9 per cent of women were obese. Of those women surveyed, 42 per cent were sedentary at leisure. Only one in six women consumed four or more portions of fruit and vegetables daily. On a more positive note, nearly 45 per cent of women said that they had attempted to change their eating habits during the previous year. The main change in eating habits reported was a reduction of fat intake. <sup>(4)</sup>

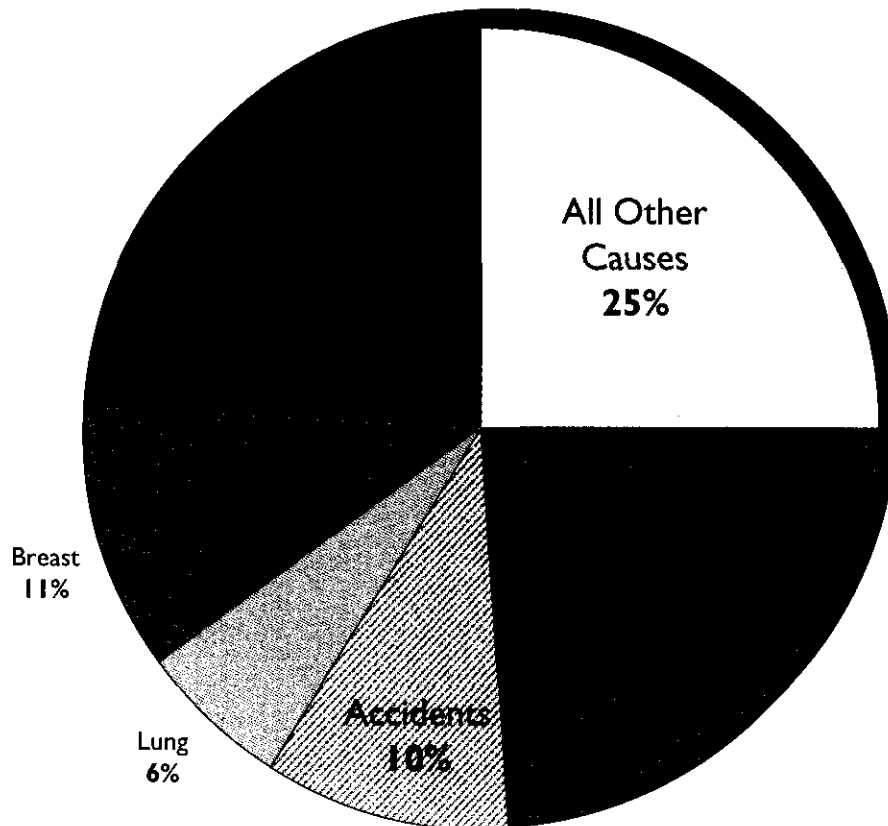
There would appear to be a need to improve the level of awareness among women of heart disease and the potential for prevention and improved quality of life in women in middle and old age. There is a welcome increase in interest internationally in the prevention of coronary heart disease in women.

*The medium-term target of the Health Strategy is to reduce the death rate from cardiovascular disease in the under-65 age group by 30 per cent in the next ten years. This compares with the reduction of about 30 per cent which was achieved over the last twenty years.*

**The action programmes to reduce cardiovascular disease outlined in the Health Strategy focus nationally and regionally on smoking, nutrition and diet, exercise, cholesterol and blood pressure.**



## CAUSES OF PREMATURE DEATHS IN IRISH WOMEN 1990



Source: Vital Statistics, 1990

Cancer and cardiovascular disease accounted for 65% of all deaths in women under 65 years.





**TABLE 2 CAUSES OF DEATH IN WOMEN IN IRELAND AND THE EU**

**AGE STANDARDISED DEATH-RATE PER 100,000, 1991**

<b>SDR/100,000 Women</b>	<b>All Ages</b>		<b>0-64 years</b>	
	<b>Irl</b>	<b>EU</b>	<b>Irl</b>	<b>EU</b>
Diseases of the Circulatory System	308.5	(257.3)	42.4	(33.1)
Ischaemic Heart Disease	146.9	(84.6)	20.8	(12.7)
Cerebrovascular Diseases	79.3	(80.0)	10.6	(9.1)
Cancer of the Digestive Organs & Peritoneum	54.3	(47.8)	20.0	(15.9)
Malignant Neoplasm of Female Breast	39.3	(31.5)	25.3	(20.0)
Trachea/Bronchus/Lung Cancer	25.1	(14.0)	10.5	(6.7)
Bronchitis/Emphysema/Asthma	11.8	(9.1)	2.5	(2.1)
Cancer of the Cervix	3.5	(3.4)	2.8	(2.4)
External Causes of Injury and Poisoning	23.1	(28.4)	-	-
Motor Vehicle Accidents	6.7	(6.7)	-	-

Source: World Health Statistics HFA 1994



## THE HEALTH OF IRISH WOMEN

There have been significant advances in the health of women in this country in the last forty years. Women have benefited from the major increase in life expectancy this century as a result of childhood immunisation programmes and improved maternity services. The life expectancy of women at birth has increased from 67 years in 1950 to 77.9 in 1991. The maternal death rate has fallen from 31 to 2 per 100,000 live and stillbirths between 1970 and 1992<sup>(1)</sup>. The infant mortality rate fell from 19.5 to 5.9 per 1,000 live births between 1970 and 1993<sup>(2)</sup>.

By comparison with the past and with the position of women in many countries at a similar level of development, the risk to the health of Irish women posed by pregnancy and birth, as measured by these limited but important indicators, have been minimised. However, the life expectancy of women at birth in this country is one of the lowest in the European Union, suggesting that there is scope to add years to the lives of Irish women. At age forty, Irish women have the lowest life expectancy in the Union. They can expect to live 39.0 more years compared to an EU average of 40.8 years. The life expectancy of Irish traveller women, which is twelve years shorter than Irish women generally, is a major cause of concern.

The Health Strategy, **Shaping a Healthier Future**, welcomes the fact that the death rate from strokes among men and women has almost halved since 1972. There has also been a

significant reduction in deaths from heart disease as well as a welcome drop in mortality from road traffic accidents, other accidents and poisoning. While death rates from heart attacks have fallen, they are still above the EU average. There has, however, been little progress in increasing life expectancy at middle age. The **Health Strategy** defines premature mortality as death before the age of 65 years. Much premature mortality could be prevented if diseases of the heart and circulatory system and certain cancers were controlled. A reduction in the toll of mortality from these diseases would have a major impact on the life expectancy of middle aged women.

The main causes of death of women are listed in Table 1 and compared with the EU average for females (Table 2). The main causes are diseases of the circulatory system, ischaemic heart disease and cancer, especially of the breast, lung and colon. The figures for Irish women compare unfavourably with the EU average, particularly for deaths from diseases of the circulatory system, heart disease and cancer of the trachea, bronchus and lung. A significant proportion of the deaths from these causes could be prevented or postponed by changes in lifestyle, particularly by a reduction in cigarette smoking.



## THE OBJECTIVES OF A WOMEN'S HEALTH POLICY

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The objectives of a policy for women's health that would promote the health and welfare of women were set out in the strategy for the health services, **Shaping a Healthier Future**.

These are:

- to ensure that women's health needs are identified and planned for in a comprehensive way;
- to promote the health and welfare of women;
- to ensure that women receive the health and welfare services they need at the right time and in a way which respects their dignity and individuality. They must have ease of access to and continuity of care;
- to promote greater consultation with women about their health and welfare needs. This must be done at national, regional and local level;
- to promote within the health services greater participation by women both in the more senior service positions and at the representative levels.

It is also suggested that the improvement of women's health in the developing world should be an objective of this country's membership of the WHO and of Irish aid to developing countries.



## A POLICY FOR WOMEN'S HEALTH

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There has been a growing concern at national and international level in recent years with the health status of women. Attention has focussed on measures to reduce premature mortality and unnecessary morbidity among women and to increase the quality of their lives. Health services for women in this country are organised at present by function - maternity and gynaecological services, family planning services, mammography, cervical screening, refuges for victims of violence. There is a need for a women's health policy to provide unifying objectives for these services. Otherwise the unique life time needs of women from the health services, from childhood to advanced old age, may be overlooked. A policy for women's health should be based on a comprehensive approach to the life experiences of women and the issues which affect their health. Such a policy should suggest a strategy for improving the health of women over the next decade. This **Discussion Document** attempts to redress this imbalance by looking at the health needs of women over their lifetime, to suggest how health services for women could be improved and to recommend priorities for action.

The World Health Organisation has identified a health target for women as part of its strategy, **Health for All by the Year 2000**. The target aims to achieve the following by the end of this decade:

- a reduction in maternal mortality to less than 15 per 100,000 live births;

- a substantial reduction in health problems that are unique to women;
- a substantial reduction in health problems of women related to their socio-economic status and the burden of their multiple roles;
- a substantial reduction in the incidence and adverse health consequences of sexual harassment, domestic violence and rape;
- sustained support for women providing informal health care;
- a reduction of at least 25 per cent in the differences in maternal mortality rates between geographical areas and socio-economic groups.

The WHO recommends that this target be achieved by implementing strategies that:

- pay special attention to women's health;
- provide improved support and care during pregnancy, including the balanced use of perinatal technology;
- accordingly make significant changes in the social environment and in lifestyle patterns.

While the Irish maternal mortality rate at 2 per 100,000 live births is well below the 15 per 100,000 mentioned in the target, the other issues are relevant to this country and put the aspirations of this **Discussion Document** in an international context.



plan. It builds on the contents of the strategy for the health service published in 1994 - **Shaping a Healthier Future** and the recommendations of the **Report of the Second Commission on the Status of Women**.

This **Discussion Document on Women's Health** looks at the health services from a women's point of view. It analyses the health of Irish women and pinpoints the main causes of mortality and morbidity among women. Following the principles of the **Health Strategy**, it examines the health services which are particularly important to women and suggests priorities for improvements. It identifies categories of women who are at a particular disadvantage as regards their health or access to health services. It suggests ways in which the structures responsible for delivering the health services could be made more responsive to the needs of women. Finally, it looks at Ireland's responsibilities in the wider world to assist with the improvement of women's health in the underdeveloped world.

This document will form the basis for consultation with all those interested in improving the health and welfare of Irish women. I hope that all organisations with responsibility for aspects of women's health and with an interest in improving the health of women will take the opportunity to comment on this document. My Department will be working closely with the Council for the Status of Women and other

representative groups to ensure the most effective consultation possible. Following this consultative process, my Department will draft a plan for women's health to be adopted by Government and implemented over a defined period.

June, 1995



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