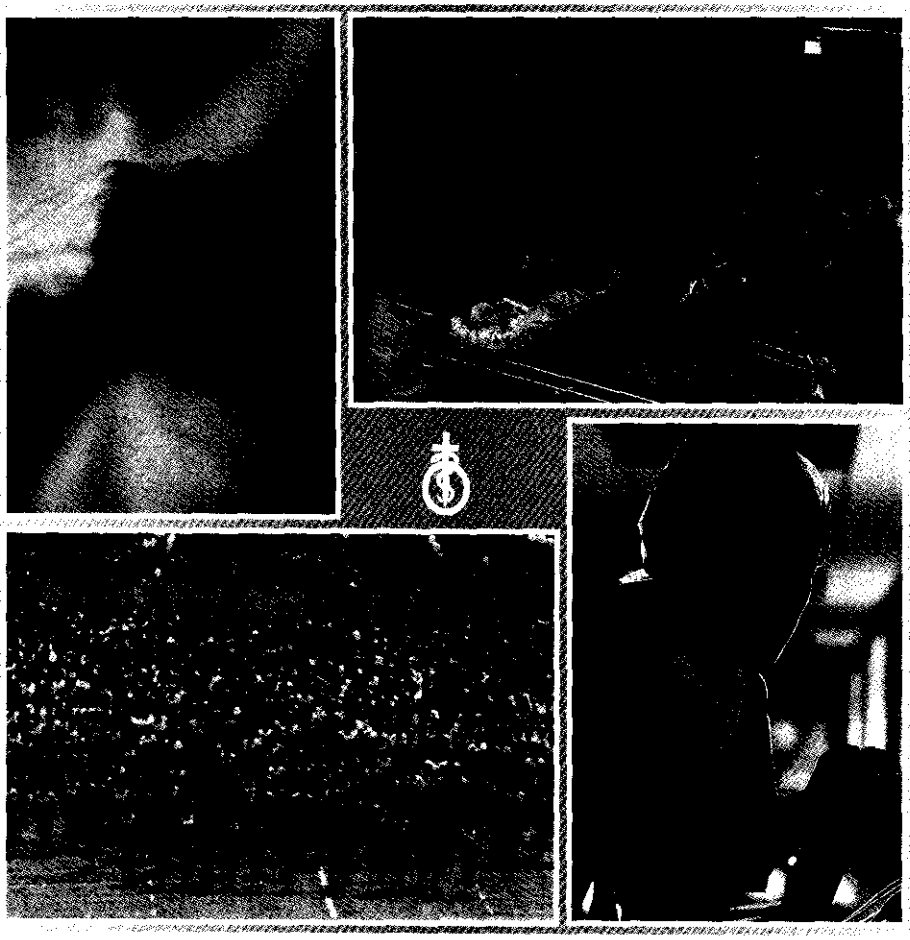
A Plan for

Women's Health



1997 – 1999

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

It gives me great pleasure to publish this Plan for Women's Health. This Plan is the fulfilment of commitments made in the Health Strategy – **Shaping a healthier future**[1] and in **A Government of Renewal**[2], the policy document of the Government. The publication of this Plan implements a key recommendation of the **Report of the Second Commission on the Status of Women**[3] and honours a commitment of the National Agreement of the Social Partners, **Partnership 2000 for Inclusion, Employment and Competitiveness**[4] The publication also has an international significance in that it is in keeping with the targets for the health of women set by the World Health Organisation as part of its strategy for **Health for All by the Year 2000**[5].

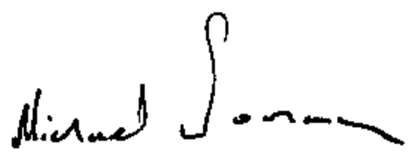
This **Plan for Women's Health** is also the result of a unique process of consultation which has taken place with women over the past eighteen months about their health needs and their priorities for improvements in the health services. The consultative process began in June 1995 when I launched the Discussion Document – **Developing a Policy for Women's Health**[6]. The consultative process on women's health which followed focused on the issues raised in the Discussion Document and women's own experiences of the health services.

I was particularly pleased that the National Women's Council of Ireland agreed to work with my Department and with the health boards to ensure that the authentic and representative voice of women would be heard and that the consultation was carried out in a way with which women felt comfortable. I would like to thank the Council and its constituent organisations for the commitment they have given to the process. I would also like to acknowledge the innovative way in which health boards approached the business of consultation, in a spirit of partnership with women's organisations. Thanks to the efforts of the Council and the health boards, thousands of women throughout the country have had an opportunity to make their views known about their health needs and about the health services.

What did women say when consulted about their health needs and about the health services? They want a health service that is woman-friendly. They want to see women's health services improved and developed. They are asking for information on health and social services that is accessible and relevant to their needs. They would like access to more complementary health services. They are calling for ongoing consultation with women by the health services and greater representation of women generally in the health services. Women want our health services to be more open to consultation, involvement, respect, empowerment and choice. They want a commitment that the partnership between the Department, health boards and the National Women's Council that has been such a successful feature of the consultative process will continue in the implementation of this **Plan for Women's Health.** If we are to take seriously the idea of developing services which are perceived by the consumer to be of high quality, a goal set out in the Health Strategy, we must listen to what women are saying about their health and design services which they feel comfortable using. The consultative process on women's health has posed a challenge to the health services, a challenge to which the health services are well able to respond.

A key objective of the Government's strategic management initiative, **Delivering Better Government**[7], is the achievement of an excellent service for the public as customers and clients, building on the good service that is provided at present. This **Plan for Women's Health** is built on the firm foundations of the Discussion Document and of consultation with women about their health needs and perceptions of the health services.

This Plan outlines the steps which will be taken, at national and regional level, to achieve these objectives and to evaluate progress by the year 2000. Achieving the objectives of this Plan will require the combined efforts of my Department, the health boards, women's organisations, the professions and staff associations. I have no doubt that the spirit of partnership and goodwill that was such a characteristic feature of the process of consultation on women's health will extend into the next phase. I am particularly pleased that the National Women's Council has agreed to continue working in partnership with my Department and the health boards to implement this Plan. I will be assisting the Council, through funding and other means, to maximise their contribution to this process. The implementation of this Plan will mean that women in this country can face a new millennium in the confidence that a key objective of the health services is to maximise the health and social gain of Irish women.



April, 1997

Introduction

A PLAN FOR WOMEN'S HEALTH

This **Plan for Women's Health** has been developed in response to a growing concern that women's health needs were not always being met by the health services. In 1993, the Second Commission on the Status of Women recommended that the Department of Health should respond to this concern by publishing a policy document on women's health and engage in extensive consultation with women prior to preparing a plan for women's health.

The first part of the recommendation was implemented with the publication of the Discussion Document – **Developing a Policy for Women's Health*** in June, 1995. The Discussion Document looked at the health services from a woman's point of view. It analysed the health status of Irish women and pinpointed the main causes of mortality and morbidity among women. Following the principles of the Health Strategy – **Shaping a healthier future,** the Document identified the scope for preventing premature mortality and increasing health and social gain. The Document provided a detailed analysis of most of the health issues of concern to women and suggested priorities to be addressed in a plan for women's health. The priorities suggested in the Discussion Document for improving the health of Irish women were:

- a reduction in smoking;
- the introduction of national screening programmes for breast and cervical cancer;
- improvements in the maternity services;
- better services for victims of domestic violence and rape;
- better access by traveller women to health services;
- increased representation of women in the health services;
- increased research on many aspects of women's health.

The Discussion Document suggested that assisting the improvement of women's health in the developing world should also be a priority of a women's health policy.

The process of consultation began at national level with a conference on women's health on 30th June, 1995. Consultation at regional and local level was organised by the health boards, building on the experience of two boards which had already invited women to comment on their health needs and the health services available to them. The process was greatly strengthened by the involvement of the National Women's Council which has 156 affiliated organisations representing over 300,000 women throughout the country. The Council agreed to be a partner with the Department and the health boards in organising the consultation process. This partnership stimulated an extensive and innovative process of consultation with women.

The Council, with funding from the Department, appointed a co-ordinator to liaise with the statutory side in structuring the consultation. In each health board region, the Council appointed 'counterparts' to work closely with health boards in organising the consultative process. Each health board in turn appointed a women's health co-ordinator to carry the consultation forward.

Consultation with women on health issues took many forms. Conferences, workshops, exhibitions and seminars were held on the full range of topics in the Discussion Document or on specific topics. Every effort was made to provide child care facilities and sign interpreters at venues and to ensure that they were accessible to disabled women. Some boards organised listening meetings with an open invitation to women to discuss any health issue of concern to them. Written submissions were also invited from a large number of organisations with an interest in women's health. Over 50 were received in the Department alone. There was considerable media coverage of the Discussion Document and of the consultation. The first debate in the Dáil on women's health began on 9th November, 1995.

The overall thrust of the consultative process was positive. Women welcomed the opportunity to give their views on health issues. The quality of the responses showed how deeply many women had reflected on health issues and how important these issues were to them. On the whole, women were appreciative of our health services, even if they were critical of certain elements. Women endorsed the analysis in the Discussion Document of women's health issues and of the need for a plan for women's health. They did, however, highlight shortcomings in the Discussion Document and issues which had been inadequately covered.

Major deficits in the health services in relation to women which were identified in the consultative process were the difficulty women experienced in accessing information on health and health services, the lack of a structured counselling and complementary health service, and the fact that the health services are not woman-friendly. These are issues which were hardly touched upon in the Discussion Document and they demonstrate how essential it was to consult women before embarking on a plan to improve their health. Women, during the consultative process, endorsed the need identified in the Discussion Document to improve services for women who are victims of violence or who are caring for a dependent family member. They asked for enhanced family planning and maternity services, and more support for breastfeeding and new mothers in general. They would like more counselling services available in non-medical settings to help women in stressful situations. There was strong support for the development of screening programmes for breast and cervical cancer and for the removal of the barriers which make it difficult for disadvantaged, traveller and disabled women to access services.

There was a strong view among the women consulted that there should be greater representation of women at all levels of the health services. They felt strongly that the kind of consultation with women which took place on the Discussion Document should find a permanent expression in the health services, at national, regional and local level.

At the conclusion of the period of consultation, a report was prepared in each health board on the organisation and outcome of the process. Some of these reports were prepared in consultation with representatives of the National Women's Council. A national seminar was held in March 1996 to reflect on the outcome of the consultative process and identify priorities to be addressed in this **Plan for Women's Health.** Health boards have already begun to respond to the issues which arose in relation to the organisation and delivery of their services.

This **Plan for Women's Health** responds to the issues raised during the consultative process and builds on the analysis in the Discussion Document. This Plan is action oriented. It specifies the action which will be taken at national level by the Department of Health to improve women's health. It identifies the action to be taken by health boards in regional plans for women's health to improve health services for women. There is a commitment in this Plan that women will be consulted more at all levels in the health services. The commitment to consultation is expressed most fully in the decision to establish a Council for Women's Health. The Council will be a centre of expertise on women's health issues, foster research into women's health, evaluate the success of this Plan in improving women's health and advise the Minister for Health on women's health issues generally.

This Plan has four main objectives for the health services in relation to women. These are:

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

This Plan will provide a coherent framework for the improvement of women's health and health services for women to the beginning of the next century. It will succeed to the extent that the gap between the health indicators for Irish women and women in the EU reduces, health issues that are important to women are addressed and women consider that they have access to the information they need about health and that the health services are more user friendly. .

The success of this Plan in achieving its objectives in relation to women's health will be measured in

a number of ways. A narrowing of the gap in health indicators for Irish women and women in the EU will be an important source of information for evaluation. The extent to which there is increased representation of, and consultation with, women in the health services can also be measured against current practice. Women's experiences of the health service and the extent to which they consider it to be more woman-friendly than now, will be evaluated on an on-going basis.

* Copies of the Discussion Document – **Developing a Policy for Women's Health** are available from the Government Publications Sales Office, Molesworth St., Dublin 2.

Information for Health

INFORMATION FOR HEALTH

While women had many comments to make about individual parts of the health service and about individual health issues, a common thread running through their comments was the need for information. They wanted this information based on an holistic model of health and developed in consultation with women. Information is a key element in enabling women to derive maximum benefit from the health services and to achieve greater control over their health. Women wanted information on issues affecting their health and that of their families. This would include information about the health services available to meet their health needs and information about health issues such as nutrition, menopause and exercise. While it is recognised that there may be some degree of overlap between these two areas of information the former relates essentially to the issue of quality assurance in the delivery of health services and is the subject of this chapter while the latter relates to broader issues of health promotion and is dealt with in the following chapter.

Women asked for information which would explain what health services are available locally to meet their needs. They asked that such information be easily accessible and not just in environments associated with illness. It would, in particular, give times and locations of clinics and screening services related to women's health issues, information on eligibility for such services and names and addresses of support groups.

"Difficulties in accessing information which was appropriate, relevant and timely was identified by women as the factor which caused the greatest disadvantage in accessing health care. This inability to access information was identified as limiting their decision making powers and reducing their options when considering health issues. This problem permeated all levels of the service."

QUOTE FROM THE CONSULTATIVE PROCESS

They asked that the information in whatever is the appropriate medium should be easily understood.

While much has been done to make information on health services available, it is clear from what women said during the consultative process that a more pro-active approach is needed in the production and dissemination of information on health services relevant to women at national and health board level. The written word has been the main method of communicating health information in the past but it is not always the most effective way of informing people. Where women hear about health is also important to

the success of the message. During the consultative process, women highlighted the importance of the workplace as a setting for health information, including information on health services, for women in employment.

New approaches are needed in relation to the nature of information to be made available to women about health services and the manner of its presentation.

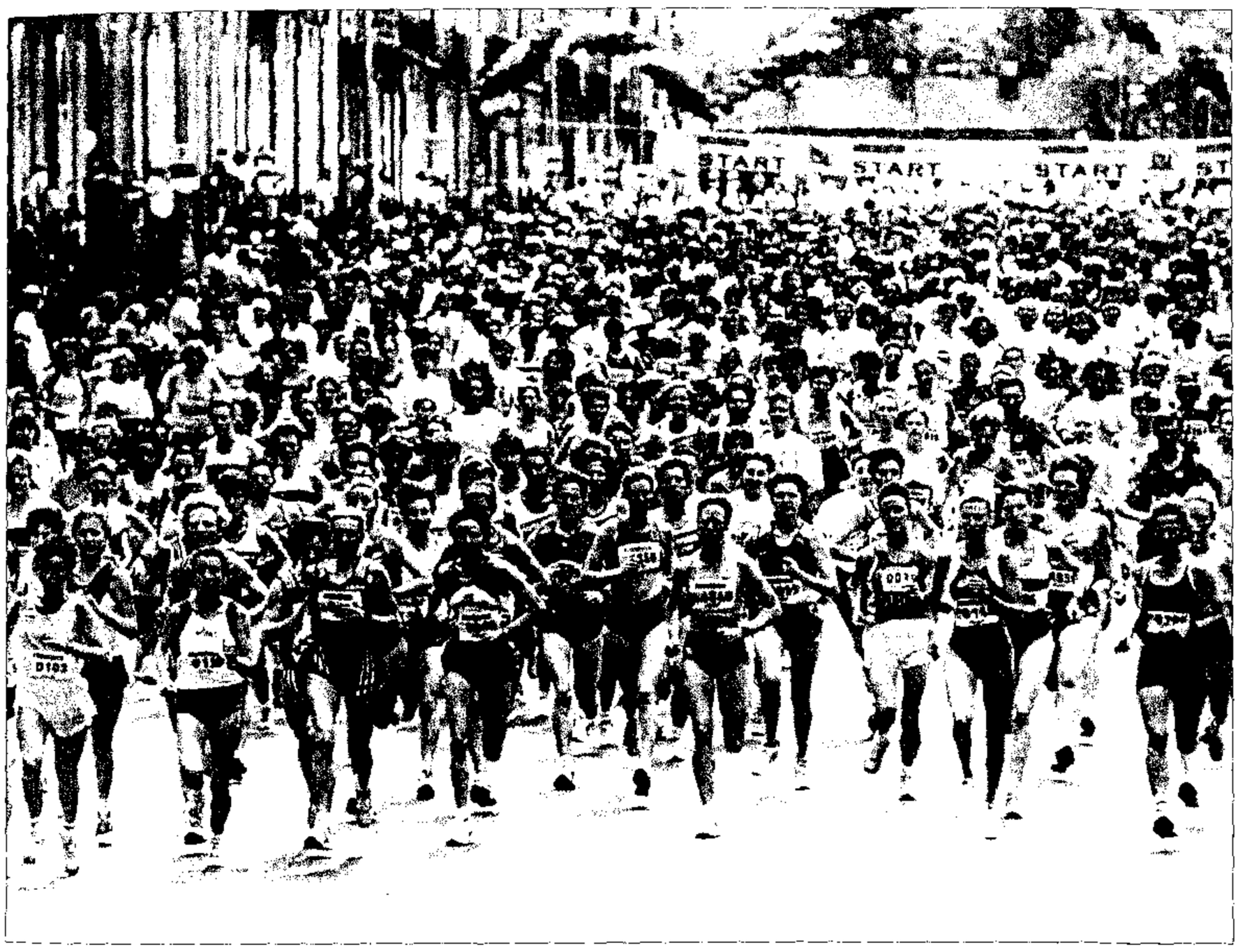
In this context a project currently underway is relevant. The Library Association of Ireland has initiated the Consumer Health Information Research Project which will study the provision of consumer health information by government and healthcare bodies, pharmacists, self-help groups, voluntary organisations and charities. The project, which is due to report at the end of 1997, is funded by the Department of Health with money from the National Lottery. The outcome of this project will be relevant to improving access for women to information about health issues including information about health services.

Action: The Department of Health will work with health boards and women's organisations to pilot innovative approaches to informing women about health services and to disseminate good practice. Actions in this area will take cognisance of the outcome of the Consumer Health Information Research Project currently underway. Surveys will be undertaken to examine the extent to which women are better informed about health services as a result of these initiatives.

"Probably the most exciting element of meeting women, either in groups or individually was the extent to which they are interested in taking care of their own health and the extent to which they realise that medicalising every problem is not a solution."

QUOTE FROM THE CONSULTATIVE PROCESS

Choosing the Healthier Lifestyle



Evening Herald/adidas Women's Mini Marathon

CHOOSING THE HEALTHIER LIFESTYLE

The consultative process highlighted the importance women attach to health – to their own health, to the health of their families and to the health of their communities generally. Because women attach such a high priority to health and because of their influence on the health of their families, they are a tremendous resource for health. However, women do not consider that they are either sufficiently informed or supported about maintaining or promoting healthy lifestyles. The aim of the Health Promotion Strategy – **Making the Healthier Choice the Easier Choice**[8] – published in 1995 is to make the healthier choice the easier choice for people. It is clear that women want the healthier choice for themselves, their families and their communities. The Health Promotion Strategy will assist women in this goal since action for health promotion involves:

- creating supportive environments;
- strengthening community action in favour of health;
- developing personal skills for health;
- re-orienting health services more towards health promotion.

Benefits from an effective health promotion programme include improvements in the quality of life as well as an increase in life expectancy.

The consultation with women highlighted the extent to which women regard the provision of information as a key factor in empowering them to promote their own health and that of their families. They expressed a need for information focused on maintaining health as well as describing illnesses. The comments made in the previous chapter in relation to the need for improved accessibility of information apply here also. Much of the current information available is provided by means of health education materials. However, the effective use of the information may require skill development for example in assertiveness and self esteem in relation to sexual issues, domestic violence and parenting.

Steps have been taken to support the community in general in developing healthy lifestyles. Following the publication of the Health Promotion Strategy, each health board has either established or is in the process of establishing a dedicated health promotion team. The Health (Amendment) (No. 3) Act, 1996, formally empowers health boards to take a pro-active approach to promoting health. It is clear that implementing a health promotion policy, in particular building healthy public policy and creating supportive environments, cannot be achieved by the health sector alone. Success requires the co-operation of many sectors of society. It is for this reason that a National Consultative Committee on Health Promotion has been appointed under the chairmanship of the Minister of State at the Department of

Health to assist in building healthy public policy and creating environments supportive of health. A framework is therefore in place at national and regional level to promote health. A major challenge now is to develop partnerships for health at national, regional and local level to ensure that the healthy choice is taken into account in all policy decisions. The networks of women's organisations, which have developed in recent years, and the workplace provide two foundations on which to build partnerships for health. As a major resource for health promotion, women have a key contribution to make to health promotion in co-operation with the Department and the health boards. The proposed Council for Women's Health and the advisory committees on women's health being established by health boards provide a means through which such alliances can be formed.

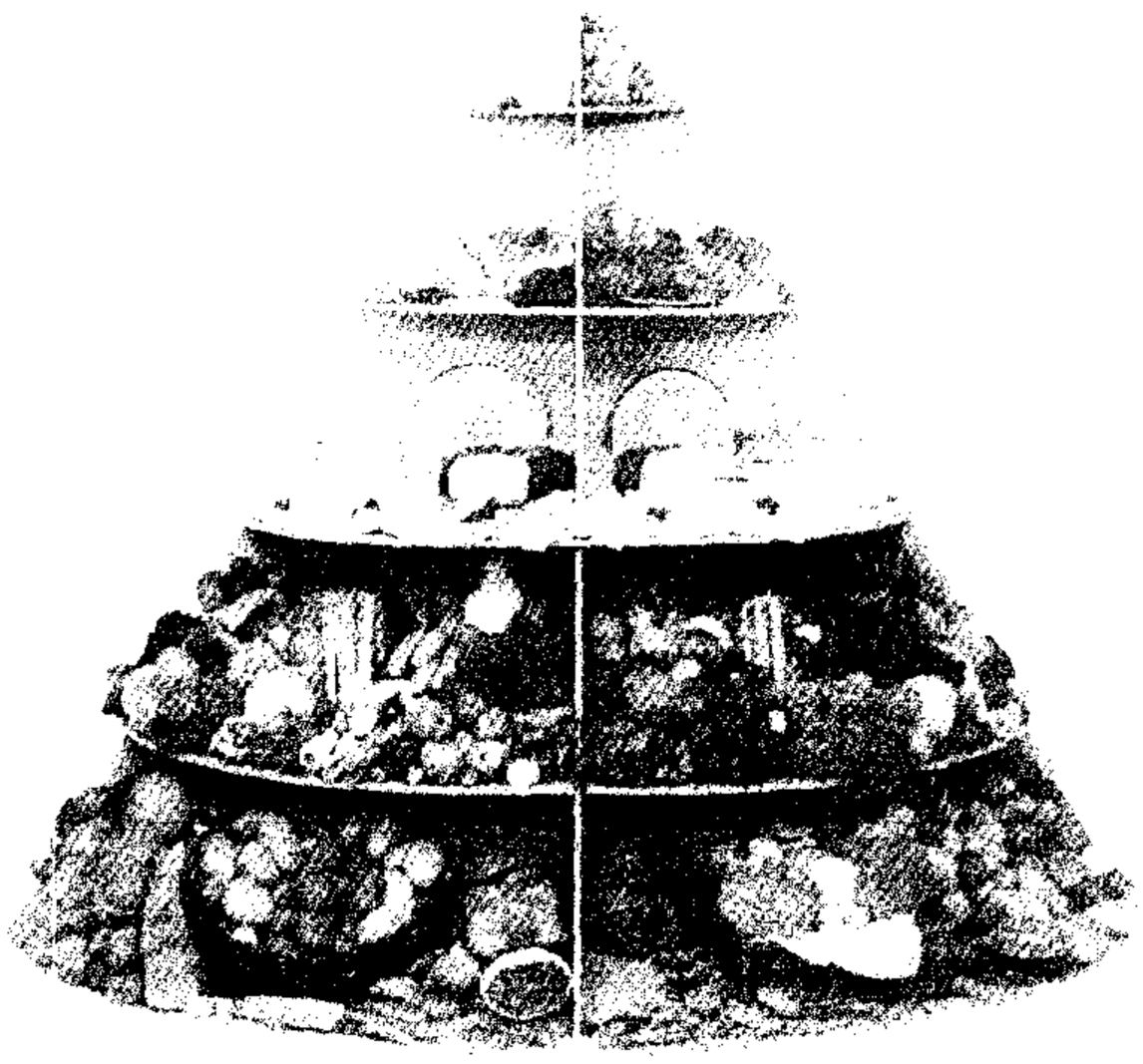
Action: The Department of Health and the health boards will work with women's organisations and other agencies at national, regional and local level to develop and enhance consultation and co-operation for health promotion.

Combating Disease

COMBATING DISEASE

The Discussion Document, **Developing a Policy for Women's Health** drew attention to the relatively lower life expectancy of Irish women, particularly in middle age, by comparison with that experienced by women in the European Union. The main causes of death of Irish women under the age of 65 are cardiovascular disease, cancer and accidents.

A principal objective of this Plan is to maximise health gain by reducing premature mortality among women so that Irish women will have a life expectancy equal to the best achieved in the European Union. If significant gains are to be made in the life expectancy of Irish women, action is needed to reduce premature mortality from cardiovascular disease, cancer and accidents.



Be healthy – eat more bread, cereals and potatoes.

CARDIOVASCULAR DISEASE

Cardiovascular disease is associated with a number of risk factors, most of which are preventable. High blood pressure, smoking, obesity and a sedentary lifestyle predispose women to the disease. Heart disease and circulatory disorders account for nearly half of all deaths of Irish women and almost one quarter of deaths in those under 65 years. Mortality from heart disease in Irish women is amongst the highest of any country of the European Union and is currently more than 20 per cent above the EU average.

The medium-term target of the Health Strategy – **Shaping a Healthier Future** is to reduce the death rate from cardiovascular disease in the under 65 age group by 30 per cent by 2005. If this target were achieved, it would contribute more than any other factor to reducing premature mortality in Irish women.

Information has a critical role to play in increasing women's understanding of the risk factors for cardiovascular disease. The consultative process suggested that, while women were very aware of some risks to their health, the scale of the risk posed by smoking, for example, was not fully appreciated. The Health Promotion Unit of the Department of Health supports a range of actions to encourage women to stop smoking. Particular emphasis is placed on supporting pregnant women to quit smoking. However, more consideration needs to be given to understanding the pattern of women's smoking and to designing effective ways of informing women of the dangers of smoking and of supporting them in stopping the habit. The network of local women's organisations which has emerged in recent years in many parts of the country provides a resource with which health promotion personnel could consult in developing strategies to promote a smoke free lifestyle. The workplace provides further opportunities for involving women in the achievement of a smoke-free environment. The involvement of women will be an essential part of achieving the Health Strategy target that 80 per cent of those over 15 years will be non-smokers by the year 2000.

Women want reliable information on nutrition. This information should reinforce at local level the message of the Healthy Eating Guidelines (1995)[9] and the annual National Healthy Eating Week in relation to the need for a balanced diet, increased fibre intake and a reduction in fat consumption. Similarly there is a need to increase women's awareness of the importance of building physical exercise into their daily lives.

Information in relation to healthy lifestyles has most potential for effectiveness when the general environment in which people live supports healthy choices. Relevant initiatives include – smoking legislation, nutrition policies which address accessibility of wholesome food for all income groups and, where necessary, support the development of cooking and budgeting skills, educational policies which encourage

participation of young girls in sports and physical activities and environmental policies which improve access for adult women to sports facilities, parks and walkways in the community. The network of local women's organisations provide a particularly valuable resource for the promotion of healthy lifestyles and of environments supportive of health.

Action: The Department of Health, in co-operation with voluntary organisations such as the Irish Heart Foundation, will work at national level to achieve the targets in the Health Strategy for smoking reduction, increased awareness of good nutrition and increased exercise, with the overall aim of reducing premature mortality from cardiovascular disease. Health boards, in implementing their women's health plans, will pay particular attention to working with woman to inform them of the benefits of a healthy lifestyle and of reducing the risks to their health posed by smoking, poor diet and lack of exercise. Both the Department of Health and health boards will add momentum to their role as catalysts for the creation of environments which support women in choosing healthy lifestyles.

The Discussion Document, **Developing a Policy for Women's Health** noted that cancer accounts for approximately 20 per cent of deaths of women in Ireland. At present, the scope for reducing premature mortality among women from cancer is greatest for cancer of the lung, breast and cervix. These three cancers account for approximately 500, 650 and 75 female deaths respectively each year. Almost all deaths of women from lung cancer could be prevented if women no longer smoked. Between 20 and 30 per cent of deaths from breast cancer of women aged over 50 could be prevented by a mass screening programme for women aged 50 to 64. It is estimated that about 60 per cent of deaths from cervical cancer could be prevented by a mass screening programme for women aged 25 to 60. Skin cancer accounts for about 50 deaths of Irish women each year. Some of these deaths could be prevented by a reduction in sun exposure and by early detection.

There is considerable scope for reducing premature mortality from cancer among Irish women. The consultative process also drew attention to the need to improve the quality of services available to those who develop cancer.

The contribution of voluntary organisations, such as the Irish Cancer Society, and the increasing co-operation which is taking place at European level through the Europe Against Cancer Programme are of great importance in motivating people to reduce the unnecessary toll of mortality from the disease.

Action: The Minister for Health has identified an improvement in cancer services as a priority for health service development. He has recently published a strategy for the development of cancer services – *Cancer Services in Ireland: A National Strategy*[10] in November 1996 – which outlines measures to prevent cancer and to improve the effectiveness of services for those with the disease. The Minister announced a major action plan in March 1997 which detailed how the National Cancer Strategy would be implemented. The Department of Health will work with the health boards, voluntary organisations in the cancer area and women's organisations to implement the strategy. Specific action in relation to lung, breast, cervical and skin cancer is discussed in the following sections.

LUNG CANCER

The challenge to women posed by lung cancer is similar to that described in relation to cardiovascular disease. The disease accounts for a high proportion of premature mortality among women in Ireland. Smoking is the main risk factor associated with the disease. Not all women are fully persuaded of the risks to their health of smoking or that the long-term benefits of not smoking outweigh the short term satisfaction of smoking. In the mid 1990s about 28 per cent of Irish women aged 15 years and over were smokers. The reasons why women smoke are complex. Research has highlighted the significance of social factors in the pattern of women's smoking. The issue of reducing smoking among women requires a sensitive approach and an understanding of the levels of stress with which some women are coping. New approaches can best be designed through dialogue with women. At national and health board level there is a need to work closely with women's organisations and representatives of women in the workforce in developing appropriate strategies to help women make the healthier choice and avoid smoking.

Action: The Department of Health will work at national level to inform women of the link between smoking and lung cancer and of the scope for preventing mortality from this disease. Health boards, in implementing their women's health plans, will work with women's organisations to increase awareness of the benefits of a smoke-free lifestyle and support women in their efforts to refrain from smoking. The Department will act on initiatives in the National Cancer Strategy in relation to training of general practitioners in counselling techniques for smoking cessation and will press for an EU-wide approach to banning advertising of tobacco products.

BREAST CANCER

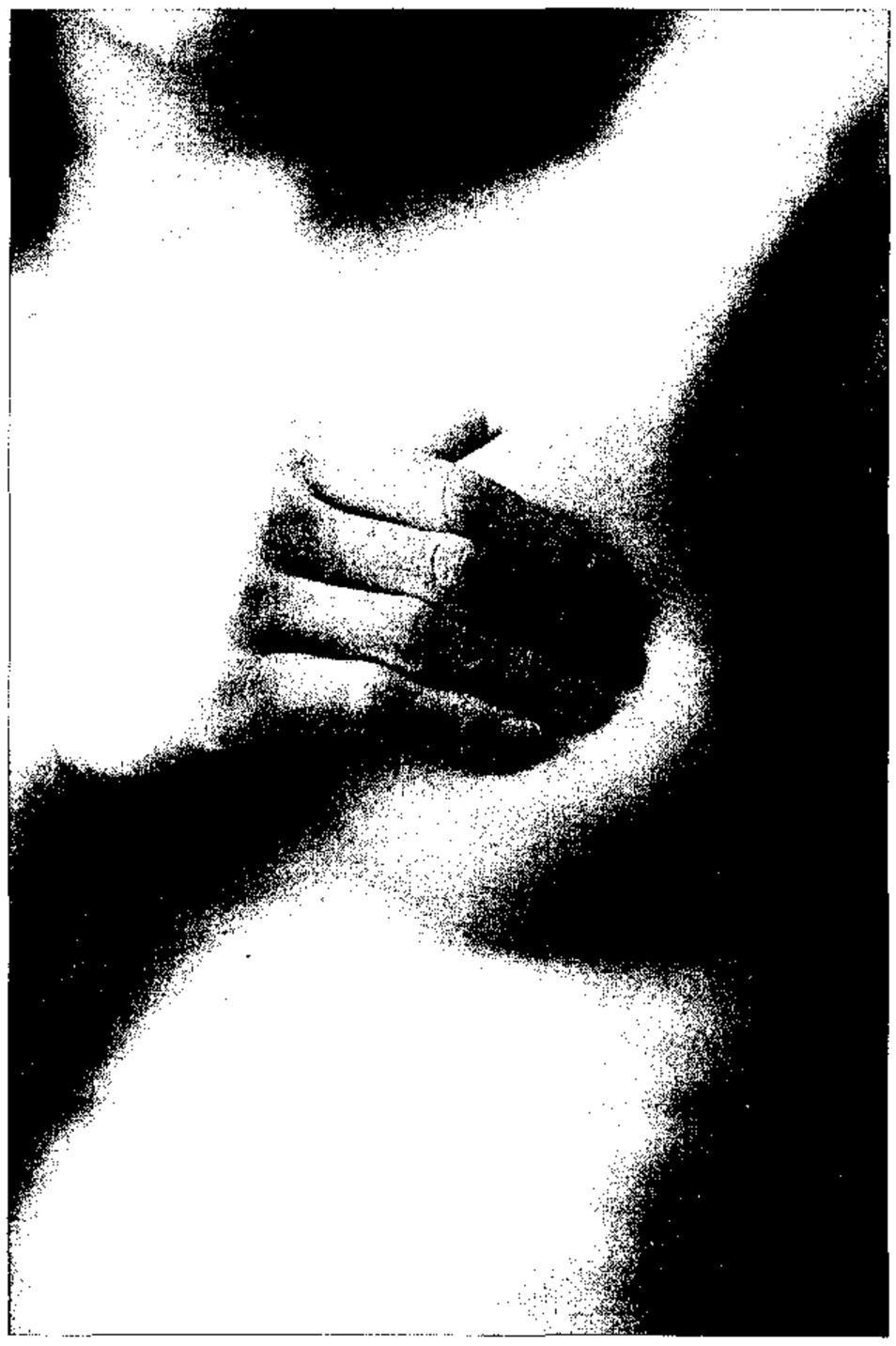
Women throughout the country, in the course of the consultative process, expressed their strong wish for a screening programme to reduce the risk of dying from breast cancer. Breast cancer accounts for about 650 deaths of women in Ireland every year. A pilot breast screening programme, based in North Dublin, Cavan and Monaghan, was conducted in the Mater Hospital, in order to evaluate the impact of mammographic screening on morbidity and mortality from breast cancer in Irish women and to address the feasibility and potential value of a national breast cancer screening programme. The age cohort for the programme was 50 – 64 years. The outcome of this pilot programme was very positive, with 18,000 cancers detected, a prevalence of breast cancer of 7.9 per 1,000. Arising from the successful outcome of this programme, the Minister for Health announced his decision to expand this screening programme.

Arrangements are proceeding for the introduction of the first phase of the National Breast Screening Programme, which will commence in the Eastern, North Eastern and Midland Health Boards. This first phase will target approximately 120,000 women in the age cohort 50 – 64 years, which represents about 50 per cent of the national target population.

In order to meet the overall objectives of a breast screening programme, certain organisational aspects must be put in place. These include the establishment of appropriate planning and management structures, the development of an accurate population register, the use of valid screening protocols, agreed patterns of referral for treatment and most importantly, the implementation of quality assurance mechanisms throughout the programme.

As noted in the Discussion Document – **Developing a Policy for Women's Health** it is important to build up expertise in this area gradually, so that the programme will be of the highest quality and of proven value. With this in mind, a Project Team was established in 1996 to investigate all of the elements of a National Breast Screening Programme. The Project Team has made its report to the Minister and, based on its recommendations, the Minister has established a National Steering Committee to advise on the implementation and operation of the Programme. Membership of the Steering Committee reflects the professional and managerial interests and includes a representative of the National Women's Council of Ireland.

To commence the programme a national population register is necessary, so that women in the target age group can be contacted and offered screening. A major factor affecting the success of a national screening programme is the establishment of this population register. International experience suggests that at least 75 per cent of the target population must participate in the screening programme if the programme is to significantly reduce mortality.



However, there were data protection issues to be resolved in order to compile this register. To this end the Health (Provision of Information), Act, 1997 was passed by the Oireachtas in March 1997. The Act enables the establishment of population registers for programmes of cancer screening authorised by the Minister for Health. The Act refers specifically to screening for breast cancer and cervical cancer, but it can be applied to other cancer screening programmes at a future date if these are found to be medically effective.

Action: As part of the implementation of the National Cancer Strategy the Department of Health will ensure that arrangements are in place for the first phase of a breast cancer screening programme in 1997 and that a national screening programme for breast cancer will be in place before the end of 1999.

CERVICAL CANCER

An Expert Group has reviewed all aspects of the current cervical screening service. It came to the conclusion that a reduction in overall mortality among women from the disease will only be achieved by a national screening programme of women aged 25 to 60. The Minister for Health recently published the report of the group and is committed to the implementation of its recommendations in the context of his strategy to combat cancer. A national screening programme for cervical cancer will commence in 1999 or earlier, if resources permit. An expert advisory committee, which includes a representative of the National Women's Council, has been set up to oversee the establishment, implementation and monitoring of the screening programme. The Director of Public Health in each health board area will have overall responsibility for the cervical cancer screening programme and for its evaluation.

Following the completion of the preparatory work for the national cervical screening programme and building on the experience of the breast screening programme it will be crucial to pilot a cervical screening programme to identify and resolve any difficulties which may become apparent. This pilot will be carried out by the Mid-Western Health Board.

Pending the establishment of a national screening programme, access by women to cervical smear tests needs to be improved and women in the age group 25 to 60 informed of the benefits of screening and the intervals at which tests should be carried out. Cervical cytology laboratories are being assisted to deal with heavy workloads as part of the implementation of the National Cancer Strategy. The aim is to ensure that results of cervical smears are available as far as possible within one month.

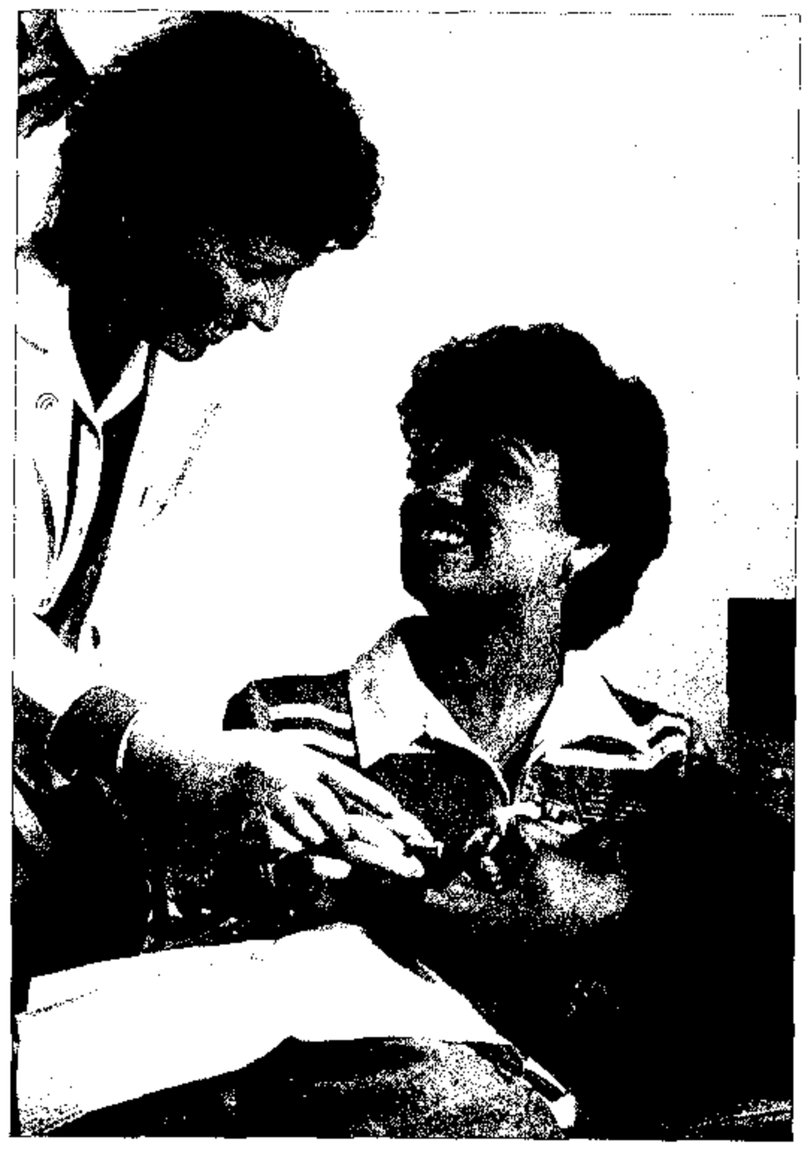
Action: A national screening programme for cervical cancer will be established in 1999 or earlier, if resources permit. An expert advisory committee, which includes a representative of the National Women's Council, will be set up to oversee the establishment, implementation and monitoring of the screening programme. The Mid-Western Health Board area will be the pilot site for the first stage of the programme. Pending the establishment of a national screening programme, the Minister has allocated £1.5 million to improve current arrangements for the taking and investigation of cervical smears.

SKIN CANCER

The greatest potential for reducing mortality in women from skin cancer is to increase awareness of the dangers of excessive exposure to sunlight and to sun beds and of the advantages of early detection.

Action: The Department of Health and the health boards will work to increase awareness among women of the dangers of excessive exposure to sunlight and of the importance of consulting a doctor early about changes in the skin.

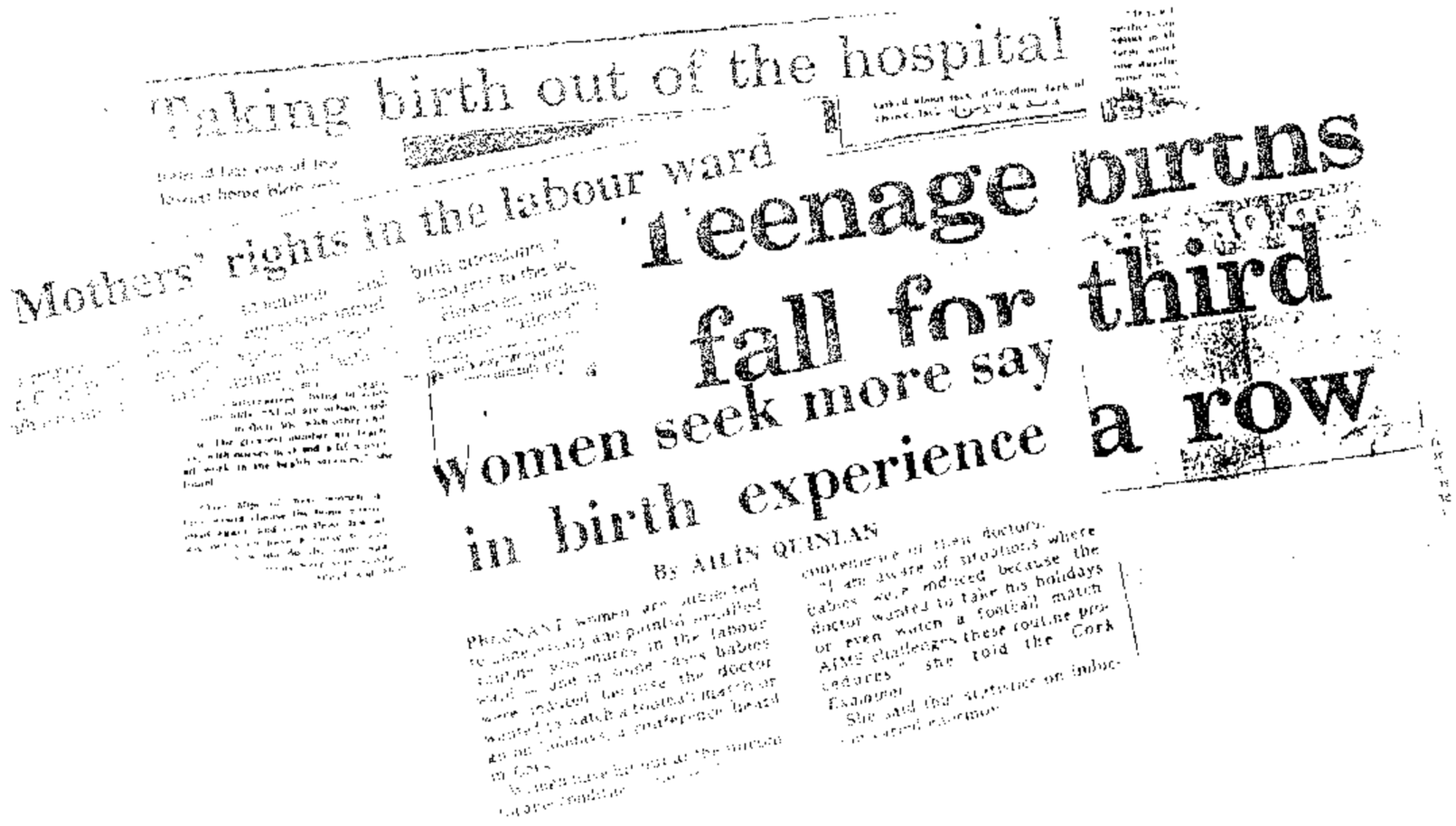
PROMOTING ORAL HEALTH



The Discussion Document identified barriers women experience in maintaining good oral health. The Dental Health Action Plan recognised these problems and the Dental Treatment Services Scheme, which was introduced in 1994, set about addressing the difficulties being experienced by people on low incomes in gaining access to dental care. The scheme is being phased in over a four year period and to date, in addition to an emergency scheme for all, routine care is available to those over 65 and to those in the age group 16 to 34 years. The latter group were included in the second phase of the scheme in response to a commitment to address the oral health needs of women of childbearing age.

Action: The Department of Health will monitor the performance of the Dental Treatment Services Scheme and the impact it is having on the oral health needs of particular groups in the population, including women.

Mother's love — a blessing


Taking birth out of the hospital

Mothers' rights in the labour ward

Teenage births fall for third row

Women seek more say in birth experience

By AILIN QUINLAN

REPRODUCTIVE HEALTH

The consultative process reaffirmed the vital importance women attach to maintaining good reproductive health, to better information about reproductive health and to services which offer women choices and are tailored to women's individual needs. In addition a high level of satisfaction was expressed with many aspects of our maternity services.

"Motherhood and all that it entails sometimes involves isolation, lack of social outlets, change in economic independence as well as the stress of culture change."

QUOTE FROM THE CONSULTATIVE PROCESS

During the consultative process, women endorsed the approach to improving our maternity services proposed in the Discussion Document. They confirmed the need for more attention to the psychological aspects of pregnancy and childbirth, greater continuity in medical and midwifery care, appointment systems in ante-natal clinics, more choice in respect of accommodation, privacy, birthing position, length of stay in maternity units, pain control, visiting times and choice of companion during labour. The case for greater support for those women who choose to give birth at home was also forcibly made. Women identified the need for more encouragement for breastfeeding and support for breastfeeding mothers. The difficulties many women face in coping with the demands of a new baby were also highlighted. These difficulties may be particularly acute if the mother or the baby is disabled.

A number of aspects of the maternity services are under review at present. Particular attention has been paid to developing the Maternity and Infant Care Scheme to which all women are entitled without charge. The Scheme provides for care of the expectant mother by a general practitioner of her choice, specialist and hospital care for her during pregnancy and childbirth and a six week post-natal check by her general practitioner. Currently about half the women who give birth each year avail of this Scheme. It is recognised that the Scheme, which was first introduced in 1956, needs to be adapted to the changes which have taken place since then in maternity care and in women's expectations of childbirth.

A Working Party has reviewed the Maternity and Infant Care Scheme. It has recommended changes in the arrangements for the provision of ante-natal and post-natal care under the Scheme which would reflect best practice today in relation to such care.

The Working Party also recommended ways in which support might be more appropriately given to women who choose to have their babies at home. The Working Party recognised that, while it was safer for mother and baby to be in hospital, the question of where to have a baby is a matter for decision by the mother and father of the child. It also acknowledged that general practitioners and health board midwives are increasingly reluctant to assist at such births, as provided for under the 1970 Health Act[11]. While the report recommended that maternity hospitals develop outreach midwifery services for women in their catchment areas who choose to have a baby at home, consultation with the health boards has shown that a community-based approach would also warrant consideration. It is proposed to pilot both approaches to establish their feasibility and effectiveness in supporting women who choose to give birth at home.

Action: The Minister accepts in principle the recommendations of the Working Group on the Maternity and Infant Care Scheme which will be published shortly. He is committed to adapting the Scheme to the needs of women in the 1990s and to their expectations as expressed in the consultative process.

Pilot schemes will be established to test both the hospital-based and the community-based approaches to supporting women who choose to have their babies at home, to establish their feasibility and comparative effectiveness, and whether different approaches may be required in different geographic or demographic circumstances. The Chief Executive Officers of the health boards will appoint an Expert Group to oversee these schemes, assess their outcomes and make recommendations as a result.

In relation to the other suggested improvements in the maternity services, the health boards, in formulating their plans for women's health, will provide a more comprehensive approach to supporting mothers and newly born children by:

- encouraging every woman to attend ante-natal care at an early stage in each pregnancy. Particular attention needs to be given to encouraging women living in remote areas, teenagers, travellers, women with disabilities and other groups such as New Age Travellers and ethnic minorities, to attend for ante-natal care early in their pregnancies;
- increasing the availability of ante-natal classes at times and places that suit women;
- providing information on the psychological effects of pregnancy and childbirth, including ante and post-natal depression, as part of the ante-natal care and classes;
- introducing appointment systems in maternity hospitals and units for ante-natal clinics;
- increasing privacy for women and their companions during childbirth.
- ensuring respect for the right of single women to have the companion of their choice present during childbirth and giving special recognition to the need for privacy of mothers who have had a miscarriage or stillbirth;
- providing more domestic type accommodation in maternity hospitals and units for women with normal pregnancy and labour;
- making available comprehensive pain relief for those women who wish to avail of such relief in labour. Women should be fully informed of the side effects both for themselves and their baby of different

methods of pain relief and of the support available to them if they wish to have a natural birth;

- ensuring that the hospital environment is as baby-friendly as possible and that in particular, every effort is made to support the mother who chooses to breastfeed;

- encouraging consultation with women who have had recent experience of the maternity services and voluntary organisations in the field, to ensure that women's voices are being heard in the planning and delivery of the maternity services;

- supporting closer links between midwives providing ante-natal care and public health nurses who currently visit the mother after birth. The possibility of the public health nurse visiting prior to the baby's birth should be explored so that a relationship can be established with the mother and the services available following birth explained. This approach would have particular advantages for first time mothers and women who are ill or disabled or disadvantaged in some way;

- expanding the support available for mothers of newly born children, some of whom experience great stress, through the home help service, support for mother and baby groups, community mothers programmes, information, advice and counselling.

The Department of Health will encourage the independent maternity hospitals to work closely with the health boards in developing a more comprehensive approach to supporting mothers and newly born children.

BREASTFEEDING

Breastfeeding is regarded as the most desirable method of infant feeding because of the way it strengthens a baby's immunity to illness and also the benefits it can bring to the mother/baby relationship. The Discussion Document pointed out that Ireland has one of the lowest rates of breastfeeding of any country in the European Union.

During the consultative process, women highlighted many of the difficulties which they face in relation to breastfeeding. Society's attitude to breastfeeding as a primitive form of feeding was identified as a major obstacle. They emphasised the importance of encouraging women early in their pregnancies to consider breastfeeding. It is not a decision which should be postponed until after the baby is born. Women emphasised that they needed to be helped to breastfeed, rather than made feel guilty or inadequate if they cannot cope. In this context, women emphasised the importance of nurses who understand breastfeeding spending time with them in the early stages until the initial problems are overcome. Women also queried the practice of providing artificial milk free of charge in maternity units and its influence on women's decisions in relation to feeding their babies.

The **National Breastfeeding Policy for Ireland**[12], launched by the Minister for Health in August, 1994 provides a framework to encourage more women to breastfeed their babies and to do so for longer. The overall target is that half of the mothers giving birth in the year 2000 should breastfeed their babies and a third would still be breastfeeding at four months. Work is underway to implement the Breastfeeding Policy. The Health Promotion Unit of the Department of Health has recently updated existing material on breastfeeding and is in the process of developing additional material. A number of maternity hospitals and units have adopted breastfeeding protocols and have increased the expertise of nurses in support of mothers who breastfeed. Breastfeeding resource persons have also been put in place in health boards. Voluntary organisations provide valuable support for breastfeeding mothers on an ongoing basis. However, a more concerted effort will be required by many different groups and organisations if the target of the Breastfeeding Policy is to be achieved. In particular, ways of creating a more supportive climate of opinion for breastfeeding mothers need to be explored, in consultation with women's organisations, at national and local level.

Action: The Department of Health is committed to the implementation of the *National Breastfeeding Policy for Ireland*. It will work closely with women's organisations and other statutory agencies at national level to create a more supportive environment for breastfeeding.

FAMILY PLANNING AND REPRODUCTIVE HEALTH

The Discussion Document on women's health outlined the legal and administrative framework which has been put in place to enable women avail of a family planning service of their choice. Despite considerable progress in recent years, the consultative process on women's health identified a number of problems which remain to be addressed. Surveys conducted by the Midland and North Eastern Health Boards during the consultative process found that the level of satisfaction with the availability of family planning services was low in both areas. In the Midland Health Board, nearly 40 per cent of women surveyed considered the availability of family planning services to be poor or very poor. The same survey found that 44 per cent of sexually active women aged 18-45 surveyed did not use any form of contraception. The surveys also highlighted the need for more information on fertility as only 62 per cent of the women surveyed were aware of the time of the month when they were most likely to become pregnant.

There is clearly a need to make more information available to women about fertility and to improve the availability of family planning services. A family planning service, however, is not just about access to contraception. A family planning service should contribute to women's overall health and well-being by enabling them to make informed choices about their sexuality and fertility. It should have particular regard to the problems of access to services by women in remote areas, of the cultural differences of traveller women, the challenges posed by teenage sexuality (a section focusing on young women and health is included separately) and of the special needs of disabled women. It should assist in the reduction of the number of unwanted pregnancies. The service should include advice in relation to infertility and provide for referral to genetic counselling, if required. It should provide information and advice on sexually transmitted diseases and their impact on women's reproductive health. The networks of women's organisations and the workplace provide important channels of communication with women in relation to information on the maintenance of reproductive health.

Action: The Department of Health will review the implementation of the *Guidelines on Family Planning*[13] issued in 1995 to ensure that services are being provided as recommended. Health boards, in their plans for women's health, will outline the steps which they are taking to develop family planning services which promote women's overall health and well-being. These steps will include information on fertility, sexuality and the way in which the needs of particular categories of women will be met. Funding will be made available for innovative proposals.

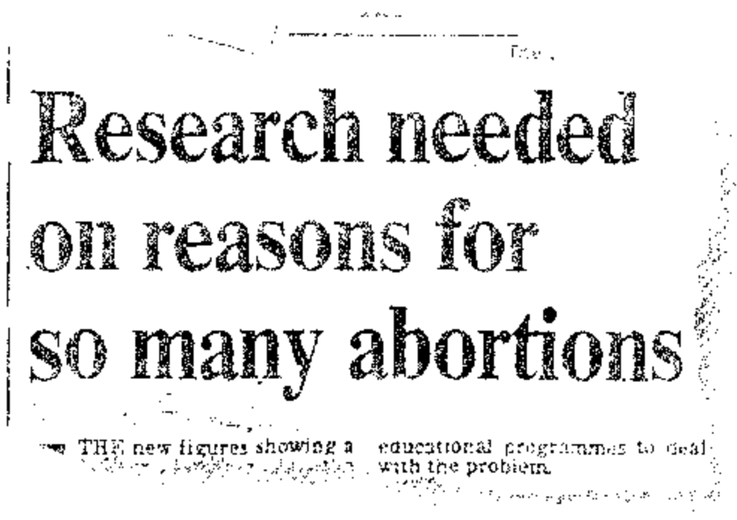
ABORTION

As a society we are increasingly recognising the challenge posed by unwanted pregnancies and the factors which bring women to the decision to seek terminations abroad. On the basis of the number of women who give Irish addresses when they seek terminations in Britain, Ireland has an abortion rate of about 9 per cent of live births. This figure is low by international standards.

The Government has put in place a series of measures to address the problem of crisis pregnancies, which include support for pregnancy counselling, the development of family planning services and research into the factors which contribute to the incidence of unwanted pregnancy. The research commissioned will be particularly valuable in understanding the reasons why some women seek an abortion in a crisis pregnancy. It will also assist in developing services for women who experience difficulties following abortions. It is expected that this research will be completed during 1997.

It is hoped that, over time, these measures will reduce the number of unwanted pregnancies and influence women to consider options other than abortion when faced with an unwanted pregnancy.

Action: The Department of Health will develop an effective and properly targeted educational programme in relation to crisis pregnancy based on the conclusions and recommendations of the abortion research study.



Research needed on reasons for so many abortions

THE new figures showing a ... educational programmes to deal with the problem.

DEVELOPMENTS IN HUMAN ASSISTED REPRODUCTION

The Discussion Document referred to the major changes which are taking place in the field of human assisted reproduction and the challenge such developments pose to our society to respond with appropriate legislative guidelines. It is recognised that the issues involved are complex and that in Ireland, perhaps more so than in most other countries, there are deeply held views about where the parameters should be drawn. However there was little mention of this particular topic during the consultative process.

Any attempt to regulate this area must be preceded by a period of informed debate to give society an opportunity to move towards consensus. This in turn will assist in arriving at an approach which reflects society's preferences to the greatest possible extent.

Action: The Department of Health is currently considering how best to encourage and inform the necessary public debate on human assisted reproduction.

During the consultative process women emphasised the importance of health professionals being sensitive to, and informed about, problems which may arise associated with their reproductive life such as the menopause, bladder and bowel dysfunction. Women consider that rather than trivialising problems of the menopause, professionals 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 help and advice if necessary.

The higher prevalence of urinary incontinence in women is due to a combination of anatomical and physiological reasons arising from complications of childbirth and muscle atrophy associated with the menopause. Factors associated with faecal incontinence include forceps delivery, third degree tears, birth weight greater than 4 kilograms and a prolonged second stage of labour. Both bladder and bowel dysfunction cause considerable stress for those women who experience them. A comprehensive approach to the problem is needed involving liaison between gynaecologists, urologists, nurses and physiotherapists. Such an approach might also involve outreach services to general practitioner clinics or screening programmes at the ante-natal stage and free availability of information to women on the issues.

Action: Health boards will, in the context of their women's health plans, review the provision of services related to the menopause. They will seek to ensure that this aspect of women's health is dealt with by sensitive and informed professionals, whether through the general practitioner service, through women's clinics in association with gynaecology services or by contract with other agencies.

Health boards will provide a comprehensive service to deal with urinary and faecal incontinence among women. This service will be based on a team approach involving gynaecologists, urologists, physiotherapists and nurses.

Violence Against Women

Women's Aid

VIOLENCE AGAINST WOMEN

Women identified violence against them as a key issue during the consultative process on women's health. It is a constant fear for many women who are subjected to physical and sexual violence in their homes. Personal safety is a recurring concern of most women in what appears to be an increasingly violent society.

In relation to domestic violence, the approach of the health services has been to support refuges which give women the option of leaving the violent situation and provide a safe place to which to bring their children. The number of these refuges has expanded and there are now 20 in total. The refuges also provide advice and counselling to women to assist them to deal with a violent partner. The refuges play a vital role in offering an alternative to women in violent relationships and in breaking the cycle of secrecy and shame that is associated with violence against women.

The Domestic Violence Act, 1996[14] provides health boards with a new way of dealing with the problem of violent spouses. Under the Act, health boards are empowered to seek a court order to remove a violent spouse from a home if the dependent spouse is not in a position to seek a barring order. This provision is designed to give protection to spouses who may be too intimidated by violence to seek protection for themselves or their children. This provision of the Act came into effect on the 1st January 1997.

It is the experience of those working in refuges that abuse of women and children are often related. Both the women and their children may be victims of violence or the children may be traumatised by witnessing their mother being assaulted. The implementation of the Child Care Act, 1991[15] has given health boards a more pro-active role in child protection and family support. The Government has approved a three year programme of developments to further expand child protection services and strengthen preventive and family support services.

During the consultative process, women expressed concern that professionals who may be the first point of contact with the health services for many women in violent relationships were not always aware of the horrific experiences which they and their children had suffered or were suffering. In particular, it was suggested that staff in accident and emergency services and some general practitioners needed to be more sensitive to the situation of these women. There is a need for a protocol in the accident and emergency department of every general hospital and in general practice to increase recognition of violent assaults on women and to manage the outcome more effectively. Public health nurses, who have unrivalled access to many homes, also have a key role in identifying women who are the victims of violence and in encouraging them to avail of support services.

"Women must be empowered so that they do not see themselves as being responsible for the behaviour of the abuser"

QUOTE FROM THE CONSULTATIVE PROCESS

In relation to rape and sexual abuse of women, the consultative process demonstrated the valuable role played by rape crisis counselling centres throughout the country and the facilities for specialist investigation and treatment of victims at the Rotunda Hospital, Dublin. There is a clear need to provide at least one adult counselling service for victims of rape and sexual abuse in each health board area and to expand facilities for specialist investigation and treatment.

In response to recommendations made by Women's Aid about the need for an integrated response across Government Departments to problems associated with domestic violence, the Government has assigned responsibility for co-ordinating policy on women and violence to the Office of the Tánaiste. That Office has established a Working Group on violence against women chaired by the Minister of State at the Office of the Tánaiste. The Working Group includes representatives from the Departments of Health, Justice, Education, Social Welfare, Equality and Law Reform and Environment, the health boards, the Gardaí and various voluntary agencies. The Department of Health welcomes the comprehensive approach being adopted by the Working Group and considers that the Working Group's report, which is due to be submitted to Government shortly, will provide a blueprint for policy in this area in the future. The Department of Health and the health boards will co-operate fully with the Office of the Tánaiste to ensure that the health services play a full role in protecting women and children from violence and in providing services for victims of violence.

Action: In relation to violence against women, the Department of Health will:

- **play a full role in relation to the co-ordination of Government policy by the Office of the Tánaiste and encourage a co-ordinated response within the health and personal social services to women who are victims of violence;**
- **ensure the implementation of section 6 of the Domestic Violence Act, 1996 which gives health boards new powers to intervene to protect women against violent spouses;**
- **work closely with health boards, voluntary hospitals and the Irish College of General Practitioners to develop protocols in relation to the recognition of violence against women and good practice in relation to referral of such women;**
- **work closely with the training and education**

bodies in the health and personal social services to increase the awareness of professionals of violence against women.

The health boards, as part of their women's health plans will:

- develop support services for women and children who are victims of violence;
- provide counselling and specialist investigation and treatment services for victims of rape and sexual abuse.

Promoting Mental Health

"Many of the issues relating to women's health are not illnesses as such – they concern life tasks or life stages which women are going through"

QUOTE FROM THE CONSULTATIVE PROCESS

PROMOTING MENTAL HEALTH

While women welcomed the changes that are transforming the mental health services from a largely institutional service to one that is based in general hospitals and in the community, there was widespread concern that the health services were not responding appropriately to women's mental health needs. Women were critical of the pre-occupation of services, reflected in the Discussion Document – **Developing a Policy on Women's Health,** with treating mental illness and of the absence of services to protect and promote mental health. As the Discussion Document pointed out, women are particularly prone to depression. Some of this depression is biological but much is associated with the stress women experience because of conflicting multiple roles, lack of control of their fertility, violence, low income, low status and self esteem. The high level of para-suicide among women may also have its roots in these social problems. As presently organised, neither the mental health services nor the health services in general are in a position to offer women support to cope with the crises which arise in their lives and which threaten their mental health. Women made the point that, in the absence of an organised response to these needs, women's mental health problems are medicalised. Medication in such circumstances can mask the underlying problems and can lead to dependence and addiction to the prescribed drug.

What women asked for during the consultative process was access to counselling services, preferably in a non-medical environment, which would help them develop coping skills and self assertiveness. Currently counselling services with some public funding are provided for women in special circumstances – women with crisis pregnancies, women who have suffered rape and/or sexual abuse, women who are victims of crime and women with marital problems. What is needed now is a more pro-active approach with access to counselling for women at an earlier stage in the stress cycle with the aim of preventing more serious problems. The Interim Report of the Commission on the Family to the Minister for Social Welfare – **Strengthening Families for Life**[16] – addressed the issue of counselling for families, couples and individuals. The Report notes that, to date, there has been no co-ordination of counselling services to consider needs, location, standardisation and funding. The Commission on the Family recommends the establishment of a Standing Committee to provide an inventory of services currently available, to identify types of counselling needed and where they are needed and to report on issues regarding standardisation, registration and accreditation necessary to protect both the consumer and the practitioner.

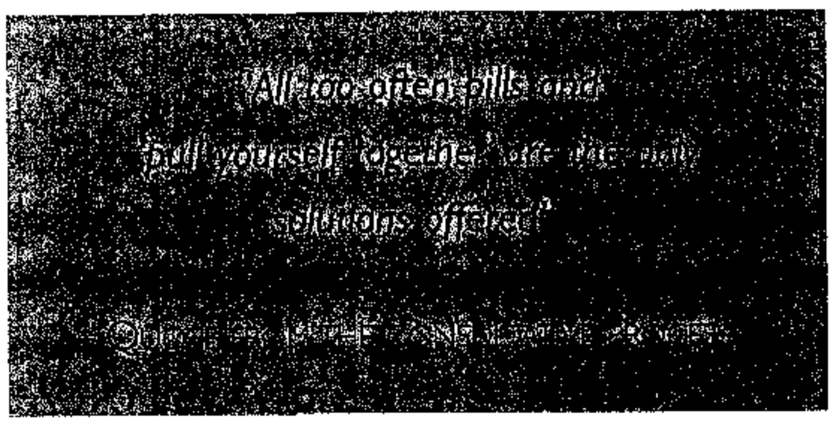
Women also emphasised the importance of alternative therapies, such as reflexology and aromatherapy, to promoting women's mental health and well-being. They asked that the value of such therapies be recognised and that they should be available to women who cannot afford to pay for them privately.

The importance of self-help groups to developing women's ability to cope was emphasised by many women during the consultative process. Such groups have traditionally provided valuable support to women recovering from mental illness, from alcoholism and drug addiction and to women coping with the effects of illness and disability. Their role in supporting mothers with young children and women experiencing bereavement is increasingly recognised. Such groups have a vital role to play in promoting mental health among women and there is a need for more explicit recognition by the health services of their role.

Women also want more information about how to maintain their mental health, information that is easily available and in language that is easily understood. In relation to services for the mentally ill, women asked for more information and greater support for families caring for a family member with mental illness.

The results of the consultative process in relation to women's mental health clearly pose a challenge to the health services. The health service is being asked to review in a fundamental way the extent to which it promotes and protects the mental health of women. The Department of Health and the health boards will need to give detailed consideration as to how best to develop services that meet the needs of women identified during the consultative process. In the Discussion Document – **Developing a Policy on Women's Health,** the Department committed itself to commissioning research on mental illness in women. The focus of this research will be widened to consider the factors which undermine mental health in women. The findings of this research will help inform a policy response to the mental health needs of women at national and health board level.

New mental health legislation, recently approved by Government, will give health boards a statutory remit to promote mental health in each region. When passed, this legislation will provide health boards with a statutory remit to develop specific programmes to promote mental health.



ALCOHOL RELATED PROBLEMS

Alcohol is a major factor undermining women's mental health. The number of women who become addicted to alcohol is increasing with serious consequences for their mental and physical health. As detailed in the Discussion Document, while alcohol misuse is harmful to both sexes it holds special dangers for women. Women's drinking is frequently more hidden than that of men so there is need for greater awareness on the part of health professionals of the likelihood of alcohol misuse in women being masked by other presenting problems. Such awareness is important if women are to benefit from appropriate interventions at the earliest possible stage. In addition to the women who themselves misuse alcohol, other women are affected by their partner's alcohol dependency or that of other family members, which can put intolerable strain on them as they try to hold their marriages and families together. In response to widespread concern about alcohol abuse, the Minister for Health launched the **National Alcohol Policy Ireland**[17] in September 1996 which aims to promote moderation in alcohol consumption and to reduce the risks to physical, mental and family health associated with alcohol misuse. The policy provides for continued support for self-help groups and an increased emphasis on treatment programmes in the community. Discussions are ongoing with a range of organisations about the most appropriate structures and projects, particularly at local community level, to implement the National Alcohol Policy.

Action: The health services will be more pro-active in relation to promoting mental health among women. The following action will be taken with a view to developing the capacity of the health services to promote mental health over the lifetime of this Plan:

- **the Department of Health will commission research on the factors which undermine women's mental health;**
- **new mental health legislation will be passed as soon as possible which will give health boards an explicit statutory remit to promote mental health. The legislation will also bring procedures for the treatment of mentally disordered patients into conformity with the requirements of the European Convention on Human Rights;**
- **the Department of Health, in implementing the Health Promotion Strategy, will work closely with the National Women's Council to promote and protect the mental health of women;**
- **the health boards, in the implementation of their plans for women's health, will promote women's mental health through providing greater access to counselling, information, support for self-help groups and liaison between primary health and the mental health services.**

Women who have contracted Hepatitis C from the Anti-D Blood Product

WOMEN WHO HAVE CONTRACTED HEPATITIS C FROM THE ANTI-D BLOOD PRODUCT

The administration of the Anti-D blood product reduces the risk of a possible adverse outcome of a pregnancy where a rhesus negative mother is pregnant with a rhesus positive baby. Prior to the development of the Anti-D blood product, 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. Some 20 years ago some Anti-D product manufactured by the Blood Transfusion Service Board (BTSB) became infected with the Hepatitis C virus. When the link between the Anti-D product manufactured by the BTSB and Hepatitis C was made, the BTSB put in place in February 1994 the National Blood Screening Programme which offered screening for Hepatitis C to Anti-D recipients. Approximately 60,000 women availed of the screening programme. To date 993 women have tested positive for Hepatitis C antibodies, of whom 472 tested positive for the Hepatitis C virus. In addition, approximately 400 blood transfusion and other blood product recipients, both men and women, have been diagnosed positive for Hepatitis C virus or antibodies.

A comprehensive health care package was agreed with the four representative groups of those affected – Positive Action, Transfusion Positive, the Irish Kidney Association and the Irish Haemophilia Society. The package includes acute hospital services, primary care services, counselling services, a special Hepatitis C research programme and the establishment of a Consultative Council on Hepatitis C.

Acute hospital services for those who contracted Hepatitis C from blood products are provided in special units in six designated hospitals. These services, provided under the Health Act ,1970, are free of charge and include in-patient and out-patient treatment, prescribed medication, access to a specialist liver consultant or hepatologist, access to a nurse/counsellor in each Hepatitis C Unit, the provision of a designated ward for patients, prompt referral to other clinicians for conditions associated with Hepatitis C and many other services. Special earmarked funding has been and will continue to be provided by the Department of Health for these services. In 1996, a sum of £2 million was provided for these hospital services and a similar sum will be allocated for 1997.

In September 1996, the **Health (Amendment) Act, 1996**[18] came into effect. This legislation gives statutory entitlement to a range of primary health care services, free of charge, to persons who have contracted Hepatitis C. The services provided include general practitioner services and drugs and medicines for all medical conditions, home nursing services, home help services, dental and ophthalmic services and counselling services. At the request of the Minister for Health, each health board has appointed a liaison officer to ensure the smooth operation of the delivery of services under the Act and to be a contact point for individuals and the various interest groups whose members will be availing of services under the Act. The Department of Health will continue to maintain contact with the representative organisations and the health board liaison officers to ensure that any problems that may arise can be tackled quickly and effectively.

COMPENSATION

In December 1995 the Compensation Tribunal was formally established by the Minister for Health. The Tribunal was designed to compensate persons who have contracted Hepatitis C from the use of Human Immunoglobulin – Anti-D, whole blood or other blood products. Compensation under the scheme is paid by the State on an ex-gratia basis and awards are calculated by reference to the principles which govern the measure of damages in the law of tort.

The Compensation Tribunal is independent in its operation of both the Minister and the Department of Health. The Tribunal had up to 21st March, 1997 received applications from 1,673 people. By the 21st March, 1997 the number of awards made by the Tribunal was 295 and the total amount awarded was £33.6 million. No award has been rejected.

RESEARCH ON HEPATITIS C

On 26th November, 1996 the Minister for Health announced that he had approved funding of £1 million to the Health Research Board for the establishment and funding of a special programme of research on Hepatitis C. A total of eight projects will be funded. The most significant project concerns the establishment of a special Hepatitis C Research Unit which will involve St. Vincent's Hospital, Elm Park, University College Dublin, St. James's Hospital, Trinity College and St. Patrick's College, Maynooth. The Unit will undertake a range of collaborative research activities which, it is hoped, will lead to the development of improved approaches to the control of the Hepatitis C infection.

CONSULTATION

On 26th November, 1996 the Minister for Health formally established a statutory Consultative Council on Hepatitis C. This Council, whose members include representation from the four support groups for Hepatitis C sufferers, will advise and make recommendations to the Minister on all aspects of Hepatitis C, including health and counselling services and the funding, organisation and delivery of these services. The Council will also monitor the health care requirements and other needs of Hepatitis C sufferers to ensure that any changes in these needs are effectively responded to.

TRIBUNAL OF INQUIRY

On 8 October, 1996, the Minister announced the establishment of a Tribunal of Inquiry into all issues of doubt or uncertainty surrounding the infection of persons arising from the administration of Anti-D manufactured and distributed by the Blood Transfusion Service Board. The Report of the Tribunal of Inquiry was published by the Government on 11th March, 1997. Arising from the findings of the Tribunal of Inquiry, the Government has decided to place the Compensation Tribunal on a statutory basis. The Government has also decided that the tribunal be free to award damages on the same basis as the High Court and that the terms of the Compensation Scheme should provide for an appeal to the High Court on the amount of awards made by the Compensation Tribunal.

The Government has accepted and is implementing the six main recommendations made by the Tribunal of Inquiry in relation to the future workings of the Blood Transfusion Service Board and the Irish Medicines Board.

Action: The health care requirements and other needs of those who have been diagnosed as positive for Hepatitis C virus/antibodies will be monitored and re-assessed on an on-going basis to ensure that the necessary support services are provided to meet their needs. The Consultative Council on Hepatitis C will play a major role in this process.

Women with Special Needs

WOMEN WITH SPECIAL NEEDS

While many health problems are common to women, certain groups of women experience particular challenges which undermine their health. The health services must be sensitive to the needs of these women if inequalities in health are to be reduced. The health services should not further marginalise women who are already marginalised. Services should be organised and delivered with sufficient flexibility to meet the needs of these groups of women.

The consultative process on women's health drew attention to the situation of women with special health needs. It helped identify their needs and the extent to which health services were meeting those needs. In particular, the consultative process helped focus attention on the problems faced by women on low incomes, women with HIV/AIDS, young women, traveller women, women with disabilities, older women, lesbian women, women in prison and women in prostitution. The need for the health services to engage in on-going consultation with these women was emphasised. Unfortunately, the consultative process did not reach all groups of women with special needs. However, the findings of any research relating to these groups, such as research on prostitutes, have been taken into account in this chapter.

WOMEN WHO ARE SOCIALLY AND ECONOMICALLY DISADVANTAGED

Many women on low incomes and who are also socially disadvantaged face multiple challenges to their health. The struggle to survive, run a house and rear a family on a low income can undermine their physical and mental health. Limited education, low self esteem and lack of information about health are barriers to these women's access to services. Some women live in communities in which violence and crime are endemic. Distance from services is a major handicap for women on low incomes in rural areas. Because of their economic dependence, such women have little control over important aspects of their lives which touch on their health and little choice in many areas of their lives. Choosing a healthier lifestyle is often not an option for these women.

One of the most encouraging developments in recent years has been the growth of local women's groups which have encouraged women in disadvantaged areas to organise and become more assertive. The improvements in health services to women outlined in this Plan, if put into effect in consultation and with the support of local women's groups, will have particular benefits for disadvantaged women.

Action: The Department of Health and the health boards in the implementation of the plans for women's health at national, regional and local levels will ensure that a high priority is given to improving the health of women who are socially and economically disadvantaged.

YOUNG WOMEN

A number of key issues were identified during the consultative process in relation to the health of young women. The need for a more focused approach to educating young women about HIV/AIDS and more support for women who develop the disease was identified as was the need for more information about sexually transmitted diseases generally. The importance of integrating drugs and alcohol education in an holistic approach to developing the personal and social skills of young women was stressed. The danger smoking poses to young women was recognised. About 15 per cent of female second level pupils nationally aged 12 to 18 years smoke daily with 23 per cent of 17 year olds doing so. Among young women who leave school early, prevalence is much higher. For some young women smoking is a 'cool' thing to do. It is a peer group activity and is closely identified with weight control. Few young smokers attach importance to the long term damage to their health. Those representing the views of young women considered that greater emphasis needed to be placed on the beneficial aspects of not smoking and on positive role images of non-smokers. Young women should be directly involved in designing approaches to persuade other young women not to smoke. At post primary level, a Substance Abuse Prevention Programme which also addresses smoking, has been developed by the Departments of Education and Health and is in use in many second level schools. The development of a similar programme for primary schools is well advanced in the Department of Education.

Personal and social education was identified in the consultation process as the key priority in enabling young women to understand and take responsibility for their own sexuality and sexual health. This education should afford an opportunity for young women to consider their attitudes and values, self worth and self-esteem, awareness of their bodies and responsibilities in relationships.

The **White Paper on Education** emphasised the role of schools in promoting the social, personal and health education of students. The National Council for Curriculum and Assessment is currently developing a programme of Social, Personal and Health Education (SPHE) for primary and second level schools. This programme will comprise a number of elements, some of which are already in place in schools. Personal and social education, through constituent elements such as good nutrition, self esteem and body care, may be preventive of some of the factors involved in the development of eating disorders such as anorexia and bulimia – disorders which are more common in females than in males.

A programme of Relationships and Sexuality Education (RSE) is currently being introduced into schools. The RSE programme will educate children to understand the nature, growth and

development of relationships within families and the different roles played by family members. A Stay Safe Programme, addressing the area of child abuse, has been developed by the Departments of Health and Education and is in operation in most primary schools. This programme complements the work being done in developing relationships and sexuality education.

A group of young women who often find themselves in particular need of support are those who become pregnant while still in their teens. It is important that young women in general are aware of the demands and responsibilities they face if they become pregnant at such a young age. Initiatives undertaken in this regard include the appointment, by one of the larger health boards, of a teenage pregnancy co-ordinator to work with some second level schools and also youth clubs and neighbourhood youth projects.

The view was expressed during the consultative process that the Discussion Document, in its analysis of the phenomenon of single teenage mothers, did not address core issues such as peer influence, sexual abuse, lack of advice on contraception, educational background, confidence and assertiveness training and responsibility within relationships and for their own bodies. In view of the vulnerability of many teenage mothers and their children, there is a need to provide greater support during pregnancy and following the birth of the baby.

Action: The Department of Health will continue to work with the Department of Education to ensure the development of programmes to promote the personal and social development of young women. Health boards as part of their plans for women's health will develop programmes to reduce the rate of unplanned pregnancy among teenage girls, recognising the particular pressures such women face. In developing the maternity services they will also provide greater support to young single mothers and their children. Funding will be made available for innovative projects which foster inter agency co-operation and develop good practice.

WOMEN AS PARENTS

One of the demanding roles most women take on is that of being a parent. While parenting is, and should be, a shared task where there are two parents, in practice much of that task still falls to women, particularly in their children's earliest years. Many parents, particularly new parents, value support in their role. An example of such support is that provided by the Community Mothers Programme which began formally in the Eastern Health Board in 1988. Friendly local women known as Community Mothers supported by Family Development Nurses, carry out monthly structured visits to parents, by appointment, during a baby's first two years, providing empathy and information in a non-directive way to foster parenting skills and parents' self-esteem. An important aspect of this programme is the organisational/management philosophy underlying it which is one of empowering all those involved – administrators, nurses, Community Mothers and the parents themselves. Evaluation of the programme has demonstrated benefits to both parents and children and indeed to the Community Mothers themselves. Other health boards are now interested in introducing the initiative and the Midland Health Board has arranged joint funding with a charitable foundation to do so. The Interim Report of the Commission on the Family to the Minister for Social Welfare – **Strengthening Families for Life** – has recommended the extension of the Community Mothers Programme to all health board areas.

Homestart, a voluntary programme supported by the Eastern Health Board is another example of a family support programme for families of young children – in this case those under five years. It has recently been introduced in the Mayfield area of Cork. For parents of older children there are a number of parenting courses in various parts of the country. A study jointly initiated by the Health Promotion Unit and the Child Care Policy Unit of the Department of Health and the National Children's Resource Centre, Barnardos, supports the view that there is a need for a variety of forms of parent education which should be available at local community level.

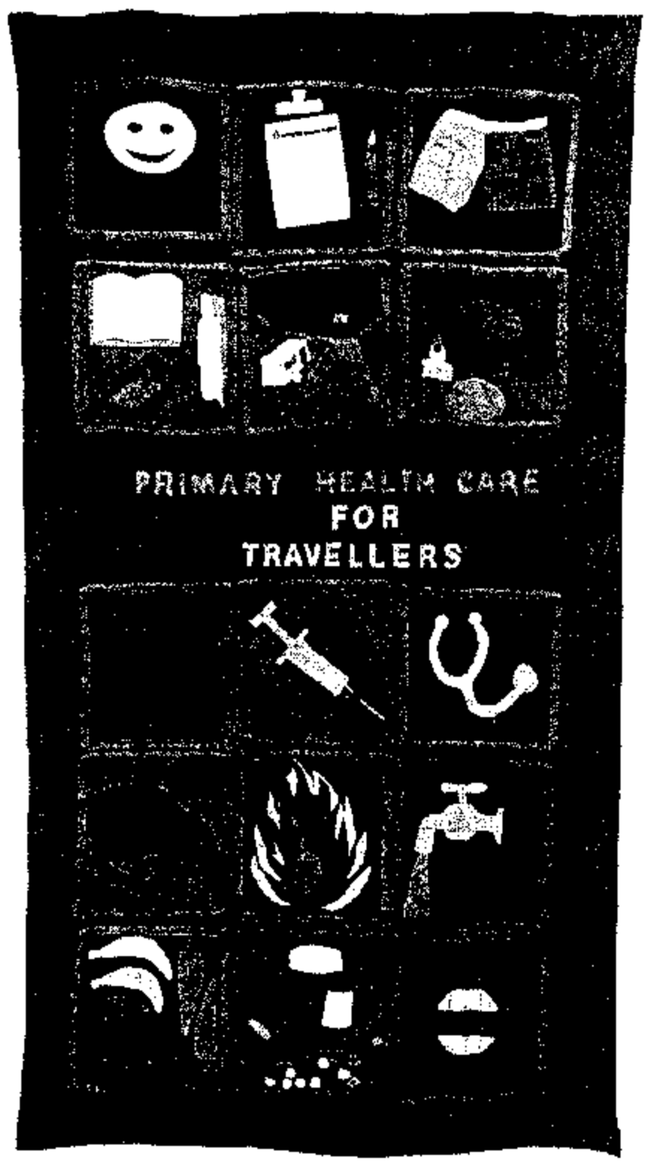
Many women, both those who work full time in the home, and particularly those who combine motherhood with a full time career outside the home, have welcomed the introduction of Part VII of the Child Care Act, 1991[15], which places a statutory obligation on health boards to supervise and inspect pre-school services. New regulations giving effect to these provisions of the Act came into operation in December 1996. The new regulations enable health boards to supervise and inspect creches, nurseries, pre-schools, playgroups and other services for pre-school children. The regulations also cover issues such as standards of care, accommodation and facilities to be provided in pre-schools. These regulations should help to reassure women who avail of pre-school services that their children are being well cared for.

Action: The Community Mothers Scheme will be extended to all health boards. Projects similar to the Homestart Programme will be introduced in each health board area. The issue of parenting programmes for older children is being considered by the Commission on the Family which has been established by the Minister for Social Welfare. The Minister for Health will take cognisance of the recommendations of the Commission on the matter.

TRAVELLER WOMEN

Women in the traveller community experience greater risks to their health than women generally. Since the publication of the Discussion Document, the Government has published the report of the **Task Force on the Traveller Community**[20] and adopted a programme to implement the main recommendations of that report. The programme includes measures to improve the health of traveller women through increased vaccination, ante-natal and post-natal care and access to family planning. It is proposed to increase the involvement of traveller women in encouraging greater use of health services.

Action: The Department of Health is committed to the implementation of the health provisions of the programme in favour of Travellers recommended in the Report of the Task Force on the Traveller Community. Health boards will improve travellers' access to health services and ensure that these services are delivered in a culturally appropriate way.



Quilt depicting key health issues for Travellers, crafted by women in the Eastern Health Board Travellers' Health Project.

WOMEN WITH DISABILITIES

The consultative process helped to highlight the many problems which women with disabilities face in relation to their health. A major issue was the difficulty facing women with disabilities in accessing services, either because of physical inaccessibility, lack of interpreters or signers, poor communication by service providers or the inappropriateness of some services to women with disabilities. Lack of information on health issues and health services in formats other than print, may make it difficult for women with disabilities to take a pro-active role in relation to their health. Women with disabilities find it difficult to get advice on sexual health or family planning. The maternity and mental health services do not always take account of the particular needs of women with a disability.

Health services for people with a physical and sensory disability have been considered by a Review Group established by the Minister for Health. The report, which was published in December 1996, together with the **Report of the Commission on the Status of People with Disabilities**[21] provide a policy framework for the development of services for people with a disability. This development includes measures to improve the access of women with a disability to services which meet their needs. The National Intellectual Disability Database is now providing information on both the current and future needs over a five year period of persons with a mental handicap. This information will be used as a basis for planning the continued development of services for persons with a mental handicap and their carers.

Action: The Department of Health is committed to the expansion of services for people with disabilities. Health boards, in their women's health plans will review the extent to which their services are accessible to women with disabilities, in consultation with such women. They will also review the need for disability awareness training for their staff. Health boards will use their role as funders of voluntary organisations and other service providers, to ensure that all projects they fund become open and welcoming to women with disabilities and deal with them fairly and equally. Funding will be made available for innovative projects and the sharing of successful approaches to improving services to women with disabilities.

The problems faced by carers were frequently raised during the consultative process, reflecting women's role as the main informal carers in our society. The strain of caring for a disabled son or daughter or an elderly dependent parent can undermine the health of those women involved. There has been increasing recognition in recent years of the contribution of informal carers and of the need for the health services to provide greater support to carers, as well as to the recipient of the care. The expansion of respite care and home support services for the dependent elderly, people with a mental handicap and the physically disabled are examples of how the health service is responding to the needs of carers in a practical way. Funding has also been made available to the Carer's Association and the Soroptomists to support their services for carers.

Action: The Minister will continue to give priority to the development of services for disabled and dependent people, including respite and home support services for carers. Health boards will consult with carers about the services they need, foster self-help groups for carers and fund voluntary organisations supporting carers.

OLDER WOMEN

More women are living longer but these extra years are often marked by chronic illness, disability and difficulties in maintaining independence. Older women are at particular risk of coronary heart disease, cancer, osteoporosis and depression. The challenge is to extend the benefits of healthy ageing to more women in the future. Maintaining a healthy lifestyle into old age, actively contributing to the life of the community, together with the early detection of disease will ensure that more older women experience healthy ageing, reducing the time of dependency to a short period at the end of their lives.

In advanced old age, many women become dependent on other people for day to day living. They often require nursing care at home or in a nursing home or hospital. Such women are among the most vulnerable of all groups in our society. The health services are committed to supporting as many dependent older people at home as possible. The Health Strategy set a target of ensuring that 90 per cent of those over 75 years of age live in dignity and independence at home. When it is no longer possible to live at home, dependent older people should have access to high quality residential care. Since the publication of the Discussion Document, the Minister has launched a **Code of Practice for Nursing Homes**[22] which sets out the standards of care which should be the norm in every home caring for dependent elderly people, the vast majority of whom are women. Progress is also being made in increasing the number and quality of nursing care places managed by health boards. The Minister has also announced his intention to establish in the Department of Health a Social Services Inspectorate which will in due course have responsibility for the promotion of high standards of care for the dependent elderly.

Action: The Minister is committed to promoting healthy ageing and to ensuring that the targets of the Health Strategy in relation to dependent elderly people, the majority of whom are women, are achieved. A Social Services Inspectorate will be established in the Department of Health which will develop an expertise in promoting high standards of care for the dependent elderly. Health boards will review the standards of care of dependent elderly patients in voluntary and private nursing homes and in their own hospitals and homes, in line with their statutory responsibility and in the context of their plans for women's health.

LESBIAN WOMEN

The most serious health issue identified by lesbian women during the consultative process was the attitudes which they encountered when seeking care from the health services. Lesbian women are also more prone to stress and depression associated with their sexual identity, particularly during adolescence. The difficulties which lesbian women face in the health services arise partly as a result of lack of knowledge on the part of professionals about the health risks associated with a lesbian lifestyle and partly because of deep seated attitudes to homosexuality generally. There is clearly an onus on health personnel to be informed about lesbian health issues and to ensure that sexual orientation is not a barrier in accessing services.

Action: Health boards will be asked to ensure that health professionals are informed about lesbian health issues and that staff respect the sexual orientation of lesbian women.

WOMEN IN PRISON

Although the number of women in prison is small, their health needs are considerable. Most are imprisoned for drug related offences. Imprisonment is of its nature stressful. There is a loss of freedom and personal autonomy and the deprivation of social and vocational contacts. Women in prison may suffer from mental health problems which require counselling and psychiatric treatment. Women who are pregnant while in prison require special care in association with the maternity and child care services.

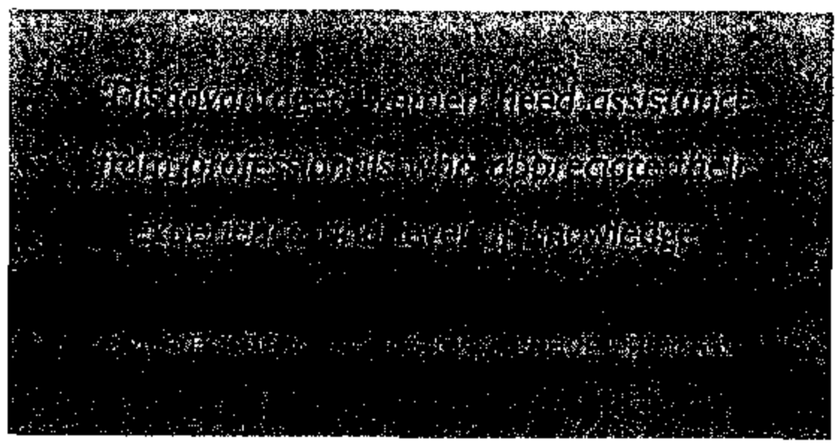
Action: The Department of Health and the relevant health boards will work closely with the prison authorities to develop programmes for drug addicted women prisoners, to improve the mental health services available to women prisoners and to ensure close co-operation in relation to maternity and child care services.

Health boards will improve the provision of liaison psychiatric services for women in prison and will, in co-operation with the prison authorities, structure posts of consultant psychiatrist and professional support staff with a significant commitment of their time to the prisons.

WOMEN IN PROSTITUTION

There is little information available on women involved in prostitution in this country. A recent Eastern Health Board survey noted that 24 per cent of the women surveyed reported on-going general health problems. Many are reluctant to make contact with the health services or to disclose the reasons why their health is at risk. Of the women interviewed in the survey only 38 per cent had been tested for HIV and the same percentage -- again only 38 per cent – had been screened for sexually transmitted diseases. The problems faced by women involved in prostitution emphasise the need for an holistic approach which focuses on the spectrum of women's health needs and not only on sexual health.

Action: The Department of Health will support health boards in the provision of health services, including screening and treatment, for women working in prostitution. Information on maintaining health and on the availability of services will be designed specifically for these women.



WOMEN AND DRUG MISUSE

While there are no hard data on the numbers of women who are misusing drugs, the most recent report by the Health Research Board on **Treated Drug Misuse in the Greater Dublin Area 1990 – 1994**[23] indicated that 21 per cent of clients attending treatment services were female. In addition to those women who are themselves drug users, the problem of drug misuse touches the lives of many women who take on the role of carers of partners and children who misuse drugs. Some women find themselves raising their grandchildren because of the serious illness or death of their son or daughter arising from drug misuse and/or drug-related HIV/AIDS.

In response to Government decisions in February 1996 health boards are expanding existing services to address drug misuse. The main objective of Government policy is to work with communities to prevent and treat drug misuse and to encourage drug misusers to undertake methadone treatment programmes as a step towards a drug-free lifestyle. The Eastern Health Board, which is experiencing the most serious drug problems, is giving priority to encouraging pregnant drug misusers to attend drug treatment centres. A special community based rehabilitation programme for women, the "SAOL" Project, has been developed in conjunction with FÁS. The programme offers stable drug abusers a bridge to mainstream and community-based education and training programmes and employment.

In October 1996 the **First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs**[24] announced a £14 million "action programme", £11 million of which will go towards drug treatment services and £3 million to improve housing estates. A major objective is to eliminate the waiting list for methadone treatment in Dublin during 1997.

In recent years women have become progressively more at risk of infection from HIV. The majority of cases of HIV/AIDS in women in Ireland is related to intravenous drug use. The consultation process identified the need to ensure that HIV/AIDS prevention is fully addressed within the context of health education, in particular as part of relationships and sexuality education and preventive drug education.

Action: Health boards will continue to support drug misuse prevention activities through a range of health education and treatment initiatives. Special attention will be paid to women drug misusers, both in prison and in the community. Rehabilitation projects such as the "SAOL" Project will be extended. Regional and local drug teams will co-ordinate voluntary and State activities.

Health boards, in their health education programmes for young people, will place greater emphasis on the particular dangers to which women are exposed in relation to HIV.

Women's Health in the Developing World

WOMEN'S HEALTH IN THE DEVELOPING WORLD

The Platform for Action agreed at the United Nations Fourth World Conference on Women in Beijing[25] in 1995 identifies the improvement of women's health in the developing world as one of the most important issues of our times. While women's life expectancy in the developing world has improved significantly over the last 20 years, it is still, on average, 17 years shorter than the average life expectancy for women living in industrialised countries. In the developing world complications from pregnancy and childbirth remain the leading cause of mortality among women, being responsible for more than half a million deaths each year.

In 1996, this country's aid budget was £105 million, of which about 30 per cent was spent on health-related aid. The provision of clean water, improved sanitation to control enteric diseases and building the capacity of women to reduce malnutrition and disease are among the priorities of the Irish aid programme. Irish aid recognises the centrality of women in development and their essential contribution to the well-being of the family, community and society. Irish aid is supporting programmes that impact directly upon the health of women, such as an improvement of education opportunities, efforts to adopt a gender approach to health planning and improvements in access to essential health services, including better maternity services. Ireland assists the work of the World Health Organisation (WHO) in improving the health of women in the developing world and in the Newly Independent States (NIS) of the former Soviet Union. The WHO has identified training of nurses as a key element in its strategy for the development of primary care in the NIS. In recent years Ireland has supported, inter alia, this aspect of WHO's work.

In view of this country's commitment to the developing world and to the improvement of women's health as part of its aid programme, the question arises as to whether the health services could play a greater role. To facilitate consultation on this issue the Department of Health with the co-operation of the Department of Foreign Affairs organised a seminar in which groups concerned with the health of women in the developing world had an opportunity to identify further steps which could be taken in this country to strengthen the contribution of the health services to promoting women's health in the developing world.

Development assistance is most effective when it facilitates the strengthening of the ability of developing countries to promote and sustain their economic and social development. A major contribution to this process, and towards promoting women's health in the developing world, is in facilitating skilled personnel to work with agencies or in projects which are part of the Irish aid programme. Current arrangements in the health service to facilitate those who wish to work in a developing country operate

satisfactorily. Many hundreds of staff in the health services have worked in developing countries providing emergency relief or on longer term projects. However, the absence of a structured approach to service in the developing world reduces the numbers willing to go. Personnel can find that the time they spend abroad is not considered of value to their careers at home and that they may lose out on career opportunities if they spend time in a developing country. There is a need for more preparation and training of staff that volunteer to work in a developing country. More formal co-ordination in this country between the health services and agencies involved in health programmes in the developing world would help to match available skills to particular needs. There is also scope for greater communication between aid agencies and women's organisations in this country to spread an understanding of the scale of the problems undermining the health of women in much of the world.

A second way in which the health services could assist in improving the health of women in the developing world is by the fostering of linkages between services in this country and those in a developing country. Such linkages have developed in the past in the context of the missionary orders active in the field of health and could be developed by other health services. Linkages could be fostered between hospitals, primary care services, voluntary organisations and professional groups to share information and expertise in women's health.

There is a need to agree a strategy to promote closer liaison between the health services, the Irish aid programme, the Agency for Personal Services Overseas (APSO) and the aid agencies. The purpose of the strategy would be to achieve a closer match between health needs in the developing world and professional expertise in this country, to make service in the developing world a more attractive option for health professionals and to encourage linkages between health services here and those in developing countries.

Action: The Department of Health will work with the Department of Foreign Affairs and the Agency for Personal Services Overseas, to develop a strategy to increase the contribution of the health services to promoting women's health in the developing world.

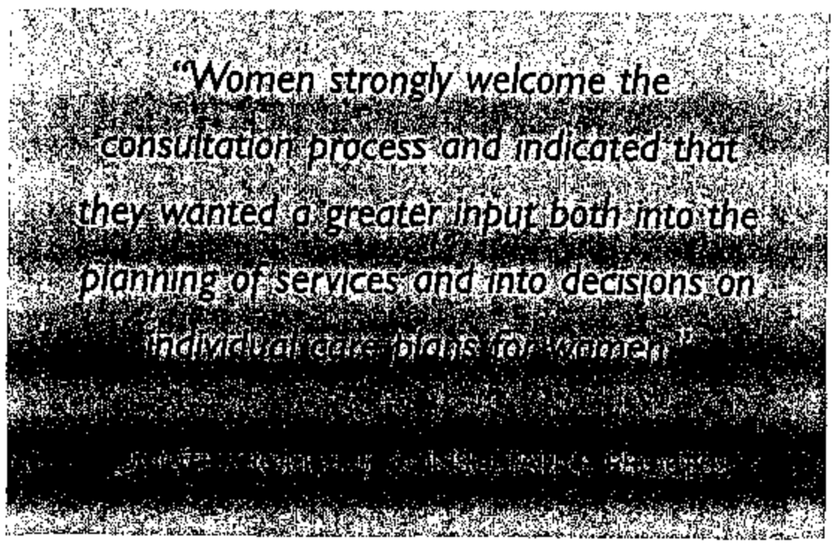
Ireland will continue to support the work of the World Health Organisation in the developing world and, in particular, in the Newly Independent States of the former Soviet Union.

Consultation

CONSULTATION

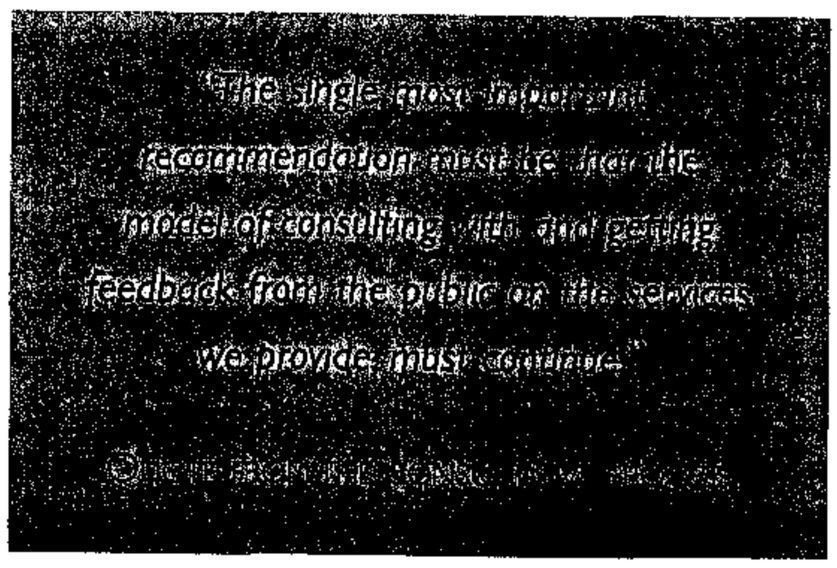
One of the positive aspects of the recent initiative on women's health was the extent to which women responded to the invitation to participate in the consultative process. Women all over the country expressed their appreciation that they were consulted and their wish that the process of consultation should lead to improvements in health services for women and that the health services would continue to consult women about matters touching on their health. The continued partnership between the National Women's Council and the health boards will ensure that women's views find expression in the future development of health services for women.

The process of consultation has already borne fruit. Each health board has completed a report on the results of the consultation and proposed a series of measures to respond to the criticisms voiced by the women consulted. The advisory committees on women's health, set up initially during the consultative phase, have been established on a permanent basis in some health boards. The purpose of the committee is to advise the board on the implementation of the recommendations to improve health services for women that emerged during the consultative process. Representatives of the National Women's Council have been invited to sit on these committees. Other health boards have decided to establish consumer groups to facilitate on-going consultation with women. It is essential, if the health services are to respond to the needs of women as outlined in this Plan, and the



partnership of women is to be given expression, that each board provides a mechanism by which women can be consulted about health issues and priorities, either by way of a single advisory committee or consumer groups. Each committee should include at least two representatives of the National Women's Council. There should be provision for rotation of the Council's representatives at regular intervals to ensure that a broad cross-section of women and women's organisations are involved in advising the boards.

At national level, the Minister proposes to establish a Women's Health Council to develop a centre of expertise on women's health issues, to foster research into women's health, to evaluate the success of this Plan for Women's Health in meeting its objectives and advise the Minister on women's health issues generally. The Minister will appoint the members of the Council. The membership will include representatives of the National Women's Council, members of the professions closely involved in women's health, academics with an interest in women's health, women in the labour force and service providers such as health boards and voluntary maternity hospitals. The Council will take on the role of advising the Minister on improvements in the maternity services, a role which had been previously proposed for a task force in the Discussion Document. The Council will be established for an initial period of 3 years to coincide with the term of this Plan, at which stage its functions will be reviewed. The Council will be established as a health corporate body with its own budget and staff.



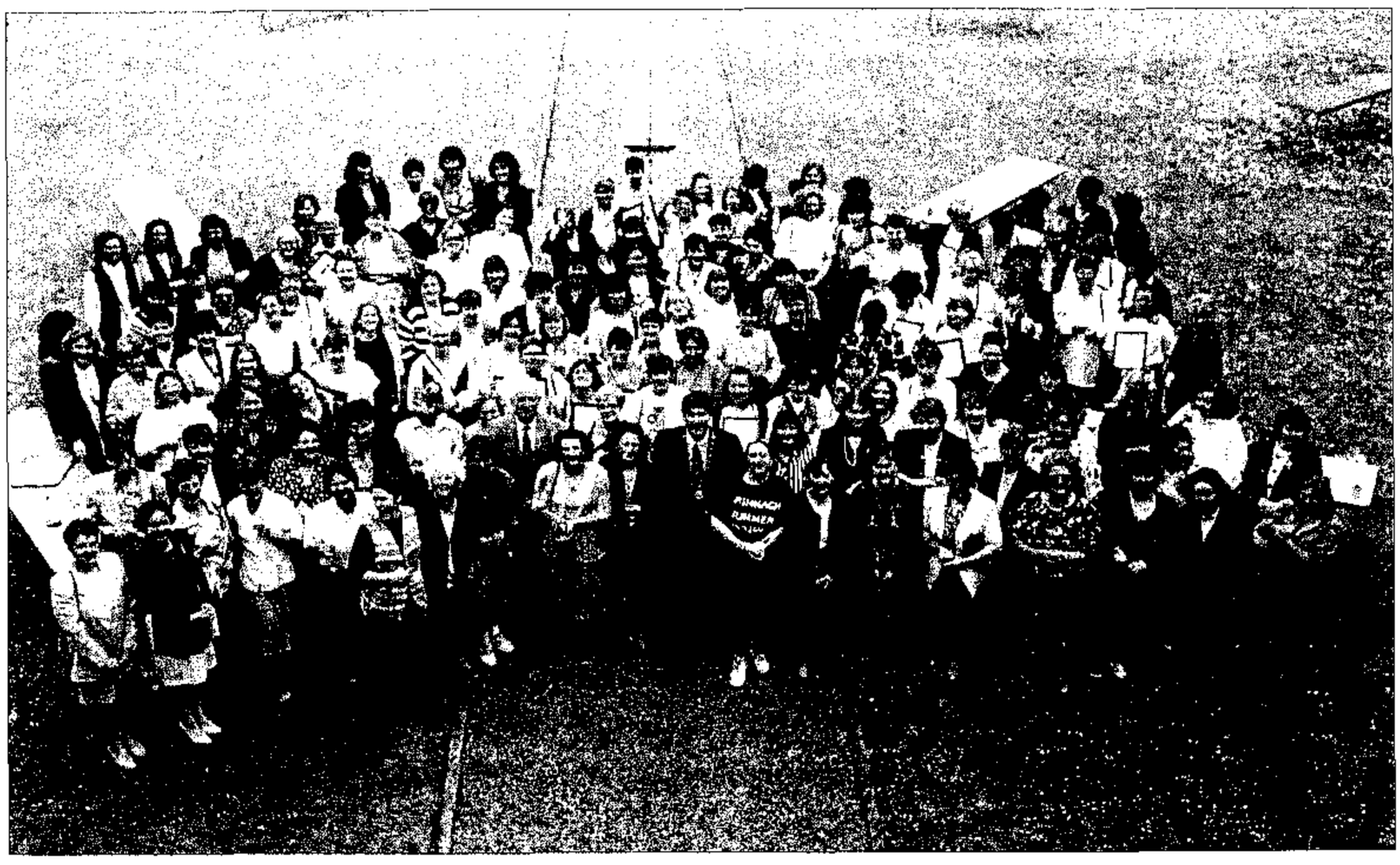
Action: Each health board will establish an advisory committee on women's health, with at least two representatives of the National Women's Council. Representation of the National Women's Council on the health board advisory committee will not preclude representation of other specific groups which have a mandate for a particular and relevant women's interest.

The Minister will establish a Women's Health Council to develop a centre of expertise on women's health issues, to foster research into women's health, to evaluate the success of this Plan for Women's Health in meeting its objectives and to advise the Minister on women's health issues generally. The membership will be representative of those with an interest in women's health, including the National Women's Council.

"We have also learned through this consultation process that the people to whom a service is delivered are the ones with practical ideas for improvement"

QUOTE FROM THE CONSULTATIVE PROCESS

Representation



REPRESENTATION

The Discussion Document, **Developing a Policy for Women's Health** documented the under-representation of women in positions of responsibility in the health services. During the consultation process with women which followed publication of the Discussion Document, the problems associated with such under-representation were raised. It was suggested that the lack of representation of women may contribute to a perceived lack of understanding within the management structure of the service of the needs of women.

The Discussion Document noted that the majority of senior posts in both the nursing and paramedical categories are held by women, while only a minority of medical consultant posts and senior management posts are filled by women. The small number of women occupying the most senior management posts in the health boards was also highlighted. However, recent initiatives such as the filling of the newly established posts of Director of Public Health within the boards' senior management structures have resulted in increased representation of women at the senior level. In overall terms, approximately 11.5 per cent of senior management posts in the health boards are filled by women. This compares favourably with the position in 1990 as documented in the Department of Equality and Law Reforms study, **Report on a Survey of Equal Opportunities in the Public Sector**[26]. That report noted that no senior management posts in the health boards were held by women. At medical consultant level, the number of women holding permanent positions within the health service increased from 178 to 190 between January 1995 and January 1996 – an increase of approximately 7 per cent.

The Discussion Document also noted a number of positive developments in the health service aimed at addressing the problem of under-representation of women at a decision making level. These include the identification of equality of opportunity in employment as a priority in health service personnel policy and the availability of schemes, such as job-sharing and career breaks, which facilitate women wishing to remain in the workplace and pursue a career while, at the same time, combining work and family responsibilities.

In addition, the commissioning by the Chief Executive Officer of the Midland and the Mid-Western Health Boards of a report[27] "to ascertain the views and advice of women on their perceptions of the barriers to promotion in the Boards' employment and how these can be removed" and the adoption by certain health agencies of equal opportunity initiatives represent examples of an increasing awareness among health service employers of the need to encourage and support women in achieving full utilisation of their skills and talents coupled with a willingness to take action towards achieving these goals.

The Management Development Strategy for the Health and Personal Social Services in Ireland,[28] which was recently launched, noted that there was a particular need for health service employers to provide opportunities for women to develop their experience and careers within the local system. The newly established Office for Health Management will have a key role to play in ensuring implementation of the Strategy. In particular, the Office will promote equal opportunities in management development.

In order to consolidate and build on the foregoing developments in a health service wide context, the Department of Health, in consultation with representatives of health service employers, is developing an Equal Opportunities Policy for the Health Services, together with a programme of action aimed at implementing the policy. A key feature of the policy will be a recognition of the duty of health service management to ensure that equality is promoted in the workplace and that this duty is an integral part of the management responsibility. It is considered that this particular initiative will provide the necessary framework within which progress can be made towards achieving change in relation to the career opportunities for women.

The Department of Health is also committed to the principle of gender balance in the membership of boards in the health service, to the extent that this principle is compatible with democratic accountability and the responsibilities of individual boards. The Department will also promote gender balance in all committees and working groups established in relation to health policy and will promote such balance throughout the health services.

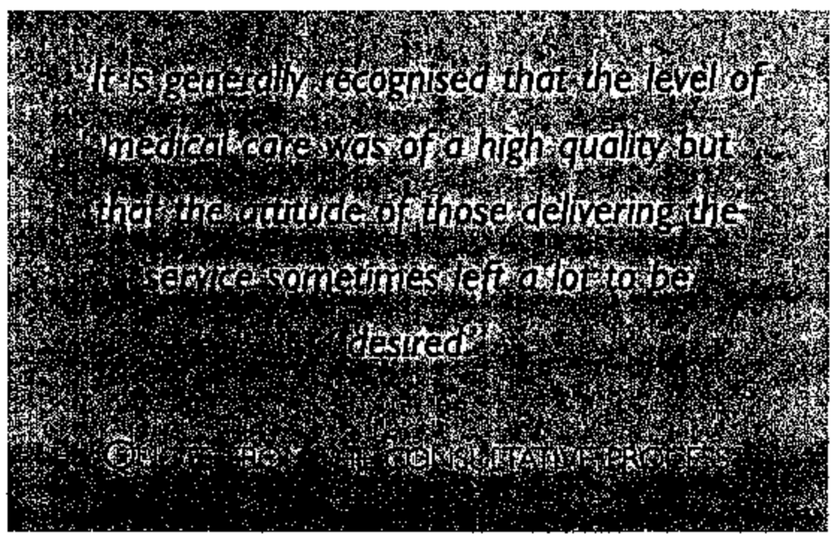
Action: The Department of Health is developing an Equal Opportunities Policy for the Health Services and a programme of action to implement the policy. The Department will also promote the principle of gender balance in the membership of health boards, committees and working groups throughout the health services. The Office for Health Management will promote equal opportunities in management development.

Creating a Woman-Friendly Health Service

CREATING A WOMAN-FRIENDLY HEALTH SERVICE

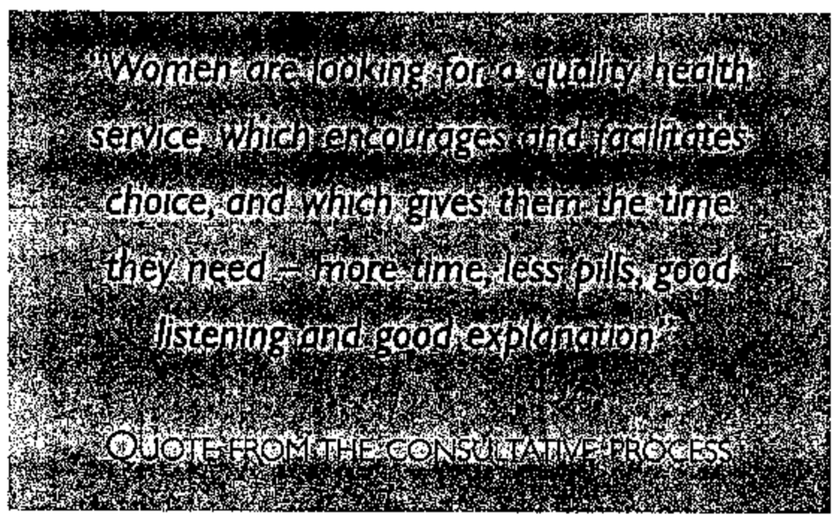
One of the key demands of women during the consultative process was for a woman friendly health service.

Throughout the consultation process, women sought a more holistic model of health. They asked that service providers treat the whole woman, both the psychological and the physical. They asked that service providers take more account of the context of the lives of the women they are treating, which may be affected by poverty, rural isolation, stress, poor housing, unemployment, violence, lack of transport or child care facilities, disability and low levels of education.

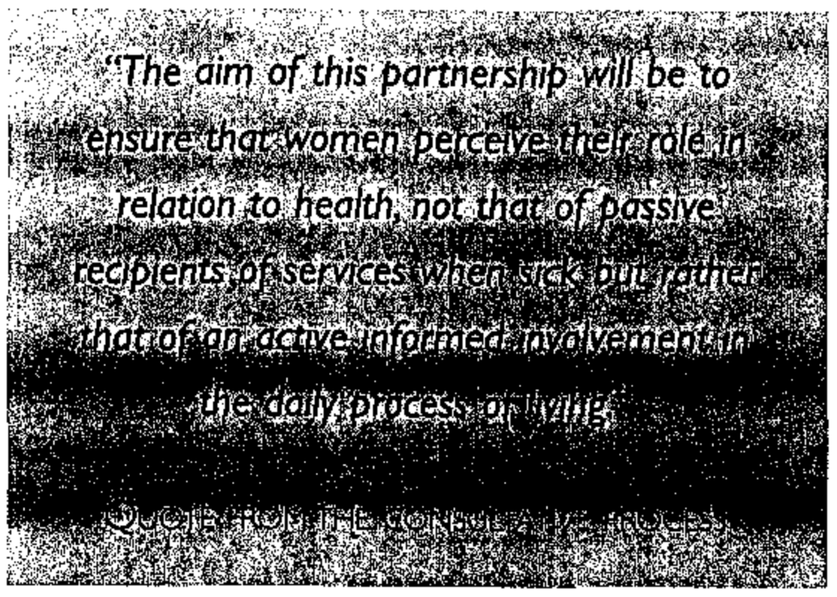


Women want the health services to respect them more, to consult them, to show greater commitment to promoting their health and to deliver services in an environment which is acceptable to women. Improvements, such as appropriate timing of clinics and facilities for small children at clinics, would increase the accessibility of health services to women, many of whom are already struggling under adverse circumstances. In many cases, women are critical of the attitude and tone with which services are delivered, rather than the technical quality of the service itself, suggesting a need for sensitivity training for staff on this issue. Where women prefer to see a female general practitioner or consultant, facilitation of this choice, where possible, by the health board would help make the health service more woman-friendly.

The adoption by Government of this Plan for Women's Health, based as it is on the analysis of women's health problems in the Discussion Document and the extensive process of consultation with women, is perhaps the most important step towards creating a woman friendly health service. This Plan will provide a focus at national, regional and local level to promote women's health, to improve health services for women and to develop constructive dialogue between women and the health services.



Health boards will play a key role in translating this Plan into action and in creating a woman-friendly health service. The boards have already made considerable progress in analysing their deficits in relation to women's health and in remedying these deficits. They are establishing structures for consulting women about health issues. This work provides a firm foundation upon which to implement this Plan. Each board will adopt a regional plan for women's health to implement the commitments of this Plan and the issues identified during the consultative process. The regional plans will address the issue of developing more positive attitudes among staff to women in contact with the health and personal social services, thereby creating a more woman friendly service. Boards will be asked to cost their proposals and to prioritise items over the course of the 3 years, 1997 – 1999. These regional plans will be considered by the board's advisory committee or committees on women's health before being finalised. The Women's Health Council will play an important role in evaluating the success of this Plan in creating a more woman-friendly health service.



Action: Each health board will prepare a regional plan for women's health to implement the commitments of the national Plan and the issues identified during the consultative process over the period 1997 – 1999. Health boards will review their staff development and training programmes to include sensitivity training in relation to attitudes to women clients and patients.

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