

**Establishing the Rationales for Gender-Specific Strategies to
Improve Women's Health: The Evidence from Research**

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Introduction: Understanding the Meanings of Women's Health

i. How Life-course Factors Contribute to Health Outcomes

Health researchers and planners now agree that achieving optimum health for each woman is dependent on three inter-related elements:

- Physical well-being
- Emotional well-being
- Social well-being

This is a properly holistic perspective. However, in order to incorporate it into policymaking, we must pay attention to many dimensions or 'societal perspectives' (Johnson and Fee, 1997: 7). Building in these perspectives about women's health can create special problems for policy planners. This is because the issue of health can fit into many more departments than the obvious one of the Department of Health and Children. To function efficiently, government departments divide up their work and take responsibility for action in quite separate areas. So there is a clear distinction, for example, between what is seen as a health issue and an education issue. But there are many instances where a problem crosses over these departmental lines of responsibility.

Research on early school leavers, for example, has consistently documented that this group of young people generally has poor literacy skills, poor long-term employment prospects, and poorer than average personal and social developmental skills. These inter-related problems may ultimately affect their health outcomes because they have less education and income to help them to enjoy a better quality of life. Conversely, if government measures are put in place to help reduce the numbers of early school leavers and to support them to gain more skills, their long-term health prospects may be improved. Thus we can see that government planning can have an impact on health from a number of different perspectives.

Every government keeps statistics on serious illness and death. The simplest of these tabulations are called crude morbidity and mortality statistics. These statistics tell us that there is a consistent relationship between low socio-economic status and poorer health outcomes. Those people with least education, least skilled jobs, living in poorer quality housing and so on, experience the worst health outcomes.¹ Building good

health for every person in all societies requires that core needs such as the following are fulfilled:

- Clean food and water
- Good housing
- Good family and community relationships
- Education
- Work
- Formal healthcare and social services

Knowing that core needs are and will continue to be fulfilled helps to create an essential sense of security and stability for the individual that contributes to good health (Bartley, et al., 2000) But the life chances to secure core needs, what might be termed social equality, are not fairly distributed, and this leads to health inequalities (ibid.), albeit within a complex pattern of factors. For women in an economically advanced society like ours, a path model of inequality leading to poor health might comprise the following factors:

- Material deprivation
- Job strain
- Poor diet
- Smoking
- Drinking

and the lack of

- Social support
- Physical exercises and sport

These factors have been found to be predictive of poor general health (ibid.).

However, what is less well understood is how these factors interact together, how different forms of inequality give rise to different risk factors in women's lives that culminate in premature or chronic ill-health. Mel Bartley (ibid.) and her team of researchers who have worked on dimensions of inequality in women's lives comment that :

Levels of social advantage as expressed in patterns of social interaction, .. do seem to have a strong effect on lifestyle and the health habits which are known to increase the risk of major diseases such as heart disease and cancer in women (ibid.: 71-72).

So we can say overall that women with fewer resources, material, social and cultural², run the risk of poorer general health.

ii. Providing a Gendered Model of Health Care

We are only beginning to understand and locate the complex factors that contribute to better or worse health in women. We are also only beginning to use arguments based on evidence and research to make the case for a model of health care provision, including health promotion and health education work that pays attention to gender.

The case for a gendered strategy of health care provision, one that goes beyond the traditional concerns that have centred on women's reproductive health needs, might be viewed as a question of special pleading for women. Many economically advanced countries face spiralling health care costs. They also face the need to justify budgetary decisions about health care allocation. In such a climate, it might be argued that developing a model specifically for women would siphon off scarce resources from over-stretched services that are already by definition seeing to the health care needs of the general population.

But tailoring health care service delivery to take in the needs of specific groups can be seen as a more refined and targeted approach which will ultimately benefit the community as a whole by improving health and life chances for those specific groups. The importance of this is acknowledged in our new health plan *Quality and Fairness* (Department of Health and Children, 2001) where health gain and social gain are seen to be linked to bringing to an end inequalities in health status. The Health Strategy looks at the specific needs of a number of groups in the country, including children, older people and people with disabilities. For the first time, men's health is reviewed as a separate category and the strategy document says that 'gender differences are emerging as a fundamental inequality in health' (2001:154).

The Health Strategy makes a commitment to begin to develop a plan for men's health. This comes at a time when there is growing research attention being paid to men's health, including their reproductive and sexual health (Schmidt and Moore, 1998; Oudshoorn, 2000; Aoun et al., 2002; Fletcher et al., 2002; Lee and Owens, 2002). This focus is perhaps related to an understanding that with the rapid decline in traditional male jobs such as factory work and the increase of service jobs which has led to a huge growth in female employment, the key role of male breadwinner is outdated and new more fluid definitions of masculinity are being identified (Brod and Kaufman, 1994; Edley and Wetherell, 1994).

But it is arguable that strategies for men's health will be building on the considerable work done by the women's movement over the last several decades to establish the relevance of gender in relation to healthcare. Our Health Strategy reviews the policy context of women's health and the issues and actions which have been government policy here since the mid-1990s. The Health Strategy also reviews the steps for specific women's health programmes that still need to be taken, as measured by the original objectives of the *Women's Health Plan, 1997-1999* (Department of Health, 1997).

In Australia and Canada too, there have been strong national efforts for some time to deliver a gender-specific health plan for women. The Canadian strategy document on women's health argues that gender differences are critical in shaping health outcomes and in addressing the problem of low socio-economic status which 'affect women's health differently to men's' (Canada, National Forum on Health, n.d.). Australia developed the first national policy for women's health in 1989 and followed this up in 1995 with a longitudinal study on women's health. The study intends to follow cohorts of young, middle-aged and older women for up to twenty years in order to explore the social, environmental and personal factors in women's lives and related factors that promote or reduce health and felt needs for health care (Lee, 2001). The research findings will be used to inform policy development.

In the Irish context, this current position paper seeks to develop a firm understanding of why men and women require different health service responses. It also explores why services must also take account of their different social and class locations. The paper is based on current up-to-date international research to contribute to a grounded understanding as to why a gendered health strategy is crucial. Throughout, it is emphasised that the presence or absence of women's health and wellness is often indivisible from their social location.

The case for an evidence-based specific health strategy for women is based on the meanings around what constitutes good physical and mental health for women in a wide range of social circumstances. Although the fulfilment of core needs is vital to protect health, to arrive at this point requires a substantive series of actions to deal with social inequalities that prevent core needs being met. It is clear that in Ireland we are still at the beginning of funding such substantive actions. This is reflected in our

health profiles for women which are poorer by the international standards of other developed countries. In order to substantially improve those outcomes, we need to adapt our thinking about health policies to take into account all the other influences.

The National Plan for Women is a new and important focus for cross-cutting these critical issues of life status, and equality. In the consultation process that has recently been completed on the Plan, health was the biggest single issue raised by women round the country (Department of Justice, Equality and Law Reform, 2002).

The distance to be travelled is challenging. The most recent baseline study of rights and justice in Ireland (Harvey, 2002), carried out for the Joseph Rowntree Charitable Trust, indicates that social spending by the Irish government is the lowest in the EU, comprising 16% of Irish GDP. Irish state pensions are the lowest in Europe (ibid.). The level of investment in education remains dramatically lower than the average for OECD countries; at the level of primary schooling (where factors stemming from social exclusion, like poor pre-literate skills can first be tackled), Ireland has one of the poorest teacher-pupil ratios of all OECD countries (ibid.). There is a functional illiteracy rate in Ireland of 23%, making it the second worst in the industrialised world (ibid.). Inequality of access and under-funding continue to characterise the Irish educational system, with the rate of participation in third-level education class-dependent; a mere 14% of children born to unskilled parents achieve third level entry, compared with 89% of children from professional families. Child poverty in Ireland, at 28%, is the second highest rate of child poverty in the EU (ibid.). Health service provision, seen as spending per person each year, is lower than both EU and OECD levels. The level of spending on health as a proportion of the European average has actually fallen between 1960 and 1998 (ibid.). Current health expenditure comprises 5% of our GDP, making it 30% below the current European average. These figures are why, as we shall see in Section 2, many morbidity and mortality rates in Ireland are poor compared with EU figures.

Therefore in reviewing current research, this position paper necessarily focuses on what goes wrong for women as a result of not having full access to the equal range of opportunities that build good health in the first instance. And, when specific ill-health does set in, women in Ireland continue to suffer from inequalities in access to

treatments, which further disimproves their life chances. (These major inequalities also impact on Irish men, but the focus of this position paper is women, so the data assembled herein addresses their unmet needs only). All ill-health brings with it related emotional and support needs. Many women with serious, chronic and long-term health problems have additional support needs because of the double burdens they already carry as carers and workers.³

It is far better for a society to determine and set in place the measures to build good health profiles at the outset, and then to build in appropriate physical care and support structures as and when ill-health occurs. This requires a commitment across a wide range of government departments and expenditure to match that commitment.

iii. Layout of Report

The report has 13 sections.

Section 1 discusses aspects of gender and gender differences and how these affect women's health.

Sections 2 and 3 present a statistical profile on Irish women's life expectancies and common major illnesses of cardiovascular diseases and cancers, compared with Irish men and compared with women in other EU countries.

Section 4 examines current research data on diagnostic and treatment needs of women in relation to these major life-threatening disease entities and discusses how the issue of gender must be kept to the fore in considering women's treatment needs.

Section 5 examines current research data on forms of chronic illness that affect women more frequently than men. Support issues are especially important in responding to women with long-term chronic illness.

Sections 6 –10 discuss research on aspects of women's health that are related to life-cycle, lifestyle, and structural, socio-economic and cultural dimensions.

Sections 11 and 12 deal with the issues of information, advocacy, and communication with health care professionals.

Section 13 concludes with a summary of why a gender-based strategy in health is imperative to have in place for women.

SECTION 1 – EXPLAINING GENDER

This section will briefly set out how the problem of gender, that is how what is socially attributed to women as appropriately feminine behaviour, affects women in respect of their health and how this can prevent their real needs from being addressed. There are three core issues affecting women that give rise to the need for a gendered strategy of service response and delivery.

These are:

- The multiple dimensions of women's lives
- Women's socio-economic status
- Gender stereotyping in medicine

1.1. The Multiple Dimensions of Women's Lives

A core problem around women's health is the multi-dimensionality of women's lives. As Patricia Kennedy (1997; 2002) has argued, most women have three complex roles to carry out in their lives: carer, earner and lifegiver. Their responsibilities for caring tend to make them the focal point of a family unit and often for the community as well, carrying out childcare, eldercare and community-based voluntary activities. Women act as advocates for family members in seeking health treatment for them. Women also make up the vast majority of paid careworkers - as nurses, social workers, and administrative support workers in the health care system (O'Connor, 1998). If women then often neglect their own health, it is because they prioritise their commitment to others (Doyal, 1995).

1.2. Women's Socio-economic Status

A second core problem involves socio-economic status, poverty and lack of access to resources and services. The European Women's Lobby has said of this:

The majority of all poor people in the European Union are women and children European Women's Lobby...The issue of care services shows how important it is that links are made between different policy areas. Employment policies for increased equality between women and men cannot be dealt with separately from issues of poverty and social exclusion, issues of care, and the issue of individualisation of social security rights...social policies are often threatened by cuts in public expenditure and by strain from macro-economic policies, and that the social protection and services vital to gender equality were the ones that suffered most in cut-backs (European Women's Lobby, 1999).

Poverty and lack of access to financial and other resources affect women's health outcomes and contribute to poorer long-term prognoses across the life-cycle. Women

with fewest resources can experience limited access to rapid-delivery quality health care. Women in the lowest-paid jobs, or who are not working at all, or who are living in partnership with men who are unemployed or in very low-paid jobs may experience one or a number of the following factors:

- Insecure working conditions;
- Fewest benefits in the workplace, including additional maternity benefit packages and retirement packages over and above the statutory requirements;
- Exposure to potentially more physically demanding or environmentally less safe conditions in the workplace;
- Least disposable income;
- Least environmentally sound housing;
- Lack of sufficient nutritious food;
- Stress related to the ongoing 'work' of dealing with long-term poverty for themselves and their children.

These are determinants which strongly affect and impact on women's health gains, as revealed by class-related data on a number of patterns of morbidity and mortality for women. Lee (2000: 32-33) argues that women's health research must take into account how the social system creates imbalances of power and resources between men and women, which she terms 'institutionalised inequity'.

1.3. Gender Stereotyping in Medicine

The third core problem is gender stereotyping in medicine and medical practice. Ussher (1992), Oakley (1993) and Doyal (1995) amongst many others, have pointed out that women's health has tended to be limited to the narrow biological definitions of women's reproductive health. While it is true that women's health deals in some respects with conditions that are exclusive to women, that is not the whole picture. Historically, gender-specific expectations of women have led to curious and unhelpful connotations between women and their reproductive bodies. In the late twentieth century, Western medicine has only slowly pulled away from stereotypes which equated female reproductive biology with 'female' emotions; for centuries, we were seen as wayward, less rational than men and therefore less fit for productive public working lives; we were seen as needing protection to be able to reproduce (Jordanova, 1989). Increasingly, equality agendas in education and employment have opened up new horizons for women. The release from unwanted childbearing through safe available contraception has given women unprecedented freedom to pursue their adult lives in many different dimensions.

However, there are still considerable problems of gender stereotyping in medicine. An example of this stereotyping relates to depression. Depression is very often discussed in medical journals and portrayed in medical advertising as a condition that primarily affects women; the condition is often seen as pathological and tied to the frequent mood shifts that are attributed to women as part of the changing cyclical nature of their reproductive lives (Jordanova, 1989).

Thus women who go to their GPs because they feel they are not coping well, may be given very inappropriate pharmacological treatment on the basis of that gender stereotype, when what they may require is a good listening ear and help in establishing practical solutions to difficult personal, familial and social problems. We know that women are prescribed more medication than men (McPherson and Waller, 1997).

Gender stereotyping works in a different way in relation to a condition like hypertension, a precursor to cardiovascular disease. This is most often portrayed in medical circles as a condition of the active busy high-powered man in the workplace (Jordanova, 1989). So, even though Ireland has the third highest mortality rate in the EU for women dying from heart disease, women here are experiencing problems of under-diagnosis and under-treatment, leading to their high rates of mortality from this disease, because doctors fail to consider soon enough that a woman might be at risk for this.

Women have different diseases, compared with men, like the specific reproductive cancers. They also experience disease entities differently to men, as with cardiovascular disease. And because of gender stereotyping, they either remain undiagnosed in respect of many disease entities or under-researched about their treatment needs. Women were not included in medical trials for common diseases over many years in the twentieth century, often because it would cost more to include women (who needed extra safeguards around drugs and pregnancy for example). But scientists also argued that results for men could be extrapolated to women (Thaul and Hotra, 1993).

Women's gender-specific health care needs can be given insufficient attention at policy level in relation to resources. The delivery of health services can fail to be sensitive to the issues that can make it difficult for women to take up services, like time and transport.

1.4. Using a Gender Analysis to Help Build Health and Reduce Illness

Paradoxically, women's health is most often spoken of in medicine in terms of what does go wrong or can go wrong. But reducing a view of women's health to just the absence of disease or the absence of illness can lead us away from the important issue of what builds health for women in all the different personal and social circumstances that women face.

A gender-based analysis can assist in developing strategies to strengthen health care services to respond to women's health care needs. It can enable those who deliver those services to begin to understand that good health and good health outcomes for women are rooted in very differently experienced personal and social circumstances.

In relation to smoking, for example, what now appear to be markedly higher rates of smoking amongst young adolescent women in Ireland, compared with twenty years ago, will translate in time to higher rates of lung cancer for that cohort of women when they are older, if they cannot be prevailed upon to stop smoking.

The decision of young girls to take up the habit is embedded in a social process which has been thought to include perceptions like smoking is 'cool' and smoking helps with weight control. These are critical issues for young women as they try to construct an acceptable identity for themselves. Health promotion campaigns have in the past emphasised only the dangers to try and convince young people not to smoke. But this approach does not realistically connect up with the concerns of young women. Instead recent public health campaigns in Ireland emphasise how smoking makes one smell unpleasant and one's teeth look unpleasant. This is a message that young women may be able to take on board because it is about their appearance.

At another level, women's responses to symptomatic breast disease are known to raise significant fears - about disfigurement and death - which can actually delay women

seeking a consultation. Equally, women's home duties and family work and problems with transport have been shown to reduce the uptake of outpatient appointments and clinics (Kennedy, Murphy-Lawless, Quin and Hickey, 2000). So a preventative health service has to respond to women's fears and real life experiences, if rates of detection at an early stage are to be improved.

In issues like these, we can see the need for a strategy that addresses women's health care needs in a holistic way, with attention paid to all the complexities of women's lives. This is why a gender analysis has such relevance. Put simply, men and women have their own different health care needs because each sex builds up those needs and responds to them in ways that reflect their roles and positions in society, including their gendered roles.

Thus service providers require a well-grounded and substantiated awareness of the fact that measurable health outcomes for women are very often the result of women's locations in the community and society as a whole.

Even though the national Women's Health Plan recognises this, its regional application and the development of the provision of gender-specific services for women have been beset by a lack of clarity about the rationales for a separate strategy for women's health and the fundamental need for this important policy.

This message emerged at the *Working together creatively for women's health – new challenges and opportunities Conference*, held in Tullamore, 28-29 November 2000. It was also a strong theme in the evaluation of the National Women's Health Plan conducted in 1999 and 2000.

Cook (1998) divides women's health into four categories:

- Experiences and physical processes that are exclusive to women, but which are not illnesses, like menstruation, childbirth, and the menopause
- Disorders directly related to women's physiology, like reproductive cancers
- Diseases and disorders which affect women as well as men
- Experiences and health issues arising for women as a result of their position in society like unwanted pregnancy.

Not only do there need to be gendered strategies of health care provision to respond to these four areas, preventative health initiatives must be grounded in a firm awareness by the medical system of what those gendered needs are.

SECTION 2 – COMPARING WOMEN’S AND MEN’S LIFE EXPECTANCY AND MAJOR ILLNESSES

This section provides a statistical overview of the differences in life expectancies and morbidity and mortality data

- Between men and women nationally and internationally

This overview helps us to see that there are significant differences and events in individual women’s lives that are directly related to the issue of gender. These events add up to a different overall statistical picture about women’s life-course when compared with men.

2.1. The Gap between the Sexes

Life expectancy is a measure of how long on average women and men can be expected to live, based on the year in which they are born. Since the seventeenth century, it has been clear that life expectancy for women was somewhat greater than for men (Nathanson, 1984). However what was a difference has widened into a perceptible gap in developed countries in the course of the twentieth century.

In 1996, according to Central Statistics data on life tables, life expectancy at birth for Irish women was 5.5 years longer than men. This means that for all children born in 1996, their life expectancy looked as follows:

Life Expectancy for those Born in 1996

Females	Males
78.5	73.0

(Central Statistics Office, 2001)

Gains in life expectancy for both men and women in Ireland have increased greatly since 1926, when the figures were 57.9 years for women and 57.4 years for men. Relatively high mortality figures for women in the Republic have decreased significantly over that period (Courtney, 1995: 62), most certainly related to the gradual tapering off of high fertility rates and the related health pressures of constant childbearing (Murphy-Lawless, 1998; Murphy-Lawless and McCarthy, 1999).

The reasons for gains for both sexes include the following:

1. Control over infectious diseases

2. Other scientific and medical advances
3. Improved public health measures, like sanitation
4. Better housing conditions
5. Better nutrition

Yet there are two aspects that should be noted about the above figures:

1. The greatest gains in life expectancy were between 1946 and 1961.
2. There has been rather less improvement from 1986 to date.
3. The gap in life expectancy between men and women has increased substantially between 1926 and now.

(Central Statistics Office, 2001)

This gap between the sexes is resulting in a growing female-dominant population amongst those over sixty-five years of age. This parallels figures elsewhere. In the fifteen EU countries, the life expectancy gap between women and men was 6.4 years in 1996 (ibid.). Here in Ireland, for every seven women who are sixty-five years of age or over, there are five men. Amongst those who are eighty-five years of age or more, there are three women for every one man (Central Statistics Office, 1999:22, 23). However women who are living longer face the problems of living alone and in greater poverty (O’Shea, 1993). They also face greater ‘functional incapacity’ (Fahey and Murray, 1994: 186, 86-7) in terms of chronic illness and degenerative diseases, as we shall see.

2.2. Explanations for Different Life Expectancy Rates for Men and Women

Epidemiologists and health researchers point to four broad elements that may contribute to our understanding of this difference in outcomes between the sexes.

These elements are:

1. Biological/genetic differences between men and women, including:
 - women’s greater immuno-responsiveness to ward off viral and bacterial agents that cause disease
 - women’s greater susceptibility to auto-immune diseases such as rheumatoid arthritis and lupus (Nathanson, 1984; Ramey, 1997).
2. Material and social differences and structural inequalities, including:
 - different forms of work and lifestyle for men compared with women (Waldron, 1985)
 - men from the lowest socio-economic groups having least good life expectancies (Townsend et al, 1982;1987)

-hazardous employment and working conditions for those men working in less prestigious manual occupations (Phillipson, 1993; Fahey and Murray, 1994; Waldron, 1985).

3. Cultural and behavioural differences linked to different social expectations of men and women, including:

-men feeling that they should take greater risks in their occupational settings in keeping with social expectations about masculinity (Waldron, 1985)
-men socialised into a heavy drinking and smoking culture from a young age and thus reducing life expectancy (Eurostat, 2000; England, Office of Population Censuses and Surveys, 1994; Ireland, Department of Health and Children, 1999)⁴

4. Gendered use of and access to the health services with earlier and more frequent attendance offering the chance to pick up on health problems sooner:

-a gendered pattern of usage with women in more frequent attendance than men (Waldron, 1985, Senior and Viveash, 1998)
-women are ill more frequently than men (Britain, Office of National Statistics, 1996)⁵

2.3. Reasons Why Women Attend Doctors More Frequently

There are a number of factors that bring women to see doctors more frequently when compared with men. These factors are heavily gender-related:

2.3.1. Reproductive health

-contraception and fertility control, pregnancy and childbirth, and the menopause bring women into contact with doctors on a regular basis.⁶

2.3.2. Taking care of the family's health

-women take responsibility for children's health; older women take responsibility for elderly relatives and for partners. This brings women into greater contact with health practitioners (Graham, 1985; Cunningham-Burley, 1990; Blackwell et al., 1992).

-this caring role in combination with other home duties, often combined with women's roles as paid workers, can lead to stress and ill-health, resulting in greater attendance at a doctor's surgery.

2.3.3. Long-term poverty, depression, and violence

-women experience greater levels of long-term poverty which leads to more illness (Cullen and Morrissey, 1984; Daly, 1989; Byrne, 1991; Senior and Viveash, 1998; European Women's Lobby, 1999).

-women experience and self-report more anxiety and depressive episodes (Cleary, 1997a)⁷

- women are more commonly diagnosed with somatic symptoms of psychological distress and depression (Raphael and Martinek, 1994; Samuels, 1995)
- women are overwhelmingly victims of rape and domestic violence (Soler and Grambs, 1997; Lees, 2000; England and Wales, Cabinet Office/Home Office, 1999).

2.3.4. Awareness of health promotion

- greater self-awareness of their reproductive bodies and more contact with health services may make women more aware of health promotion and preventative health strategies
- greater availability of screening programmes for major reproductive cancers, notably breast and cervical cancers, may help to bring women into the health services before life-threatening complications develop.

2.4. Differing Rates of Mortality from Major Diseases Affecting Both Sexes

The principal sex differences in Ireland involving the major causes of mortality are set out below.

2.4.1 Cardiovascular disease

Nationally and indeed throughout the EU, cardiovascular disease (including coronary heart disease –CHD, cerebrovascular disease, and other diseases of the circulatory system) accounts for the largest number of deaths annually, 40% of the total number of deaths before the age of 75 years (Department of Health and Children, n.d.). Deaths for men from all circulatory diseases comprise 46.1% of total male deaths in the EU, while for women the figure is 38.6% of all deaths (Eurostat, 2000). However, Irish rates are much higher than EU averages.

The rates of death for men in Ireland from circulatory diseases are 465 male deaths per 100,000 of the population. Again looking at the Standard Death Rate for CHD (ischaemic heart disease) as a proportion of all men's deaths, the Irish rate is 306.1 per 100,000 men, all ages. The EU Standard Death Rate for CHD for men is 169.5 male deaths per 100,000 men (ibid.).

For Irish women, the rates of death from all circulatory diseases are 279 per 100,000 of the population, while the average EU rate for women all circulatory diseases is 227 per 100,000 of the population (ibid.). Using the Standard Death Rate for CHD (ischaemic heart disease), the latest figures from Ireland are 144.8 deaths from CHD

for every 100, 000 women, compared with a Standard Death Rate across the 15 EU countries of 79.4 for every 100,000 women.

2.4.2. Common cancers

Across the world, the number of cancer cases has doubled between 1970 and 2000. Beyond 2000 cases are expected to increase as a larger proportion of the population globally reaches the ages where age-specific rates of cancer begin to increase (Boyle, 1997). In the Republic, in 1995, just over 50% of all cancers were diagnosed in women, with 49% diagnosed in men.⁸ Excluding non-melanoma skin cancer, amongst women, breast and ovarian cancer were the two most common reproductive cancers, while colon and lung cancer were the two most common non-reproductive cancers. The overall risk of developing cancer before the age of seventy-five was just over one in three for the whole of the population (excluding skin cancer), with slightly higher rates for men, 39% of the male population, than women, 35% (Department of Health, 1999).

Men, when they develop cancer, have higher death rates: of every 100 men who contract cancer in Ireland, 41 will die. Women have better overall survival rates. Of every 100 women who contract cancer, 34 women will die. Another way of looking at this is that by the age of 74, women have a 1-in-8 chance of dying from cancer, while men have a 1-in-6 chance of dying from cancer (Cancer Consortium: 2001).

Of the cancers not involving the reproductive system, there is only one, melanoma, in which the rates diagnosed are higher in women than in men (329 women in 1995 compared with 169 men). Also women tend to be younger when this cancer is diagnosed in them (Cancer Consortium, 2001). Otherwise, of the four most common non-reproductive cancers – bowel, lung, bladder and stomach - men are diagnosed with them at higher levels, compared with women (Department of Health, 1999). Cancer is most prevalent an occurrence from middle age onwards and across Ireland half of all people diagnosed with cancer between 1994 and 1996 were 68 years of age or older (Cancer Consortium, 2001). Women were somewhat older at the time of diagnosis than men. However in relation to breast and cervical cancer, more than 60% of women who were diagnosed were under 65 years of age (ibid.).

Overall rates of cancer for women were higher than the EU average rates of cancer whereas for men, the Irish and EU figures for all cancers are similar (ibid.).

2.4.3. Summary of mortality and morbidity data

In summary, we have a picture in Ireland of the following:

- Higher rates of death from cardiovascular disease for men compared with women
- Higher rates of death from cardiovascular disease for both men and women compared with EU averages
- Somewhat higher rates of cancer in men compared with women (with the exception of melanoma)
- Once cancer is contracted, men have higher rates of death compared with women
- In women, breast and ovarian cancer are the two most common reproductive cancers
- The two most common non-reproductive cancers in women are colon and lung cancer

SECTION 3 –COMPARING LIFE EXPECTANCY AND MAJOR ILLNESSES OF IRISH WOMEN WITH WOMEN FROM OTHER EU COUNTRIES

This section provides a statistical overview of the differences in life expectancies and morbidity and mortality data

- Between Irish women and their European counterparts

When comparing data on Irish women with data from women in other European countries, we are indirectly seeing how differences in outcomes and life chances are created firstly, through lifestyle and socio-economic issues, and secondly through the quality and breadth of health service provision of women's diagnostic and treatment needs.

The life expectancy of Irish women ranks twenty-second internationally, with women in twenty-one other developed countries living longer (UNDP, 1998:131). In 1996, the average EU life expectancy for a woman was 80.6 years compared with 78.5 years for an Irish woman. In the league table of fifteen member states, Irish women were second from the bottom (Central Statistics Office, 2001:1).

3.1. Cardiovascular Disease

We have seen above that the rates of death for Irish women for circulatory disease is higher than average EU figures. But ours is not the worst profile in the EU: for all circulatory diseases, Irish women have a Standard Death Rate per 100,000 of the population that ranks fourth from the top, with women in Greece, Portugal and Austria having the highest rates (Eurostat, 2000). However, for coronary heart disease alone, the Standard Death Rate for women per 100,000 women of the population for Ireland is 144.8, the highest of all the EU countries (ibid.).

3.2. Cancers, Including Reproductive Cancers

Compared with the EU averages for women, Irish women contract more cancer types at relatively high rates, with melanoma, lung and oesophageal cancers especially high. The Republic of Ireland has the highest rate of oesophageal cancer amongst women in the EU (Cancer Consortium, 2001).

Across Europe, the most common form of female reproductive cancer is breast cancer, representing 19% of all cancer deaths and 28.5% of all new female cancers

(Eurostat, 2000). Incidence and mortality rates are highest in Northern EU countries. The Irish Standard Death Rate for breast cancer is 35.7 per 100,000 of the population. This is the third highest rate in the EU. The average EU Standard Death Rate for breast cancer is 29.9 per 100,000 of the population.

Irish women have the second highest Standard Death Rate for cervical cancer, at 4.9 deaths per 100,000 of the population. The average EU Standard Death Rate is 2.8 deaths per 100,000 of the population (ibid.).

Ovarian cancer is very difficult to treat because it is most often diagnosed very late in its development. Only one woman in three survives for five years (European Institute of Women's Health, 1996: 27). Ovarian cancer death rates for Irish women are the third highest in the EU, with a Standard Death Rate of 11.5 deaths per 100,000 of the population. The average EU Standard Death Rate is 8.9 deaths per 100,000 of the population (ibid.).

The EU average Standard Death Rate for cancer of the uterus is 4.5 per 100,000 of the population. This is the only reproductive cancer where the Irish figure falls below the EU average, at 3.3 deaths per 100,00 of the population (ibid.).

3.3. Summary of Mortality Data

- Irish women have the second lowest life expectancy of all EU countries
- Irish women have the second highest rate of death from breast cancer of all EU countries
- For cervical and ovarian cancer, Irish women have the third highest rate of death across the EU
- The only reproductive cancer which falls below the average EU death rate is ovarian cancer.

Section 4 – Women’s Major Diagnostic and Treatment Needs

The data on mortality and morbidity in Sections 2 and 3 raise issues about whether improved detection and better forms of treatment can help to lower rates of mortality and morbidity. Below, we examine current research approaches to diagnosis and treatment of these critical illnesses. This research takes into account how gender differences can impact on women’s chances of treatment and recovery. Data is presented on the diagnostic and treatment needs in relation to the following life-threatening illnesses:

- Cardiovascular disease
- Breast cancer
- Other reproductive cancers – cervical, ovarian, and uterine
- Some common non-reproductive cancers.

4.1. Cardiovascular Disease

4.1.1. Research issues about cardiovascular disease (CVD) and coronary heart disease (CHD)

Recently, it has been argued in a number of arenas that there is a serious problem in the promotion of gender equity in health services across Europe and that the problem is especially apparent in relation to cardiovascular disease. Two difficulties have been pinpointed:

- Failure to refer women soon enough for treatment in cases of suspected coronary heart disease
- Delays in having life-saving treatments administered

(Sans, 2000)

The non-recognition of CHD is a serious issue for women. It is linked to the perception that this is largely a man’s illness, a trend that goes back for quite some decades (Woods and Jacobson, 1997). Yet the epidemiological statistics discussed in Sections 2 and 3 belie this perception. Although death rates from CHD are coming down internationally, they are coming down more slowly for women (Khaw and Sharp, 1994). A principal difficulty here is that the disease manifests itself differently in women and men. This means that practitioners must incorporate these gender differences into initial diagnostic approaches (Woods and Jacobson, 1997).

Certainly, the lifestyle risk factors are the same for both sexes:

- Smoking
- Obesity
- Physical inactivity

- High blood pressure
- Elevated cholesterol
- Family history of CHD
- Diabetes mellitus

(Speroff et al., 1994; Sapsford et al. 1998).

But of the 500,000 women who die every year of CVD in the United States, 36% of women experience sudden cardiac death or fatal myocardial infarction (Wenger, 1994). Even if women are treated with clot-destroying drugs, after an incident of myocardial infarction, the rate of early death is still higher than for men; they have a worse outcome in the wake of medical and surgical interventions (Woods and Jacobson, 1997). Women also have a higher incidence of reinfarction and thus are less likely to return to the workforce (Collins, 1994).

The critical gender difference in diagnosis appears to be that chest pain in women is very often non-cardiac in origin and also that cardiac flow disturbances, possibly affected by hormonal status, often cause chest pain (Craig, 1995).

Thus a practitioner may discard the possibility of cardiac disturbance too readily, reducing the chance for early diagnosis. The problem of gender bias in medical referrals appears to remain a significant problem (Travis et al., 1993). Data indicates that women are referred far less frequently for diagnostic and therapeutic procedures, especially coronary arteriography, although they have greater functional limitation as a result of chest pain than men (Chesney, 1994). The issue is further complicated by the fact that cardiologists can see different rates of referral by sex as appropriate, if they are based on positive exercise test results amongst patients at GP level prior to referral (Mark et al., 1994).

Four broad issues about women's mortality patterns from CHD and the different presenting patterns are seen to require extensive research to understand better what the inter-relationships are between them and poorer outcomes for women

1. The smaller coronary arteries of women and how this might affect outcomes
2. The older age at which women come to exhibit CHD
3. The problem of more frequent co-existing diseases at this older age
4. Delayed or inadequate medical care (Wenger, et al., 1993)

It is argued that the lack of research on these factors has prevented the development of a solid understanding of the following in dealing more adequately with coronary heart disease in women:

1. What can constitute women-centred prevention
2. What diagnostic testing would be useful in light of women's different physical profiles and physical reactions
3. Women's responses to medical and surgical therapies (Woods and Jacobson, 1997)

Carrying out women-specific research is itself problematic for the following reasons:

1. An historical tendency to see the male body as the 'normal' or generic body, that led for many years to the exclusion of women in clinical trials
2. The exclusion of pre-menopausal women from clinical trials because of the possibility of pregnancy.
3. The exclusion of postmenopausal because of other co-existing medical conditions (Cardiovascular Panel, 1992).

The result of these trends was that up until the early 1990s, almost all of our information about heart disease has come from studies of men.

In order to deal with this gender bias, the National Institutes of Health in the United States set up the Women's Health Initiative in the early 1990s to investigate cardiovascular disease and its prevention in perimenopausal and older women. In 1992, it also held a special conference on cardiovascular disease and health in women with the specific purpose of highlighting new clinical information and where gaps in research remain unaddressed.

Two new large scale prospective studies in the UK are concentrating on women and heart disease. In the first, the emphasis will be on identifying genetic factors which may make some women more prone to heart disease. It will involve 4,000 women and is being conducted on behalf of the British Heart Foundation. In the second study, the Women's Heart Study, being run from the National Heart and Lung Institute in London, 20,000 women employees from the ages of 30 to 64 of the Marks and Spencer retail shops, will have data collected to investigate the male/female differences in heart disease; the relationship between physical activity and heart disease; the relationship between alcohol consumption and safe drinking limits for women; and metabolic aspects of hypertension in women.

4.1.2. Role of the menopause in CHD

Recent attention to the role that Hormone Replacement Therapy (HRT) might play in preventing cardiovascular disease has focused attention on women's menopause as a potentially important risk factor for coronary heart disease. The statistical data is clear that the risks of contracting cardiovascular disease and suffering coronary death are less for women than for men in middle age.

However, a leading epidemiologist in CHD has recently raised some pressing questions about what he terms the 'myth' of coronary risk in and after the menopause. According to his meta-analysis⁹ of international data (Tunstall-Pedoe, 1998), coronary deaths for women under the age of 50 number 500 per year in the UK, compared with 2900 per year in men. However, for those 80 years of age or over, there are 36,000 coronary deaths amongst women, compared with 22,000 for men (ibid.).

'The absolute difference in risk of coronary death between women and men continues to rise with age and never closes' (ibid.:1426).

But critically, Tunstall-Pedoe argues that analytical explanations about this difference have inaccurately focused on the experience of menopause as a watershed experience with its associated hormonal changes. Working with data from the WHO project on heart disease prevalence, the MONICA project, he points out that there is a constant acceleration of coronary risk for women in their middle years and beyond, with a near constant multiple by which mortality increases in each consecutive five year age group from 30-34 years to 60-64 years. Menopause per se does not correlate with a sudden increase in coronary deaths for women according to the epidemiological data. For men there is actually a decline in the rate of acceleration in their middle years and beyond.

Tunstall-Pedoe points out that studies of greater coronary risk for women after the menopause have actually been conducted with women who underwent early menopause, where there might be complicating epidemiological or developmental risk factors leading to both early menopause and increased coronary risk. Two other types of studies have been involved in suggesting this link: those on changes in lipids and other risk factors as women undergo menopause and observational studies on the

apparent protective effect of HRT (ibid.). However this data on the benefits of HRT in relation to heart disease has not been subjected to the rigour of randomised controlled trials. Tunstall-Pedoe argues that such randomised controlled trials about the impact of HRT should take place and that studies on the menopause should also be directed to the possible existence of as yet unidentified coronary protective factors that are associated with the ending of menopause that prevent a sudden acceleration of coronary heart disease taking place.

4.1.3. HRT and the Women's Health Initiative study

The long-term study by the National Institutes of Health in the United States, the Women's Health Initiative, mentioned in Section 4.1.1. above, was the largest research study of its kind ever funded. It was designed to last over a fourteen-year period and to comprehensively test and review prevention strategies on the three leading causes of death and poor quality of life for older women: cardiovascular disease, breast cancer and osteoporotic fractures (Thaul and Hotra, 1993). The clinical trial on 63,000 postmenopausal women was meant to explore interventions in these three diseases; two other interventions - dietary modification and hormone replacement therapy - concern cardiovascular health. The hypothesis for the intervention on dietary modification was that a low fat dietary pattern reduces the risk of coronary heart disease; the hypothesis for hormone replacement therapy (HRT) was that progestin and estrogen replacement reduces the risk of cardiovascular disease (ibid.). This is precisely the randomised controlled trial called for by Tunstall-Pedoe to test the claims about HRT and cardiovascular health.

In respect of the trial on HRT and the prevention of CVD, involving more than 16,000 women with an average age of 63, the NIH reported in July, 2002 that the adverse effects of progestin and estrogen replacement outweighed the benefits. Furthermore, on the basis of their cumulative data about adverse effects, they were ending this trial (Writing Group for the Women's Health Initiative Investigators, 2002). What researchers had noted was a very small increase in heart attacks, strokes and thromboembolic events amongst women in the trial group taking HRT, compared with the control group. This amounts to 1 excess case per 1,000 women each year. There was also a small but statistically significant increase in the risk of breast cancer. On the positive side, the role of HRT in reducing spine and hip fractures was

confirmed. There was also a reduction on colorectal cancer. However, there was an increase in back pain and in urinary incontinence in those women using HRT. Because of the rigor with which this trial was conducted, the medical conclusion is clear that HRT does not provide cardiovascular protection and should not be prescribed for that one purpose (ibid.). In January, 2003, the Food and Drug Administration of the United States government approved new labelling for all estrogen and estrogen-progestin replacement therapy stating that these drugs carry an increased risk of heart disease, heart attacks, strokes, and breast cancer. The warning also states that these products are not approved for heart disease prevention.

4.1.4. Diagnostic and treatment needs and prevention initiatives

The two preceding sections should alert us to the need for the following:

1. Greater research amongst cardiologists on the woman-specific aspects of cardiovascular disease, including CHD.
2. Greater emphasis in training of GPs on CHD and women and its very different profile in women. This should include some examination of diagnostic differentials, especially those for coronary arteriography.

The Cardiovascular Health Strategy Group in its report to the Department of Health and Children (Department of Health and Children, n.d.) has commented that in general, investigation and intervention rates are low in Ireland compared with the rest of Europe (ibid.: 8). There are also disparities between the rates of coronary arteriography by health board regions, with rates highest in the Eastern region, Northeastern and Midland Health Boards and lowest in the Western Health Board (ibid.:9). Critically, the report comments on the lower rates of coronary arteriography for women, amongst other coronary care procedures, compared with men (ibid.: 10).

Initiatives on prevention of CVD are important to undertake directly with women. Lifestyle issues such as giving up smoking are emphasised by the Cardiovascular Health Strategy Group along with exercise. The European Institute of Women's Health (1996:24) also outlines a series of lifestyle recommendations. The EIWH document recommends a two-sided approach to dealing with CHD: tackling how health care professionals screen for CHD and the need for women-specific research on CHD.

4.2. Breast Cancer

4.2.1. Risk factors

A small number of women carry genes responsible for breast cancer and thus carry a much higher chance of developing breast cancer. These genes are called BRAC1 and BRAC2 and are hereditary. About 5% to 10% of all breast cancers exhibit these genes which are hereditary (Curling and Burnet, 2001:287). Approximately another 20% of breast cancers are part of a broad family history of breast cancer, that is, where a first-degree relative (mother, sister, child) on the maternal side has had breast cancer, especially if the breast cancer was pre-menopausal. This clustering may be due to chance, to inherited genes with only a slight increased cancer risk, or to the sharing of common environmental cancers. Other risk factors for breast cancer include:

- Menstruation starting before the age of 12;
- A late menopause after the age of 55;
- Age – the increase of risk rises steadily from the age of 40
- Having no children
- Having a first child after the age of 30
- Radiation exposure
- Obesity
- Current users of the combined oral contraceptive pill (ibid.)

The role of HRT in contributing to breast cancer has been examined in the Women's Health Initiative report of 2002 (see Section 4.1.3 above). An earlier meta-analysis⁹ of the combined oral contraceptive pill, concluded that there is a small increased risk of developing breast cancer and that this risk is the same, regardless of dosage or duration of use (Collaborative Group on Hormonal Factors in Breast Cancer, 1996). However it also appears that if women are already taking HRT, the breast cancer is usually detected at an earlier stage and tends to be of a lower grade (Collaborative Group on Hormonal Factors in Breast Cancer, 1997). This points to a continuing need for great care in prescribing of HRT.

Here in Ireland, a recent random sample survey by the Department of Health Promotion, NUI Galway, of 600 GPs on current prescribing practices for HRT, found significant differences between female and male GPs on pre-screening of women for acceptability of HRT use. Female GPs were:

- more likely to send women routinely for a mammogram before commencing HRT
- more likely to consider a first degree relative with breast cancer a contraindication for HRT

-less likely to prescribe HRT for longer than 10 years because of cancer risk (Fallon and Kelleher, 2000). Importantly in the light of the Women's Health Initiative findings on HRT and CVD, the majority of GPs were prepared to prescribe for the prevention of osteoporosis, but were reluctant to prescribe solely for the prevention of cardiovascular disease (ibid., 2000). The authors conclude that the greater sensitivity to the issue of breast cancer on the part of women GPs led to this statistically significant difference in screening for breast cancer. The obvious problem of a gendered difference of awareness remains and male GPs need to be as sensitive to the issue as women GPs appear to be already.

4.2.2. Breast self-examination and screening

Early detection of symptoms has been seen as critical in promoting breast health and increasing survival rates for breast cancer. In Ireland, health promotion campaigns have urged women to conduct monthly breast self-examination. With most breast cancers occurring in women over the age of 50, screening for women of this age group also has also been targeted to increase early detection.

Only between 1 in 4 and 1 in 3 Irish woman conduct a breast self-examination regularly (Wiley and Merriman, 1996; IMS Survey, 2001). Only one in three women check breasts on a monthly basis for changes, while 35% of women check their breasts every six months or even less often, while 28% never check their breasts for changes (ibid.).

In a study for the Women's Health Council in 2000, it was found that of a sample of women attending clinics around the country for symptomatic breast disease, 69% discovered breast symptoms themselves which led to their referral to a special breast clinic (Kennedy et al., 2000). That figure compares with 90% of women in Britain discovering breast symptoms themselves (England and Wales, Department of Health, 1998). This would seem to reinforce the value of breast awareness and associated health promotion campaigns.

But very recent research questions the value of self-examination. The Canadian Task Force on Preventative Health Care released a review study in June, 2001 in which they called for caution about the value of regular monthly breast self-examination for

all age groups (Baxter et al., 2001). The review of two randomised controlled trials, a quasi-randomised trial, and cohort and case studies failed to show significant benefits in respect of prevention of death through regular monthly breast self-examination. For women under 40, there was no benefit; for women over 70, there was insufficient evidence to judge; and for middle-aged women, it was recommended to discontinue the practice because of the increases in benign biopsies (ibid.). These findings, which caused considerable dismay to health education professionals, were subsequently backed by the UK Early Detection of Breast Cancer Group which also confirmed from its results that there were no significant differences in breast cancer mortality rates between women who did regular monthly examinations and those who did not (Richmond and McKie, 2001). The point was made that breast cancer mortality has fallen in all age groups by 30% in the last fifteen years due to new drugs such as tamoxifen and improvements in chemotherapy (ibid.).

In the mid-1990s, as part of the Plan for Women's Health, the government undertook to establish the National Breast Screening Programme for all women over the age of 50. The screening programme is only very slowly being extended across the country with the western half likely to remain without screening until at least 2006.

However, women report widespread anxiety about the process of screening and detection (Kennedy et al. 2000).

The process of screening itself is not without controversy amongst cancer and epidemiologists. A recent large scale study of breast screening in Canada indicated that although mammography does detect some cancers earlier on in their growth, many of these may not be the most lethal cancers. Clinical examination, on the other hand, involving where appropriate, techniques like physical examination, fine needle aspiration, biopsy and scanning are used alongside or in addition to a mammogram, is more likely to detect potentially lethal cancers (Mittra et al., 2000).

A 1999 study of screening for breast cancer found no decrease in mortality in Sweden where screening had been recommended policy since 1985 (Gøtzsche and Olsen, 2000). A subsequent Nordic Cochrane Centre meta-analysis⁹ meta-analysis of seven randomised controlled trials on mammography reviewed the methodological quality

of these trials and concluded that ‘there is no reliable evidence that screening decreases breast-cancer mortality’ (Olsen and Gøtzsche, 2001). The authors of this review found that screening leads to ‘more aggressive treatment, increasing the number of mastectomies by about 20% and tumourectomies by about 30%’ (ibid.), even where some cancers were so slow-growing that they never ‘would have developed into cancer in the women’s remaining lifetimes’. This Cochrane review has proved very controversial. In an editorial on this review, the Editor of the *Lancet*, Richard Horton, commented:

‘The methods underpinning this controversial review are now transparent and open to scrutiny. Detailed narrative critiques of the individual randomised controlled trials are provided, which allow the principal investigators of these trials to respond to concerns that have so far been scattered in many different journals. Finally important additional data about rates of mastectomy, lumpectomy, and radiotherapy give further insight into how screening influences treatment of breast cancer after diagnosis. The implications for women and policymakers are substantial and require careful reflection and analysis’.
(Horton, 2001)

In the wake of this review, the British Department of Health has now issued guidelines that women should be informed about possible advantages and drawbacks to using mammography. A similar controversy about screening emerged in the United States in 1997, after which a leading European cancer epidemiologist commented:

‘Uncertainties [about screening] remain, but women deserve better ways to receive reliable information and recommendations about such an important issue that are available at present.’ (Boyle, 1997)

4.3. Other Reproductive Cancers

4.3.1. Cervical cancer

Penetrative sex with men seen has been seen as the biggest risk factor for the transmission of the Human Papilloma Virus (HPV) which leads to cervical cancer (Doyal, 1995:74; Fish and Wilkinson, 2000: 224). Risks are thought to be highest in women who start sexual intercourse at very young ages and who have multiple sexual partners (Doyal, 1995:74). Cervical cancer has a distinctive class profile with the highest mortality rates associated with the lowest socio-economic classes and minority ethnic groups (ibid.). A higher number of pregnancies, during which the cervix may be more vulnerable to infecting agencies, and smoking may be some other co-factors, as well as a lowered immune system, AIDS, and chemotherapy treatments for other cancers (Padbury, 2001). Previous use of medication such as DES, which

was widely available some decades ago as a treatment for morning sickness, has now caused cervical abnormalities in daughters born to women who used the drug, which may leave them open to a higher risk of developing cervical cancer.

However, researchers argue that there is not a straightforward relationship between the HPV and cervical cancer. Only a small number of women with high risk factors such as those listed above, will develop clinically evident lesions and only a very small number of these will go on to develop cervical cancer (Kenny and Reuss, 1994).

The reduction of rates of death from cervical cancer has relied in the first instance on the use of screening which is meant to identify cancer at the pre-invasive stage (Sutherland, 2001:35). In the UK, it is estimated that screening has resulted in 8,250 fewer deaths between 1988 and 1997 (Sasieni and Adams, 1999).

The commitment to a national screening programme in Ireland for cervical cancer in women aged 25 to 60 was made in the *Plan for Women's Health*, with the aim of having test results available within one month. In 2000, Phase I of this programme was announced by the Department of Health and Children in the Mid Western Health Board, with 67,000 women between the ages of 25-60 years targeted for screening.

Screening has been part of health delivery care systems in other countries for almost 40 years, with the Scandinavian countries beginning screening in the 1960s with almost complete coverage of their target populations (Padbury, 2001). In Britain, efforts to routinise screening resulted in guidelines recommending amongst other features, that women be tested at five-yearly intervals between the ages of 20 and 64 (England and Wales, Department of Health, 1993). Mortality rates from cervical cancer fell by 7% every year since the introduction of the national screening programme in 1988 (England and Wales, Department of Health, 2000).

However, there has been adverse publicity in the UK about wrong diagnoses from cervical screening, most of which is carried out in primary care settings. Two broad factors were seen as responsible for missed or inappropriate diagnoses of cervical cancer:

- Inadequate training on the part of health care professionals taking the smears

-Poor diagnosis of abnormal smears in the laboratories (England and Wales, NHS Executive, 1998).

Other problems about screening have included:

- Inappropriate screening of sexually inactive women;
- Difficulty in contacting women for screening in highly mobile populations (Padbury, 2001:330).

A national study of lesbian women's health needs has pinpointed the fact fewer lesbian women attend for cervical screening in the UK than heterosexual women on the grounds that it is not necessary; they also object to the invasiveness of the procedure (Fish and Wilkinson, 2000; Padbury, 2001). These perceptions should be taken into account with future health education and cervical cancer screening programmes (ibid.) To improve the success of screening requires protocols and guidelines to ensure best quality services. Improved communications between the screening programme and women are also vital (Padbury, 2001:330).

Promotion of screening has proved complicated in New Zealand. There the government dropped health promotion linking active sexual behaviour and the transmission of the virus (Braun and Gavey, 1999). Researchers concluded that the emphasis on sexual risk factors led women to avoid smear tests, because they feared being labelled 'promiscuous'. But it is thought that this lack of emphasis meant that health promotion bodies could not draw attention to the role of men in transmitting the HPV and taking responsibility for that through condom use. It also meant less emphasis on women's sexual health overall in promotional material (ibid.).

4.3.2. Ovarian cancer

Ovarian cancer is seen as the most lethal of gynaecological cancers, a 'silent killer' with the poorest prognosis (Smith, 2000). Death rates are high because the disease can be present for some time without any apparent symptoms. It is seldom detected at an early stage. In the United States, ovarian cancer constitutes 25% of all reproductive tract cancers but 50% of deaths from such cancers (Queenan and Beauregard, 1997). In the UK, about 5,000 women are diagnosed each year and over 4,300 of these women will die (Sutherland, 2001:307). Nearly 75% of those diagnosed will have had the cancer already spreading beyond the ovaries at time of diagnosis (Vasey, 2001).

Because so few women can therefore avail of surgical means to localise the cancer, by removing the ovaries and surrounding tissue, chemotherapy is the principal form of treatment. But the survival rate from this remains low, with an overall survival rate after five years of less than 30% (ibid.) Eventual symptoms may include increasing abdominal distension, abdominal discomfort, change in bowel habit, fatigue and weight loss (Lee and Rider, 2001). Risk factors include the following:

- Age – most cases occurring over 45 years
- Social class and ethnicity – most common in white women in higher social classes
- Family history of the disease in a first-degree relative
- Family history of breast or bowel cancer
- History of breast, colon or endometrial cancer
- Parity – more common in women with no children, risk decreases with number of pregnancies
- Infertility
- Late menopause
- Pelvic irradiation
- Obesity

(Queenan and Beauregard, 1997; Smith, 2000; Sunderland, 2001).

Routine mass screening for ovarian cancer is not possible at present. Therefore, health care professionals are urged to think about the importance of

- early detection and diagnosis in order to optimise the prognosis;
- taking a full family history;
- the impact on the woman and her family of a diagnosis with such poor survival rates.

(Sunderland, 2001)

As with other forms of cancer, rapid access dedicated assessment units are seen as key to handling treatment (Lee and Rider, 2001). Any woman with a first-degree relative with ovarian cancer should be carefully monitored (Queenan and Beauregard, 1997).

It is also clear from research that women who suffer any form of gynaecological cancer, cervical, ovarian or uterine, have special psychosexual needs; the reported prevalence of sexual difficulties after treatment range from 30 to 90% (Pitts and Bradley, 2000). Women require specialised and individualised counselling to determine their information and support needs (ibid.).

4.4. Other Common Cancers

4.4.1. Lung cancer

The single largest increase of cancer in women world-wide has been lung cancer, 73% since the 1970s, and has come about almost entirely because of increased smoking by women (Boyle, 1997). The current research also indicates that women smokers are less likely to give up than men smokers (McPherson and Waller, 1997).

According to work from the European Institute of Oncology:

" the greatest impact to reduce the burden of cancer would be from the control of tobacco smoking and the control of breast cancer... tobacco control could be achieved by government and societal actions... With the expansion in absolute numbers set to continue in the next century, the role of prevention in cancer-control strategies will increase in importance' " (ibid.).

The UK government has acted on this challenge in the publication of its *NHS Cancer Plan*, (England and Wales, Department of Health, 2000) where it has flagged prevention of smoking. The Department had already set out targets in a White Paper, *Smoking Kills*, to reduce the rates of smoking in three key groups by 2010 and to bring about 1.5 million fewer smokers:

- Children – from 13% to 9%
 - Adults – 28% to 24%
 - Pregnant Women – 23% to 15%
- (quoted in England and Wales, Department of Health, 2000).

It has introduced legislation to tighten its tobacco control regulations. Additionally, it has already introduced special smoking cessation services as part of the NHS and made Nicotine Replacement Therapy (NRT) available on prescription from GPs.

As part of the Cancer Plan, it has now begun to address the socio-economic differences in rates of smoking. In 1998, 15% of those in the higher professional socio-economic groups smoked, compared with 36% in unskilled manual work. The Department has therefore introduced targets for the 20 local health authorities with the highest rates of smoking to:

- Establish pro-active smoking cessation services with high-risk groups
- Pilot projects in socially deprived areas
- Dedicate a trained health care professional in each authority to support smokers wanting to quit
- Build local alliances between the treatment services, local and community groups, ethnic minority groups, businesses, schools, leisure facilities etc.

- Special projects for prisons and supports.

It has also introduced a research programme to work on additional policies for

- Children
- Pregnant women
- Disadvantaged groups

Here in Ireland a more modest approach has been initiated with the policy paper *Towards a tobacco free society* (Mooney, 2000). In this action plan, the Department of Health and Children has announced the ongoing development of counselling and social support services for smokers wishing to quit at regional health board level and the availability of NRT for free for people participating in smoking cessation programmes. Special support should be available for any pregnant woman who is smoking through each maternity unit. The Department will also continue to promote its health education work amongst schoolchildren with the SCRAP and Smokebusters programmes, in addition to its increased regulations of the tobacco industry both in advertising and retail sales.

In 2001, the Irish Cancer Society launched an anti-tobacco campaign emphasising women and tobacco. Entitled ‘Tobacco Free. It’s a Beautiful Thing’, the campaign specifically targets women in the 20-35 age range, focusing on the damage to skin, teeth, lips and general ageing brought on as a result of smoking.

4.4.2. Bowel, colorectal and stomach cancer

Health education for prevention of bowel, colorectal cancer and stomach cancer focuses on increasing the consumption of fruit, vegetables and cereals. The

Department of Health in the UK notes about this:

After smoking, what people eat is the next biggest contributor to cancer deaths, and may be responsible for up to a third of all cancer deaths.

(England and Wales, Department of Health, 2000)

The UK, which shares a similar profile with Ireland for these common cancers, has been pro-active in its *NHS Cancer Plan*, in trying to increase consumption of fruit and vegetables. People in the lowest socio-economic groups consume substantially less than higher socio-economic groups. The *Plan* states:

This contributes, with smoking to the cancer health gap in England.

(ibid.)

The *Plan* therefore focuses on a national ‘Five a Day’ campaign of fruit and vegetables. It has run an extensive health promotion campaign on this, along with the Food Standards Agency, and been given assistance by large supermarket chains such as Tesco to flag the campaign in its shops.

Allowing for the circumstances in deprived communities, it has also set up five pilot sites for five-a-day initiatives around the country. This work is subject to evaluation and includes amongst other actions:

- The provision of a community food service to residents with free home delivery of groceries
- Promoting fruit and vegetables through local football teams and coaching schemes
- Developing school food initiatives on fruit and vegetables
- Setting up local food co-ops which also deliver to homes
- Promoting grow-your-own schemes etc.

(ibid.)

This work has special salience for women. We know from a number of studies on women and poverty that women eat less fruit and vegetables and that their gender status affects food consumption patterns adversely (Charles and Kerr, 1988; Doyal, 1998; Lee and Gibney, 1988; Murphy-Lawless, 1992). The SLÁN lifestyle report on lifestyle attitudes and nutrition in Ireland (Friel et al., 1999) indicated that almost two-thirds of the 13,633 postal sample said they did take the recommended quantities of fruit and vegetables daily. But such positive self-reporting is not yet reflected in reduced rates of the common cancers in Ireland.

SECTION 5 – DISEASES THAT AFFECT MORE WOMEN THAN MEN

There is a cluster of chronic illnesses that afflict women more frequently than men. Because of this greater incidence, they need to be better understood from the perspective of gender. If women have multiple roles as carers, if an appreciable minority of women suffer from long-term poverty, and if gender can complicate how women are treated by doctors, these three factors may also complicate how women manage such long-term chronic illness. Research on this cluster of illnesses is presented in this section.

5.1. Diabetes and Auto-immune Diseases

The diseases listed below, three of which are characterised by auto-immune malfunctioning are far more prevalent in women:

- Diabetes mellitus
- Multiple Sclerosis
- Rheumatoid Arthritis
- Systemic Lupus

This greater prevalence may be related to the aspect mentioned in Section 2.2 above, the greater immuno-responsiveness that women appear to have.¹¹ As yet, there is no single overall theory to explain why this happens (Queenan and Beauregard, 1997). A very recent line of research, presented at the American Association for the Advancement of Science in 2001 by scientists from the University of Washington is that foetal cells still surviving in the mother after pregnancy may lead to these auto-immune diseases (Ahlstrom, 2001).

5.1.1. Diabetes Mellitus

The World Health Organisation says that there is a growing scourge of diabetes, with an estimated 150 million people world-wide affected by the disease. This is expected to double to 300 million people in the next two decades. Increased incidences of cardiovascular disease, kidney failure, blindness and amputations are associated with diabetes. After the age of 45, about twice as many women as men develop diabetes (Boston Women's Health Collective, 1998). In the United States, 80% to 90% of all cases of diabetes are non-insulin dependent diabetes; the most important risk factor associated with its development is extreme weight gain (ibid.; Kirkegard, 1997). The rate of cardiovascular mortality is three to five times higher in women with diabetes

than those without diabetes (Gerstein et al., 2000). Non-insulin dependent diabetes is especially prevalent amongst ethnic minority women in the United States and in the UK (ibid.; Douglas, 1998). There is a reported significant association between IUGR (intrauterine growth retardation) and increased rates of non-insulin dependent diabetes later in life for these babies, so attention to good maternal diet in pregnancy is an important issue for future prevention (Illman, 2001).

In Ireland, it is estimated that as many as 200,000 people have diabetes, with a huge increase in the non-insulin dependent type (Type II) which is a chronic progressive disease of adulthood. A recent survey in Ireland found that two-thirds of those affected by diabetes do not take any exercise to help manage their illness (Thompson, 2001). In 2001, the Minister for Health and Children in the Republic and the Health, Social Services and Public Safety Minister in Northern Ireland released a joint statement on the launch of a publicity campaign to 'Get a Life, Get Active' which forms part of the Change of Heart Campaign (Department of Health and Children, 2001). The Ministers pointed out that non-insulin dependent diabetes could be reduced by 25% through regular physical activity, which is not a feature of life for many people north and south. It is estimated that half of all women in the 51 to 64 age group take no part in vigorous physical activity (ibid.).

The key to prevention of non-insulin dependent diabetes remains diet and lifestyle with a reduction of saturated fats, an increase in fibre and whole grains and an increase in exercise crucial to reduce the risk of developing the disease (Thompson, 2001). Research in Sweden, Australia and the United States also points to the protective effect of breastfeeding in reducing the incidence for those babies as they reach adulthood (Queenan and Beauregard, 1997:145). This research should be used to reinforce health education for women in the antenatal period.

5.1.2. Multiple Sclerosis

This auto-immune disease affects twice as many women as men (ibid.). Because it typically develops between the ages of 20 and 40, it is also a disease of young adulthood that re-shapes the course of people's lives. There are now an estimated 6,000 people with MS in Ireland, or 1 in 800, according to the Multiple Sclerosis Society of Ireland. Between 200 and 250 new diagnoses are made annually. A

degenerative disease of the central nervous system, MS also has a curious geographical pattern of dispersal, with the north-west of Ireland having the highest incidence. It is argued that services for people in Ireland with MS are poor (Holmquist, 1999); for example, transport for many of those sufferers who are still able to work is problematic. As recently as 1999, there was no neurologist employed by the North Western Health Board and sufferers were having to travel to Dublin for tests and scans (*Irish Times*, 15 October, 1999). In 1997, the National Rehabilitation Board piloted an EU-funded pilot project to enable people with MS who were employed to claim back three-quarters of their taxi fares. It was meant to help support sufferers continuing to work as long as possible, but the project was not mainstreamed. A multi-disciplinary rehabilitation service for MS was opened in 1999 in Beaumont Hospital.

5.1.3. Rheumatoid Arthritis

Although only 1% of the population ever contracts rheumatoid arthritis (RA), three sufferers out of four are women. This is an auto-immune disease in which the body begins to directly attack joints, bones and sometimes internal organs, with 5% of sufferers experiencing severe disability. People with long-term rheumatoid arthritis are also at risk of accelerated atherosclerosis or narrowing of the arteries (Wallberg-Jonsson et al., 2001). The disease usually sets in between the ages of 25 and 50, but there is an increased incidence in middle-aged women. Early diagnosis and treatment are vital if, where appropriate, disease-modifying drugs can be brought into play. The role of HRT may also have some beneficial impact for menopausal women with RA (Kirkegard, 1997). Osteoporosis is a common problem with RA, perhaps due to decreased strength from less exercise and periods of immobilisation and also to a reduction in bone mass (Sambrook and Reeve, 1988). Women with RA who become pregnant will generally experience some relief from the disease during pregnancy, due, it is thought, to hormonal changes, but the vast majority will then experience a flare-up during the puerperium (McLachlan, 1997). Women with RA have special support needs during pregnancy, birth and after the birth to enable them to cope with their physical transition to motherhood while dealing with ongoing serious chronic illness (ibid.). RA has a direct impact on a woman's sexuality and the avoidance of pain and pressure on the joints when engaging in sex is critical (Boston Women's Health Collective, 1998:252.).

5.1.4. Systemic Lupus Erythematosus

Lupus is another auto-immune disease which affects women more than men, nine times as frequently. Many women who are affected are of childbearing age (Queenan and Beauregard, 1997:138). Its impact - inflammation of the skin, joints, blood, central nervous system, heart, lungs, gastrointestinal system and kidneys - can be mild to life-threatening, with other symptoms such as weight loss and fatigue common. There appears to be an ethnic dimension to the disease prevalence with more women of African genetic heritage than white women affected. The impact on reproduction is considerable:

- More spontaneous abortions
- Higher incidence of IUGR
- Higher incidence of pre-eclampsia and hypertension
- More premature births
- More stillbirths

(ibid.)

As with rheumatoid arthritis, early diagnosis can help to temper the severity of the disease, and over the last fifteen years there has been a huge improvement in mortality rates due to better diagnostic methods and much improved treatments; compared with two decades ago, when 50% of those diagnosed died within five years, the disease is now controllable so that 90% are alive ten years after initial diagnosis (ibid.). Again as with RA, there is a need to be sensitive to the disabling impact of the disease on women's sexuality (Boston Women's Health Collective, 1998:252).

5.2. Chronic Long-term Illnesses and Special Needs

These four illnesses are the most common serious chronic illnesses that affect women more than men. The important point to be made about them is the gendered nature of the needs which these illnesses produce. They all involve the need for careful diagnosis and specialised care and treatment. Such dimensions as the following may impinge on the chances of both men and women sufferers of these chronic diseases doing better or worse:

- Family circumstances
- Income
- Geographical location in relation to specialised medical and treatment services
- Availability of patient advocates
- Transport
- Work and employment
- Re-training and rehabilitation

- Counselling for personal, emotional and sexual problems

Furthermore, the health and social service responses needed for men and women will differ. Dealing with their reproductive health is clearly more complicated for women; especially with pregnancy, there is a need for greater ongoing expert support. The social context of ill-health for women differs. Women in Ireland still shoulder more family care, both childcare and eldercare (O'Connor, 1998). Many women with chronic long-term illness may still have to carry out their duties as family carers. This changes the nature of their support needs. Bringing symptoms to the attention of a doctor in the first place presents problems for women, because of the differing perceptions of their social roles (see Section 1, above).

SECTION 6 – WOMEN’S HEALTH AND SOCIAL, ETHNIC AND CULTURAL INFLUENCES

A central theme in discussions of women’s health is the need to recognise the totality of their circumstances and way of life. There are vital reasons why health services, seeking to improve women’s physical health, and to undertake preventative or health promotion strategies, must understand the social determinants of health in order to be responsive to individual women’s circumstances. These determinants include factors such as:

- Socio-economic status
- Geographical location
- Paid and unpaid work – childcare and eldercare^{12e1}
- Ethnicity
- Disabilities

6.1. Socio-economic Status and Geographical Location

Socio-economic status has a huge impact on women’s health outcomes, as we have seen already. For the most part, poverty for women translates to more ill-health, compared with women from a more affluent background. We know that:

- Living and working conditions all impact on health status
- Class-related differentials affect women on almost all measures of morbidity and mortality
- Higher rates of stillbirth, perinatal, and neonatal mortality occur to women in the lowest socio-economic classes
- Social isolation contributes to poorer health outcomes
- Women from lower socio-economic classes experience a higher incidence of depression
- Women from lower socio-economic classes are less likely to go to their GP
- Availability of quality care can privilege those from higher socio-economic groups
- Preventative health strategies are least taken up by the poorest women, an outcome directly related to their lack of material and social support.

(McPherson and Waller, 1997; Whitehead, 1992).

We also know that poverty afflicts women with children. Women as lone parents are especially vulnerable to the effects of long-term poverty according to the Combat Poverty Study of their circumstances (McCashin, 1996). Women in the lower socio-economic groups are more likely to have deficient diet and are more likely to smoke

¹ Women in low-paid work or those trying to access re-training have tremendous problems trying to access affordable good-quality childcare because of prohibitive fees. See Coveney et al. (1998) and English and Murphy-Lawless (2000).

(Graham, 1998). Almost every other aspect of their lives is also impacted adversely in respect of adequate housing, available transport, access to ongoing education, adequate employment opportunities, all of which ultimately have connections to their health and their capacity to safeguard and build their health (Daly and Leonard, 2001).

A recent British study on cancer treatment has established significant gaps in understanding by health care providers of the needs of lone parents, the rural poor, the homeless and minority ethnic people (Macmillan, 2001). Delays in accessing cancer services are grounded in the realities of socio-economic barriers, like inability to find childcare or to take time off work because wages are so vital (ibid.).

For women in non-urban settings, access to health services remains a huge issue. The lack of good or even any available public transport is a huge and continuing problem in rural Ireland where levels have actually decreased and the resultant gap has not been matched by private car ownership for women (Byrne et al., 1995; English and Murphy-Lawless, 2000); Daly and Leonard, 2001). Women are more likely to own a car if they are in paid employment in rural areas; otherwise they must rely on sharing a family car or on relatives and neighbours to help them out (Byrne et al., 1995; Kennedy et al., 1999). Women in urban areas are also more likely to have to depend on poor public transport to take up outpatient appointments (Kennedy et al. 1999; Daly and Leonard, 2001).

6.2. Paid and Unpaid Work

The profile of paid employment for women in Ireland has changed beyond all recognition in the last two decades; married women's share in paid employment has risen to 45% from a low of 14% in the 1970s (Murphy-Lawless, 2000). However, this engagement has not been matched by an equality of wages nor by initiatives to support women in respect of unpaid work. As a result, a common strategy is for women to work part-time to enable them to deal with their home and caring duties (ibid.). According to the European Women's Lobby, this remains a problem across Europe:

EU employment guidelines strongly stress flexibility as a means to "reconcile work and family life", which too often is translated into part-time work for women... part-time work as a solution to combine work and family life ...is understood as something that mainly concerns women. Such a view limits women's choices in the labour market and cements the unequal sharing of family responsibilities between women and men.

European Women's Lobby (1999:15)

This unequal distribution ends in poorer socio-economic outcomes for women over time:

Women's work and life still differ from that of men...the current social protection systems are not structured to accommodate women's life patterns, which leaves women with a patchwork of inadequate social protection providing them with insufficient or non-existent individual security...It was strongly pointed out that women's life choices to a larger extent than men's depend on the existence or not of social services, especially child-care. The provision of social services with the emphasis on care services, is consequently seen as crucial instruments for increased equality between men and women.

European Women's Lobby (1999:17)

As yet there is little sign of such equality here in Ireland. The lack of government support for women in respect of childcare, even after extensive expert group reports and recommendations on the issue (Murphy-Lawless, 2000), means that women do the double burden of work. In relation to elder care, the majority of private carers are women with an average age of 52 years (Blackwell et al., 1992).

6.3. Ethnicity

As with socio-economic class, ethnicity can influence health adversely, often because of the way in which racial prejudice and institutional racism adversely influence the life chances of people in minority ethnic groups (Douglas, 1998). In the UK, minority ethnic women, especially black women have similar lifetime experiences to those set out above for women in poverty. Additionally they face:

- Previous poor service from health care providers
- Poor or mistaken perceptions of their cultural practices and beliefs around health and illness

Women from minority ethnic backgrounds can also have different patterns of disease, with greater prevalence of the haemeoglobinopathies and other disease entities (ibid.).

The needs of women travellers have been on the policy agenda for some years, and the primary health care for travellers project has been an especially important initiative (Traveller Health Partnership, 1995). The project has sought to develop travelling women's skills as community health workers. It has also involved training for professionals to increase their awareness and sensitivity to traveller needs (Kennedy, 2002). The project is now asking for proper accreditation of its workers and a Primary Health Care certificate has been established for them (ibid.).

This work, supporting women to access health care and family planning in ways that are comfortable for them, is a model for the new dimensions of ethnicity Ireland now faces, with the increased numbers of asylum seekers over recent years. Women, often on their own, and with very young children, or pregnant, form a significant minority of this asylum group. Research on the needs of minority ethnic women is slowly building up in Ireland; there is a full-length study on the maternity care needs of refugee and asylum-seeking women (Kennedy and Murphy-Lawless, 2002) and there is also a full-length study on poverty and asylum children (Fanning et al. 2001). One of the critical aspects of health care for this vulnerable group of women is that because of the breakdown of civil society, they may have been without adequate formal health care services for sometime. An indication of this adverse impact can be seen in the perinatal mortality rates in Nigeria, from which a majority of asylum-seeking women are coming: there the current rates are 90 perinatal deaths per 1,000 births compared with a figure of lower than 7 per 1,000 for Ireland. One other aspect from this recent research is worth noting, namely that women's cultural practices around health often involve very different patterns of food consumption – with lots of fresh indigenous vegetables -which is not taken into account in the temporary accommodation on offer to them. This has a particular impact on pregnant women and women who have just given birth (Kennedy and Murphy-Lawless, 2002). Women from ethnic minority backgrounds require health care which is accessible and sensitive to diversity.

6.4. Disabilities

Women with disabilities, whether these are physical, mental, or learning disabilities, have special needs in relation to their health and sexual health. Any socio-economic inequalities will have increased impact on their needs and whether and how they can meet them. Women with disabilities may have problems dealing with childcare and parenting. They also report a high incidence of domestic violence. According to the National Disability Authority, three out of four households headed by a disabled person survive on only half the average national wage and unemployment rates amongst these with a disability are as high as 70% (O'Keeffe, 2001). Thus encouraging and sustaining a sense of control in disabled people over their health needs is a priority. In respect of their sexual health, they may rarely have been given an opportunity to discuss their needs (Everett, 2001:278). One of the keenest

problems is that women with disabilities are somehow ‘sanitised, asexual, and degendered’ (Burns, 2000). They also very frequently experience discrimination at primary health care level and within the very institutional support services which should understand their needs. A telling example of this can be their exclusion from sexual health programmes, like cervical screening, on the grounds that they are not sexually active and do not require such services (ibid.). There is a need for far greater research in this area, far more observational studies of how needs are being met or not, and far greater consciousness-raising amongst health care professionals about the levels and standards of care and support being offered to this group of women.

6.5. Physical Activity and Cultural Patterns

Beneficial physical activity is seen as fundamental to good health. Yet there are huge problems here for women in general and in particular for women from lower socio-economic groups. Latest Irish data suggests that women do less physical exercise weekly than men and that women from the lower socio-economic groups do least of all:

Women Doing No Exercise At All in a Week

Age	Social Class	Percentage Reporting
18-34	1-2	8%
18-34	3-4	12%
18-34	5-6	13%
35-54	1-2	9%
35-54	3-4	20%
35-54	5-6	21%
55+	1-2	23%
55+	3-4	23%
55+	5-6	34%

(Department of Health and Children, 1999:74)

The figures for girls are not especially encouraging in respect of future health trends, with older teenage girls beginning to reflect an adult pattern of relative inactivity:

Girls Doing Vigorous Exercise at Least 4 Times per Week

Age	Social Class	Percentage Reporting
9-11	1-2	59%
9-11	3-4	61%
9-11	5-6	56%
12-14	1-3	53%
12-14	3-4	49%
12-14	5-6	47%
15-17	1-2	29%
15-17	3-4	26%
15-17	5-6	24%

(Department of Health and Children, 1999:74)

There are major challenges here in respect of recent trends in consumer culture encouraging a sedentary way of life.

SECTION 7 – RESPONDING TO WOMEN’S MENTAL HEALTH NEEDS

In this section, research on women’s mental health needs is presented in relation to the following issues:

- Women’s Self Esteem and Personal Autonomy
- Body Image and Food
- Responding to Depression and Stress
- Harassment in the Workplace, Including Sexual Harassment
- The Impact of Physical and Sexual Violence on Mental Health
- Sexual and Gender Orientations

7.1. Women’s Self Esteem and Personal Autonomy

In the last decade, several Irish researchers have pointed out that when women in Ireland are limited to full-time home duties, they have consistently indicated less self-fulfilment and self-contentment (O’Connor, 1992; Whelan, et al., 1991; Whelan, 1994):

On each of the items relating to positive psychological experiences, women in full-time unpaid home duties fare worse than other women (Whelan, 1994: 203).

O’Connor (1992; 1998) suggests that in a society where becoming a wife and a mother is still valued as the norm, women may still idealise the love relationships in which they invest so much caring work. As a result the costs of creating and maintaining these caring relationships are underplayed. At the same time, women experience real tensions about this unpaid caring work and about the quantifiable costs involved for them:

Within an increasingly materialistic culture, their work, given its unpaid, nurturant and frequently symbolic nature, is often seen as not having value (O’Connor, 1998:132).

There is a clear relationship between women feeling more distressed and less valued and their having low socio-economic status (Whelan et al., 1991; O’Connor, 1998).

Women in other categories suffering from lack of self-esteem in significant numbers typically include:

- Women with a child under six years of age;
- Women who lack significant personal support from husband/partner and/or close friends.

In the last two decades, there has been an explosion of women’s activism to challenge such patterns of personal and social isolation and to improve personal self-esteem.

Women from more marginalised communities began to organise themselves in the 1980s, in projects to promote personal development, health, education, literacy, skills training and to respond to local community needs including play-schools, childcare, and the safety of the wider community; there were ninety-eight local women's groups by 1989 and by 1992, 480 groups were receiving funding from the Department of Social, Family and Community Affairs (Daly, 1989, 1992). This trend has continued as a very strong dimension of the community sector. O'Connor (1998: 77), English and Murphy-Lawless (2000), and Murphy-Lawless (2002) note that locally-based women's groups have brought about improvements in women's position in their families and within their communities. The investment in this area has clearly borne good results for women.

An important programme which has been fully evaluated for its success is the Community Mothers Programme, in the Mid-Western Health Board. This programme has linked up experienced mothers with more vulnerable women, especially in the period after a baby's birth, on the premise that if the mother is well and confident, her baby will benefit (O'Connor, 1999). As recipients of the service, mothers reported that they felt more secure in themselves and their parenting (ibid.)

7.2. Body Image and Food

Much work in the 1980s and 1990s has explored the complex problem of women, body size and image. Women may have always sought to control their bodies, but in the late twentieth century, the problem appears to have changed in western countries from just the need to be thin, which itself has been a recent phenomenon (Chernin, 1981), to one of total tight control of the female sexual body in order to keep it 'normal', including fitness regimes (Bordo, 1990). Research studies across the United States, Britain and Australia indicate a constant 80% of women, of all ages who are dissatisfied with their body shape and wish to lose weight (Ussher, 2000:17). The pressure on women to be slim may account for EU-wide statistics indicating that underweight to severe underweight affects 15% of women across the European Union, compared with only 5% of men (Eurostat, 2000). According to Eurostat figures, the highest proportion of women who diet regularly are in the 25-34 age group (Eurostat, 2000). But across EU countries, girls as young as 13-15 are the most likely to feel that they should be on a diet: 47% of this age group in Finland and 37%

of girls this age in Ireland report a need to diet (ibid. 63-64). Bartky (1990) has argued that women now feel estranged from their bodies. Dissatisfaction with their bodies and low self-esteem appears for all age groups of women – men are not afflicted to the same extent (Pliner et al., 1990). Yet women experience pressure from men, including their male partners to be thin (Charles and Kerr, 1986). This ‘social pressure to be slim’ (Grogan, 2000) also seems strongly related to perceptions of being successful in work and career, in addition to pressures from heterosexual partners; in small-scale studies, women in lesbian relationships have expressed less dissatisfaction with body size than heterosexual women (Beren et al., 1997). Grogan (2000) sets out the health implications for these disturbed body images for women, identifying four distinct trends:

- Dieting
- Eating disorders
- Cosmetic surgery
- Excessive exercise

The trend to dieting has led to reductions in self-esteem for women as they have dieted and failed to either lose the weight they set out to lose or re-gained it (Charles and Kerr, 1986). Dieting has contributed to many negative health impacts, including hypertension (Brownell and Rodin, 1994) and may also ultimately contribute to a crisis of osteoporosis due to insufficient calcium absorption before the age of 25 in the effort to avoid foods which are seen as ‘fattening’ (Beauregard, 1997:212-213). Eating disorders increasingly affect numbers of girls and young women, and this is seen as related to the media industry (Malson, 2001). This works in two ways: first of all, unnaturally thin young women are used extensively in the entertainment, advertising and public relations industries. On the other hand, anorexia nervosa, bulimia and other eating disorders are increasingly discussed as a topic. However, the dividing line between ‘normal’ young women who report experiencing deep dissatisfaction and rejection of their bodies and anorexic young women can be hard to discern, especially when the popular media project such confused images as ‘heroin chic’ fashion. In 2000, concerns about these confusions led to a UK government conference on the issue, in which the editors of fashion magazines were asked to discontinue using unhealthy thin models. The government considered bringing in a code of practice to encourage the fashion industry to promote clothes for a wider range of body sizes and to ban advertisements using images of ultra-thin women

(Ward, 2000). However, these initial efforts did not result in concrete actions. In 2001, an advertising campaign by Marks and Spencers of an average-sized UK woman, that is Size 16, was dropped after a short period as being unsuccessful.

Cosmetic surgery is a growing trend in affluent Ireland and every weekly and monthly Irish women's magazine now carries advertisements for cosmetic surgery clinics (see for example, *Image Magazine*, December, 2001). Some researchers have argued that it enables women to take charge of their bodies and to do what they feel they want (Davis, 1995). Others argue that this view is too limited and does not address the initial widespread pressures women are under to conform to certain idealised body types which exposes a 'personal' decision as the circumscribed social action it is.

Grogan (2000) sees the trend to exercise as being the one positive health outcome of the now common preoccupation with body image; she argues that exercise leads to a better self-concept and better image of the body, whatever about the physiological benefits of having exercise on a regular basis.

7.3. Responding to Depression and Stress

In Section 2.3.3. and in this section above, mention has already been made of depression. This condition appears to afflict women more than men in a ratio of at least two to one. Women are thought to run a 10% to 25% lifetime chance of developing depression (Graham-Jones and Duxbury, 1997). Cleary (1997b) in her work reports one-fifth of all women in an urban working-class sample experiencing clinical depression and more than half her sample receiving medical help for depression or anxiety at some point in their lives.

Doyal (1995) comments that depression in women has too often been seen within the medical profession as something either intrinsic to female psychology, female biology, female reproduction, or specifically to hormonal disturbance. But it is strongly argued that women's depression is a reaction to unendurable burdens in their lives, especially where there are problems of poverty and isolation (Byrne, 1991). Some of the work discussed above in this section on self-esteem makes it clear that for many thousands of women, their difficult and unsupported circumstances result in episodes of depression and anxiety.

Biological and psychological theories of women's depression are still part of the dominant approaches to dealing with depression (Stoppard, 2000). But they have now been joined by social theories which permit some of women's difficult daily realities to be explored. Stoppard (ibid.) is critical of the mainstream thinking for the following reasons:

- The medical-psychiatric concept of depression as a disorder defines it as having certain symptoms, but this is the experts' version of depression and not women's accounts
- Mainstream thinking encourages treatment strategies which are too restricted
- This approach rarely permits women to define their own circumstances as their knowledge is considered too 'subjective'
- The knowledge of these disciplines lacks both social context and a full appreciation of the complexity of gender and gender roles.

(ibid.: 408-409)

Stoppard argues that women's depression must be understood in terms of both the material conditions of women's lives and the gendered nature of everyday activities that underpins women's perceptions of how they ought to be living their lives. The emphasis on women as natural carers, for example, can create real conflict for women, as noted above.

Stress at work and managing the work/home interface can also be a significant factor implicating depression in women (Lawthorn, 2000). The research on paid work indicates that their 'psychosocial status' in relation to workplace demands has a significant bearing on women's health (ibid.). A 1998 study on occupational stress in the UK covering 1,000 civil servants found that women reported much higher levels of job dissatisfaction, and poorer mental and physical health; women were also more concerned about their work roles and the constraints under which they were trying to perform (Bogg and Cooper, 1998). The most important predictors for depression in the workplace are high psychological demands combined with low built-in scope for decision-making capacity and low support in the workplace (Amick et al., 1998).

Counselling and therapy for women suffering from depression and/or the use of antidepressants are important interventions. But they have to be used in a framework that recognises the complexity of the dilemmas women face about their roles and lives. In respect of workplace interventions, learning from woman to woman in a

protected structured atmosphere has enabled women to think critically about their situations and to build better physical and mental health (Hunt, 1998).

7.4. Harassment in the Workplace, Including Sexual Harassment

As women's employment patterns have changed in Ireland over the last two decades, a new mental health hazard has emerged, that of harassment in the workplace. In Ireland, there is an increasing focus on bullying and harassment in the workplace. In 1998, a study for the European Foundation for the Improvement of Living and Working Conditions found that 9% of employees had been subjected to workplace intimidation. Ten per cent of women have reported intimidation, according to the Impact Trade Union (Yeates, 2001). The government Task Force on Workplace Bullying found only 15% per cent of victims of bullying had raised the issue with their union, even though 30% per cent of bullying victims knew that their unions were willing to offer help and advice.

Under the Sexual Harassment Act, 1998, the Employment Equality Act, 1998 and the Equal Status Act 2000, harassment and sexual harassment are prohibited in the workplace or in the course of employment. Harassment is defined as 'where the person subjects a victim to any unwelcome act, request or conduct which is based on any discriminatory ground and which could reasonably be regarded as offensive humiliating, or intimidating to the victim'. Under the Employment Equality Act 1998, sexual harassment is defined as 'unwanted physical intimacy, requests for sexual favours, spoken words and gestures and the display or circulation of written words, pictures or other materials in the workplace.' It can also include 'persistent, unwanted attention that is sex-based and continues after the person receiving it makes it clear that they want it to stop.'

For women, sexual harassment remains a continuing serious issue. It first received attention from the women's movement in the 1970s and 1980s and then subsequently received mainstream attention from state governments around the world as it became clear that there was a need for legislation. Researchers have seen sexual harassment as a way for men to exercise power over women (Wise and Stanley, 1987). In Britain, 50% of women have reported sexual harassment at work (Industrial Society, 1993).

The strain of coping with ongoing harassment can provoke both physical and psychological stress (Gutek and Koss, 1993; Thomas, 2000).

Under Irish legislation, employers are responsible for sexual harassment and harassment perpetrated in the course of their employment unless the employer took reasonable steps to prevent the harassment from occurring. Clear regulations and guidelines are responsibilities of employers. Additionally, to deal with stress and general harassment in the workplace, communications training, stress management, and personal development and self-care seminars and workshops comprise practical steps employers can take to help support their employees. The constituent health boards in the Eastern Regional Health Authority and the North Eastern Health Boards have begun to work on the provision of such workshops for their employees.

7.5. The Impact of Physical and Sexual Violence on Mental Health

In Section 2.3.3. above, it was pointed out that domestic violence results in women going to health care services for treatment. The prevalence of physical and psychological violence against women remains a serious international issue; prevalence studies across the EU indicate that a substantial minority of women have experienced physical violence from their partners or husbands (European Women's Lobby, 1999; Murphy-Lawless, 2001). This remains a woman-predominant problem, with 5% of men experiencing domestic violence. It is overwhelmingly women who come into doctors' surgeries and A and E wards with the visible consequences of violence and who seek barring orders on the grounds of violence. Refuges in Ireland that run telephone helplines do have some male callers, but the vast majority are women. In 2001, the Eastern Regional Planning Committee on Violence against Women announced that:

- Dublin refuges were availed of by 2,060 women and children in 1999 alone, with 1,104 being turned away for lack of space
- Three-quarters of all women in refuges brought children with them
- Half of all women who left a refuge returned to their abusive partner in the home with no safeguards to protect them from further violence

Domestic violence has long-term direct and indirect effects (Lees, 2000). Lowered self-esteem and self-confidence are two of the mental effects of physical violence, which can also precipitate serious depression. Women suffer fear and a sense of powerlessness in situations of domestic violence; they can feel that there is no way

out of a situation of powerlessness and that services are unsupportive (Kelleher, 2001; Murphy-Lawless, 2001). Improved social and legal responses, improved practical support services, training for health care professionals and long-term counselling for a woman are some of the measures which are beginning to make a difference (British Medical Association, 1998; England and Wales, Cabinet Office/Home Office, 1999; Murphy-Lawless, 2001). But this is a long-term and systemic social problem. Here in Ireland, our health and social services are beginning to build in programmes which have been positively evaluated for their effectiveness elsewhere (Kelleher, 2001).

Sexual violence is also a long-term systemic social problem that leaves terrible scars. The research indicates that between 30% to 50% of women have physical trauma as a result of rape; 15% have significant vaginal tears (Russo et al., 2000). Injuries to other parts of the body outside the genital area are also common (ibid.). Sexually transmitted diseases can further harm women's long-term physical health. The huge range of psychological and emotional traumas that women experience are well-documented as is the fact that women require extensive, effective and sensitive ongoing counselling support in addition to responsive emergency, police and legal services. As with domestic violence, it is important to note that it is women's activism which has made this an issue for national governments and international bodies. Many of the original emergency support services like telephone helplines, crisis centres and refuges arose as a result of women's local activism and commitment.

7.6. Sexual and Gender Orientations

This is a rapidly changing field in relation to women's health and challenges conventional definitions about women. Lesbian, bisexual and transsexual identities have created new challenges in the field of women's health.

The physical health needs of lesbian women have begun to be recognised as deserving special and sensitive attention (Boston Women's Health Collective, 1998). But it is also argued that lesbian women have special mental health needs and support structures. In one sense, young lesbian women have many of the same concerns that affect young heterosexual women. But the outsize experiences of discrimination, rejection and verbal and physical violence also lead to a higher risk rating for mental health problems (Mooney-Somers and Ussher, 2000). Research from the United

States indicates that very nearly half of all young lesbian women have experienced verbal threats and almost one-fifth have experienced direct physical attacks (Herschberger and D'Augelli, 1995). Social rejection and social isolation are common experiences according to UK research (Mooney-Somers and Ussher, 2000) and lead in turn to depression and negative self-image. Thus the trying out of sex and sexual experience which is a central part of young women's sexuality and which can lead to a sense of confidence and empowerment is made more difficult (ibid.). Mooney-Somers and Ussher (ibid.) argue that it is critical for health care professionals to take seriously the experiences of discrimination and their ill-effects suffered by lesbian women and to prioritise support services. Much of this also relates to the needs of bisexual women also. Here in Ireland, the work of groups like LOT have drawn attention to these and similar dimensions of need.

Trans-sexualism presents a very different order of concern – all the issues listed above, of isolation and consequent depression, the need for good support structures and so on, are relevant. But because trans-sexualism has really come of age with the current sophisticated pharmacological and medical technologies to help people change their sex, we are in new arenas (Newman, 2000). One of the core problems is that trans-sexualism is considered a psychiatric disorder (Lewis, 1995) and that caregivers who refer people for treatment must conform to assessment and diagnostic standards laid down by national health authorities or international clinical schedules such as those contained in the *Diagnostic Skills Manual* which is part of international psychiatric medicine, where transsexual problems are referred to as 'gender identity disorders'. This is in spite of the fact that cross-cultural studies reveal a huge variability about appropriate sex and gender roles and behaviour.

Newman (2000) argues that for those people who seek out surgery and are turned down for it on the basis of unmet criteria, health care givers should endeavour to continue to offer support, including other ways to express their subjectively-experienced gender identities.

SECTION 8 - WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH NEEDS

Research on critical aspects sexual and reproductive lives is presented here, concentrating on the following issues:

- Sexual Health
- Menstrual Cycle Problems
- Contraception and Unwanted Pregnancy
- Impact of Pregnancy, Birth and the Postpartum Period
- Infertility, Miscarriage, Stillbirth and Hysterectomy
- Incontinence

8.1. Sexual Health

The World Health Organisation sees sexual health as part of overall physical and mental health and defines sexual health as

'The integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are enriching and that enhance personality, communication, and love.'

This wide concept takes us well beyond the provision of information and services to build sexual health. It also gives us the context and objectives which these services should aim to fulfil – it means that services should respond to the needs of each and every woman. The context of services responding to women's sexual health needs in Ireland is one that has only changed and taken a contemporary shape under pressure from women, women as individuals and women as members and leaders of broader social campaigns. That context continues to change and to be open to question. Older and usually male-dominant thinking about women's sexuality, reflected in laws that constrained women as sexual beings have been challenged and overthrown; for example, laws restricting access to contraception, which was finally made available to every woman in the early 1990s, no matter what her age or status (Murphy-Lawless, 1993). Changing theories of sexuality have led to expanded thinking on many fronts so that, for example, the sexual health needs of women after breast cancer surgery or gynaecological surgery or those of older postmenopausal women or those of lesbian women can now, in theory, all be discussed openly.

Current overviews (Nelson, 2001; Smith, 2000) argue that that it is crucial that women now have the power to be active agents and to decide and define their own sexuality and what gives them satisfaction. In the past, medicine has defined

women's needs for them. For example, women in their 50s were given unnecessary hysterectomies because of the rationale that removal was better if women were no longer able to bear children. This is no longer the case. Perhaps the single most revolutionary aspect of changing sexual attitudes is the fact that sex and reproduction are no longer tied together (Smith, 2000).

In practice, however, every single aspect of our sexual being and functioning is hedged about with complex beliefs, emotions and expectations, both ours and others. Nelson (ibid.) argues that this personal and social complexity contributes to making even what appears a 'simple decision' like going on the contraceptive pill, one that is laden with personal, social and cultural values. Even the statement of being sexually active or of having sexual needs still arouses contradictory and ambiguous reactions. And despite the freedom of action that is now part of most young women's expectations as they come of age sexually, problems of sexual activity and risk have an increasing focus in the arena of sexual health (Smith, 2000). Some of these will be covered in this section; others will be discussed in Section 10 below.

8.2. Menstrual Cycle Problems

Menstrual problems remain amongst the most common conditions seen by GPs (Scambler and Scambler, 1993). These include irregularities like amenorrhoea, dysmenorrhoea and menorrhagia (Nelson, 2001). All disturbances have to be treated with the utmost sensitivity around a woman's history and current circumstances. If there are no clear pathological explanations, other explanations may emerge. For example, amenorrhoea may come about as a result of extreme stress, eating disorders, or very strenuous exercise.

The most common and controversial aspect of menstrual problems is PMS or premenstrual syndrome. It is difficult to find a definition that is wide enough to take in the breadth of experiences that women self-report about PMS. Over 150 different symptoms have been noted in the research literature on PMS (Nelson, 2001). At the same time, women need to protect themselves from having PMS labelled as a psychiatric illness (Oakley, 1993:14). PMS is listed in the *Diagnostic Skills Manual*, the international classification of psychiatric illness as a pathological condition and has been argued as a twentieth century one (Reilly, 2000). And yet Hippocrates

offered a description of PMS in 460 BC that does not pathologise it: ‘ “women are subjected to intermittent ‘agitations’ and ‘shivering, lassitude and heaviness of the head [which] denote the onset of menstruation” ’ (quoted in Andrews, 2001:399).

The empirical research has been ‘confusing’; researchers have often set out to prove a range of theories, including whether the condition is ‘real’ or not; part of an inherent female instability; and whether or not pharmacological or non-pharmacological treatment is the best course of action (Reilly, 2000). Psychological, endocrine, social and environmental theories have all been investigated to account for the wide variation of physical, behavioural and psychological symptoms. None has proved to entirely explanatory or relevant (Andrews, 2001). Much feminist research has tried to argue that PMS is in the range of the normal for menstrual cycles and that any attempt to pathologise it further disadvantages women (ibid.). Recent efforts to carry out research on PMS based on women’s own accounts of their experiences probably makes most sense in trying to develop a woman-centred approach to treatment and advice for use by health care professionals. And some women, between 5 and 15%, actually report feeling better during the premenstrual period in terms of wellbeing, physical and sexual energy (Logue and Moos, 1988). What has been recognised is a high placebo response rate, more so with psychological than with physiological measures (Andrews, 2001). A sensitive listening ear, reassurance, self-help measures like stress management techniques, dietary adjustments like eating regularly and avoiding an excess of caffeine, and alternative therapies may all have a role to play (ibid.). A Menstrual Distress Questionnaire, helping women to document their symptoms may also be helpful (ibid.).

8.3. Contraception and Unwanted Pregnancy

The use and availability of contraception in Ireland have been transformed from the 1980s to the 1990s. Even so, overall usage and availability are still limited: 31% of Irish women who are sexually active were still using no formal method of contraception at all, according to an extensive ESRI survey in the mid-1990s (Wiley and Merriman, 1996); the survey also indicated that only half of sexually active women considered that family planning advice was easily available; women in rural areas were most subject to very limited access (Wiley and Merriman, 1996). The government-sponsored study on women and abortion, on the basis of its findings,

recommended amongst other proposals that the morning-after pill be available over the counter (Mahon, et al., 1998).

Emergency hormonal contraceptives have been available over the counter in the UK since the beginning of January, 2001. In a move to bring down unwanted pregnancies and increase available sources of contraception, Levonelle was removed from prescription-only control for 15,000 pharmacists; Boots said it would be available in all its shops (Moore, 2001). Levonelle is known to prevent 95% of expected pregnancies if taken within 24 hours, but less than 60% if taken within 48-72 hours.

Availability is not the only problem in helping women to safe effective contraception of their choice. The range of hormonal contraceptives, while remaining the single most efficient route for handling an active sexual life for women, does not resolve the increasing problem of STD transmission (see also Section 10). While condoms offer protection to women from the latter, the difficulty remains of educating men to their responsibilities in this, especially where women remain in an unequal position of power in respect of contraception (Smith, 2000). The most detailed qualitative study we have in Ireland on women and contraception indicates that even in relatively stable relationships, women of all ages across the childbearing spectrum still have difficulties with this topic (Hyde, 1996). However, it appears that within marriage women generally have the main influence on decision-making about the choice of contraceptive (Alder, 2000).

Women need to know that their choice of contraceptive, however hedged by their social realities, can have an impact on their health; STDs present but one issue. Hormonal contraception can have many benefits for women, especially those with menstrual problems. There are both positive and negative psychological outcomes: women find the freedom from worry about pregnancy an essential part of their sexual lives, but studies have also reported guilt and doubt for women about this freedom and delaying pregnancy – often because there are other aspects of their lives which are unsatisfactory (Alder, 2000; Everett, 2001). It then becomes the task of the health care professional to be very sensitive to what a woman is saying to her about her contraceptive, sexual and psychological health (Everett, 2001).

Since the introduction of the female condom in 1992, there has been little new research on female contraception, with work mostly concentrating on dealing with further reducing the side-effects of hormonal contraceptives. New information is emerging however about the menstrual and ovulatory cycle. For example, the information on the safe period has now been found to be inaccurate. Up-to-date use of the measurement of urinary metabolites to determine oestrogen and progesterone done over 696 menstrual cycles has indicated that the 'safe period' is much more variable than women have been led to believe in the past. The old information was that from day 10 to day 17, was the fertile period, with ovulation occurring around day 14. New tests indicate this holds in only 30% of women. The great majority of women reach the 'fertile window' either before day 10 or after day 17. So the timing of the 'fertile window' is unpredictable rather than predictable (Wilcox et al. 2000).

In this context the problem of unwanted pregnancy continues to be politically extremely controversial in Ireland. In the wake of government green and white papers on this issue, the Department of Health and Children has set up the Crisis Pregnancy Agency. The agency has three objectives:

- To work through education and other programmes to reduce crisis pregnancies
- To work with women having crisis pregnancies, to offer them options in Ireland
- To develop supports for women who have had an abortion.

Prevention, campaigning and education will be part of the agency's remit.

This government move came in the wake of the latest statistics on Irish women and abortions in the UK (McNally, 2001). These indicate that figures for Irish women having abortions in Britain in the second quarter of 2001 were the highest on record, and were due to pass 7,000 per annum for 2001; the figures passed 5,000 per annum in 1997, and 6,000 in 1999. The figure for 2000 was 6,381 (ibid.).

8.4. Impact of Pregnancy, Birth and the Postpartum Period

The last two decades have seen an unprecedented series of studies and critiques about childbirth coming from women researchers who argue that as birth has become ever safer, with women having better health in general, it has also become an ever more medicalised process (Oakley, 1993; Murphy-Lawless, 1998). In brief, the factors which have made birth safer comprise:

- The marked improvement in women's general health profiles, including far better nutrition;
- Control over their fertility for women with access to reliable and safe contraception, reducing prolonged childbearing with its threat of ill-health.
- Antibiotics to control post-birth infections.
- Pharmacological and technological improvements in emergency obstetric procedures – administration of oxytocic drugs for haemorrhage; blood transfusion and safer emergency Caesarean section because of asepsis, antisepsis and changes in surgical techniques like the lower segment operation; these latter developments helped for the better, anywhere from 5% to 15% of women giving birth.

Perinatal mortality rates have also dropped dramatically. But with the exception of pre-term infants and a range of serious congenital abnormalities, which once would have proved fatal, the drop in perinatal mortality rates, like the drop in maternal mortality, is largely about social and economic factors. In a WHO study of perinatal practices across the European region of the Organisation, there was as much as a fourfold variation between countries on the rates of intervention during labour, yet there was no proven correlation between higher rates of intervention and improved pregnancy and birth outcomes (Wagner, 1994). Another aspect of perinatal mortality is worth noting. Although the overall rates have dropped, the intervals between the highest and the lowest socio-economic classes have remained almost unchanged. In other words, a baby born to a woman in a higher professional social grouping has at least a fourfold better chance of survival after birth than the baby born to the woman in the lowest socio-economic class. Poverty still kills.

Especially marked in Ireland has been the growth of consultant-led care, with the vast majority of births taking place in consultant units. This in turn has led to the widespread application of the system known as active management of labour, strongly associated with the National Maternity Hospital since the 1970s, but used throughout Ireland. Under active management, 50% to 70% of first-time mothers in Ireland have their labours accelerated with artificial oxytocic drugs, while up to a further 25% of women have their labours similarly induced. Caesarean section rates have increased to over 18% nationally (Cuidiú, 1999). A tiny fraction of births, 0.4%, are domiciliary, assisted by a small number of independent midwives. Over 50% of women attend obstetricians for private antenatal care. The deep disaffection of Irish midwives with this system has led to a critical hospital shortage as many have left the profession (Begley, 1997; O'Connor, 2002). To counter problems with this medical model of

birth, the 1998 Commission on Nursing recommended direct entry midwifery training and pilot home birth schemes, both of which are currently under evaluation.

The research remains clear that adequate support for women during pregnancy, labour and after the birth, and control over the birth process is critically important to women's psychological outcomes and to their mothering (Aston, 2001; Weaver, 2000). However, both the medicalisation of pregnancy and birth and the ambivalent social support for women as mothers continue to impact on women's well-being, especially as they increasingly try to combine paid work, pregnancy and motherhood (Benn, 1999; Gross and Pattison, 1997). Recent evidence in Ireland, contained in a study for the Employment Equality Agency, that women were not reporting their real due dates to employers in order to have as much maternity leave as possible after the baby's birth (Murphy-Lawless et al. 1999; Murphy-Lawless, 2000), helped to bring the Irish government in line with that of the UK and offer an additional four weeks paid maternity leave.

What women actually want in childbirth is not so clear however. It has been argued recently that the high rates of epidurals and Caesarean sections in Ireland represent a coping strategy on the part of women who now see little alternative to mechanised birth, not least because they no longer have confidence that they can labour well in an unhurried and protected atmosphere of support.

Support for that view has arisen in a series of unexpected developments in the Northeastern Health Board. The Condon Report (2000) had recommended, inter alia, the closure of maternity units in Monaghan and Dundalk. This led to a storm of local protest. As a result of that local protest, a second review group was convened in 2001. This second review group consulted widely in the NEHB region and concluded that midwife-led care should be the normal standard of care available locally in Monaghan, Dundalk, and Navan. Midwifery-led care, now being introduced on a pilot basis in the NEHB, will permit the development of community midwifery and, it is thought, greater access to home births. The review group has also recommended the setting up of a consumer committee on maternity and childcare services (Maternity Services Review Group, 2001). These developments taken together with the direct entry midwifery scheme and the pilot home births schemes could begin to bring

childbirth services in Ireland closer to establishing women-centred care. Kennedy (2002) argues that the maternity period must be redefined in Ireland to extend from the beginning of pregnancy to the end of the first year of a child's life. This is a framework within which health and social policies could be built to fully support women in their treble roles as earners, carers and lifegivers.

8.5. Infertility, Miscarriage, Stillbirth and Hysterectomy

The women's movement has worked to advance the notion that women are competent and rounded people in many spheres of life, and not just as childbearers. Yet infertility, a failed pregnancy, stillbirth and the experience of hysterectomy are still crushing experiences for women with huge consequences for their psychological health.

Infertility is thought to affect from 15% to 19% of women in developed societies, with perhaps a quarter of these cases linked to male problems. One in four of all pregnancies is thought to end in miscarriage. Although perinatal mortality rates are dropping in every developed country, the deaths of very premature babies and stillbirths remain an issue for women, an issue that will never go away entirely. All of these experiences pose a crisis for women and an acute sense of failure and bereavement for a way of life and a role as mother which has become temporarily or perhaps even permanently unattainable. Depression is commonplace and there are many difficulties for women in these situations, including that of re-establishing a loving relationship with their partners (Mander, 1994). More Irish hospitals have attempted to build in support procedures and pastoral care for women in respect of miscarriage and stillbirth, as it has become increasingly evident how crucial this can be for women and their partners. Some hospitals have special bereavement clinics for women (Cuidiú, 1999). But with the current critical shortage of midwives, and hospitals relying on agency staff, it is inevitable that staff will be pressured in terms of immediate and long-term support structures.

The dominant biomedical perspective on hysterectomy is still to see the uterus as a removable part of a reproductive body that has become less useful and potentially more pathological (Dell, 2000). It is the most common major surgery performed on women in Europe, the United States and Australia, with incidences ranging from 20% to 33%; 70,000 alone are performed in the UK every year (Hawe et al., 1999; Greer,

1999). There are two aspects to the increase in surgery. The first is the problem of how hysterectomy may be used inappropriately as a first-line treatment for gynaecological problems before other solutions or lines of treatment have been fully investigated. The second is that many women may feel free to choose the treatment because they are less inclined to live with difficulties and want to take advantage of improved surgical techniques (Dell, 2000). The clue seems to be how much information, control, support and counselling women can command in undergoing this surgery. One of the most important aspects of this is to ensure that women of reproductive age fully understand the incidence and consequences of early menopause and other such changes (Kinnick and Leners, 1995). The removal of the uterus can severely impact on a woman's understanding of her femininity and fear is a not uncommon reaction to this surgery (Dell, 2000; Lee and Rider, 2001).

Hysterectomy support groups are widespread in the UK.

8.6. Incontinence

Sutherland (2001: 268) summarises the facts about urinary incontinence in women:

- It is not a normal part of the ageing process
- It is not an inevitable outcome of childbirth
- It can curtail physical activity
- It can affect sexual and social relationships
- It is usually kept a secret

Prevalence is thought to range from 14% of women, to 25% - when mild incontinence is included- with incidences increasing with age and for those women in long-stay hospitals and institutions (ibid.; Dolman, 2001). But this increasing incidence is also about women's location, about control over their circumstances and about the freedom or not to communicate successfully about a topic which causes embarrassment; women frequently feel that they have lost their femininity and sexuality when they experience incontinence (Dolman, 2001). Although there are many approaches to treatment and help possible (Sapsford, 1997; Sutherland, 2001), these depend on informing and encouraging women to seek early treatment (Dolman, 2001). But Dolman (ibid.:478) also makes the point that because the subject is a taboo one, most women suffer in silent shame, even though 85% of women can be treated if symptoms are caught in the early stage. She recommends that every chance is taken in the course of health care and health education to 'open up lines of communication about pelvic floor function' (ibid.).

SECTION 9 – OLDER WOMEN’S HEALTH NEEDS

Many core health needs for older women also differ from those of men to the point of needing a gender-specific strategy which is sensitive to women’s requirements.

Research will be presented on the following:

- Approaches to Menopause - Signs and Psychosocial Factors
- Osteoporosis

9.1. Growing Older – the Context for Women

The context of growing older has changed considerably in Ireland. Edmondson (1997:156, 165) argues that as Ireland changed from a largely agrarian society in the mid-to-late twentieth century, older people were converted from people with status and power to employees who lose power on retirement. Now, in the context of a youth-oriented, work-oriented society, the process of growing older, even with the buffer of a pension, can feel like being cut off from the mainstream. There are sharp differences in living standards for older people in different occupational classes and living standards (Fahey and Murray, 1994). Geography also makes a difference. Almost 25% of older people living alone in rural areas, do not own cars and have no access to public transport (Fahey and Murray, 1994: 17, 171). This is not a problem of ageing as such, but it makes everything harder, including of course access to health care.

Four-fifths of older women in Ireland never go out for a drink (ibid.: 82). This points to the issue of relative social isolation. The problem of isolation for older rural women is especially acute (Byrne, 1992). The numbers of older women living on their own will increase as marriage breakdown, separation and divorce are added to experiences of widowhood. This will bring older Irish women closer to mainstream European patterns. A key aspect of older women alone is their financial vulnerability. Work done by the ESRI on poverty lines over the last decade has indicated the greater risk of living in poverty experienced by those in their mid-60s onwards. The situation is even harder for women who, if they have worked in paid employment, will not have worked as long as men (having taken time out from work to have children and carry out unpaid family caring) and will have been subject to wage differentials that continue to see women being paid less than men (O’Connor, 1998; Ruane and Sutherland, 1999). Thus they will this have smaller pension entitlements. Those

women who have worked only in the home are even worse off. This is a European-wide problem, as the European Women's Lobby has commented:

'Part-time work may provide a sufficient income while being in the labour force, but pension and social security rights are very often linked to the income and /or length of employment. Therefore women are more likely to become poor when reaching pension age... older women ...have no or little pension rights in many countries'

European Women's Lobby (1999:15;17).

Poverty affects the ability of women to fulfil core needs such as good quality foodstuffs, levels of heating and so on. The European Institute of Women's Health (1996) has pointed out the impact of sub-standard housing as part of this pattern of multiple deprivation which has physical and psychological consequences for women.

Women who do unpaid caring work for older partners/husbands or elderly relatives continue to do this work in their older years and it does impact on their quality of life (Byrne et al., 1995). The pattern of more common chronic illness for older women has already been mentioned in Section 2 above.

9.2. Growing Older as a Positive Experience

However, Edmondson (1997:157) argues that conceptions of ageing are currently in flux as ageing itself changes: 'it is developing differently with different changes throughout the life-course'. This is not a static homogenous group, she argues, nor is increasing age now automatically equated with poorer health. Edmondson suggests that an empowerment model of ageing could lead to individual and creative approaches to later years. O'Loughlin (1999) points out the important shift in health policy towards older people as participants in their health needs and health care that first appeared in the then Department of Health's *Shaping a Healthier Future* (1994). This perspective was subsequently reinforced by the focus on healthy ageing for older women in the *Plan for Women's Health*, where the commitment was to enable older women to maintain an active and healthy lifestyle for as long a period as possible. With a demographic profile that suggests an absolute increase in the 'old elderly', especially women (Fahey, 1995), the importance of this policy of active participation is the potential cost savings on health expenditure to deal with chronic incapacitating illness. The cost of care is why O'Loughlin suggests that Fries' theory of 'compression of morbidity', where ill-health leading to death becomes progressively

contained to only the last few months of life, has great appeal to policymakers (O'Loughlin, 1999; Fries, 1980).

The women's movement has been firmly behind the effort to encourage women to see growing older as a positive experience and to help them to displace the images of ageing that appear to evoke 'aversion and disgust' in a contemporary youth-oriented society (Featherstone and Hepworth, 1990:273). Leonard and Burns (2000) comment on the paradox that despite the ranges of physical difficulties and long-term chronic disabilities faced by older women in developed countries, they consistently self-report in national surveys as having very good, good or at least satisfactory health; an important variable appears to be an independent non-institutionalised way of life. The medical model with an assumption of a 'rise and fall' pattern to the lifespan does not match up with women's lived experiences of 'high energy and good health' until terminal illness sets in (ibid; Onyx, 1999). There are huge tensions between these two perceptions and it is likely that the medical profession sees ageing as undesirable (reflecting current societal values) and therefore a site for intervention to prevent that happening through further medicalisation. A more appropriate model would be a life-course or lifespan model of development which values all stages of a person's life (ibid.) and which 'captures the dynamic and changing nature of women's health' (Greene, 2000). Thus what can be construed in one model as loss – the loss of fertility, children leaving home, cessation of employment, the loss of a husband – can also be sources of change that impart new and different energies to women (Gergen, 1990). In Leonard and Burns' study (2000), 89% of women in their sixties self-reported their health as being good. Interestingly, these were women on low incomes, many with health problems, but who continued to frame their lives as important and to identify 'turning points' involving psychological self-work that enabled them to make changes, even small ones, in the ways that they lived.

So, the challenge becomes how health and community care services can effectively support the 30% of women in their older years who are feeling vulnerable, anxious and depressed (Goudie and Richards, 1993), while encouraging the majority of women to seek continuing personal development and to keep living well in their own terms.

9.3. Approaches to Menopause - Signs and Psychosocial Factors

The medical approach that menopause is a problem is one of the prime points of tension between medicine and the women's movement. Is menopause to be seen as a normal life transition or as one requiring ongoing medical attention and hormonal support? In many cultures, it is viewed as a positive experience and not as an oestrogen-deficiency disease (Oakley, 1993:200). Emily Martin (1987) argues that in western societies, where women most often have subordinate positions to men, the embarrassment of hot flushes may be more due to what is deemed as an inappropriate out-of-control female bodily function. This is a serious issue, especially in the United States where women in their 40s are often urged by medical practitioners to begin hormonal treatment before they are even peri-menopausal and where Premarin, a brand of commercially produced oestrogen, is the number one selling drug in the country (Boston Women's Health Collective, 1998:554).¹³

Menstrual problems, severe PMS, flooding, hot flushes, night sweats and sleeplessness are the common classic signs of the onset of menopause. But it is important to note that this is the norm in western societies only, where up to 80% of women report some or all of these symptoms (Lock, 1991). In Japanese and other southeast Asian societies, the percentages of women reporting this are as low as 5-10% (Lock, 1991; Boulet et al., 1994). Randomised controlled trials on Hormone Replacement Therapy indicate that it can give relief to these signs (Speroff, 1993), but the research literature also notes that there is a strong placebo response, especially in relation to hot flushes (Abernathy, 2001:427). And in light of the findings of the Women's Health Initiative discussed in Section 4.1.3. above, practitioners are being encouraged to review their prescribing practices for HRT. Alternative approaches and therapies such as natural progesterone crème and evening primrose oil have received significant attention in the last several years. The use of phytoestrogens, present in the diets of women from Japan and other southeast Asian countries, to relieve menopausal symptoms are currently subject to a meta-analysis of randomised controlled trials in the Cochrane systematic reviews (Lethaby, A. et al., 2001).

It is most important that a woman can seek help on the basis of her own individual circumstances and that she can rely on health care professionals to listen to her particular circumstances. She needs to be presented with all the relevant information

on the risks and side-effects of various approaches to dealing with the menopause (Abernathy, 2001), rather than having a health care professional trying to fit her experiences into an identikit of menopause.

9.4. Osteoporosis

Osteoporosis is a growing affliction for older women; the size of the problem is also a measure of the larger number of women living into their elder years. The incidence is greater for white women than women from African ethnic backgrounds and greatest of all in Asian women (Abernathy, 2001). The first decade after menopause shows the fastest decline in bone mass, after which the rate of loss slows down (ibid.).

Osteoporotic fractures are common – 40 to 50% of all women will experience this (Ellerington and Stevenson, 1993). HRT is now widely prescribed to deal with osteoporosis and protects against fractures in hip, wrist and spine (Abernathy, 2001). Although lack of physical activity and long periods of immobility contribute to a loss of bone density, how far the opposite holds true – increasing physical activity, especially weight-bearing activity to help slow down bone loss - is not known with precision at present. Nevertheless, mobility and weight-bearing exercise are crucial preventative measures for women in their older years.

SECTION 10 – YOUNGER WOMEN AND EMERGING HEALTH TRENDS

Strategies to build younger women's health must be alert to rapidly changing contexts. For example, the Human Papilloma Virus, which is thought to be associated with cervical cancer, is now the commonest sexually transmitted disease in the United States. Changes like these have implications for teaching and awareness programmes for young women who are about to become sexually active. Young women's involvement with potentially risky activities such as recreational drug use also needs to be understood within their terms of reference.

Research is presented on the following issues, concentrating on how young women themselves see these issues:

- Recreational Drug Use
- Women and Alcohol
- Women and Smoking
- HIV and Other Sexually Transmitted Diseases
- Teenage Pregnancy

10.1. Recreational Drug Use

Recreational drug use is well on its way to becoming normalised in Ireland. In a context where alcohol use amongst young people has been steadily increasing, recreational drug use no longer carries any particular opprobrium. A number of recent studies in Ireland indicate the widespread availability and relative cheapness of recreational drugs, including amphetamines, cannabis and Ecstasy (Bisset, 1997; Hibell et al., 1997; O'Keeffe, 1998; Mayock, 2000). The ESPAD study (Hibell et al., 1997) recorded that 37% of Irish students had tried cannabis compared with a European average of 12%. The authors also commented that 54% of young Irish people perceived Ecstasy as being easy to fairly easy to obtain; amphetamines were also reported as being easy to access, while cannabis was reported as the first drug experienced by 33% of respondents.

However, those actually presenting for treatment represent a small minority of those who are now using non-opiate drugs. In other words, young people are using non-opiates either occasionally or long-term without seeing their use as problematic. This pattern creates a considerable challenge for prevention and education strategies.

The engagement of girls and young women in the dance and night club cultures with which recreational drug use is interwoven is very different to the youth culture of two decades ago. Young women are now active participants, and are not dependent on young men to facilitate their involvement in the club scene (Henderson, 1997).

Moreover, they are managing and making decisions about the known risks they are taking in using Ecstasy: young women are used to arranging themselves to buy their drugs from regular suppliers

- The need for hydration
- Taking a break and cooling down
- Having a rest time the following day to come down from the drug
- Knowing how not to mix alcohol with the drug so as to minimise dehydration (Pini, 2000).

What young women need in respect of their drug use is best up-to-the minute advice on harm reduction in order to have as safe a lifestyle as possible.

10.2. Women and Alcohol

The National Health and Lifestyle Survey has indicated that self-reported overuse of alcohol, that is, more than the recommended limits of alcohol each week, ranges from 22% to 34% of adult women, aged 18-34 years (Department of Health and Children, 1999:82). By social class the over-consumption figures for women (that is, more than 14 units per week) in this age group are:

- Social Class 1-2 27%
- Social Class 3-4 34%
- Social Class 5-6 22%

(ibid.)

The figures on the percentages of girls under the age of 18 who reported having an alcoholic drink in the previous month before the survey was conducted are:

Alcohol Consumption amongst Girls Under 18

Age	Social Class	Percentage Reporting
9-11	1-2	7%
9-11	3-4	2%
9-11	5-6	4%
12-14	1-4	13%
12-14	3-4	16%
12-14	5-6	19%
15-17	1-2	49%
15-17	3-4	50%
15-17	5-6	52%

(ibid.)

Ultimately these rates of over-consumption, if continued, will mean higher rates of liver damage, including liver cancer for women. Women are more vulnerable to liver damage than men because they have more fat and less water in their bodies and hence produce a higher blood-alcohol level than men because there is less water in which to distribute the alcohol. Women are also more susceptible to alcohol just before menstruation because oxidation of alcohol is then at its lowest (Ramey, 1997:60).

10.3. Women and Smoking

Mention has already been made in earlier sections of this paper about women, and increased patterns of smoking. Rates of lung cancer amongst women will increase in Ireland if girls and young women cannot be persuaded to stop smoking. Here is current Irish data of girls smoking under the age of 18:

Smoking amongst Girls Under 18

Age	Social Class	Percentage Reporting
9-11	1-2	3%
9-11	3-4	5%
9-11	5-6	1%
12-14	1-2	16%
12-14	3-4	20%
12-14	5-6	20%
15-17	1-2	35%
15-17	3-4	33%
15-17	5-6	40%

(Department of Health and Children, 1999:79)

These figures clearly present a huge challenge to health education. They underline the need for pro-active programmes such as those run by the UK government, mentioned in Section 3.2 above. These need to be designed specifically for young women to respond to the reasons why they smoke, including concerns about weight gain and the perception that smoking helps to curb appetite and body size.

10.4. HIV and Other Sexually Transmitted Diseases

HIV and AIDS have been largely male diseases in Ireland. HIV has also deeply affected intravenous heroin drug users who constitute the largest single group infected, 41% of the official total (followed by gay/bisexual men). A small group with HIV has comprised the children born to HIV-infected mothers.

However, the reluctance to develop full-scale comprehensive safe sex education efforts for children and young people can now be seen in rising rates of sexual transmission of the virus.

Within the opening months of 2003, it was announced that there has been a steep rise in the numbers of people presenting with STDs. There is now a six-week waiting list to be seen at St. James Hospital in Dublin, with 200 new HIV cases in 2002 and the services there have reported a crisis (Donnellan, 2003). In February 2003, the National Disease Surveillance Centre reported an increase of STDs of 10% in the first six months of 2001, compared with 2000. The largest increases were in syphilis, up by 1,233% with gonorrhoea up almost 80% and herpes up 36% (ibid.).

While women still comprise a small minority of the total population currently affected by HIV, education and health promotion efforts to convince women to protect themselves from sexually transmitted diseases are vital. This applies also to Hepatitis C, chlamydia, genital herpes, and the other STDs. Every new STD can potentially be a new case of HIV because it means that unprotected sex has taken place. It has been said that in the UK 'sexual health is an idea that was forced on to the social agenda by the arrival of HIV and AIDS and should recognise individual needs and sexual diversity' (Duffin and Nash, 2001:363). Education and prevention as empowerment will need to be the watchwords here in Ireland as well. Sexual diversity and experimentation have become part of the lives of young women in the same way as other behaviours that are part of the youth culture. Sound education on risk management and sound support services to help young women deal with the risks they take will be the only sensible policy steps.

10.5. Teenage Pregnancy

Fortunately very young teenage pregnancies have not yet become as pronounced a trend as they have been in the UK. But the same theme of empowerment needs to be part of our education of teenaged women on unprotected sex. Numbers have recently fallen back somewhat in the UK and this is thought to be in direct response to the increase in dedicated services for young people (Sutherland, 2001:100). The need for

such services, working on an empowerment model, is made clear by survey work elsewhere on sexual relations amongst teenagers.

In the first large-scale survey of sexual behaviour in British teenagers under the age of 15, a study group of 7,935 teenagers in Scotland, using questionnaires, 18% of boys and 15.4% of girls reported having sex; 20% of girls said they were pressured to have sex, a figure which held for both their first sexual experience and their most recent sexual encounter; 32% of girls expressed regret that sex had happened too early as did 27 per cent of boys. Thirteen per cent of girls said it should not have happened at all, compared with 5% of boys. These answers about regret were not associated with any one socio-economic class group, with family composition or with the use or not of condoms. However, where boys admitted to putting pressure on girls to have sex, there were more in that group who later regretted having had sex.

Regret for girls was strongly associated with being pressured or exerting pressure, with unplanned intercourse and with parental monitoring where there was insufficient control. The researchers concluded that relationship training and training in negotiations and also raising awareness among young people about the emotional consequences of having sex early may delay first sexual encounters (Wight et al., 2000).

Establishing good communication and assertiveness skills seems a critical part of sexual health for young women. A study of Canadian university students indicates that consistent condom use does get good peer support and is viewed positively by peers. This may be helpful in establishing the need for effective communication on matters to do with sex, including condom use (Harden et al., 2000).

The lowest teenage pregnancy rate in Europe is in the Netherlands where the norm for sex education programmes remains strict compulsory work in school from primary school onwards.

Although not specifically tailored for young women, the Mental Health Association of Ireland has a new training manual, aimed at 14-18 year olds, called *Mental Health Matters*, which deals with assertiveness, self-esteem and so on. This is the type of material that needs to be adapted for young women in respect of dealing with active sexuality and contraception.

SECTION 11 – WOMEN AND HOW THEY COMMUNICATE WITH HEALTH PROFESSIONALS

11.1. Problems in Communicating with Doctors

In a classic research paper in the early 1980s, the sociologists Hilary Graham and Ann Oakley analysed a number of taped transcripts from antenatal consultations between women and their doctors, which included the following exchange:

Doctor: (reading case notes) Ah, I see you've got a boy and a girl.

Woman: No, two girls.

Doctor: Really! Are you sure? I thought it said ... [checks in notes] oh no, you're quite right, two girls.

(Graham and Oakley, 1981:66).

The fact that the doctor first trusted case notes over the word of the woman who certainly knew how many children she had, illustrates a problem that women continue to experience in accessing health care: doctors often do not listen to women's accounts of themselves. This is a problem throughout the health care system and men also experience difficulties. But given the far more frequent attendance women have at doctors' surgeries, women encounter it more frequently. They also encounter it because of their reproductive roles. Throughout the 1980s and early 1990s, academic social research on this topic became a recognised specialism so that we have excellent data on a whole range of interactions.

11.2. Identifying the Difficulties

In her work on childbirth (1979, 1980), Ann Oakley identified communication as a key issue for women. She argued that good communication increases women's competence over and about their medical experiences (Oakley, 1993:75-76). Findings from research studies where women have been given the chance to take more control of their care through, for example, being given their case notes to keep between consultations, women are more satisfied (*ibid.*). Outcomes for women are better and women express less anxiety when they feel they can communicate fully and have some control over their medical encounters (*ibid.*). Where such research has been done as part of randomised controlled trials, the findings are still the same: outcomes for women are improved. Oakley refers to supportive communication as 'non-specific social support' (*ibid.*).

Where this is not available, and where health care professionals proceed along the old model of communication, information which is important both for the doctor and for the woman is significantly reduced to the detriment of the woman and her care needs. Two lengthy studies of women as patients, one concentrating on women seeking contraceptive help, bear out these realities. Fisher and Todd (1983) and Todd (1989) show how women continue to be treated by doctors as simply the sum of their reproductive parts; Todd has numerous examples in her taped transcripts of interviews between women and male doctors, where doctors

- Make inappropriate suggestions about women's sexual lives – eg. their duty to satisfy their husbands sexually
 - Miss vital social contextual information about women's health
 - Ignore questions that women are raising about their health
- (Todd, 1989)

Again, using taped data, Davis (1987) examines how doctors frequently try to assert control over exchanges in the surgery, interrupting women's stories or accounts of themselves, offering inappropriate 'advice', platitudes, or even making jokes, all of which leaves women feeling disempowered. Todd (1989) and West (1990) point out that doctors ask almost all the questions in a typical patient interview, with the result that women typically go away with most of their questions unanswered.¹⁴ More recently, in research carried out in Ireland on women receiving initial diagnostic procedures for suspected breast cancer, respondents stated that there was a need for much improved communication and information:

Women expressed a sense of vulnerability because of lack of staff communication to them about protocols and procedures. Some staff appeared not to adhere to the basic courtesy of introducing themselves or their colleagues to women.

(Kennedy, et al., 2000: 53).

11.3. Changing the Paradigm

Academic work like the above bears out the realities of thousands of women on a daily basis. There is a vital requirement for medical doctors to be aware of each woman not as a set of symptoms in relation to a particular health problem, but a woman with her own complex social and material circumstances which are also part of her well-being and/or contribute to her ill-health. Women's health research, much of it carried out by those in the nursing and midwifery professions, has become increasingly substantive and has thoroughly documented how women perceive their health, health problems and medical encounters from their own perspectives (Murray and Chamberlain, 1998). Frequently, researchers have found that it is what women

are reluctant to discuss about their experiences that helps to explain the ways women have felt disempowered in receiving or seeking out health care (Belshem, 1991; Murray and Chamberlain, 2000). But women are no longer prepared to see themselves as victims of a medical system that has so often refused to listen; in the instances of women in the United States who were given DES (diethylstilbesterol) to prevent miscarriage in the 1950s and 1960s and whose daughters, as many as three million young women, were genetically damaged as a result, leading them to have miscarriages, infertility and cervical and vaginal cancer directly related to the DES, the experience became a springboard for political activism (Bell, 1988).

Communication and identification of their needs enables women to take responsibility for their health in terms they and their professional health carers can understand best (Malterud and Hollnagel, 1998). The problem of communication also applies to women doctors in that they also are heard less well by their male colleagues. In a country-wide survey in Norway of 3,589 male and female doctors and a small qualitative sample, women doctors reported that they are given less help and treated with less respect than their male colleagues. Women doctors coped by doing as much as possible by themselves or by making friends with nurses (Gjerberg and Kjolsrod, 2001).

SECTION 12 - ADVOCACY STRATEGIES TO PROMOTE WOMEN'S HEALTH

12.1. The Right to Best Quality Health Care

This section is specifically concerned with advocacy, activism and women's work in achieving a concept of health that reflects our personal and social needs in all their diversity. As both providers and consumers of formal health care, women are in a potentially powerful position to make changes. But as Doyal (1998) has argued, women's experiences are often devalued, compared with the 'expert' knowledge of medicine. Moreover, for a complex of reasons to do with gender, class and status, women are often denied the chance to participate fully in decisions about their diagnosis and treatment (ibid.). And yet an empowerment model has to be the way to break down these older patterns of medical response to women.

This was the thesis behind the first edition of *Our Bodies, Ourselves*, in 1970: the Boston Women's Health Collective assumed that if women could articulate their experiences of what was unsatisfactory in health care services and if they had best quality information about what should be available, they would be able to make changes. In the event, it proved to be a very complicated task, and yet the women's movement in the last three decades has brought about great changes. Notions of centres of excellence and of evidence-based practice reflect our expectations and demands that we should have best quality health services. Indeed it is arguable that the women's movement and its continuing probing has been critical in developing the perspective that all consumers of health services should enjoy a more equitable and responsive health service.

Getting women's health units and women-based research onto national agendas such as Australia, Canada, the United States, the UK and Ireland has been a major step forward in challenging the tendency in western medicine to see an illness rather than a person in her unique personal circumstances. What is striking is that the women's movement, in tandem with huge changes in how women live their lives, has been able to make a convincing case that women's health is multi-faceted and certainly not limited to her health as a reproductive being: well woman clinics speak of the whole of a woman, physical psychological and social. Here there have been fertile cross-overs with health promotion agendas (see also below).

Much remains to be done. In the current edition of *Our Bodies, Ourselves*, the Boston Women's Health Collective lists the following problems which are still apparent for women in our health care experiences:

- Not being listened to; not being believed
 - Being treated without informed consent
 - Not being informed of risks and negative side effects of forms of treatment
 - Being treated poorly because of class, ethnic background, sexual identity, age or disability
 - Offered tranquillisers or moral advice rather than serious social support
 - Being prescribed drugs that had serious negative effects
 - Being given unnecessary and/or inappropriate treatments or operations
 - Having necessary or important knowledge withheld from us
 - Being refused high-cost treatment options that would have been beneficial
- (Boston Women's Health Collective, 1998:681)

12.2. Advocacy, Support Groups, Patients' Rights and Information

Patient advocacy is now part of the professional practice of groups like specialist nurses and occupational therapists. Breast care nurses, for example, take on the work of counselling and supporting women going through incidents of breast cancer and liaising with the woman and the professionals responsible for her surgery, chemotherapy and so on. As part of their training, occupational therapists are taught about patient advocacy. A core part of their work is the role of presenting client needs in case conferences etc. Government departments of health and hospitals are increasingly publishing patients' rights charters and freedom of information acts to enable people to access their medical records also increases personal autonomy. Here in Ireland, stemming from the Freedom of Information Act, most hospitals now have a dedicated administrative officer to deal with requests from patients for their records. Another development in the United States and in the UK – here as a result of the Bristol and Alder Hay Hospital scandals over children's heart surgery – is for hospitals to publish their records in surgery so that there is transparency which enables people to make comparisons and choices about where they wish to access treatment.

A much smaller scale equivalent development in Ireland is the publication of Cuidiú's guide to maternity services (1999) which has comparative tables of rates of intervention, including Caesarean section rates. Advocacy now has a legitimated role in childbirth: a woman can have a birth partner or doala to support her through the

birth, including speaking on her behalf about her birth preferences or birth plan to the health care professionals. Taking a family member or close friend to the doctor when there are crucial discussions and decisions to be made is advised by many support groups. Support, self-help, self-care, information and consumer health groups have proliferated across a huge range of issues; they can offer excellent information and advice. And women's community resource centres have made a tremendous impact in their localities. Even where the focus of the resource group is not initially health, health and self-development naturally flow into the work over time, as with the Parents Alone Resource Centre and St. Michael's Resource Centre, Inchicore. The Letterkenny Women's Centre has had a specific health focus from the outset, both personal health of women and the health of the community. Their work has now developed into health courses for women, in addition to the range of personal health and counselling services they offer.

The Web has become an increasingly powerful tool in respect of advocacy and woman-to-woman information. A list of women-oriented health sites is included in the latest edition of *Our Bodies, Ourselves* (1998:26). Many government health department and state broadcasting sites also put up information about women's health issues and link them to relevant support sites. An important new contribution in Ireland is one for young people set up by the Northeastern Health Board, www.youthhealthne.ie, in consultation with young people, where sexual health and personal and lifestyle issues are discussed.

Few of these forms of social support have been subject to randomised controlled trials (although there has been work done on group psychotherapy). There is one Cochrane review of information and support for children with cancer in which the authors of the review conclude that much more of this type of evaluation needs to be undertaken to fully understand the efficacy of such interventions (Scott et al., 2001). There are a number of observational studies about the effectiveness of social support – see Section 11. 1. Here in Ireland, in a study of breast care services, women spoke extensively about their support needs and where and how these were responded to, or not (Kennedy, 2000 et al.).

12.3. Representative Consumer Committees

The new health strategy, *Quality and Fairness: A Health System for You: Health Strategy* (2002) has called for an increase in consumer representation and formal representation structures. This has been a growing trend elsewhere with for example, evaluated studies of consumer health representation in the UK. New Zealand has fifteen years' experience of establishing consumer representation across a range of health services. A common approach is to use locally-based groups as 'sounding boards' to draw up priorities for health service provision. There are also instances in the literature where consumer representation has been involved in actual policy-making, monitoring and evaluation of health services (Picken et al, 2002). The North Western Health Board has already set up a series of local consumer panels. But the role of these panels appears to be limited to offering advice, feedback and suggestions about service delivery (North Western Health Board, n.d.). Nevertheless, this is an initiative which does offer huge potential for women's direct engagement at hospital and Health Board level to present the case for unmet needs. The success of consumer committees is dependent, amongst other factors, on their acceptance by health professionals of the value of such committees and on professionals seeing consumers explicitly and actively as 'co-producers and maintainers of health' (Picken et al., 2002:36).

12.4. Health Education and Health Promotion

Health education and health promotion are social processes which have the potential to improve the health of both women and men throughout their lives. In the 1980s there was a growing recognition that a major impact on individual and community health could only be achieved through health-related policy development. As long ago as 1986, the Health Education Bureau in Dublin defined health promotion as 'The process which aims at improving the quality of life of the whole population[...] based on the understanding that health is more than an absence of disease.' The HEB went on to accept that those individuals who wish to adopt healthier ways of living may be constrained from doing so by environmental and socio-economic factors beyond their control.

However, much health information literature and related national media campaigns continue to be couched in individual terms and are often gender-blind. Practitioners

and researchers both recognise that campaigns exhorting people to modify their behaviour are counterproductive on their own because they do not address the complexity of people's lives or because they portray people's health-damaging behaviour as irrational (Daykin and Naidoo, 1995). In relation to women and smoking, for example, the data indicates that poorer women smoke to help them cope with the stresses of a very difficult life. Therefore their decision is not irrational – for them smoking is a coping mechanism (Graham, 1988).

Daykin and Naidoo (1995) caution that health promotion must not place more responsibilities on women when they may have neither the maternal and social power to make changes. They suggest instead that community development approaches allied to health issues may make far more sense, providing appropriate and sensitive support for women and fully taking into account the constraints and difficulties under which many women are carrying out their daily lives. They write:

There is a need to consistently challenge the assumption of responsibility without power that characterises women's relationship to health promotion in order to transform this relationship into one which offers positive health through support for real choices.

(Daykin and Naidoo, 1995:69)

SECTION 13 - CONCLUSION

Drawing on the research literature, this document has presented the case for a gendered health care strategy. It has explored the argument that gender crucially affects women's health. There is a growing awareness that building gender into health care improves outcomes for women, as is demonstrated by the many studies that have been reviewed here. More research taking gender into account is coming on stream all the time and in theory, should enable the health services to develop more sensitised approaches to health promotion, prevention of ill-health, diagnosis and treatment of ill-health, and to build appropriate support structures throughout the health care services.

The Women's Health Initiative and its randomised controlled trial on the use of combined HRT to improve health in older women is a perfect illustration of the critical role that research with a gendered awareness can play in women's lives. Prior to this large and carefully structured controlled trial, it had been generally accepted in the medical profession that long-term combined HRT was a sensible routine medication for women to prevent chronic illnesses like osteoporosis and to reduce the incidence of cardiovascular disease. In fact what the trial results have indicated is that routine prescribing of combined HRT is not safe. Instead of relying on a single approach, medical practitioners must re-evaluate the individual circumstances of each woman in respect of her health needs and assess with her the risks and benefits of a number of approaches to maintaining her health in her older years.

Such careful and individual assessment done in conjunction with the woman could be said to lie at the heart of a gendered health strategy overall. Such a strategy must

- Respect the diversity of women's lives
- Challenge discrimination against women
- Challenge stereotyping of women
- Change for the better, circumstances of poor health outcomes for women related to social exclusion and poverty

In practice, achieving such objectives is difficult. This is in part due to the problem referred to in the Introduction (i) above of building policies about health that cross-cut a number of government arenas. We do have examples of it: the working group in the

Department of Health and Children with responsibility for the health and social policy linkages with the National Anti-Poverty Strategy is a vital step in the right direction. But we need more developments of this kind. Where the Irish government could learn from the current UK work, for example, is in the pro-active nature of their pilot programmes to target smokers or their Five a Day fruit and vegetable action plans. These are specifically targeting the issue of lower socio-economic status and poorer communities. We need to build on such examples here.

We also need to work on how we deal with prevention and education for women. Heart disease and Type II diabetes reflect both lifestyle issues and poorer socio-economic status. There appears to be a huge need to formulate health education initiatives on exercise, for example, that can speak to the realities of women's busy lives and all the tasks and caring work they are trying to fit in.

We are now challenged by our emerging multi-ethnic society to establish initiatives for women from minority communities. Here we have a proven example to hand that needs to be extended. The outstanding dimension of the Travellers Health Project is its potential for replicability amongst other minority ethnic groups, training women from those communities to become community health workers to support women's health at local level.

There are problems of diagnosis and treatment facilities, which can partly reflect less than adequate facilities. But it can also reflect lack of awareness of latest research findings and the lack of adequate mechanisms to incorporate evidence-based practices related to those findings.

Arising from the research we have reviewed, we can see for example, how problems of gender bias and lack of awareness on the part of GPs about women and CVD can adversely affect women's health outcomes. But we do not know why there are variations in referral rates for coronary arteriography across the country, mentioned in section 4.1.4. above. It is urgent to know why there is a relative lack of referrals for women of this first step diagnostic procedure. This should be made part of an action plan for developing clinical protocols and clinical audit and evaluation that are women-specific. As the independent Forum to advise on such protocols, the Heart

Health Task Force has the scope to establish sub-groups to deal with more specific service areas and one on women-specific issues to do with CHD may be very appropriate.

There appears to be no awareness in how the BreastCheck programme has been rolled out in Ireland of the recent moves in the UK (Section 4.2.2. above) to advise women of the benefits and drawbacks to breast screening. Yet enabling women to make an informed choice based on all the evidence should be part of empowering women.

If outcomes for women are to be improved and morbidity and mortality levels reduced, it is vital that health care policies and services should reflect up-to-date research on women's needs.

The healthcare system in Ireland continues to fall short of the progress elsewhere, e.g. in Health Canada, of planning all programmes on a gender-sensitive basis. This lack of attention has emerged most recently in the consultation process on the National Plan for Women. The provision of a 'woman-friendly health service' and a holistic approach to women's treatment and gender-sensitive medical staff were of paramount concern to women who participated in the consultation (Kelleher and Kelleher, 2002:61).

The Australian Women's Health Plan has sought to advance a holistic approach within a framework of equity where gender can be seen to crosscut issues such as age, class, ethnicity and disability. These complex connections end in poor health outcomes when women confront social and institutional discrimination. Using an equity framework prioritises changing such situations to bring about improved equality of access to health-enhancing strategies and thus improved equality of life chances.

The efforts to achieve this in Australia for their National Women's Health Policy have centred on challenging institutional inequalities and lack of responsiveness through such approaches as

- Developing shared responsibilities for policy planning at regional and national levels
- Using research and evidence-based data to direct policy, service and treatment provision

- Working in partnership
- Focusing on monitoring the improvement in health outcomes
- Focusing on women who are most disadvantaged

This can be very uncomfortable for institutions and practitioners who are accustomed to ring-fencing access to the way they do their business. Professional and largely male medical domination and the lack of trust of lay voices pose real stumbling blocks. The New Zealand experience of building strong consumer representation where the purpose and value of that representation is part of all levels of government thinking provides an appropriate example of dealing with this problem.

In Ireland, one important development would be to increase women's representation at institutional and governmental department levels. The call for women's direct involvement at all levels of the health services was first made in the government's discussion document, *Developing a Policy for Women's Health* in 1995. Key recommendations that formed part of the recent consultation on the National Women's Plan were quite specific on this point: a gender balance of 40:60 was called for on state boards, to be enforced by legislation. This representation needs to include the diversity of women, including minority ethnic groups, older women and lone parents (Kelleher and Kelleher, 2002:157-158). A specific recommendation coming from that process was that a woman should be Minister of the Department of Health and Children (ibid.).

These examples of new directions that are research-based and gender specific underscore the relevance of using a gender-based analysis. This paper demonstrates severe and real gaps in health outcomes in Ireland for women. A gender-based strategy for health care provision permits us to see how these outcomes can be changed for the better.

End Notes

1. On the impact of income and health over the life-course, see M. Benzeval et al. (2000); on housing tenure and related physical and mental ill-health, see S. Macintyre et al. (2000).
2. Here cultural resources refer to the capacity to seek out life and health-enhancing activities as part of one's ordinary expectations. For example, a woman may need to feel a sense of entitlement and appropriateness about her going to use a gym, or to seek out complementary therapies such as aromatherapy or massage. She might have the financial resources to seek these out, or they might even be readily available at very low cost or no cost. But she could still be prevented from accessing them if her cultural values dictate that women from her background, whatever that background is, do not do that sort of thing.
3. Chronic illness is defined in the British General Household Survey (1992) as an illness, infirmity or disability that is likely to persist on an ongoing basis.
4. Irish data indicates that men in Social Classes 3-6 have significantly higher rates of smoking than men in Social Classes 1 and 2 (74% compared with 26%). See Department of Health and Children (1999). However as more young women make lifestyle choices in favour of smoking, this will have a negative impact on long-term health outcomes. In the United States, lung cancer is the greatest single killer of women and represents the huge cohort of women who took up smoking from the late 1940s (Ramey, 1997). In Ireland, 40% of women between the ages of eighteen and thirty-four years now smoke, and 35% to 40% of young women between the ages of fifteen and seventeen years smoke (Department of Health, 1999).
5. There are disparities about available data on this matter. In Britain, there appears to be little gender difference in the rates of people visiting doctors under the age of fifteen or over the age of sixty-five (Senior and Viveash, 1998:136). Iredale (2001) points out that there is relatively poor information available on gendered patterns of health care across Europe.
6. If these visits are excluded, it appears that men may actually visit doctors more frequently (Macfarlane, 1990).
7. Differences between men and women tend to level out in respect of clinical depression.
8. These figures included non-melanoma skin cancers, comprising 35% of the 19,833 cases of cancer in 1995. These are often excluded because mortality rates are very tiny and because they are concentrated in older age groups which skews the data on average age upwards (Department of Health, 1999:57).
9. A meta-analysis entails a rigorous review of all studies and data on a particular health issue with the objective of eliminating bias and distorting factors from each individual study in order to emerge with the best quality of data possible. Meta-analyses form the basis of reviews on evidence-based care with which we have become familiar through the Cochrane Library database which conducts their meta-analyses with the strictest and most rigorous protocols.
10. These would be similar to the rapid access one stop diagnostic clinics now being set up in Ireland for breast cancer.
11. Auto-immune malfunctioning is beginning to be suggested as a component in the development of diabetes.

12. Women in low-paid work or those trying to access re-training have tremendous problems trying to access affordable good-quality childcare because of prohibitive fees. See Coveney et al. (1998) and English and Murphy-Lawless (2000).
13. The ethics of the production of Premarin, where mares are kept continuously pregnant, in very small confined boxes, with daily collection of their urine to be processed into the drug, have probably not been sufficiently widely discussed. It is worth noting that the 1999 EU Treaty of Amsterdam states that member states of the European Community must 'pay full regard to the welfare requirements of animals' because there must be 'improved protection and respect for the welfare of animals as sentient beings'. Therefore, violations of animal welfare such as takes place in the production of Premarin may be increasingly challenged in the future.
14. In her research, West (1990) found that women doctors were more likely to couch their requests in a perceived polite manner, compared with male doctors.

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