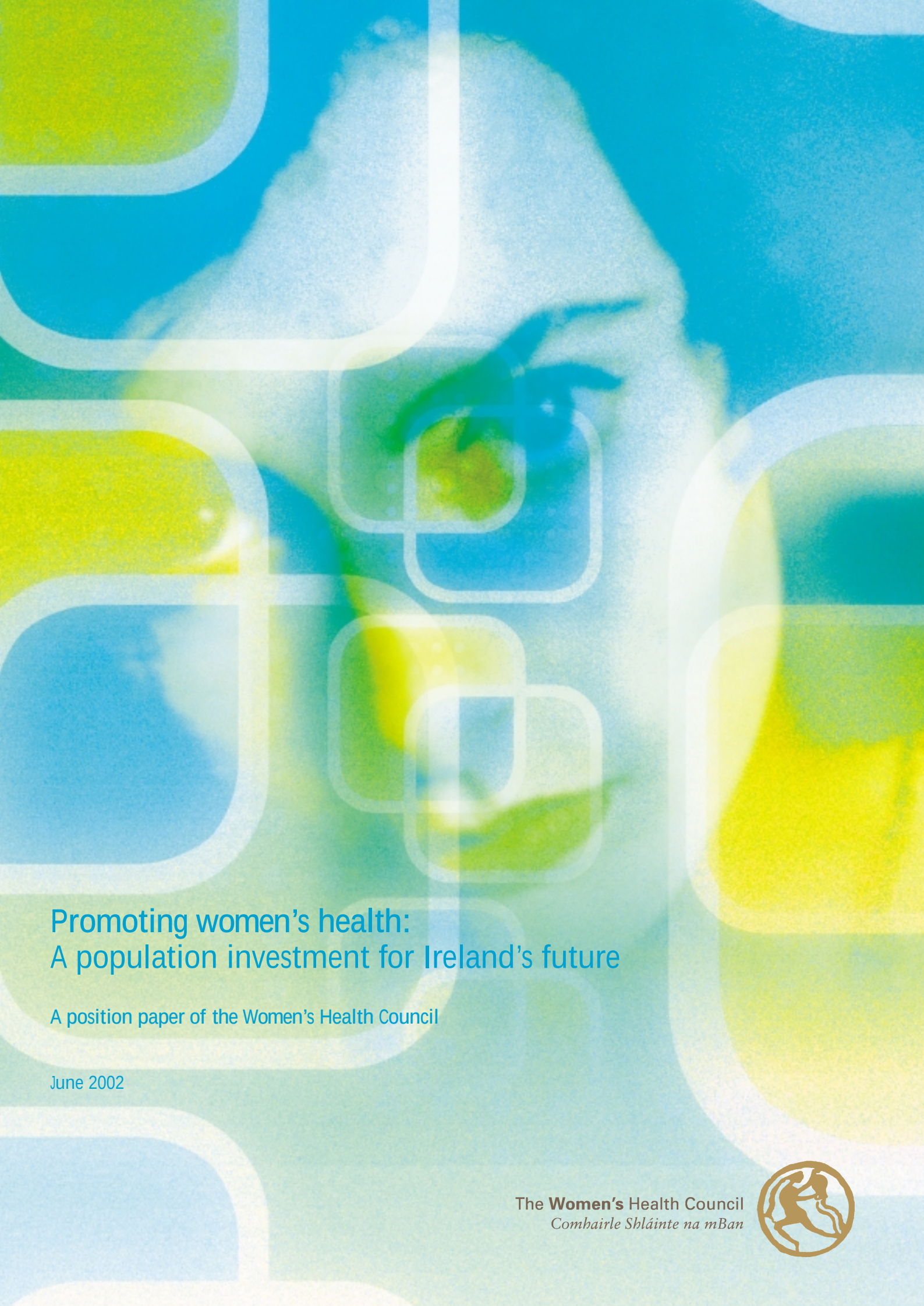

# Promoting women's health: A population investment for Ireland's future

A position paper of the Women's Health Council

June 2002

The **Women's** Health Council
*Comhairle Shláinte na mBan*

# Preface

I am often asked why there is a specific need for a Women's Health Council. The fact is that there are major demographic variations in health status according to age, gender and social class. These variations occur across the life course. There is increasing evidence for instance that biological programming in the womb contributes to adult onset diseases like heart disease in addition to the more immediate and expected effects on birth outcome and early development. Furthermore, social circumstances across the lifespan are influential on health at all life stages. For this reason policy measures to promote health are increasingly more integrated, with recognition that health, well-being and avoidance of disease are achieved by sound health promoting public policy and a seamless approach to health care delivery at all levels.

Both women and men are entitled to the best possible health. While there have been welcome changes in Irish society, with a more equitable distribution in roles and tasks between men and women, the fact is that women are still the primary care givers and their social support is crucial to the well-being of the population as a whole. Selfevidently there are a number of important sex specific diseases but there is a broader concept to be addressed in health policy terms. Women are not alone the biological bearers of children but their social role in family support is extensive and can be particularly critical in situations of relative disadvantage and poverty. The national and international experience is that women are very often the participants in processes of consultation and discussion about health matters and influence their partners and children in seeking appropriate care.

The level of education of women is a powerful predictor of the overall health status of any population. This reflects two processes; first a society committed to the personal development of women equitably with men is one likely to place value on its citizens generally. Second, health status is crucially determined by the capacities of individuals themselves, a core tenet of the Ottawa Charter (1986) for health promotion. A comprehensive health delivery service is but one component. Families and individuals educated in skills for living and with discretion and control over their lives enjoy better health. It is in this sense that the personal development and health promotion of women is an investment for society as a whole as well as a right for women themselves.

The Women's Health Council was established as part of a process of health service re-orientation that included the plan for Women's Health. This position document we publish here reflects our review of that women's health plan, as a process set up to achieve an equitable health system in this country of benefit to everyone. We set out the desired objectives for women's health, with the population health profile as a baseline by which to mark the success or otherwise of the women's health plan to date and with recommendations on the desired future frameworks. I would like to extend my thanks to the many people who contributed to this document, the researchers who undertook various aspects of the fieldwork, those in the department of Health and Children, the health boards, statutory and non statutory agencies who facilitated the process, the chief executive and staff of the Women's Health Council and my fellow board members, all of whom gave generously of their time to this project. We present it to the Minister of Health and Children and we hope it will make a constructive contribution to current and future health policy directions.

Professor Cecily Kelleher MD FRCPI MPH MFPHM FFPHMI

*Chair, Women's Health Council*
1 July 2002

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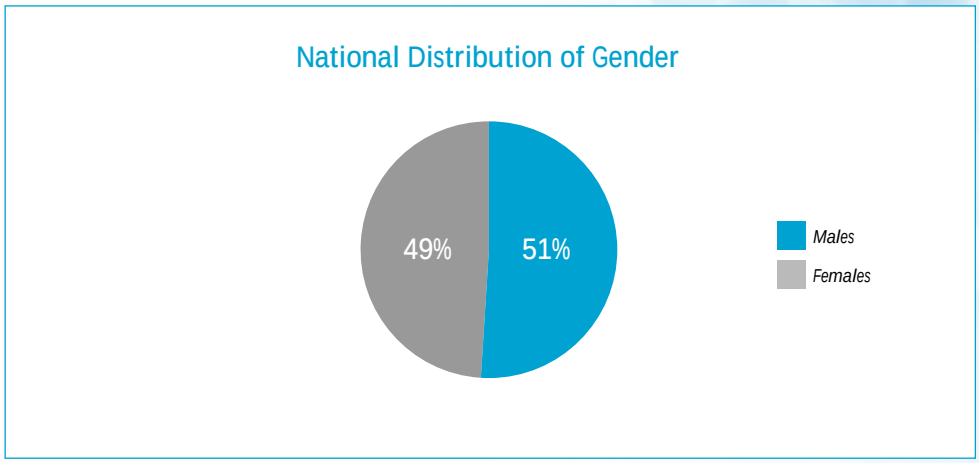



*Source: Census, 1996*

# Executive summary

In line with its statutory brief, the Women's Health Council commissioned research to evaluate progress in achieving the objectives of the Department of Health and Children's 1997 *Plan for Women's Health 1997-1999* (the Plan) at national and regional level. This was used as the basis of a critique of the effectiveness of the implementation of the Plan to date and the development of proposals for:

- building on the achievements to date
- ensuring a dynamic role for the structures established as a result of the Plan, especially the regional Women's Health Advisory Committees (WHACs)
- securing measurable health gain for women over the next 7-10 years.

The *Plan for Women's Health* grew from a Department of Health and Children discussion document, *Developing a Policy for Women's Health* (1995), which profiled many issues relating to the health status of women in Ireland and their relationship with health services. The document was used as the basis of a wide-ranging public consultation with organisations and individual women in 1995-6, organised by the eight health boards (as they were at the time) in co-operation with the National Women's Council of Ireland (NWCI). With the publication in 1997 by the Department of Health of *A Plan for Women's Health 1997-1999* Ireland became only the second country internationally, after Australia, to have a national policy specifically dealing with women's health.

The publication of the Plan stimulated a great deal of activity at local, regional and national level aimed at achieving health gain for women and improving the quality of their interaction with and experience of health services. It also stimulated debate on the rationale for specific targets relating to women's health. Section 1 (pp10-21) clarifies the rationale with reference to a range of health indicators, both for women as a whole and for groups of women with particular health needs.

The *Plan for Women's Health 1997-1999* identified four main objectives:

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

Several structures were established to implement and evaluate the Plan:

- a Women's Health Policy Unit (WHPU) in the Department of Health and Children (discussed in Section 2, p26)
- a Women's Health Council (discussed in Section 2, p26)
- WHACs (discussed in Section 2, p28).

The timeframe of the Plan was used to establish the structures and, in the case of the WHACs, to prepare regional plans for women's health. In this way the Plan acted as a catalyst both nationally and regionally and gave health boards a broad framework within which to develop their own regional priorities.

The Plan itself comprises a mix of affirmations of support for existing government strategies, broad aspirations for the development of women's health services and specific recommendations. For the most part, it does not contain timeframes for implementation or measures for the monitoring and evaluation of actions. Without indicators of success, accurate costing or explicit ring-fenced funding the Plan reads as aspirational rather than as a blueprint for targeted action. This meant that the evaluation process concentrated primarily on the structures, as actions and outcomes varied across regions and were largely not comparable.

### *Structures*

Since 1997 the WHPU has maintained a national overview and undertaken actions at international level. The Women's Health Council has informed the progress of health gain for women by publishing research and policy positions in a number of areas relating to women's health, including health service delivery, crisis pregnancy and personal and community development. The WHACs, in response to regional priorities, have prepared plans and have overseen the development of innovative projects pertaining to health gain for women. Women's Health Development Officers have been appointed in several health boards. These achievements are detailed in Section 2, pp26-36.

### *Regional variation*

The level of regional variation with regard to the Plan points to the need for clarification and refocusing of organisation and activity in the advisory process concerning women's health. The regional women's health plans mirror broadly the key themes and structures of the national Plan, while varying considerably in structure, length, timeframe and content and the number and scope of recommended actions (Section 2, pp32-38). It proved difficult to identify actions resulting specifically from the recommendations of the regional plans.

There is a need for greater co-ordination and unity of purpose between the various health boards. This need for co-ordinated action is emphasised by the findings of the national Survey of Lifestyle, Attitudes and Nutrition (SLAN) (Friel, Nic Gabhainn et al., 1999), considered in Section 1, pp10-21, which showed that women experience similar health issues regardless of the health board region they live in. Given this similarity, there are obvious opportunities for health boards to benefit from increased co-operation. From the point of view of achieving health and social gain for women throughout Ireland on an equitable basis, there clearly needs to be greater consensus on the priorities to be tackled (Section 2, p36).

### *Progress in women's health*

In terms of concentration on women's health issues, the Plan's achievements are more visible in structures than in changed practice. It succeeded in putting women's health on the national and regional agendas by a mixture of structural, policy and practical measures and by linking explicitly with other national strategies. The establishment of the WHPU and the Women's Health Council at national level, and the WHACs and Women's Health Development

Officers at health board level, is significant and provides a solid basis on which future work can be built. It is, however, questionable as to what improvement is discernible at the level of the ordinary female consumer of health services. Depending on her age and locality she may now have more information or better or new services - or she may not. Even if she does she is unlikely to be able to link these to a specific policy initiative on women's health. Section 3, pp37-39, discusses the lessons to be learnt from the outcomes and limitations of the Plan.

In practice, the aspirational nature of the Plan rendered it more of a statement of strategic intent than a practical plan per se, and the resulting wide regional differences in interpretation and implementation have made it almost impossible to identify models of good practice in any meaningful way. Similarly, to have status women's health policy must be linked explicitly with other key strategies and initiatives at both national and health board level. Implementation of many of the Plan's objectives necessitated crossing different health disciplines, requiring the establishment of new structures and new working relationships. In the absence of an agreed framework, however, such innovative and far-reaching work assumed a low priority. The lack of clearly-articulated targets and specific ring-fenced funding meant that of necessity time was spent in defining what could be done, rather than actually doing it. The nature of the WHACs placed them remote from planning structures and the centre of power and decision-making.

In many health boards development of regional plans was a long and arduous process. Publication of plans gave way to a loss of momentum and a sense of drift in several regions, leading to confusion about role, and even disbandment. Implementation of recommendations contained in regional plans was hampered by many factors, notably lack of clarity with regard to role and responsibility, funding, level of priority etc. The lack of implementation structures, poor co-ordination of services and a relatively low level of inter-board co-operation also mitigated against effective implementation. Consequently, as noted above, many recommendations remain unimplemented and those actions taken have tended to be modest in scale.

### *Proposals for progress*

The very existence of the Plan, however, has galvanised both debate and action, and has kept issues relating to women's health on the agenda at many levels of policy-making and service development. The principles and premises of the Plan are still valid. The required structures are broadly in place and their potential recognised. Section 4, pp39-43, contains proposals for three specific initiatives to build on the Plan's achievements and to secure health gain for women:

## 1. Focusing the women's health agenda for the 21st century

The Women's Health Council proposes, in conjunction with the Department of Health and Children and the health boards, to provide a policy framework for focused health measures for women by updating the provisions of the Plan in relation to:

- other current health strategies and plans, with particular reference to those which have come into being since 1999
- identifying positive achievement for replication
- identifying gaps in provision in relation to women's health
- integrating targets relating to women's health into current and future health strategy and planning.

The Women's Health Council proposes, with the Department of Health and Children, to invite all major stakeholders to assist it to define the principles and parameters for policy and action in the field of women's health in Ireland. The health boards and relevant non-statutory and consumer bodies will be invited to participate.

The resulting policy framework will set the scene for targeted, measurable work aimed at maximising health gain for women over the next 7-10 years. Specific priorities for targeted action both nationally and regionally might include gender-related aspects of cancer and cardiovascular disease, and measures relating to improving the health status of disadvantaged women and young women.

## 2. Achieving national agreement on optimal structures and procedures

The Women's Health Council proposes the harmonisation of structures and procedures in the area of women's health. Harmonisation is proposed in order to enhance the coherence and effectiveness of the WHACs as agents for positive change in women's health and to ensure collaboration and co-operation of shared experience and practices.

National agreement should be achieved on:

- a clear rationale for concentration on women's health issues within the context of broadening approaches beyond the confines of the traditional medical model
- clear definition of the roles, responsibilities and contribution of the various partners and players in the field, including the WHACs, to ensure maximum effectiveness in the coming decade
- structures and procedures for maximum co-ordination and co-operation between the partners, to ensure optimal and coherent outcomes.

The effectiveness of the WHACs is germane to the achievement of health gain for women. The Women's Health Council proposes that this be enhanced by broad agreement between all partners on:

- the composition, terms of reference, funding, servicing by Women's Health Development Officers and reporting relationships of WHACs to health board management at director level
- an explicit brief with regard to gender-sensitive targets and the gender-proofing of health board policy and practice generally, including service plans
- the primacy of an advocacy and leadership role on issues relating to women's health, above any operational considerations
- intra- and inter-agency working, communication and co-operation
    - within the statutory sector, including with other structures involved in cross-cutting issues
    - between the statutory and not-for-profit sectors.

The harmonisation of job descriptions and parameters for the activity of Women's Health Development Officers should also be agreed.

The Women's Health Council proposes to monitor and evaluate the resulting activity with a view to ensuring the continued effectiveness of actions.

With regard to national structures, the Women's Health Council proposes:

- for itself, an executive structure and capacity, and a streamlined board, in line with its enhanced role in ensuring health gain for women (see also below)
- for the WHPU, more dedicated staff time, a direct line to Department of Health and Children senior management team and closer co-operation with the Women's Health Council.

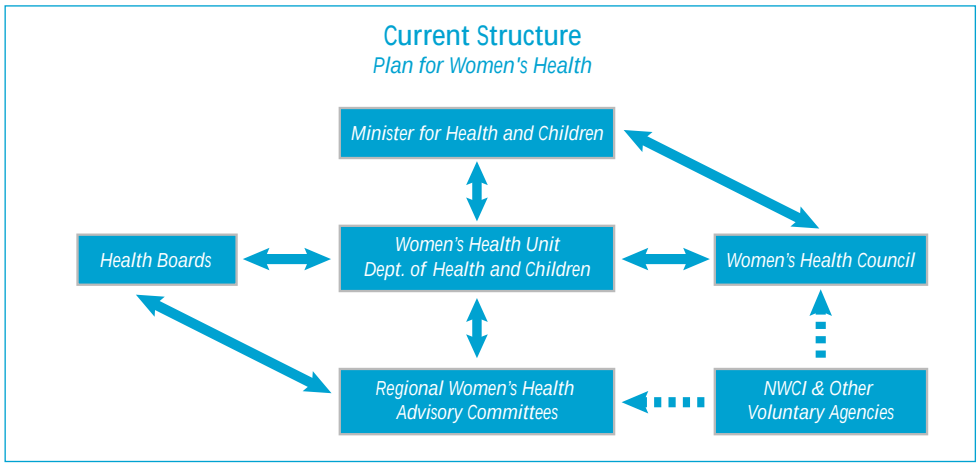
## 3. Ensuring gender equity in health services and initiatives

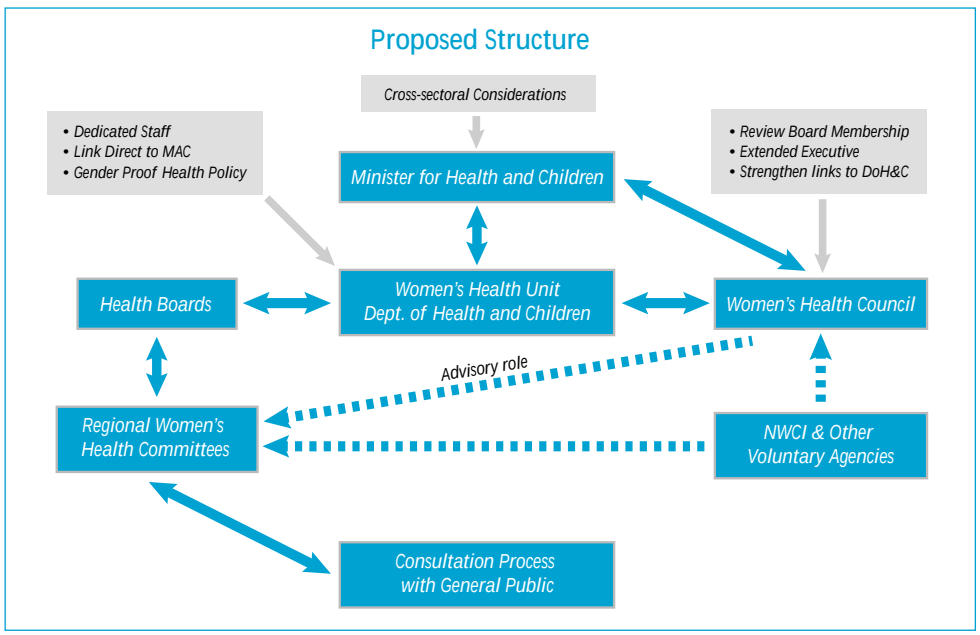
The Women's Health Council proposes that the Department of Health and Children develop criteria, models, structures and procedures for gender-proofing national and regional policy and practice related to the health of women, to be implemented by appropriate bodies at local and national level.

The resulting activity will be monitored and evaluated by the Women's Health Council with a view to ensuring its continued effectiveness over time. The interplay between women's health policy, plans and initiatives and current and future general and specific policy, plans and initiatives in related areas will be a key focus of concern. The Women's Health Council will continue to advise the Minister on areas of unmet or inappropriately met need.

Taken together, these three proposals provide a viable framework for securing significant health gain for women, and for improving significantly their satisfaction with regard to their interactions with the health services. Such a framework will constitute a worthy, practical and targeted successor to the inspiration and leadership of the *Plan for Women's Health 1997-1999.* The net result will be the achievement of better health, not just for women, but for everyone.

The charts below summarise the current structures and the improvements proposed at national level by the Women's Health Council.



## Department of Health and Children

- direct line to Management Advisory Committee (MAC)
- develop gender proofing guidelines for the health sector
- additional dedicated staff
- formal channel of communication with WHC to facilitate statutory role.

## Women's Health Council

- membership of board to reflect explicitly service, academic and lay representation
- statutory advisory role to be developed at operational level
- extended executive.

## At regional level the Women's Health Council proposes:

- standardised process and procedures for the WHACs, including terms of reference and reporting relationships to senior management
- continued representation from NWCI and other relevant non-statutory bodies
- dedicated women's health development officer, with a brief to include working directly with WHACs
- WHACs to have advocacy role on issues pertaining to women's health, rather than operational responsibilities
- key roles to include:
  - gender proofing health board policy and practice concerning service provision
  - inter-sectoral co-operation with other agencies
  - continued consultation with general public.

## Specific topics in women's health proposed for priority action:

- Cancer - the Cancer Strategy clearly sets out an unmet need in relation to preventive, early risk detection and treatment services and this report re-iterates the relatively high levels of some cancers in this country. The WHC endorses the recommendations in the strategy and recommends the speedy implementation in particular of the Breast and Cervical Screening programmes from pilot to full service phases with appropriate follow-up services in place.
- Cardiovascular disease - the Cardiovascular Strategy should be implemented in full. Though over their lifetimes women are as affected as men by cardiovascular disease, there is evidence in the scientific literature of less focus on their needs at all levels, from health promotion through to tertiary care. The CVD task force should therefore give specific attention to gender equity in relation to management of cardiovascular diseases, which account for almost half of all deaths and are inordinately common in Ireland. The WHC is currently preparing a review of this issue.

- Disadvantaged women - the needs of disadvantaged women have constituted a priority for the WHC in all its documents and submissions to date. It is clear that inequalities exist in relation to health in Irish society, those who live in poverty are subject to poorer or bad health, and women have a critical influence in relation to family and social support as well as to their own direct health needs. The WHC supports any initiative at policy, community, or health service level that addresses this situation of disadvantage by reducing social inequality, promoting well-being, providing support for improvement in lifestyle and health practices and providing equitable access to healthcare.
- Mothers/children - the epidemiological evidence indicates that early life influences are of crucial importance, not alone in predicting good maternity and paediatric outcomes but also in affecting health risk in adult life. It follows therefore that mothers and children require a comprehensive service to provide seamless care during this early life period. In this context a review of the GMS scheme, in line with the recently proposed changes for older people, would be appropriate. The WHC is also preparing a review paper of the issue on early life influences on mother and child health.

# Section 1

# Planning for improvements in women's health

## Background

Hailed as a major breakthrough in achieving recognition of the specific health issues relating to women, the publication of the *Plan for Women's Health 1997-1999* (the Plan) was a key outcome of the final report of the Second Commission on the Status of Women (1993). The Second Commission recommended that the Department of Health, in consultation with women's groups and other interested parties, should conduct a review of its service provision to women and should incorporate the results into a national plan. In 1995 the Department of Health responded to these recommendations by publishing *Developing a Policy for Women's Health: a discussion document* which profiled many issues relating to the health status of women in Ireland and their relationship with health services. The document was used as the basis of a wide-ranging public consultation with organisations and individual women that took place in 1995-6, organised by the eight health boards (as they were at the time) in co-operation with the National Women's Council of Ireland (NWCI). With the publication in 1997 by the Department of Health of *A Plan for Women's Health 1997-1999* Ireland became only the second country internationally, after Australia, to have a national policy specifically dealing with women's health.

As this document will show, the publication of the Plan stimulated a great deal of activity at local, regional and national level aimed at achieving health gain for women and improving the quality of their interaction with and experience of health services. Since that time women's health issues have been the subject of much debate and a Constitutional referendum. Despite - or, perhaps, because of - this attention, there remains some confusion concerning the rationale for continued prioritisation of health issues relating specifically to women. Similarly, issues relating to the gender sensitivity of policy and practice appear to require further delineation. The rest of this section comprises an inexhaustive overview of some key concepts and indicators which point to the need for gender sensitivity and gender-related targets in the field of health, with a view to the achievement of maximum health gain for women.

## Rationale for promoting measures specific to women's health

According to the United Nations' *Platform for Action: Fourth International Conference on Women,*

> "health policies and programmes often perpetuate gender stereotypes and fail to consider socio-economic disparities and other differences among women and may not fully take account of the lack of autonomy of women regarding health. Women's health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate services to women" (United Nations, 1995).

In his foreword to *Developing a Policy for Women's Health*, the Minister for Health recognised that

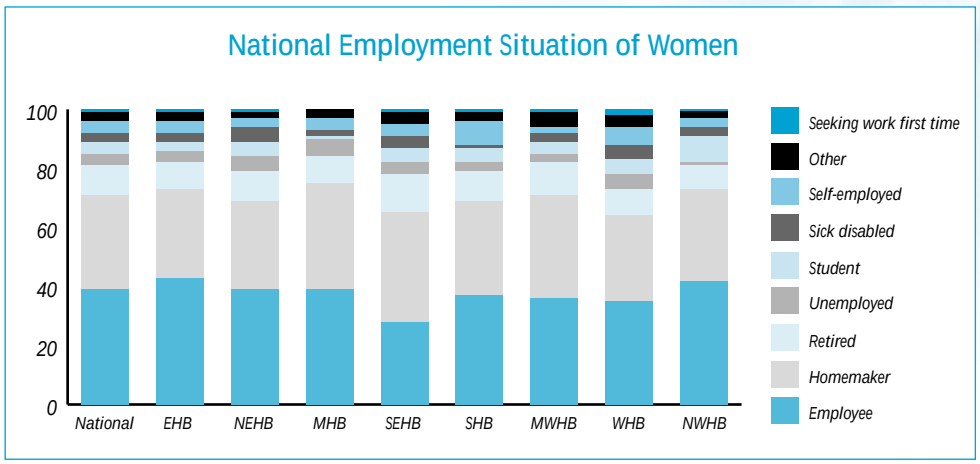
> "a policy for women's health must encompass a spectrum of health issues from those which are unique to women through those which impact more on them than men, to those which affect them differently to men"(Department of Health, 1995).

The gender perspective in health is recognised in the latest Health Strategy *Quality and Fairness: a health system for you*, which contains sections on issues and priorities relating specifically to both men's and women's health (Department of Health and Children, 2001).

The rest of this section delineates some of the major topics to which specific attention should be paid and targets developed.

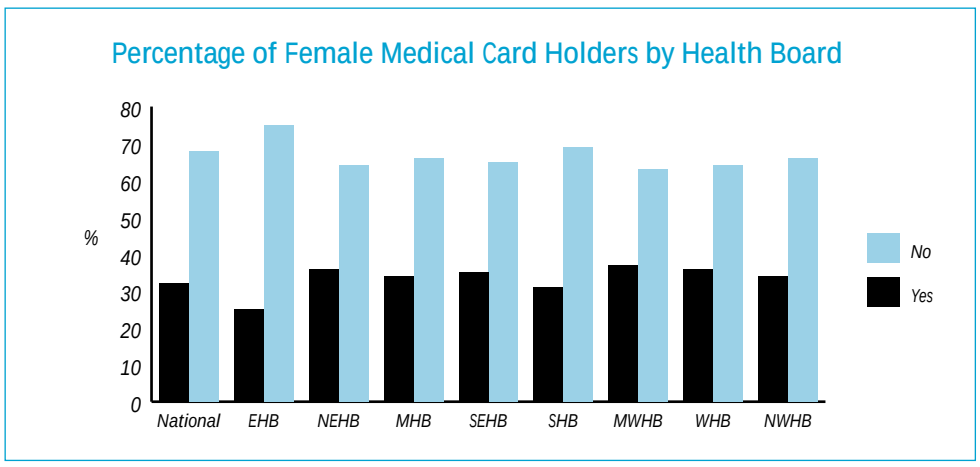
## *Socio-economic disparities*

Socio-economic status is acknowledged as a key indicator of inequalities in health status. In 1994, the *Monitoring Poverty Trends* study found that women in Ireland experience greater risk of poverty than men (Callan, Layte et al., 1999). This is largely due to the risk of poverty for single adult households (mainly headed by women) and households headed by someone working full-time in the home (again, chiefly women). The SLAN study broke down the employment situation of women in Ireland as follows:

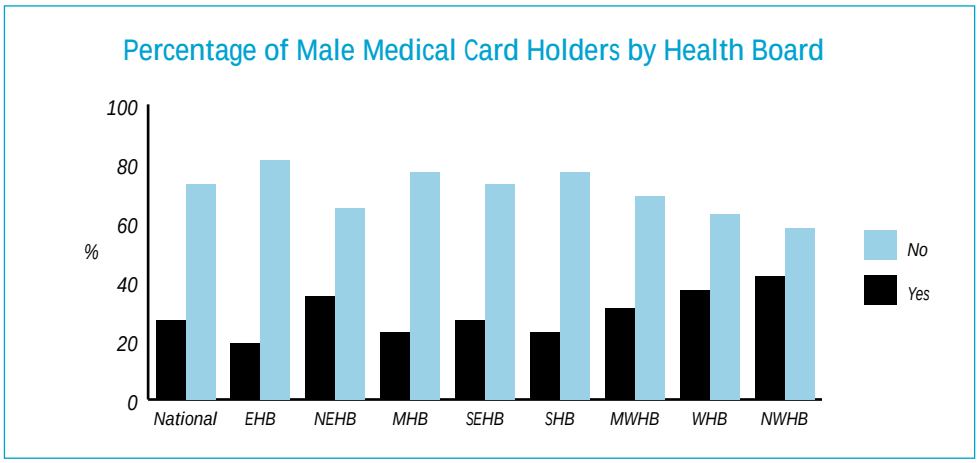



*Source: SLAN, 1999*

Women in less well-off socio-economic groups have been shown consistently to be at the greatest disadvantage with regard to many aspects of health. For example, in their 1996 study of women and health care in Ireland, Wiley and Merriman found that women with medical cards (ie. those on lower incomes) and with lower levels of education were the least knowledgeable about reproductive health matters and harm reduction approaches to combating the spread of AIDS and other sexually transmitted diseases. Women in the lower socio-economic groups were also found to have a higher incidence of smoking, including smoking during pregnancy, and to be more likely to have taken tranquillisers to cope with day-to-day living (Wiley and Merriman, 1996).




*Source: SLAN, 1999*

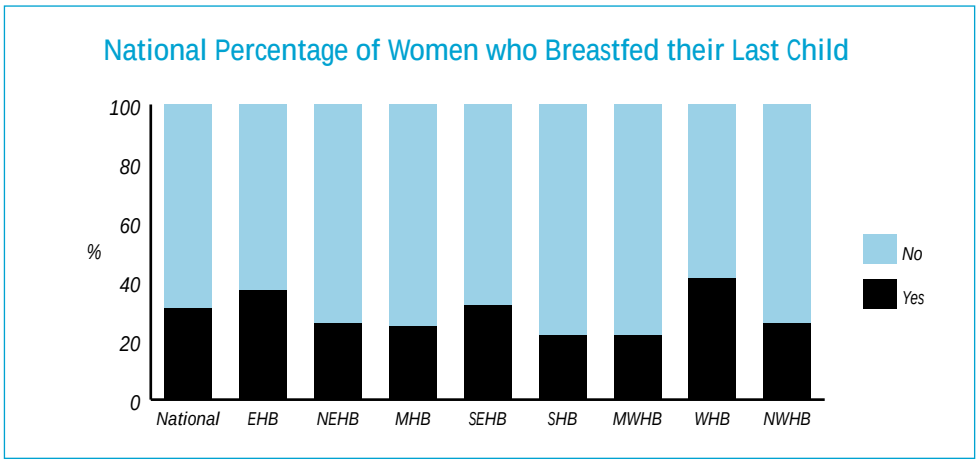



*Source: SLAN, 1999*

## *Multiple roles*

In 21st century Ireland women are expected to perform multiple roles. Along with participating in the labour market, women continue to perform their traditional roles as mothers, wives and carers. The stress of these competing responsibilities can have adverse effects on their health. The role of wife and mother, for example, has been shown to be a significant stressor for women. Wiley and Merriman found that one in five married women and mothers had taken tranquillisers at some time, compared to only 7% of single women and those who had no children (ibid.).

The difficulty of achieving a balance between the demands of the family and work outside the home can be particularly hard for women who have children, and can be a significant cause of stress for them. In trying to fulfil the role of worker and that of mother, for example, women may decide not to breastfeed because of the additional workload it places on them. Breastfeeding, however, provides optimal benefits in terms of disease prevention, which persist during infancy and into later life. The decision to breastfeed is influenced by a number of factors, including access to information, education and legislation. A further extension in the length of maternity leave, an integrated approach between Government Departments in promoting breastfeeding and employers taking a proactive approach to breastfeeding in the workplace would contribute to improving the current low levels of breastfeeding in Ireland.




*Source: SLAN, 1999*

The role of carer can also have negative effects on health. Carers, predominantly women, have been found to receive little social, practical or financial support from formal health services, despite their common experience of isolation, reduced social interaction, high levels of strain and psychological distress and compromised health status (Conlon, 1999).

### *Inadequate and inappropriate services*

Access to good quality, appropriate services, including transport and childcare, have been shown to be particularly pertinent for women. These can be especially hard to access in rural areas, with a concomitant negative effect on women's health (Wiley and Merriman, 1996). The White Paper on Rural Development asserted that

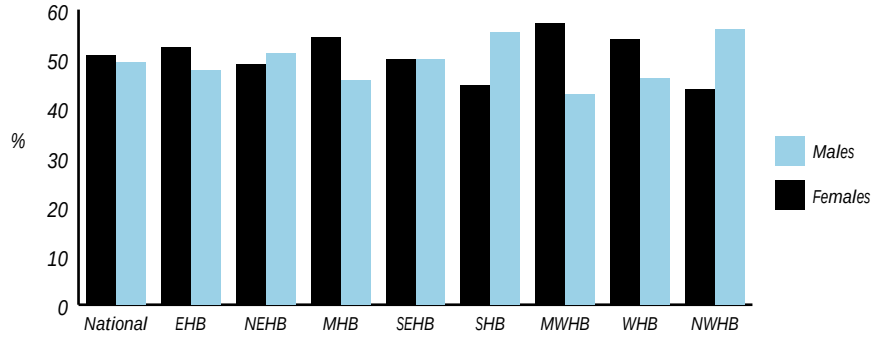
> "the problems of poverty and social exclusion have a distinct impact on rural women. Economic dependency, isolation, unequal opportunity and participation are compounded by the distance from services and amenities" (Department of Agriculture Food and Rural Development, 1999).

The lack of counselling and support services in rural areas may contribute to social exclusion. Service depletion in rural areas may place more severe strain on women, especially as they often have responsibility for caring for others (children, young people, older people, people with compromised health etc).

Gender imbalance also exists with regard to drug misuse and take-up of drug treatment services. Although fewer women than men misuse drugs, female drug users are perceived as a hidden population, hard to reach and under-represented as clients of drug services (Hedrich, 2000) . The stigma attaching to women who misuse drugs has been found to be much greater than for male misusers and serves to inhibit women's contact with drug (and alcohol) services. For example, women misusers, who are more likely to be primary caregivers than their male counterparts, fear that seeking help for drug use could lead to their children being taken into care. This situation may be exacerbated by services which fail to take women's specific needs into account. For example, Moran found that providing childcare facilities in drug treatment services made it easier for women to attend and also reassured them that the services were sympathetic to and accepting of women drug users with children (Moran, 1999).

Women with disabilities experience particular difficulty in accessing basic health services, often being excluded from everyday participation in society due to inaccessible buildings, transport and services. Attending health services can present many barriers, including the inaccessibility of equipment such as examination tables. Women with disabilities are often treated as if they are asexual, which results in them being significantly less likely than non-disabled women to have reproductive health checks, such as pelvic examinations, with concomitant effects on their health (Thierry, 1998). Avoidable secondary conditions, such as osteoporosis, chronic bladder infections and depression, can also result.

National Percentage of Males and Females Whose Work is Limited by a Long Term Illness, Health Problem or Disability




*Source: SLAN, 1999*

There are significant additional financial costs associated with having a disability, for example, for special foods, extra heating or medication. Higher transport and insurance costs also contribute to a greater cost of living for women with disabilities than for non-disabled women, whether or not they are employed outside the home. There are consistently high unemployment levels among people with disabilities and households headed by a person with a disability or by someone who is ill have a 28% risk of poverty (National Disability Authority, 2001). A plethora of issues arises from the experience of being a woman with a disability, as distinct from being a disabled man, which can have a deleterious effect on women's health and which require specific targets and attention (National Rehabilitation Board, 1994) .

### *Gender stereotyping*

Within medicine, the perception of women's health has tended to refer to reproductive health alone, rather than taking a holistic view. This, along with the exclusion of women from medical research trials, has led to a situation where certain pathologies and conditions are perceived as "men's diseases" in spite of growing evidence to the contrary.

Cardiovascular disease provides an example of this type of gender stereotyping. Despite the numbers of women dying from the condition every year, traditionally cardiovascular disease has been thought of as typical of men. The problem seems to stem from the different manifestations of the disease in men and women, and from the lack of clinical research focusing on women's cardiovascular health. The literature consistently refers to women's "atypical" symptoms of heart disease, with men's symptoms being perceived as normative (Laher, 2001; MacSheridan, 2001). Instead of the pattern of chest pains commonly reported by men experiencing difficulties, women have been found to present with symptoms such as neck, shoulder or abdominal discomfort, dyspnoea, fatigue and nausea and vomiting. Women have also been found to present with cardiovascular disease at a later age than men, with concomitant effects on hospitalisation and survival rates. The Hospital In-Patient Enquiry database (HIPE) for 1999 shows the peak age range for hospitalisation of males with ischaemic heart disease and/or acute myocardial infarction at 60 to 74 years, while that for women was 65 to 79 years.

The concentration of research concerning prevention of cardiovascular disease on male subjects was partly due to the historical tendency in medicine to see the male body as "normal" and to assume that data collected with regard to male subjects could be extended to women. The American Medical Association asserted:

> "Medical treatments for women are based on a male model, regardless of the fact that women may react differently to treatments than men or that some diseases manifest themselves differently in women than men. The results of medical research on men are generalised to women without sufficient evidence of applicability to women"(American Medical Association Council on Ethical and Judicial Affairs, 1991) .

Women have also been excluded from clinical trials because of the possibility of pregnancy or other co-existing medical conditions (Laher, 2001; Thaul and Hotra, 1993).

Consequently, until recently the manifestations of cardiovascular disease in women were not fully recognised. This led to under-diagnosis, resulting in avoidably high rates of mortality. Laher asserts that

> "fewer women than men with suspected acute heart attack symptoms are referred for non-invasive tests, and fewer women than men who tested positive for heart disease are recommended for further testing and treatment…probably due to a combination of gender differences and gender bias" (Laher, 2001).

The Cardiovascular Health Strategy report, *Building Healthier Hearts*, addressed the particular needs of women to some extent, however, noting that special attention is required to ensure adequate participation by women and by older patients in cardiac rehabilitation programmes

(Department of Health and Children Cardiovascular Health Strategy Group, 1999). The report recommended that current services be expanded appropriately, though it did not incorporate the recommendation of the European Institute of Women's Health to develop a two-sided approach to dealing with heart disease with a view to tackling both how health care professionals screen for the disease and the need for women-specific research in the area (European Institute of Women's Health, 1996).

### *Health issues unique to women*

As well as the need for gender sensitivity in policy, planning and services, discussed above, any consideration of specific concentration on health issues for women must also deal with concerns specific to women alone, including diseases of women's reproductive organs, like cancers of the cervix and ovaries. Data from the National Cancer Registry in Ireland have indicated that there were 61 deaths from cervical cancer in the year 2000, and 236 from ovarian cancer (personal communication to the Women's Health Council, 2002). Health issues unique to women also encompass reproductive events, such as pregnancy and giving birth, menstrual problems, for example, dysmenorrhoea and pre-menstrual syndrome (PMS), and the menopause.

Within this, the sexual and reproductive health needs of refugee women, in particular, are often neglected (International Planned Parenthood Federation, 2000). Services such as family planning, antenatal care, safe childbirth and the prevention and treatment of AIDS/HIV and sexually transmitted infections are vital for the wellbeing of these women. Cultural differences which restrict the access of female refugees and asylum seekers to health services also require attention. For example, women from some cultural backgrounds will not accept services from a male practitioner so additional female health workers may be needed and female interpreters should also be available (UNHCR, 1994).

### *Health issues that impact on women more than on men*

Health issues which affect women disproportionately to men also require specific attention and targets. Some factors which contribute to poor health among men have been shown to have an even more negative effect on the health of women.

This is particularly clear in the case of the Traveller population in Ireland. Overall, Travellers have a lower standard of health than the settled community (Pavee Point, 1995). Traveller women are particularly susceptible to poor health. Among their multiple roles, Traveller women take responsibility for the home, family and children, they broker with service providers on behalf of their families and often assume leadership roles in acting as spokespeople for the community.

Racism and social exclusion have been shown to affect Traveller women disproportionately. For example, the lack of access to basic facilities has a direct negative impact on the lives and health of Traveller women because of their domestic role. It has also been suggested that Traveller women may encounter particular exposure to direct discrimination in their role as "go-between" or broker with settled service providers. Traveller women have been found to have a lower level of uptake than settled women of antenatal care, and to attend later. Many have no postnatal check-up. Pavee Point also reports that the incidence of still births, infant mortality and birth difficulties is significantly higher among Travellers, especially those who are unhoused, due to a number of factors including maternal malnutrition during pregnancy, recurrent pregnancies with short intervals between each and low standards of accommodation, as well as lower levels of antenatal care (ibid).

In the wider community, women's longevity in comparison with men brings its own problems. Women's longer lives have been found to expose them to greater levels of chronic ill health. The Health and Social Services for Older People study, published by the National Council on Ageing and Older People in conjunction with the Western Health Board and the Eastern Regional Health Authority in 2001, identified that older women as a group have

higher levels of need in relation to health services (Garavan, Winder et al., 2001). Women in the study reported poorer health status than men, even when matched for age. They were found to rate their quality of life as significantly lower than that of men and to have more difficulties in carrying out activities of daily living.

Osteoporosis is one of many conditions which have been shown to affect women more than men, particularly in old age. Although it also occurs in men, osteoporosis is more marked in women, with the fastest decline in bone mass happening in the first decade after menopause. Some 40-50% of Caucasian women experience osteoporotic fracture, with vertebral fractures attributable to osteoporosis occurring in 25% of Caucasian women aged 65 or less (Ellerington and Stevenson, 1993). There is a mortality rate of 5-20% within the first year after vertebral fracture (Rosenfeld, 2001).

### *Health issues that affect women differently from men*

Stress has been shown to have adverse effects on women's health, especially their mental health, and to affect women differently from men. Although Irish men have a higher rate of completed suicide, research has shown that in general women have higher rates of parasuicide (National Parasuicide Registry Ireland, 2001).

Gender differences in mental illness are well recognised. Depression, one of the most prevalent mental health problems, affects more women than men in a ratio of at least two to one (Stoppard, 2000) but there is no clear consensus as to why. Traditional biological, hormonal and psychological theories still dominate, although recent work addresses the social influences and sources of stress in women's lives that give rise to depression (ibid). It has been proposed that depression is a reaction to the difficulties with which many women have to contend in their daily lives, particularly in situations of social deprivation (Byrne, 1991). A further argument suggests that exploring the socio-cultural contexts of women's lives, rather than focusing on subjective and individual causes of distress, would allow an examination of the systemic cultural inequities that underlie women's reaction to their circumstances (Lee, 2000).

Irish statistics relating to mental illness are, in the absence of substantial community-based research, based largely on in-patient data, focusing on those treated in psychiatric hospitals and units and therefore not providing a complete picture of prevalence. More men than women are admitted to psychiatric hospitals and units overall but more females than males are admitted each year for depressive disorders, with a rate in 2001 of 31.9 per 100,000 compared to 23.8 for males (Daly and Walsh, 2002). This pattern has been consistent for some years.

Data from SLAN below shows rates of depression for males and females, both nationally and broken down by health board area.

*Females*

| Anxiety/Depression | National | EHB | NEHB | MHB | SEHB | SHB | MWHB | WHB | NWHB |
|---|---|---|---|---|---|---|---|---|---|
| Not | 2,199 (69.0%) | 633 (64.2%) | 380 (72.4%) | 122 (70.5%) | 243 (74.1%) | 279 (69.8%) | 179 (67.3%) | 206 (70.3%) | 150 (73.9%) |
| Moderately | 937 (29.4%) | 341 (34.6%) | 133 (25.3%) | 48 (27.7%) | 80 (24.4%) | 115 (28.8%) | 82 (30.8%) | 83 (28.3%) | 51 (25.1%) |
| Extremely | 51 (1.6%) | 12 (1.2%) | 12 (2.3%) | 3 (1.7%) | 5 (1.5%) | 6 (1.5%) | 5 (1.9%) | 4 (1.4%) | 2 (1.0%) |
| Total | 3,187 (100%) | 986 (100%) | 525 (100%) | 173 (100%) | 328 (100%) | 400 (100%) | 266 (100%) | 293 (100%) | 203 (100%) |

*Males*

| Anxiety/Depression | National | EHB | NEHB | MHB | SEHB | SHB | MWHB | WHB | NWHB |
|---|---|---|---|---|---|---|---|---|---|
| Not | 2,078 (74.9%) | 595 (68.2%) | 345 (79.5%) | 107 (74.3%) | 234 (79.9%) | 278 (75.3%) | 174 (77.7%) | 208 (80.3%) | 122 (80.3%) |
| Moderately | 658 (23.7%) | 266 (30.5%) | 83 (19.1%) | 37 (25.7%) | 57 (19.5%) | 79 (21.4%) | 49 (21.9%) | 48 (18.5%) | 28 (18.4%) |
| Extremely | 39 (1.4%) | 12 (1.4%) | 6 (1.4%) | 0 | 2 (0.7%) | 12 (3.3%) | 1 (0.4%) | 3 (1.2%) | 2 (1.3%) |
| Total | 2,775 (100%) | 873 (100%) | 434 (100%) | 144 (100%) | 293 (100%) | 369 (100%) | 224 (100%) | 259 (100%) | 152 (100%) |

*Source: SLAN, 1999*

## Health indicators

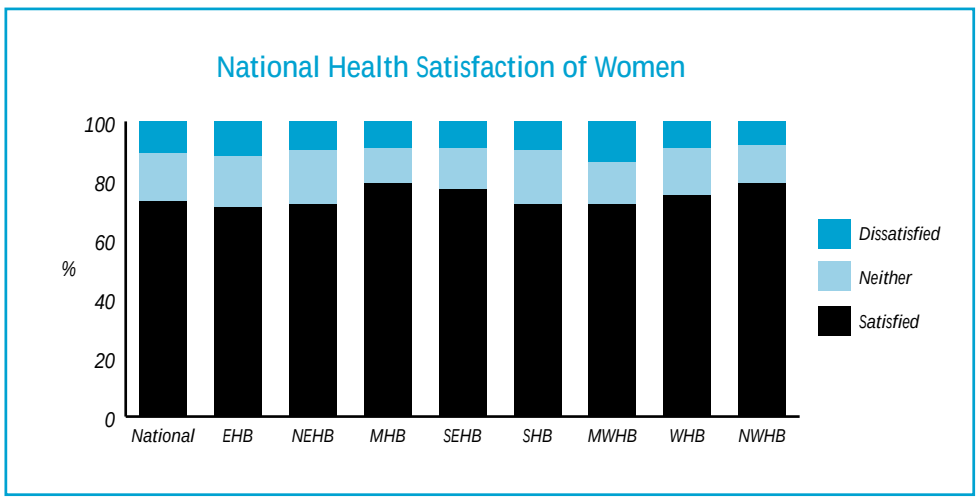
The Women's Health Council uses the WHO definition of health, asserting that health is

> "a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity".

This section draws on data from SLAN and from the 2002 Eurostat Yearbook to illustrate the picture of women's health in Ireland. The SLAN study produced a reliable baseline survey of health related behaviours among young adults in Ireland, the first of its kind in the country. Although the percentage difference between males and females in the data appears quite small in some instances, trends emerging from the SLAN survey highlighted the need to target young women and disadvantaged women as a matter of urgency.

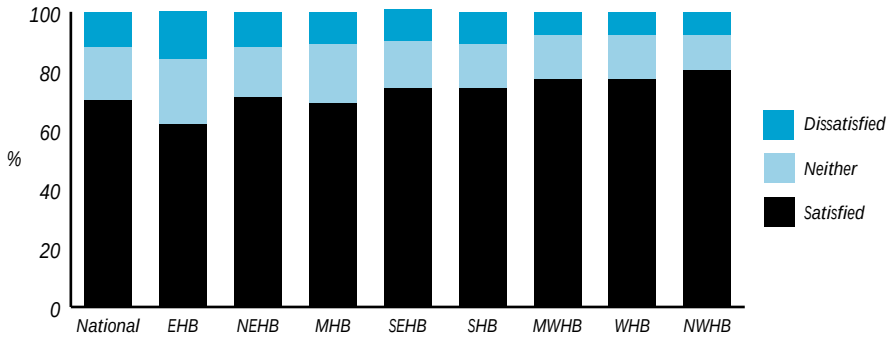
### *Introduction*

Life expectancy for Irish women increased significantly during the twentieth century. While life expectancy for both sexes lengthened due to factors such as enhanced public health measures and control over infectious diseases, the decline in premature mortality for women was related not least to the reduction in fertility rates and the related impact on health of less continuous child-bearing. This may have had a bearing on women's satisfaction with their health: most respondents in the SLAN survey were satisfied with their health.



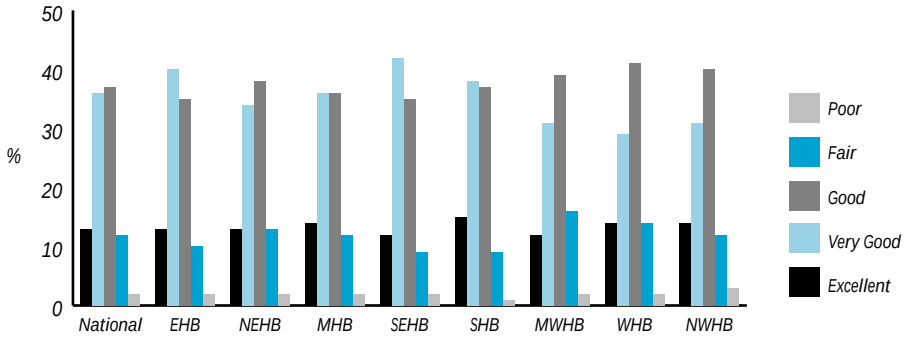

*Source: SLAN, 1999*

## National Health Satisfaction of Men



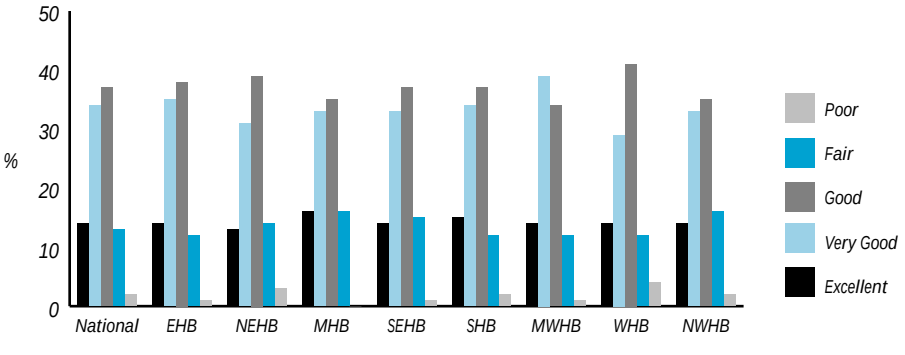

Source: SLAN, 1999

## National Percentage Response for Perceived General Health Among Women




Source: SLAN, 1999

## National Percentage Response for Perceived General Health Among Men

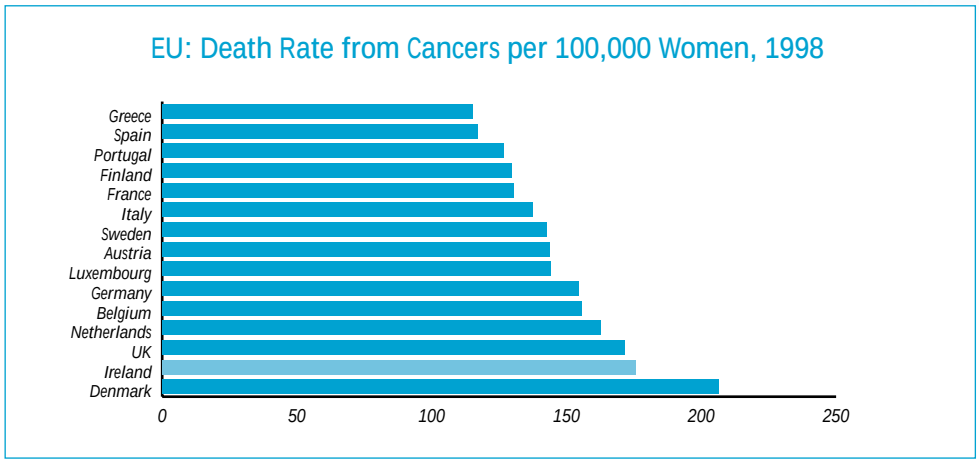



Source: SLAN, 1999

There is no room for complacency, however. The life expectancy at birth of women in Ireland is still one of the lowest in the European Union. In 1999 the average life expectancy at birth for females across the fifteen EU countries was 81.2 years, compared to 79.1 for Irish women. This is 4.2 years longer than for Irish men, whose life expectancy at birth in 1999 was 74.9 years (Eurostat, 2002). Irish women are gaining in longevity at a greater rate than their male counterparts, leaving them more exposed to problems associated with later life, such as poverty, isolation and impairment, as well as rationing in health services for older people.

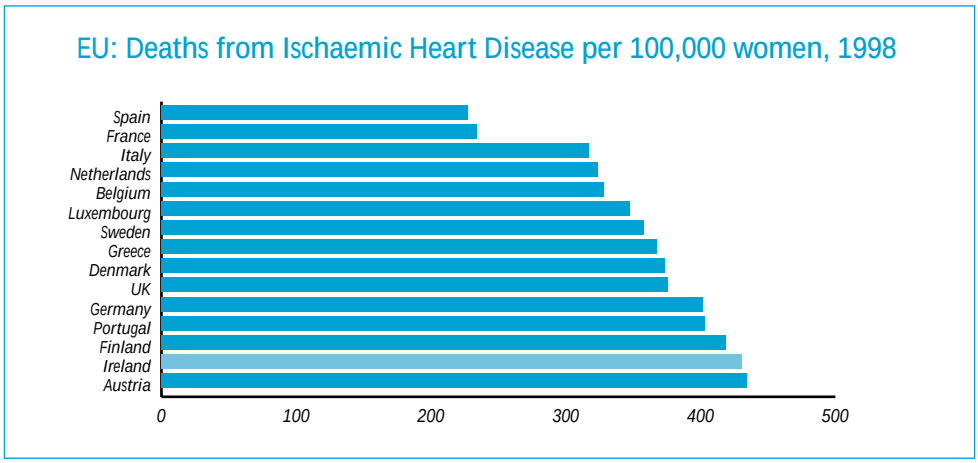
### *Differing rates of mortality from major diseases affecting both sexes*

Across all age groups, the main causes of death for women are diseases of the circulatory system, ischaemic heart disease (CHD) and cancer, especially of the breast, lung and colon. Ireland has one of the highest mortality rates from breast cancer in the EU, with a rate in 1998 of 32.6 per 100,000, compared with an EU average of 28.9 (ibid). The Irish mortality rate for cervical cancer is 4.3 per 100,000 in 1998, compared with an average EU rate of 2.7 deaths per 100,000 (ibid). Irish women contract more cancer types than the EU average and at relatively high rates, with melanoma, lung and oesophageal cancers especially high. Ireland has the highest rate of oesophageal cancer among women in the EU (Cancer Consortium, 2001).




*Source: Eurostat, 2002*

Diseases of the circulatory system are the main cause of mortality among women generally in the EU. In 1998 the rate of death for Irish women from circulatory system diseases was 257 per 100,000, compared with an EU average of 214.1 per 100,000 (Eurostat, 2002). Although deaths from CHD have reduced considerably over the last 20 years, they are still much higher than the EU average. In 1997 the Standard Death Rate from ischaemic heart disease for Irish women was 125.8 per 100,000, compared with a rate across the EU of 74.2 for every 100,000 women (ibid).

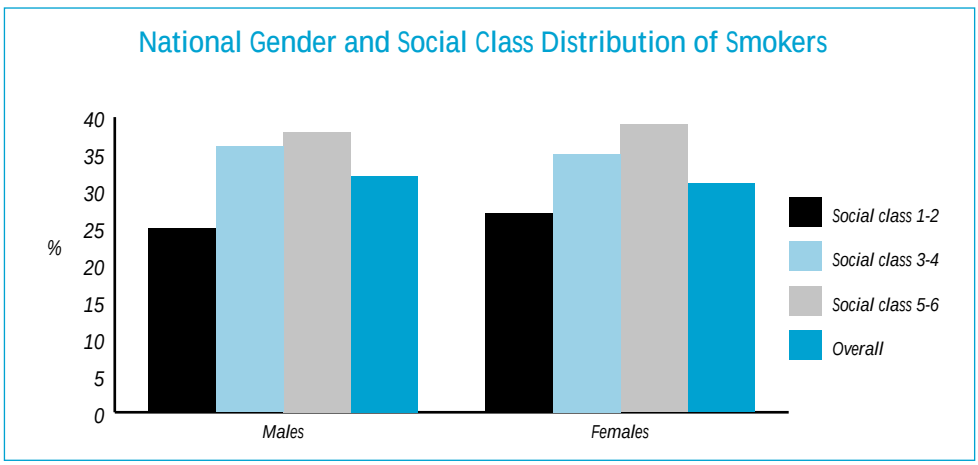



*Source: Eurostat, 2002*

Age standardised rates for Irish men for diseases of the circulatory system and ischaemic heart disease are also considerably higher than the EU average but are declining. Standard Death Rates for Irish men from cancer of the trachea, bronchus or lung are now below the EU average but those for Irish women are continuing to rise (ibid).

## *Smoking and lung cancer*

The single largest increase of cancer in women world-wide is lung cancer. This is almost entirely due to a change in smoking patterns in women. Almost all deaths from cancer of the lung, trachea and bronchus could be prevented or postponed if women did not smoke. Tobacco-related diseases usually develop after smoking for 15-20 years or more, and the results of increasing smoking rates among EU women are only just beginning to be seen. Ireland has one of the highest rates of female tobacco-related mortality in the EU.




*Source: SLAN, 1999*

In 1998 the Standard Death Rate for Irish women from cancer of the lung, bronchus or trachea was 28.2 per 100,000, compared with an EU average of 15.3 (Eurostat, 2002). Recent Irish statistics show that 40% of women between the ages of 18 and 34 years are smokers, and 35-40 % of women between the ages of 15 and 17 years (Department of Health and Children, 1999). It can be expected that this will translate to a greater number of smoking-related cancers for women over time unless targeted health promotion campaigns can help to reverse the trend. Smoking is also a major contributor to cardiovascular disease, the risk of developing ischaemic heart disease being approximately twice as high among smokers as among non-smokers.

Actions aimed at reducing smoking for young women, in line with the targets set out in the National Health Promotion Strategy (2000-2005), are named as a priority in the recent Health Strategy (Department of Health and Children, 2001). The policy paper on smoking prevention, *Towards a tobacco free society* provides for special support services for pregnant women who are smoking but contains no other initiatives targeted specifically at women (Mooney, 2000).

### *Conclusion*

The brief survey of health issues outlined shows clearly that women have particular needs regarding their health which differ from the health needs of men. As previously noted, trends emerging from the SLAN survey highlighted the need to target young women and disadvantaged women as a matter of urgency. For example, among young women, the increasing numbers taking up smoking is of particular concern and the health needs of disadvantaged women cut across a number of areas. The SLAN survey data are currently being updated (2002). The results will point to emerging concerns for health of the population.

The particular needs of women provide the basis for introducing gender-specific measures for tackling women's health and for developing gender-sensitivity in the health field generally. Current service provision may well represent no more than an approximation of the needs of both men and women, serving neither group optimally.

The recent Programme for Government (2002) contains no direct reference to women's health. However, the Women's Health Council understands the commitment to bringing "the targeting of health inequalities to the fore in health policy" and to providing "a high-quality and accessible health service for all" to encompass this vital area. Improved health status for women translates as improved health status for everyone. A Government committed to the implementation of the recent Health Strategy can be expected to prioritise both quality and fairness on that basis.

# Section 2

# Evaluating the Plan for Women's Health 1997-1999

In line with its statutory brief, the Women's Health Council commissioned research to evaluate progress in achieving the objectives of *A Plan for Women's Health 1997-1999* at national and regional levels.

The main sources of information for the evaluation included:

- consultation with the Women's Health Policy Unit at the Department of Health and Children
- analysis of the national Plan and the regional Plans for Women's Health produced by the Women's Health Advisory Committees (WHACs)
- reports from the WHACs to the Women's Health Council (2001 and 2002)
- interviews with key stakeholders (the Department of Health and Children, the Chief Executive Officers of the health boards, the Women's Health Council, the WHACs and the National Women's Council of Ireland), conducted by Anne Cleary, Orla McDonnell, Jo Murphy-Lawless and Orla O'Donovan in the period October 2000-March 2001.
- analysis by Ailís ní Riain.

All relevant agencies were involved in the review. Full co-operation was given by the Minister for Health and Children and his Departmental officials, the Women's Health Council and NWCI. Six of the eight Chief Executive Officers of Health Boards agreed to be interviewed, with the others nominating an employee with more direct responsibility for women's health issues. Seven of the eight Chairpersons of WHACs agreed to be interviewed, with one nominating another member of the committee. Group interviews were conducted with seven of the WHACs. The eighth could not be convened during the timescale of the fieldwork and in this case an interview was conducted with two members of the committee.

The review of the Plan and its outcomes informed the development of this Women's Health Council position paper and the proposals it contains for refocusing and revitalising the field of planning for health gain for women. It should not be taken as representing the views of respondents in the research.

## Context

Figure 1 outlines the historical context in which the Plan and its influence should be viewed.

*Fig. 1: Key events in the development of women's health policy in Ireland*

| | |
|---|---|
| 1991 | DoH establishes Committee on Women's Health |
| 1993 | Final report of Second Commission on the Status of Women recommends that the DoH should conduct a consultative review of its services for women |
| 1994 | In its strategy document *Shaping a healthier future* DoH commits to publish and implement a plan for women's health |
| 1995 | Partnership between NWCI and DoH to facilitate a public consultation process DoH publishes *Developing A Policy for Women's Health*<br>Health Boards begin to establish WHACs to facilitate public consultation and partnership agreement<br>Public consultation process undertaken |
| 1996 | Health Boards submit consultation reports to DoH |
| 1997 | DoH publishes *A Plan for Women's Health 1997-1999*<br>Women's Health Council established on statutory basis<br>WHACs begin to develop regional plans<br>Department of Justice, Equality and Law Reform (DEJLR) introduces a national initiative on violence against women |
| 1999 | WHACs begin implementing plans<br>Women's Health Council formally launched<br>Women's Health Council and Irish College of General Practitioners (ICGP) run joint conference, *Women taking control of their health*, with aim of developing joint agenda for action<br>Women's Health Council makes written submission on the Green Paper on Abortion to the All-Party Committee on the Constitution |
| 2000 | Women's Health Council makes oral submission to the All-Party Committee<br>Midlands Health Board and Women's Health Council organise *Working together creatively for women's health*, a national conference of WHACs |
| 2001 | National health strategy *Quality and Fairness* endorses existing policy approaches to women's health<br>Government adopts Women's Health Council's detailed proposals for a national strategy to reduce the rate of crisis pregnancy<br>Crisis Pregnancy Agency established |
| 2002 | DEJLR launches discussion document and consultation process on *National Plan for Women 2001-2005* |

## The Plan for Women's Health

The *Plan for Women's Health 1997-1999* identified four main objectives:

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

The Plan focused on twelve key issues in women's health, committing to action in relation to each:

- Information for health
- Choosing the healthier lifestyle
- Combating disease
- Reproductive health
- Violence against women
- Promoting mental health
- Women who contracted hepatitis C from the anti-D blood product
- Women with special needs
- Women's health in the developing world
- Consultation
- Representation
- Creating a woman-friendly health service.

At national level, the Department of Health established a Women's Health Policy Unit (WHPU), with a brief to:

- monitor the implementation of the Women's Health Plan
- facilitate the creation of an environment within the health services for the delivery of a female-centred health service to female clients
- liaise with and monitor the activity of the Women's Health Council
- liaise with Women's Health Co-ordinators in Health Boards
- secure adequate funding for maintenance and development of health services for female victims of violence.

Among its recommendations the Plan proposed the establishment of the Women's Health Council

> "to develop a centre of expertise on women's health issues, to foster research into women's health, to evaluate the success of this Plan for Women's Health in meeting its objectives and to advise the Minister on women's health issues generally"(Department of Health and Children, 1997).

Although originally envisaged as being established for the term of the Plan and then being reviewed, the Women's Health Council was set up on a statutory footing in 1997 (SI No. 278 of 1997).

To ensure effectiveness at regional level, the Plan proposed that each "health board will establish an advisory committee on women's health, with at least two representatives of the National Women's Council."

The National Women's Council of Ireland has worked in partnership with the DoH and the health boards since the period leading to the publication of *Developing a Policy for Women's Health* in 1995. The WHAC committees were intended to advise the health boards on the implementation of the Plan. Each health board was mandated to adopt a regional plan for women's health to implement the commitments of this Plan and the issues identified during the consultative process. Prior to being finalised, these regional plans were to be considered by the advisory committees on women's health (WHACs).

Recommendations are laid out as "actions" at the end of each section in the Plan and include:

- commitments to action by the Minister and the Department of Health
- collaborative actions between the Department of Health, the health boards and national statutory and voluntary bodies
- actions which are the responsibility of the health boards (in implementing their regional plans for women's health).

The actions are summarised in Appendix A (pp43-47).

## Summary evaluation of the Plan

The consultation process from which the Plan grew represented a major change in health policy development, giving women an unprecedented opportunity for input. The chief demand of the majority of women was for improved information and education so that they could make their own decisions about their health care. Women asked for empowerment rather than capital investment programmes.

The most significant weakness of the consultation process was that it did not involve service providers, many of whom are women with a unique perspective as both service providers and service users. Consultation with service providers would likely have provided some realistic evaluation of the practicality of recommended actions. Without this practical perspective the consultation process became, to some extent, an end in itself.

The establishment of structures to ensure the effective implementation of the Plan (Women's Health Council, WHACs) was a prerequisite of real progress. In many regions the timeframe of the Plan (1997-1999) was used to establish WHACs and to draft and agree regional plans. Likewise the Women's Health Council was set up in 1997 but did not have offices until mid-1999. This meant that both national and regional progress was delayed beyond the timeframe originally expected for completion. A Women's Health Policy Unit (WHPU) was established in the Department of Health in 1997 to oversee the implementation of the Plan but allocated staff had to balance work on the Plan with other duties.

The NWCI, while supportive of progress to date, continue to have concerns relating to the implementation of the Plan, including

- lack of direction and coherence
- lack of information in relation to actions undertaken
- lack of correlation between the findings of the consultation process and the actions undertaken as part of the Plan
- questioning the innovative nature of actions - it was suggested that many of the actions would have been undertaken regardless of the Plan.

Despite this, the Plan acted as a catalyst both nationally and regionally and gave health boards a broad framework in which to develop their own regional priorities. By the end of 1999 each of the health boards had produced a regional plan for women's health.

The actions listed at the end of each section of the Plan comprise a mix of affirmations of support for existing government strategies, broad aspirations for the development of women's health services and specific recommendations. For the most part, the Plan is silent on timeframes for implementation and the monitoring and evaluation of actions. Without indicators of success, accurate costing and explicit ring-fenced funding the Plan reads as more aspirational than as a blueprint for targeted action.

The aspirational wording of the actions makes accurate evaluation difficult. Many are multi-dimensional and not always gender-specific, for example, the actions around achieving national targets in smoking reduction, awareness of good nutrition and increased exercise or the degree of implementation of the National Cancer Strategy.

However, as previously noted, the Plan has essentially succeeded in putting women's health on the national and regional agendas by a mixture of structural, policy and practical measures and by linking explicitly with other national strategies. Many of the specific projects outlined in the Plan have been undertaken, albeit in an often uncoordinated manner (see below, pp30-36). Since meaningful evaluation of the actions is almost impossible, this document concentrates primarily on the efficacy of the structures that were set up.

## Women's Health Policy Unit

The WHPU reports continuing support, facilitation and promotion of the actions as outlined in the Plan. In particular, ongoing support is being provided for the implementation of the recommendations of linked strategies, such as *Building Healthier Hearts* and the *Health Promotion Strategy 2000-2005.* Specific initiatives include the appointment of a national breastfeeding co-ordinator in 2001, the establishment of a baby-friendly hospital initiative, the commencement of the first phase of both BreastCheck and the Irish Cervical Screening Programme in 2000 and the establishment of the Crisis Pregnancy Agency in 2001. Routine antenatal HIV testing has been introduced and consultation is underway in relation to the best way forward in regard to the development of services for symptomatic breast disease. Dealing with the international aspects of the Plan, multi-annual funding has been allocated to UNAIDS and additional funding provided to International AIDS Vaccine Initiative in 2001.

The WHPU is also involved in ensuring that health policy continues to support the needs of particular groups of women, including those involved in prostitution, in the misuse of drugs, and women with special needs, such as those with hepatitis C. As previously noted, however, the potential of the WPHU is compromised by its lack of fully dedicated staff and its indirect link to senior Departmental management.

## Women's Health Council

As previously noted, the Women's Health Council was set up in 1997. Its establishing legislation outlined its functions as:

- To advise the Minister for Health on all aspects of women's health, either on its own initiative or at the request of the Minister
- To assist the development of national and regional policies and strategies designed to increase health gain and social gain for women
- To develop expertise on women's health within the health services
- To liaise with international bodies which have functions similar to the functions of the Council.

Officially established in June 1997, the Council first met three months later. Various teething troubles meant that a Director was not appointed until October 1998 and the Council's offices opened in May 1999. These delays and operating difficulties meant that the Council was not able to work directly on the recommendations of the Plan for most of its duration.

The summary of Women's Health Council activities to date appears below under the following headings:

- Policy and legislation
- Research strategy
- Health services delivery
- Personal and community development.

All Council actions are related to improving health and social gain for women, in line with the key objective of the Plan. Significant activities include:

### *Policy and Legislation*

- Agreeing with Department of Health a framework for reviewing forthcoming health legislation
- Policy submissions, including on the Health Strategy (into which the Council recommended that issues raised in the *Plan for Women's Health 1997-1999* should be incorporated), crisis pregnancy and information, and on health-related aspects of the draft National Plan for Women 2001-2005
- Policy positions, including on the Twenty-fifth Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill, 2001
- Representation on the board of the Crisis Pregnancy Agency, the Commission on Assisted Human Reproduction and the National Committee on Breastfeeding.

### *Research Strategy*

- Commissioning and publication of research, associated with health and social gain for women, including:
    - *Perspectives on the Provision of Counselling for Women in Ireland* (2002), commissioned in association with the Eastern Regional Health Authority and the North Western Southern Health Boards. The research showed a need for improved access to services, as well as better dissemination of information on the availability of counselling services amongst the general public and health service professionals, and made a number of recommendations for improving services
    - At the request of the National Cancer Forum, the Women's Health Council commissioned research surveying the views and experience of women attending symptomatic breast clinics. The study *Survey of Views and Perceptions of Women who attended Symptomatic Breast Clinics* (2000) found that stress from the fears arising from breast symptoms was compounded by unacceptable delays and inability to deliver quality services, not least due to under-resourcing of clinics, and made recommendations for practical improvements.
    - *Women - The Picture of Health: a review of research on women's health in Ireland* (1999) described the extent of research on women's health in Ireland and assessed its adequacy as a basis for policy. It demonstrated how the main objectives of the Plan correspond to general health policy principles, and showed a clear need for an improved, gender-proofed information base and for more research on women's health to inform policy development.

- Establishing a Research Programme Grant in collaboration with the Health Research Board (2001), with a view to setting up a programme of high quality research in women's health over a five-year period.

### *Health Services Delivery*

- Considering standards and legislation relating to nursing homes in a *Review of Nursing Home Services in Ireland* (2002), an issue pertinent to the growing numbers of older women in Ireland. The review highlighted the need for the targeting of services relating to older women's health and raised concerns around regulations, resources and confusion around entitlements to subventions.
- Instigating communication with the Department of Health Primary Care Task Force in relation the delivery of services to women.
- Literature review on Parasuicide (2001)
- Priorities identified for future attention include:
    - easier assess to services
    - the needs of vulnerable groups
    - the need for consistent approaches to service evaluation
    - effective and user-friendly complaints procedures
    - the need for a holistic approach to service planning and delivery.

### *Personal and Community Development*

- Conducting a literature review on *Best Practice for Supporting Women's Decision Making Around Health*. This examined decision-making from the individual, community and organisational perspectives, concluding that structural and bureaucratic issues associated with health services frequently prevent women from participating actively in decision-making concerning their own health.

Current Women's Health Council initiatives address cross-cutting issues such as cardiovascular health, the role of social disadvantage in women's health and the Primary Care Strategy. The resulting position papers will provide direction for future Council activity.

## Women's Health Advisory Committees (WHACs)

WHACs were identified in the Plan as crucial mechanisms for ongoing partnership between statutory health services and non-statutory agencies and also for consultation with women about their health priorities. All eight health boards complied with the Plan's recommendations to establish WHACs and to draw up regional plans for women's health. Their timeframes, however, differed greatly. Two regions, the North Eastern and the North Western Health Boards, had established structures to address women's health following the 1994 publication of *Shaping a Healthier Future* and thus were able to conduct consultations and finalise regional plans prior to the publication of the national Plan in 1997. Their 1999/2000 service plans brought them into line with the other health boards.

Regional differences were also evident in terms of the composition of WHACs, their operational mechanisms and the publication of their plans. For example, while the Eastern Health Board committee had 10 members, there were 29 on the Mid-Western Health Board's committee. While all committees included at least two representatives of the NWCI, some also involved extensive representation of other voluntary organisations. In the Mid-Western region, for example, there were 16 members of the committee who were not health board personnel, of whom three represented NWCI. By contrast, the Southern Health Board WHAC involved only three non-health board personnel, all of whom were NWCI representatives.

In all but the South Eastern Health Board, the chairs of the committees were employees of the health board.

Some regions involved a wide variety of people in the development of the regional plan. In the South Eastern Health Board, six subcommittees with a total of 85 members were established to work alongside the WHAC, drawing on local voluntary organisations, the WHAC and the wider health board for their personnel. In the Mid-Western Health Board, some 35 individuals, in addition to WHAC members, made contributions to the regional plan.

The merit of the variation between health boards of composition and methodology of the WHACs was that it allowed for a regional focus in the planning process. It also made detailed comparisons of regional plans difficult, however, and fragmented and isolated the committees within and between health boards.

Partly to address these shortcomings the WHACs and other key stakeholders met at a national conference, *Working together creatively for women's health*, in November 2000. Led by the Midland Health Board in conjunction with the other Health Boards and the Women's Health Council, the conference used an open space format in which participants set the agenda. Thirty-three formal workshops were held on themes identified by delegates, including:

- Cardiovascular health
- Older women/osteoporosis
- Woman-friendly health service
- Adolescent pregnancy/teenage sexual health
- Mental health
- Breast and cervical screening
- Equality of access to service
- Anti-poverty strategy
- Refugees' and non-nationals' health issues
- Moving the process forward and influencing policy
- Women's right to alternative health,

demonstrating the broad range of issues relevant to women's health being considered by WHACs around the country.

Key points which emerged from workshops included:

- the lack of engagement in the women's health process by senior management of health boards
- the need for clarity in and revision of the remit and structure of WHACs
- the low political profile of the national Plan
- the need for a gender analysis within a model of structural detriments to good health
- debate on possible outcomes of the present review of the Plan.

Beyond the level of harmonisation achieved through debate on the day, a practical outcome of the conference was the establishment of quarterly networking meetings of Women's Health Development Officers. The conference also resulted in the commissioning of a paper on *Establishing the Rationale for Gender-Specific Strategies to Improve Women's Health* which is due for publication soon.

All respondents interviewed in the evaluation of the Plan posited the retention (or, in some cases, the revival) of the WHACs with a clearly specified brief. There was widespread support for an advocacy role for WHACs within health boards although there was no consensus concerning a possible operational role in relation to specific actions in women's health or a role in the dispersal of funds. Closer co-ordination between WHACs, and also between regional committees on violence against women and WHACs, was recommended.

WHACs were regarded as demonstrating their potential to serve as a model of good practice in promoting inter-sectoral collaboration and also in improving communication within the health service and between the health boards and local community and voluntary organisations. The South Eastern Health Board's sub-committee structure was regarded as particularly effective. It was recommended that the membership of WHACs should include senior health board officials and increased representation from women's organisations and/or health service user groups.

### Women's Health Development Officers

The appointment of Women's Health Development Officers (called Co-ordinators in some health boards) was identified by many interviewees as crucial for the future development and co-ordination of women's health initiatives at regional level. The officers were perceived as playing a central role in "driving" the focus on women's health and as acting as "champions" within the health boards, as well as being of critical significance in regard to supporting the work of the WHACs. Women's Health Development Officers have been appointed by four of the health boards. Some are part-time posts, some are full-time and they are positioned at varying levels of responsibility and within different sections in the various health boards. A unified approach to the job description and the optimal location of these posts within the health board structure would assist in ensuring equitable outcomes across the country.

#### *Current situation*

Of seven health boards responding to contact from the Women's Health Council in March 2002 six had included measures specific to women's health in their service plan for 2002. Only three had a distinct plan for women's health. Current actions on women's health included ongoing consultation with women, the provision of grants for women's groups in the community, the development of a website and the translation of health information guides into languages other than English. Not all of these were configured as gender-specific.

Membership of most WHACs had changed since the fieldwork for the evaluation had been conducted. More fundamental changes had taken place in some regions. In two health boards the WHACs were now designated as Women's Health *Implementation* Committees, while another had retained the title but also changed the role to implementation. Two health boards reported that their WHACs had been disbanded after their regional plans had been published and Women's Health Development Officers appointed, although both were intending to establish new committees based on the outcome of the present Women's Health Council review.

It is clear from the level of regional variation that clarification and refocusing of organisation and activity in the advisory process concerning women's health are necessary. Proposals mapping out future directions in the area are contained in Section 4, pp39-42.

## Regional plans for women's health

All eight health boards published regional women's health plans. While mirroring broadly the key themes and structures of the national Plan, they vary considerably in structure, length, timeframe and content and the number of recommended actions (Fig. 2).

*Fig 2: Structure of regional plans for women's health*

| Health Board | Year published and period covered | Length, number of recommendations and comment | Short-term priorities |
|---|---|---|---|
| Eastern Health Board* | 1997<br><br>1997-1999 | 27 pages/74 recommendations<br>Structured around the twelve headings in the national plan. Under each heading the actions proposed in the national plan, current initiatives in the EHB and proposed actions with cost, timeframe and programme responsible for implementation, are specified. | None specified. |
| Midland Health Board | Part 1-1997<br><br>1997-1999<br><br>Part 2-2001<br><br>2001-2004 | Part 1 27 pages/34 recommendations<br>Focuses on health promotion interventions. It is organised around six objectives that reflect some of the priorities in the national Plan. A brief account of the proposed action is included, with funding requirements.<br>Part 2 39 pages/24 recommendations<br>Includes brief review of progress on recommendations of Part 1. Identifies key actions covering many areas in the national Plan with timeframe, lead service and funding sources identified. | Priorities identified for each year (Part 1 - 1998 and 1999, Part 2 - key actions and time frame). |
| Mid-Western Health Board | 1999<br><br>1999-2000 | 91 pages/229 recommendations<br>Structured around broadly similar headings to the national Plan. Recommendations are accompanied by details of current service provision. The responsible department within the HB is specified for each target. | Priorities for 1999 and 2000 identified. |
| North Eastern Health Board | First version 1995<br><br>1999 update<br><br>1999-2000<br><br>2001 review undertaken | 66 pages/143 recommendations<br>Follows the headings of the national Plan with each section noting the actions proposed in national Plan, and the NEHB recommendations and how these are represented in the 1999 service plan and priority areas for 2000.<br>*Developments for 2000/1 are outlined on the NEHB website: www.nehb.ie* | 1999 and 2000 priorities identified. |
| North Western Health Board | 1996<br><br>Not specified | 71 pages/285 recommendations<br>Includes socio-demographic profile of women in the region, a report on the public consultation process and recommendations under nine headings, broadly mirroring the headings in the national Plan. | None specified. |
| South Eastern Health Board | 2000<br><br>2000 and beyond | 36 pages/176 recommendations<br>Organised around the themes addressed by six subcommittees, broadly reflecting headings of the national Plan. The framework, recommendations and priorities are detailed in each section. 1999 and 2000 priorities are costed. | 4 overall priorities identified. |
| Southern Health Board | 1999<br><br>2000- 2002 | 19 pages/91 recommendations<br>Organised around broadly similar headings to the national plan. Proposed actions are briefly outlined, with reasons for prioritisation, key groups, key settings and funding requirements specified. | Priority given in some areas. |
| Western Health Board | 1998<br><br>Period covered not specified | 73 pages/273 recommendations<br>Contains a detailed discussion of the background rationale for each set of recommendations, including a review of national and regional epidemiological research. | 23 priority areas are identified with between 4 and 24 recommendations for each. |

* The EHB WHAC was established and published its regional plan prior to the establishment of the ERHA with its three constituent Area Health Boards.

As can be seen from fig 2, the timescales of the plans varies from the time period of the national Plan (1997-1999) to 2000-2002, with some unspecified. Differences in the timescales of plans relate generally to variations in the duration of the process of developing a plan in each region. In some health boards, regional plans were in the place the same year as the national Plan was published, while in others plans were not agreed until 2-3 years after the publication of the national Plan.

The plans also differ widely in their length and content, running from 19 to 91 pages. While some follow closely the recommendations of the national Plan, others do not. The Midland Health Board plan, for example, concentrates on health promotion, information and on-going consultation. Some regional plans include recommendations in areas additional to those made in the national Plan. The Mid-Western Health Board plan, for example, includes recommendations in relation to refugees and asylum-seekers. Similarly, some regional plans differ from the national Plan in terms of the weighting given to issues. In the South Eastern Health Board, for example, prominence is given to carers and to sexual health, while in the Western Health Board plan counselling, miscarriage and stillbirth are prioritised to a greater degree than in the national Plan.

The number of recommendations and priorities identified in the plans also reflect regional variation. The number of recommendations in each plan ranges from 28 to 279. Some follow the lead of the national Plan and are aspirational, with few clear actions specified. Others, by contrast, are very precise, are costed and the programme with responsibility for their implementation specified. Similarly, not all plans identify short-term priority actions. Few, beyond health information, are common to more than one region, apart from urinary continence and the continuation of the WHAC itself. Some plans identify and cost priority activities and many detail submissions to their Board's service plans.

## Actions

Following on from the variations between regional plans for women's health, the actions undertaken differ widely. Many people interviewed for this review reported that they had difficulty in attributing actions that were undertaken directly to the Plan. This point was made repeatedly in relation to the national breast and cervical screening programmes, which were identified as significant for women's health but which many interviewees felt would have happened irrespective of the national Plan.

Similarly it proved difficult to identify actions resulting specifically from the recommendations of the regional plans. Actions discussed here were primarily extracted from reports by the WHACs to the Women's Health Council in 2001-2 and thus cannot be regarded as comprehensive. Some WHACs identified all actions within their region that could affect women's health, while others highlighted initiatives specifically funded from the budget allocated to the WHACs by the Department of Health.

Some examples of actions common to a number of the health boards include:

- appointment of Women's Health Development Officers (see above, p30)
- health information initiatives, including directories of services, health information leaflets, menopause awareness packs, a consumer health information project (SEHB) and computerised health information outlets (NEHB)
- research, including research on counselling services, incontinence (MWHB), a review of antenatal education (NWHB), a feasibility study on the need for outreach services for marginalised women (SEHB) and research into the needs of carers (WHB, in collaboration with NUIG)
- provision of grants to community-based women's groups and to local voluntary organisations dealing with subjects such as pregnancy counselling and contraceptive service provision

- linking with the regional committees organised under the DJELR initiative on violence against women (all WHACs)
- undertaking initiatives to improve maternity and contraceptive services (all WHACs).

Figure 3 below provides detail on the actions undertaken in each health board region.

*Fig 3: Actions reported by the Women's Health Advisory Committees*

| Section Headings of National Plan | Actions reported by WHACs |
|---|---|
| Information for health | WHB community health awareness projects, information leaflets, brochure holders, distribution of WHB plan<br>SEHB seminars on WH issues in each community care area, consumer information project<br>SHB WH directory<br>NWHB links with community information projects and research, development of NWHB women's network<br>MWHB research, women's health conference<br>MHB information on WH, contraception, health information support women's groups, older persons<br>EHB black and white guides, WH information booklet, FP for healthcare professionals, Side by side, PND, translation into French, Russian and Romanian.<br>NEHB interactive website being developed, community grants to women's groups for initiative to promote WH |
| Choosing a healthier lifestyle | WHB nutrition education and training programmes for health professionals and voluntary groups, nutrition information leaflets for teenagers<br>SHB health promotion initiatives including smoking cessation programmes, five community nutritionists appointed<br>NEHB smoking cessation/nutrition/physical activity promotion initiatives<br>MHB smoking, nutrition, exercise initiatives, workplace health promotion<br>EHB development of OP prevention pack for 12-14 year olds |
| Combating disease | SHB appointed development officer for cancer and cardiovascular services, developing strategy |
| *CVD* | |
| *Cancer* | NEHB cancer prevention co-ordinator appointed |
| *Lung cancer* | *Smoking cessation initiatives reported above* |
| *Breast cancer* | NEHB Phase 1 of BreastCheck, Regional centre for symptomatic services being developed<br>MHB breast cancer initiative |
| *Cervical cancer* | NEHB promotion of cervical screening by GPs<br>MWHB Phase 1 of Irish Cervical Screening Programme |
| Skin cancer | |
| *Oral health* | *No actions specified* |

| | | |
|---|---|---|
| Reproductive Health | | |
| *Childbirth* | WHB | home birth services, bereavement services for miscarriage, health education midwife at MGH, midwife-led postnatal clinics, |
| | SEHB | review of antenatal education, training for midwives, PHNs and practice nurses, appointment of regional midwifery project officer, establishment of regional midwifery development groups, home birth services in all community care areas, domino service being developed, community antenatal service, community mothers/first steps project |
| | SHB | new maternity services unit planned, pilot home birth project, 24 hour epidural services, outreach antenatal clinics |
| | NWHB | review of antenatal education, antenatal information package development |
| | NEHB | development of regional services, midwifery-led unit, outreach services |
| | MWHB | antenatal services |
| | MHB | maternity and early childhood review |
| | EHB | home birth initiatives, conferences, research into maternity care needs of refugee women |
| *Breastfeeding* | WHB | breastfeeding room at UCHG |
| | SEHB | baby-friendly hospitals, breastfeeding project officer appointed, home helps for breastfeeding mothers |
| | SHB | breastfeeding initiatives |
| | NWHB | infant feeding research, homebirth policy |
| | NEHB | promotion of breast feeding |
| | EHB | training courses |
| *Family Planning and Reproductive Health* | WHB | designated WH clinics in primary care, bilingual information leaflets, grants to GPs to provide FP and WH services, |
| | SEHB | designated WH/FP sessions in general practice, funding to GPs and PNs to take FPC, WH education for GPs and PNs (in collaboration with ICGP) |
| | SHB | family planning initiatives, sexual health strategy |
| | NWHB | contraceptive services research, sexual health strategy |
| | NEHB | family planning training for GPs and PNs, more female GPs and PNs, inter-referral system, survey of service users, family planning and pregnancy counselling services have been extended and improved |
| | NEHB | sexual health strategy development |
| | MWHB | practice nurses |
| | MHB | family planning and sexual health initiatives, |
| | EHB | funding to NGOs for FP services for GMS clients, funding to GP services |
| Abortion | SHB | pregnancy counselling initiatives |
| | EHB | grants to six organisations to provide pregnancy counselling |
| | NEHB | research on crisis pregnancy services |
| *Human Assisted Reproduction* | | |
| Other | | |
| Violence against women | WHB | conference, information leaflets, links with women and violence committee |
| | NWHB | links to women against violence committee |
| | NEHB | links with women and violence committee, education and training initiatives, database development, regional training officer appointed, extension of links with organisations providing services for women who experience violence |
| | MHB | domestic violence project |
| | EHB | links with regional committee and its activities |
| | SHB | links with regional committee, funding for rape crisis centre, review of refuge services, staff training to raise awareness, network groups, appointment of designated social worker |
| | SEHB | women's refuges opened |

| | | |
|---|---|---|
| Promoting Mental Health | SEHB | mental health resource officers, PND training project |
| | NWHB | counselling research, counselling service for young people, PND research working group formed |
| | WHB | counselling service, PND counselling services |
| | NEHB | counselling service |
| | MHB | women and mental health initiative |
| | EHB | community counselling services, grant to Bodywhys to compile directory of services, PND support group, |
| | SHB | information booklet on PND, funding to Postnatal Distress group, funding to support group for eating disorders (SHINE), continued support to voluntary agencies for treatment of addiction, outpatient programme for alcohol, drug and gambling addiction, training in life-skills for those on addiction programme |
| Women with Hepatitis C | NEHB | Hepatitis C liaison officer |
| | SHB | services according to Health Amendment Act 1996 |
| Women with special needs | SHB | access to information and support for rural women's groups |
| *Socially and economically disadvantaged* | EHB | grants to self help groups |
| *Young women* | WHB | Teenage parenting project |
| | SEHB | research on teenage pregnancy, peer-led relationship and sexuality education project |
| | NEHB | development of student health services, youth initiative partnership, support project for young single mothers |
| | MHB | teenage pregnancy initiative |
| | EHB | teenage health co-ordinator appointed, training for youth workers, funding of IFPA research on FP needs of young people |
| *Women as parents* | NEHB | community parenting programme, parentcraft classes for young mothers |
| | MWHB | community mothers scheme |
| | MHB | parenting initiative |
| | SHB | community mothers programme, funding for lone parent programme |
| *Traveller women* | WHB | education programme for community health workers, culturally sensitive information on violence |
| | NWHB | links with travellers project |
| | NEHB | traveller health projects |
| | MHB | traveller health initiative |
| | SHB | traveller health unit well established, funding to traveller organisations |
| *Women with disabilities* | MHB | women with disabilities initiative |
| | SHB | strategy being developed, directory of services published |
| *Women as carers* | WHB | carer's research |
| | SEHB | study of information needs of carers, provision of extra respite facilities, regional Child Health review, pilot project on information provision to parents/carers of children |
| | MHB | carers initiative |
| | SHB | development manager for services for carers appointed, continuing support for outreach day care, development of carer support group, Home Carers Course |
| *Older women* | WHB | osteoporosis services |
| | SEHB | women's health physiotherapist appointed |
| | MHB | continence promotion programme, older women initiative |
| | EHB | continence promotion programmes |
| | SHB | strategy for older people "Ageing with confidence" |
| | NEHB | research on continence promotion |

| | | |
|---|---|---|
| *Lesbian women* | | |
| *Women in prison* | | |
| *Women in prostitution* | SEHB | funding to voluntary groups working with women in prostitution |
| *Women and drug misuse* | NEHB | addiction counselling |
| Women's health in the developing world | SHB | staff who take a career break to work in developing countries are supported |
| Consultation | WHB | liaison with women's organisations, grants to voluntary organisations, consultation meetings throughout area in 2001 |
| | SHB | grants to voluntary organisations |
| | NWHB | links with community development and information projects incl cross-border project |
| | MWHB | joint working with MWHB Partnership Forum to investigate how community and HB can work together in service planning process |
| Representation | MHB | organised networking conference, HR strategy, equal opportunities report |
| | SHB | equal opportunities employer |
| Creating a woman-friendly service | NWHB | pilot staff health initiative in community care, user-friendly health centre checklist |
| | NEHB | research on peer education and women's resource centres |

The variation in layout, focus and level of detail in the regional plans makes direct comparison and evaluation difficult. Some issues do emerge clearly, however, including:

- not all listed actions were gender-specific. For example, under the heading *Choosing a healthier lifestyle* some of the actions were undertaken as part of general health programmes. While these certainly had the potential to impact on women's health, they were not formulated *specifically* to target women and did not take account of the differing needs of women and men. There was no evidence of gender-specific actions as part of major initiatives such as the cardiovascular strategy
- similarly, not all listed actions were setting-specific, taking into account the needs of women in different social groups
- many actions appeared to be ad hoc in nature
- there was little evidence of sharing of best practice among health boards
- there was no activity in some categories identified as priorities in the Plan, such as oral health.

The strength of the regional plans lies in their ability to mirror regional needs and priorities within the framework of the national Plan. From the point of view of achieving health and social gain for women throughout Ireland on an equitable basis, however, there is clearly a pressing need for greater co-ordination and unity of purpose between the various health boards, in order to establish greater consensus on the priorities to be tackled. Proposals mapping out future directions in this area are contained in Section 4.

# Section 3

## Learning from the Plan's outcomes and limitations

As outlined in the previous section, there is general agreement among key stakeholders that the Plan and its resultant activities contributed significantly to the creation of a positive climate for the consideration and advancement of women's health issues. This in turn has raised debate about gender sensitivity in health generally and has contributed to the formation of a parallel interest in men's health issues. This is all to the good: it may well be that current services and health policy development are based on gender-blind generalities which have grown out of custom and practice and which, in effect, meet nobody's real needs.

In terms of concentration on women's health issues, the Plan's achievements are more visible in structures than in changed practice. The establishment of the WHPU and the Women's Health Council at national level, and the WHACs and Women's Health Development Officers at health board level, is significant and provides a solid basis on which future work can be built. It is, however, questionable as to what improvement is discernible at the level of the ordinary female consumer of health services. Depending on her age and locality she may now have more information or better or new services - or she may not. Even if she does she is unlikely to be able to link these to a specific policy initiative on women's health. The introduction of cervical and breast screening, cited by many respondents to the fieldwork for this review as a key achievement, is also widely believed to be innovation which would have happened anyway, irrespective of the Plan.

In practice, the aspirational nature of the Plan rendered it more of a statement of strategic intent than a practical plan per se, and the resulting wide regional differences in interpretation and implementation make it almost impossible to identify models of good practice in any meaningful way. Lacking agreed criteria, targets or formal evaluation of project outcomes, regions identified the establishment of the structures and the provision of small grants to health-related, community-based women's groups as models of good practice. Small-scale regional initiatives, ranging from teenage health projects to continence promotion to pilot programmes for home births, were also cited. Without consumer-based independent evaluation, real creative communication and co-ordination between regions, however, these initiatives will remain local, and the multiplier benefits for women nationwide will remain untapped.

Perhaps the practical outcomes would have been clearer if there was greater understanding of the rationale for specific targets and attention on women's health. When key stakeholders question the need for an initiative distinctly focused on women's health it is a sign that communication is less than optimal. The relationship between mainstreaming, gender sensitivity and distinct woman-focused policy is little understood and there are fears that specifically targeted plans can lead to fragmentation rather than progress. Clarification of the rationale for women-specific health policy and the resolution of confusion concerning the respective roles of the various structures are also required.

The invisibility of specific targets for women's health in recent national policy-making reinforces the notion that the current lack of clarity could lead to the downgrading of women's health issues. To have status women's health policy must be linked explicitly with other key strategies and initiatives at both national and health board level. Without the clear articulation of these links women's health initiatives may well continue to fare poorly in the competition for official attention and resources.

While key stakeholders praised the Plan as a catalyst, they also referred to it as "ambitious" and "challenging". Implementation of many of the Plan's objectives necessitates crossing different health disciplines, requiring the establishment of new structures and new working relationships. In the absence of an agreed rationale such innovative and far-reaching work is likely to assume a low priority. The lack of clearly-articulated targets and specific ring-fenced funding meant that time was spent in defining what could be done, time which could not then be allocated to actually doing it. There was also some confusion as to the purpose of monies given to health boards by the Department of Health and Children for the operation of WHACs, with some using this as seed funding for projects. This meant that only small-scale initiatives could be funded, and mainstream health board funding was uninvolved.

Within the health boards the nature of the WHACs resulted in their marginalisation from planning structures and the centre of power and decision-making. They were also generally perceived as lacking in administrative capacity. The latter is likely to be corrected, at least to some extent, by the appointment of Women's Health Development Officers, although their effectiveness is somewhat compromised by the variation in their location in the health board hierarchy. Ownership by senior management is essential to progress in cross-cutting areas such as women's health and the continued under-representation of women at higher levels of health board management may be another factor inhibiting progress.

The nature of the WHACs also meant that in many health boards development of regional plans was a long and arduous process. Publication of plans gave way to a loss of momentum and a sense of drift in several regions, leading to confusion about role and even disbandment. Implementation of recommendations contained in regional plans was hampered by many factors, notably lack of clarity with regard to role and responsibility, funding, level of priority etc. The lack of implementation structures, poor co-ordination of services and a relatively low level of inter-board co-operation also mitigated against effective implementation. Consequently, as noted above, many recommendations remain unimplemented and those actions which were taken tended to be modest in scale.

The Plan for Women's Health has not entirely run into sand, however. The very existence of the Plan has galvanised both debate and action, and has kept issues relating to women's health on the agenda of a multiplicity of levels of policy-making and service development. The principles and premises of the Plan are still valid. The required structures are broadly in place and their potential recognised. What remains to be agreed is a unified approach to ensuring their effectiveness in achieving real health gain for women. The final section of this document contains proposals for achieving just that.

Section 4

# Refocusing the women's health agenda - proposals for progress

Over the last decade there has been increased acknowledgement of the social dimensions of gender difference in health. Gender inequalities are most obvious in the distribution of income and wealth and there is ample evidence of the intimate relationship between these and patterns of health and health care. While there are obvious sex-specific conditions, many of the health issues women face are not related in any direct way to their particular biological characteristics.

International consensus on the broader economic and social gains to be made from promoting the health of women is growing. Debate continues as to how best to achieve gender-related health objectives, with the result that gender equity strategies are as yet rarely visible within public health policies.

In the Irish context, the preparation of a national Plan in turn prompted the publication of regional plans and the development of regional structures and partnerships to implement the resulting recommendations. Notwithstanding the limitations detailed in this document, the Plan for Women's Health acted as a catalyst for much activity aimed at improving the health of women and the quality of their interactions with health services. The very existence of the Plan, and the establishment of the structures it recommended, ensured a specific place on national and regional agendas for vital issues relating to women's health. Partnerships, projects, awareness and initiatives resulting from the Plan and its implementation have continued to produce positive results for women long after the end of the period to which the Plan related.

The most pressing issues now are:

- building on the achievements to date
- ensuring a dynamic role for the structures established as a result of the Plan, especially the WHACs
- securing measurable health gain for women over the next 7-10 years.

To build on the Plan's achievements and to secure health gain for women the Women's Health Council proposes three specific initiatives:

## 1. Focusing the women's health agenda for the 21st century

The Women's Health Council proposes, in conjunction with the Department of Health and Children and the health boards, to provide a policy framework for focused health measures for women by updating the provisions of the Plan in relation to:

- other current health strategies and plans, with particular reference to those which have come into being since 1999
- identifying positive achievement for replication
- identifying gaps in provision in relation to women's health
- integrating targets relating to women's health into current and future health strategy and planning.

The Women's Health Council proposes, with the Department of Health and Children, to invite all major stakeholders to assist it to define the principles and parameters for policy and action in the field of women's health in Ireland. The health boards and relevant non-statutory and consumer bodies will be invited to participate.

The resulting policy framework will set the scene for targeted, measurable work aimed at maximising health gain for women over the next 7-10 years. Specific priorities for targeted action

both nationally and regionally might include gender-related aspects of cancer and cardiovascular disease, and measures relating to improving the health status of disadvantaged women and young women.

## 2. Achieving national agreement on optimal structures and procedures

The Women's Health Council proposes the harmonisation of structures and procedures in the area of women's health. Harmonisation is proposed in order to enhance the coherence and effectiveness of the WHACs as agents for positive change in women's health and to ensure collaboration and co-operation of shared experiences and practices.

National agreement should be achieved on:

- a clear rationale for concentration on women's health issues within the context of broadening approaches beyond the confines of the traditional medical model
- clear definition of the roles, responsibilities and contribution of the various partners and players in the field, including the WHACs, to ensure maximum effectiveness in the coming decade
- structures and procedures for maximum co-ordination and co-operation between the partners, to ensure optimal and coherent outcomes.

The effectiveness of the WHACs is germane to the achievement of health gain for women. The Women's Health Council proposes that this be enhanced by broad agreement between all partners on:

- the composition, terms of reference, funding, servicing by Women's Health Development Officers and reporting relationships of WHACs to health board management at director level
- an explicit brief with regard to gender-sensitive targets and the gender-proofing of health board policy and practice generally, including service plans
- the primacy of an advocacy and leadership role on issues relating to women's health, above any operational considerations
- intra- and inter-agency working, communication and co-operation
    - within the statutory sector, including with other structures involved in cross-cutting issues
    - between the statutory and not-for-profit sectors.

The harmonisation of job descriptions and parameters for the activity of Women's Health Development Officers should also be agreed.

The Women's Health Council proposes to monitor and evaluate the resulting activity with a view to ensuring the continued effectiveness of actions.

With regard to national structures, the Women's Health Council proposes:

- for itself, an executive structure and capacity and a streamlined board in line with its enhanced role in ensuring health gain for women (see also below)
- for the WHPU, more dedicated staff time, a direct line to the senior management team and closer co-operation with the Women's Health Council.

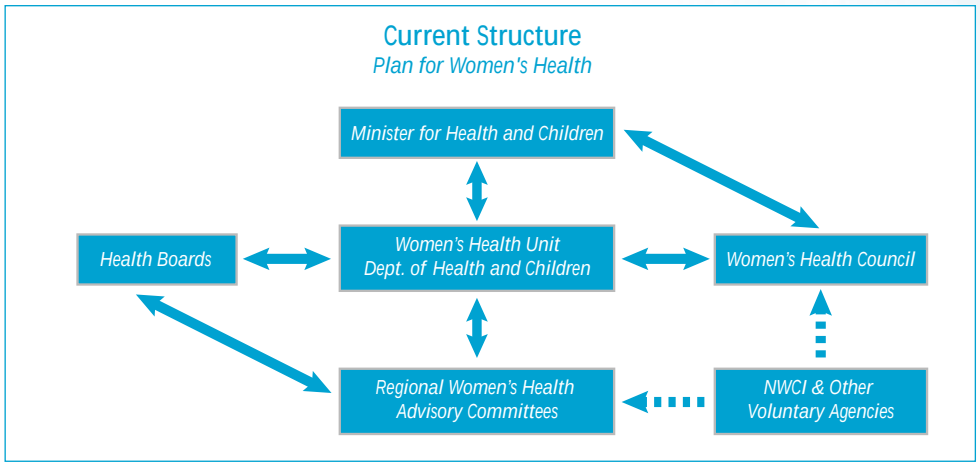
## 3. Ensuring gender equity in health services and initiatives

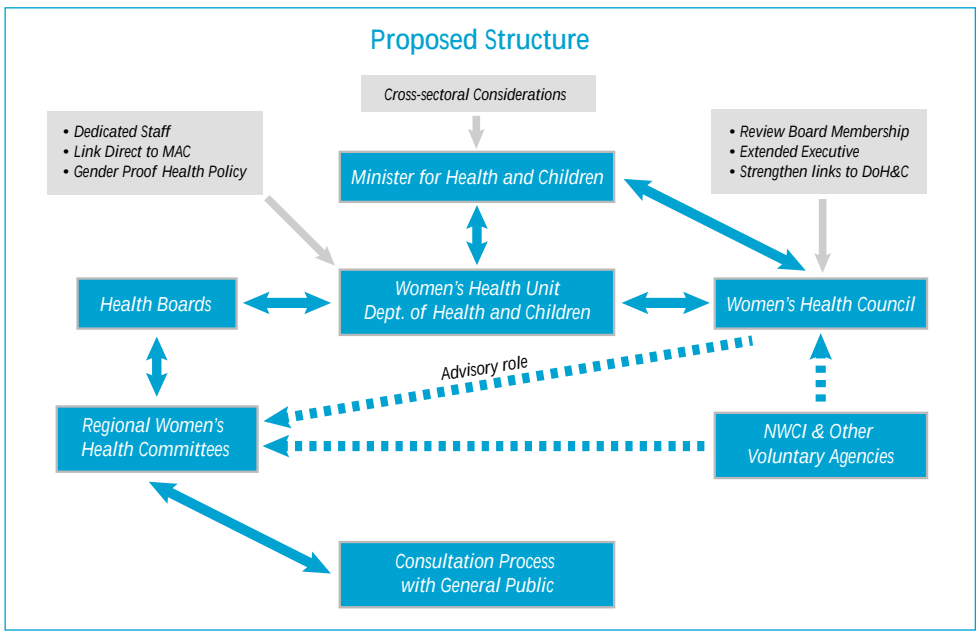
The Women's Health Council proposes that the Department of Health and Children develop criteria, models, structures and procedures for gender-proofing national and regional policy and practice related to the health of women, to be implemented by appropriate bodies at local and national level.

The resulting activity will be monitored and evaluated by the Women's Health Council with a view to ensuring its continued effectiveness over time. The interplay between women's health policy, plans and initiatives and current and future general and specific policy, plans and initiatives in related areas will be a key focus of concern. The Women's Health Council will continue to advise the Minister on areas of unmet or inappropriately met need.

Taken together, these three proposals provide a viable framework for securing significant health gain for women, and for improving significantly their satisfaction with regard to their interactions with the health services. Such a framework will constitute a worthy, practical and targeted successor to the inspiration and leadership of the *Plan for Women's Health 1997-1999.* The net result will be the achievement of better health, not just for women, but for everyone.

The charts below summarise the current structures and the improvements proposed at national level by the Women's Health Council.




## Department of Health and Children

- direct line to Management Advisory Committee (MAC)
- develop gender proofing guidelines for the health sector.
- additional dedicated staff
- formal channel of communication with WHC to facilitate statutory role

## Women's Health Council

- membership of board to reflect explicitly service, academic and lay representation
- statutory advisory role to be developed at operational level
- extended executive.

## At regional level the Women's Health Council proposes:

- standardised process and procedures for the WHACs, including terms of reference and reporting relationships to senior management
- continued representation from NWCI and other relevant non-statutory bodies
- dedicated women's health development officer, with a brief to include working directly with WHACs
- WHACs to have advocacy role on issues pertaining to women's health, rather than operational responsibilities
- key roles to include:
  - gender proofing health board policy and practice concerning service provision
  - inter-sectoral co-operation with other agencies
  - continued consultation with general public.

## Specific topics in women's health proposed for priority action:

- Cancer - the Cancer Strategy clearly sets out an unmet need in relation to preventive, early risk detection and treatment services and this report re-iterates the relatively high levels of some cancers in this country. The WHC endorses the recommendations in the strategy and recommends in particular the speedy implementation the Breast and Cervical Screening programmes from pilot to full service phases with appropriate follow-up services in place.
- Cardiovascular disease - the Cardiovascular Strategy should be implemented in full. Though over their lifetimes women are as affected as men by cardiovascular disease, there is evidence in the scientific literature of less focus on their needs at all levels, from health promotion through to tertiary care. The CVD task force should therefore give specific attention to gender equity in relation to management of cardiovascular diseases, which account for almost half of all deaths and are inordinately common in Ireland. The WHC is currently preparing a review of this issue.
- Disadvantaged women - the needs of disadvantaged women have constituted a priority for the WHC in all its documents and submissions to date. It is clear that inequalities exist in relation to health in Irish society, those who live in poverty are subject to poorer or bad health, and women have a critical influence in relation to family and social support as well as to their own direct health needs. The WHC supports any initiative at policy, community, or health service level that addresses this situation of disadvantage by reducing social inequality, promoting well-being, providing support for improvement in lifestyle and health practices, and providing equitable access to healthcare.
- Mothers/children - the epidemiological evidence indicates that early life influences are of crucial importance, not alone in predicting good maternity and paediatric outcomes but also in affecting health risk in adult life. It follows, therefore, that mothers and children require a comprehensive service to provide seamless care during this early life period. In this context a review of the GMS scheme, in line with the recently proposed changes for older people, would be appropriate. The WHC is also preparing a review paper on the issue of early life influences on mother and child health.

# Appendix A

## Actions outlined in the Plan for Women's Health, 1997-1999

| Actions in National Plan | DOH/MOH | DOH with HBs (and other agencies) | HBs (in implementing their Plans for Women's Health) |
|---|---|---|---|
| Information for health | | *3 recommendations*<br>Pilot innovative approaches<br>1. To inform women about health services<br>2. To disseminate good practice<br>3. Surveys to be undertaken to evaluate success of these initiatives | |
| Choosing a healthier lifestyle | | *1 recommendation*<br>1. Development and enhancement of consultation and co-operation for health promotion | |
| Combating disease | | | |
| *CVD* | | *4 recommendations*<br>Achieving national targets re:<br>1. Smoking reduction<br>2. Increased awareness of good nutrition<br>3. Increased exercise<br>4. Role as catalysts for creation of supportive environment | *2 recommendations*<br>To pay particular attention to working with women to inform them of benefits of:<br>1. A healthy lifestyle<br>2. Reducing risk posed by smoking, poor diet and lack of exercise |
| *Cancer* | *1 recommendation*<br>1. Will implement National Cancer Strategy | *1 recommendation*<br>1. Will work to implement the Cancer Strategy | |
| *Lung cancer* | *3 recommendations*<br>1. Will inform women of link between smoking and lung cancer and scope for prevention<br>2. Will act on training of GPs in counselling techniques for smoking cessation<br>3. Will press for EU-wide approach to banning advertising of tobacco products | | *2 recommendations*<br>1. Will work with women's organisations to increase awareness of benefits of smoke-free lifestyle<br>2. Will support women in their efforts to refrain from smoking |

| Actions in National Plan | DOH/MOH | DOH with HBs (and other agencies) | HBs (in implementing their Plans for Women's Health) |
|---|---|---|---|
| *Breast cancer* | *2 recommendations*<br>1. Will put first phase of breast cancer screening programme in place by 1997<br>2. Will put national screening programme in place before the end of 1999 | | |
| *Cervical cancer* | *3 recommendations*<br>1. Will establish national screening programme in 1999<br>2. Will set up expert advisory committee<br>3. Has allocated £1.5 million to improve current smear services | | *1 recommendation*<br>1. MWHB will be the pilot site for the first stage of the programme |
| *Skin cancer* | | *2 recommendations*<br>Will increase awareness among women of<br>1. Dangers of excessive exposure to sunlight<br>2. Importance of early consultation about skin changes | |
| *Oral health* | *1 recommendation*<br>1. Will monitor impact of Dental Treatment Services Scheme on oral health needs of women | | |
| Reproductive Health | | | |
| *Childbirth* | *2 recommendations*<br>1. Will adapt the Maternity and Infant Care Scheme<br>2. Pilot schemes to test approaches to home births | *1 recommendation*<br>1. Will encourage independent maternity hospitals to work closely with HBs to develop a more comprehensive approach to supporting mothers and newly born children | *15 recommendations*<br>1. CEOs to appoint Expert Group to oversee pilot maternity schemes<br>14 specific recommendations to improve maternity services, addressing ante-natal care, labour and delivery, post-natal care and consultation with consumers |
| *Breastfeeding* | *1 recommendation*<br>1. Commitment to implementation of National Breastfeeding Policy for Ireland | *1 recommendation*<br>1. Will work with other agencies at to create a more supportive environment for breastfeeding | |
| *Family Planning and Reproductive Health* | *2 recommendations*<br>1. Will review implementation of HB Guidelines on FP<br>2. Will fund innovative projects | | *1 (general) recommendation*<br>1. Will outline steps to develop FP services which promote women's health and well-being |

| Actions in National Plan | DOH/MOH | DOH with HBs (and other agencies) | HBs (in implementing their Plans for Women's Health) |
|---|---|---|---|
| *Abortion* | *1 recommendation*<br>1. Will develop an educational programme on crisis pregnancy | | |
| *Human Assisted Reproduction* | *1 recommendation*<br>1. Is considering how best to encourage and inform the public debate on HAR | | |
| *Other* | | | *2 recommendations*<br>1. Will review provision of menopause services<br>2. Will provide a comprehensive service for urinary and faecal incontinence in women |
| Violence against women | *2 recommendations*<br>1. Will co-ordinate Government policy on violence against women<br>2. Will ensure implementation of section 6 of Domestic Violence Act, 1996 | *2 recommendations*<br>Will work closely<br>1. To develop protocols on violence against women<br>2. To increase awareness of professionals on violence against women | *2 recommendations*<br>1. Will develop support services for women and children who are victims of violence<br>2. Will provide counselling and specialist services for victims of rape and sexual assault |
| Women with Hepatitis C | *1 recommendation*<br>1. Will monitor needs of those with Hepatitis C to ensure the necessary support services are provided | | |
| Women with special needs | | | |
| *Socially and economically disadvantaged* | | | *1 recommendation*<br>1. Will give high priority to improving the health of women who are socially and economically disadvantaged |
| *Young women* | *1 recommendation*<br>1. Will fund innovative projects which foster inter agency co-operation and develop good practice regarding pregnancy in young women | | *2 recommendations*<br>1. Will develop programmes to reduce the rate of unplanned pregnancies among teenage girls<br>2. Will develop maternity services to provide greater support for young single women and their children |

| Actions in National Plan | DOH/MOH | DOH with HBs (and other agencies) | HBs (in implementing their Plans for Women's Health) |
|---|---|---|---|
| *Women as parents* | *1 recommendation*<br>1. Will consider recommendations of Commission on the family on parenting programmes for older children | | *2 recommendations*<br>1. Will extend Community Mothers Scheme to all HBs<br>2. Will introduce projects similar to the Homestart Programme in each HB |
| *Traveller women* | *1 recommendation*<br>1. Committed to implementation of health provisions of Report on the Task Force on the Traveller Community | | *2 recommendations*<br>1. Will improve travellers' access to health services<br>2. Will ensure delivery of health services in a culturally appropriate way |
| *Women with disabilities* | *2 recommendations*<br>1. Committed to expansion of services for people with disabilities<br>2. Will fund innovative projects to improve services to women with disabilities | | *3 recommendations*<br>1. Will review the accessibility of their services to women with disabilities<br>2. Will review the need for disability awareness training for their staff<br>3. Will use their role as funders of service providers to ensure that projects deal with women with disabilities fairly |
| *Women as carers* | *1 recommendation*<br>1. Will continue to give priority to development of services for disabled and dependent people | | *3 recommendations*<br>1. Will consult with carers about the services they need<br>2. Will foster self-help groups for carers<br>3. Will fund voluntary organisations supporting carers |
| *Older women* | *2 recommendations*<br>1. Committed to meeting targets of the Health Strategy in relation to dependant elderly people<br>2. Will establish Social Services Inspectorate | | *1 recommendation*<br>1. Will review the standards of care of dependant elderly patients in voluntary and private nursing homes and in their own hospitals and homes |
| *Lesbian women* | | | *2 recommendations*<br>1. Will ensure that health professionals are informed about lesbian health issues<br>2. Will ensure that staff respect the sexual orientation of lesbian women |
| *Women in prison* | | *3 recommendations*<br>Will work<br>1. To develop programmes for drug addicted women<br>2. To improve mental health services for women prisoners<br>3. To ensure close co-operation on maternity and child care services | *2 recommendations*<br>1. Will improve provision of liaison psychiatry services for women in prison<br>2. Will structure posts of professional support staff with a significant commitment to the prisons |

| Actions in National Plan | DOH/MOH | DOH with HBs (and other agencies) | HBs (in implementing their Plans for Women's Health) |
|---|---|---|---|
| *Women in prostitution* | | *2 recommendations*<br>1. Will support provision of health services for women in prostitution<br>2. Will design health information packages specifically for these women | |
| *Women and drug misuse* | | | *5 recommendations*<br>1. Will support drug misuse prevention activities<br>2. Will pay special attention to women drug misusers<br>3. Will extend rehabilitation programmes<br>4. Drug teams will co-ordinate voluntary and state activities<br>5. Will place greater emphasis on dangers to women from HIV |
| Women's health in the developing world | *2 recommendations*<br>1. Will work with Department of Foreign Affairs and APSO to increase contribution to promoting women's health in the developing world<br>2. Will continue to support the work of WHO | | |
| Consultation | *1 recommendation*<br>1. Will establish a Women's Health Council | | *1 recommendation*<br>1. Each HB will establish an advisory committee on women's health |
| Representation | *2 recommendations*<br>1. Is developing an Equal Opportunities Policy for the Health Services<br>2. Will promote the principle of gender balance in membership of health boards etc. | | |
| Creating a woman-friendly service | | | *2 recommendations*<br>1. Will prepare a regional plan for women's health<br>2. Will review their staff development and training programmes to include sensitivity training on attitudes to women. |

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