

Women — The Picture of Health

A Review of Research on Women's Health in Ireland

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Comhairle Shláinte na mBan



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ISBN 1 873820 51 8

Designed at Language

Contents

Women – The Picture of Health

Executive Summary

1.0	Introduction	v
1.1	Framework of the review	v
2.0	Health gain	v
3.0	Social gain	vi
4.0	Equity	vi
5.0	Quality	vii
6.0	Accountability	viii
7.0	Conclusion	viii

Section 1

1.0	Introduction	2
1.1	The health policy context	2
1.2	International health policy	2
1.3	Health policy in Ireland	3
1.4	The Plan for Women's Health	5

Section 2

2.0	Health gain	8
2.1	Mortality	8
2.2	Morbidity data	12
2.3	Gender and morbidity	13
2.4	Health service utilisation	14
2.5	Health lifestyles	14
2.6	Conclusion	15

Section 3

3.0	Social Gain	18
3.1	Women's activities and women's health	18
3.2	Domestic role	19
3.3	Women as carers	20
3.4	Women at risk of domestic violence	21
3.5	Women's reproductive role	21
3.6	Women's body image	21
3.7	Contextualising women's health	22

Section 4	
4.0	Equity 24
4.1	Equity and male-female health differences 25
4.2	Social class differences in health 25
4.3	Young, lone and single mothers 27
4.4	Rurality 27
4.5	Traveller women 28
4.6	Equity: an overview 29
Section 5	
5.0	Quality 32
5.1	Appropriateness of treatment 33
5.2	Counselling 34
5.3	Pregnancy counselling 34
5.4	Reproductive health 34
5.5	Women drug users with HIV 35
5.6	Women and health information 35
5.7	Women-friendly health services: a summary 36
Section 6	
6.0	Accountability 38
Section 7	
7.0	Conclusion – Research For women’s health policy 40
Bibliographies	
	Annotated bibliography 43
	Subject based bibliography 65
	Reference bibliography 71

Executive Summary

1.0 Introduction

This review describes the extent of research on women's health in Ireland and assesses its adequacy as a basis for policy. Distinguishing between data collection and data analysis as components of research, the findings of the review could be summarised thus: there are some areas of women's health on which we do not have any data; in other areas data are collected but the data collection methods need to be gender proofed to ensure they are capable of revealing accurately the situation regarding women. There are further areas where data are collected which could be informative about women's health but these data have not been analysed or otherwise used for policy purposes. Finally, there are some areas where available data have been analysed with regard to women and have provided revealing insights for policy makers.

Thus research on women's health emerges as fragmented and further data collection and analysis are required so that policy can be informed by a comprehensive knowledge base.

1.1 Framework of the Review

To assess the adequacy of research from a policy perspective, five key policy principles were identified from Shaping A Healthier Future (1994), the Irish Government's major health strategy document of recent years. Where clarification of these principles was required (particularly in connection with women's health) reference was made to the World Health Organisations' (WHO) Health For All policy, which forms an important part of the background to current health policy in Ireland, as well as to Irish policy documents in women's health, particularly the Discussion Document on women's health, Developing a Policy for Women's Health (1995) and A Plan for Women's Health (1997). The five key policy principles are Health Gain, Social Gain, Equity, Quality and Accountability.

2.0 Health Gain

'Health Gain' means increases in life expectancy and improvements in the quality of life through the cure or alleviation of an illness or disability or through any other general improvement in the health of the individual or the population at whom the service is aimed. For policy on health gain in relation to women to have an adequate research basis, it is necessary to collect and analyse data on women's mortality and morbidity. It is only on this basis that health trends for women can be assessed, targets set, and progress towards those targets monitored. Currently the CSO, on behalf of the Minister for Health and Children collects and publishes extensive quarterly and annual mortality data, classified by age, sex, cause of death and county. These data can be and have been used to examine mortality patterns and trends among Irish women, though their full potential for these purposes has not been utilised. Maternal mortality rates are also available though the data collection procedures have been criticised for being deficient, analysis of the data has been sporadic rather than

systematic, while it has been argued that the definition of maternal mortality used in Ireland is capable of missing some deaths and should be reviewed.

Data collection relating to morbidity is underdeveloped in Ireland. The only currently available regular indicators of morbidity are indirect, relating to health service utilisation rates. Their use as an indicator of morbidity has been criticised. Regular standardised health status surveys have not been carried out in Ireland to date, though a range of one-off surveys have included health status indicators. The recently commissioned Survey of Lifestyle and Nutrition, though valuable and informative on the subject of health risk factors (such as smoking, alcohol use, exercise, nutrition, etc.), does not fill the gap in data about health status since it contains only limited items on health status.

Overall, it seems that there is adequate data collected on mortality which, if analysed to its full potential in relation to gender, would provide detailed information on women's mortality trends. However a database is not available which allows the development of indicators of morbidity which are standard in other health administrations. Given the universal finding in literature on women's health that while women live longer they experience greater levels of ill-health during their lifetime, it is particularly important that women's health policy be informed by more sophisticated data collection and analysis on morbidity than is currently available.

3.0 Social Gain

Social gain is described in *Shaping A Healthier Future* (1994) as being concerned with broader aspects of the quality of life. The concept, however, is not defined or developed in Irish health policy documents and so its precise meaning is not clear. International literature on the social dimension of health and the concept of social gain, highlights the effects of the social context of women's lives on their health and quality of life. There has been some research looking at how certain social roles and activities women engage in shape their health status in the Irish context. However, the research to date is piecemeal and many facets of women's lives have not been looked at. Policy on women's health would be greatly enhanced if it were informed by research that located women's health in the context of the broader social, cultural and economic factors structuring their lives.

4.0 Equity

The concept of equity in health was defined in a narrow way in *Shaping A Healthier Future* (1994), in that it referred to equity in access to health services rather than to equity in health status or health outcomes. This narrow focus on service access was at odds with the broader emphasis of *Shaping A Healthier Future* on health and social gain (that is, on health outcomes) rather than on service provision. As in the case of social gain, therefore, there is a need to clarify this concept and how it could be

applied and measured. Currently we know that Irish women live longer than men but is this an indication of the level of equity in the health enjoyed by the two groups? There are two possible sites of difference or inequity in health relating to gender; inter-gender health differences and intra-gender health differences. These differences can relate to either mortality or morbidity. Data is available to show the mortality trends and differentials for women and men in Ireland and it also allows for international comparisons. However, the analysis of this data does not extend to looking at the effect of age or marital status on health either between women and men or within the population of women. Neither do current data collection procedures allow for an analysis of mortality differentials for women across socio-economic groups. The absence of data collection on morbidity means that there is no systematic evidence for showing differences in the health status of women and men or between women. However, there is evidence of a link between disadvantage and poor health status as well as health inequalities within the female population resulting from socio-economic disadvantage, family status, living in a rural area and membership of the ethnic minority Traveller group. It is important for policy that mechanisms be incorporated into data collection and analysis procedures to assess whether these parameters lead to inequalities in women's health status and the extent to which they represent inequities in women's health.

5.0 Quality

Two dimensions to the quality of health services were noted in *Shaping A Healthier Future* (1994). The first relates to technical quality of the treatment or care which must be such that the best possible outcome is achieved in return for the resources committed. The second relates to the consumer's perception of the quality of the service they receive. It is this second dimension which has been focused on in relation to women's health in the *Plan for Women Health* (1997). The plan highlighted the level of criticism expressed by women towards the health services and concluded that the failure to be 'woman-friendly' is one of the major deficits of the health services. Areas specifically mentioned were reproductive health services, complementary health care, counselling services, health information services and the extent to which services display cultural sensitivity particularly towards Traveller women. Research in Ireland on these issues supports the position taken by the *Plan for Women Health* (1997), though few of the studies in this area were focused specifically on perception of the quality of the health service. The first task then is to engage in research which specifically asks this question. A second issue is the tendency for research on women's health to focus on reproductive health to the exclusion of other areas of health relevant to women. There was a greater amount of information about the quality of the reproductive health services than was available on any other area. However that is not to say that there is sufficient research into the quality of reproductive health services for women. The issue of quality health care from the perspective of women as consumers has yet to be researched in a comprehensive and structured way,

particularly in light of the fact that women have higher health service utilisation rates and also are recognised as acting as intermediaries between the health services and their families and often their communities as well. Research is also needed into the question of technical quality to ensure the most efficient use of resources in relation to women's health.

6.0 Accountability

Accountability was another concept which *Shaping A Healthier Future* (1994) described as having a number of strands. Service providers are required to be accountable in both formal and legal ways, service providers must take responsibility for the achievement of agreed targets, and there is a need for mechanisms to ensure that those with decision-making powers are accountable to the consumers of the service. This latter dimension to the principle of accountability was included in the *Women's Health Plan* (1994) and was the focus of research commissioned by the Midland and the Mid-Western Health Boards (O'Connor, 1995). Women's participation in all levels, including senior decision-making positions within the health services is considered integral for a greater sensitivity to gender in the implementation of health policy and the delivery of health services. O'Connor (1995) described how aspects of the organisational procedures and culture of the health services acted as barriers to women's participation at decision-making level of the health services. However, her research was confined to senior and middle level of the two health boards for the Administrative, Nursing and Paramedical staff. A general Gender Audit of the health services would locate where women are within the overall services and assist in the development of policies towards the level of female participation necessary in the interests of the principle of accountability.

7.0 Conclusion

This review set out to assess the adequacy of current knowledge on women's health as a basis for policy. It demonstrated how the main objectives of the *Plan for Women Health* (1997) correspond to general health policy principles. However, a clear need emerged for a better information base than currently exists and available research on women's health in the interests of policy development. A starting point needs to be a clear conceptualisation of the guiding principles of current health policy. The collection and analysis of data in relation to mortality and in particular morbidity needs to be developed. Mortality data collected by Vital Statistics should be analysed to its full potential with reference to gender to provide a picture of women's mortality trends and the definition of maternal mortality should be examined while a more systematic approach should be taken to the analysis of maternal deaths. A database on morbidity needs to be developed which is capable of revealing morbidity trends for women at a level comparable with other health administrations particularly in light of the finding that while women live longer they experience greater levels of ill-health. The notion of social gain requires policy to take account of the social dimension of

health and this creates a need for research which locates women's health in the context of the broader social, cultural and economic factors which structure their lives and in turn impact on their health. There is a need to develop a database capable of generating indicators of equity in relation to both inter-gender and intra-gender health differences which is sensitive to parameters identified in this review as contributing to inequalities in health. Policy needs to assess whether these inequalities in health status are indicative of inequity in health and be capable of addressing such inequities as are identified. Policy and research around quality in women's health has focused on the notion of a 'woman-friendly' service. While this review was able to identify some information on the quality of women's health service this was drawn from research which was neither sufficiently comprehensive nor sufficiently dedicated to investigating the issue of quality to constitute an adequate basis for policy. Thus more structured, comprehensive research is needed into this area of women's health. In relation to the accountability of the health services, the research commissioned by the Midland and Mid-Western Health Boards (O'Connor, 1995) provided a very insightful account of women's participation in health services which in itself would function quite well as a basis for policy. This would be further enhanced if a more general Gender Audit of the health services were conducted.

Further to these conclusions some other general issues emerged from the review as important considerations for the design and implementation of any research which would be informative for policy on women's health. The first relates to the gender sensitivity of a data base. The inability of some data sets described here to reveal issues around women's health has constrained our understanding of the situation regarding women's health. To guard against this data sets need to be gender proofed to ensure that a true picture of women's health can be constructed as a basis for policy. Structures need to be put in place to support and sustain a focus on gender in health research not only through a dedicated Women's Health Council but through other agencies such as a Health Research Board. Research methodology must also be examined. Some of the research reviewed here took an innovative approach in order to centralise women's experiences in their research. Social research on women has recently been responsive to the argument that research methods need to be sensitive to the structural inequalities in society which may render women's experiences invisible when traditional, positivistic research methods are used. This standpoint should be incorporated into gender based health research.

Section 1

- 1.0 Introduction
- 1.1 The health policy context
- 1.2 International health policy
- 1.3 Health policy in Ireland
- 1.4 The plan for women's health



Section 1

1.0 Introduction

The terms of reference for this review were to identify, collate and review published research on women's health in Ireland. The purpose was to evaluate the adequacy of current research as a basis for policy in the field of women's health, particularly in the context of A Plan For Women's Health (1997) and Shaping a Healthier Future (1994). The scope of the review was limited to research which had been published in a journal of record or other recognised published format (it therefore excluded 'grey' literature which existed in typescript or other unpublished format within health agencies, research organisations or local groups of activists or lobbyists).

Since the main purpose of the exercise is to collate and evaluate existing research from a policy point of view, the review first outlines the policy context which provides the framework for the evaluation. From that outline, five principles of current health policy are identified which provide key reference points for the assessment of the current research base in this field in Ireland. Those principles are health gain, social gain, equity, quality and accountability. The review then takes up these five principles in turn and evaluates the current state of research in Ireland in regard to each. It concludes with recommendations on how the knowledge and information base on women's health in Ireland could be expanded and improved so as to provide a more comprehensive and insightful basis for the formulation of policy on women's health.

1.1 The health policy context

The principal components of current health policy in Ireland are set out in the 1994 document Shaping a Healthier Future (1994). This document represents a major review of health policy which was prompted by the following concerns: the need to take account of the changing nature of health problems; the mismatch between prospective demands for health services and available resources under the current model; and the need to absorb international developments in thinking on health and health services into Irish health policy. Its underlying aim was to re-direct health policy away from an almost exclusive concern with the provision of curative health services towards a more balanced mix of prevention, cure and care – described as a focus with a more positive attitude to health.

1.2 International health policy

The new approach reflects the principles set out in the World Health Organisation's programme, Health For All by the Year 2000. The WHO's Health For All programme identified the nature of contemporary health problems and over-reliance on high technology acute medicine as aspects of international health policy which needed to be addressed. It proposed four fundamental objectives which national health policies should be geared to achieve: to ensure equity in health; to add life to years; to add

health to life; and to add years to life. These fundamental objectives in turn lead to five basic tenets for health policy:

- **Equity**
Services should provide universal coverage of the population with care provided according to need. This means that no one should be left out, no matter how poor or how remote and if all cannot be served, those most in need should have priority.
- **Health promotion**
Services should be promotive, preventive, curative and rehabilitative. As well as treating illness, services should promote the population's understanding of health and healthy styles of life and reach towards the root causes of disease with preventive emphasis.
- **Effective, culturally acceptable services**
Planning and management of programmes to ensure their effectiveness are seen as essential, and decision-makers need to be informed by additional information. However, effectiveness should not be at the cost of cultural acceptability as both are seen to be mutually dependent.
- **Community participation**
Communities should be involved in the development of services so as to promote self-reliance and reduce dependence. They should have a role in the entire process of defining health problems and needs, defining solutions, and implementing and evaluating programmes.
- **Multi-sectoral approach**
Approaches to health should relate to other sectors of development, including: education for literacy, income supplementation, clean water and sanitation, improved housing, ecological sustainability, more effective marketing of products, building of roads or waterways and enhanced roles for women.

1.3 Health policy in Ireland

Health For All was adopted by the European region of the WHO, of which Ireland is a member, as a programme to be achieved by the year 2000. Its implementation in Ireland was channelled through Shaping a Healthier Future (1994). Reflecting the emphases of Health For All, the key principles which underpin this strategy document are equity, quality of service and accountability, allied to the concepts of health gain and social gain. The document also sets out specific objectives for women's health which are: to ensure that women's health needs are identified and planned for in a comprehensive way; to promote the health and welfare of women; to ensure that

women receive the health and welfare services they need at the right time in a way which respects their dignity and gives ease of access and continuity of care; to promote greater consultation with women about their health and welfare needs; and to promote greater participation by women in senior service positions and at representative level in the health services.

These objectives formed the basis of the discussion document, *Developing a Policy For Women's Health* (1995). The discussion document follows the principles of *Shaping A Healthier Future* (1994) in its focus on preventing premature mortality and increasing health and social gain. It suggests the following objectives for a women's health policy:

- that it would provide unifying objectives for health services for women;
- that it would take a comprehensive approach to the life experiences of women and the issues which affect their lives;
- that it would suggest a strategy for improving the health of women over the next decade. (*Developing a Policy For Women's Health*, 1995).

Following publication of the discussion document, a year long process of consultation with women at both national and regional level ensued. Out of this process a women's health plan was drawn up. The plan identified the following deficits in the health services in relation to women which did not form part of the document:

- difficulty accessing information on health and health services;
- the lack of a structured counselling and complementary health service;
- health services not being perceived as woman-friendly. (*A Plan for Women's Health*, 1997)

It endorsed the following aspirations of the discussion document:

- improvement in services for women who are victims of violence;
- improvement in services for women who are caring for dependants;
- enhanced family planning and maternity services;
- more support for breastfeeding and new mothers in general;

- provision of more counselling services in non-medical settings to help women in stressful situations;
- development of screening programmes for breast and cervical cancer;
- removal of barriers which make it difficult for disadvantaged, Traveller and disabled women to access services;
- greater representation of women at all levels of the health services. (A Plan for Women's Health, 1997)

1.4 The Plan for Women's Health

The Plan For Women's Health (1997) was described as a response to the issues raised during the consultative process building on the analysis in the discussion document and as action orientated. It set out four main objectives for the health services in relation to women:

- 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. (A Plan for Women's Health, 1997)

However, at the end of this process, while specific health needs grounded in a thorough process of consultation have been highlighted, the stated aims of the discussion document which were the development of unifying objectives for women's health services, taking a comprehensive approach to the life experiences of women and a strategy for improving the health of women, still evades us.

These objectives reflect the key principles underlying health policy generally, that is health gain, social gain, equity, quality and accountability. Health gain refers to the improvement of women's health status by curing or alleviating illness or disability or through any other general improvement in life expectancy or quality of life. Social gain refers to broader aspects of quality of life which can be improved through changes in health care provision. Equity relates to both equity of access to care and treatment as determined by need, as well as equity of access to health by addressing the variations in the health status of different groups in society through health policy planning. Quality refers to both the technical quality of the service and consumers'

perceptions of the quality of the service and in this instance refers to women's perceptions of the service as woman-friendly. Accountability refers to legal and political accountability of the health care system as well as accountability to the user or consumer of health services. It is useful then to locate a discussion on women's health in the framework of these principles so as to identify what is needed to ensure women's interests are incorporated into the formulation of Irish health policy.

Section 2

- 2.0 Health gain
- 2.1 Mortality
- 2.2 Morbidity data
- 2.3 Gender and morbidity
- 2.4 Health service utilisation
- 2.5 Health lifestyles
- 2.6 Conclusion



Section 2

2.0 Health gain

The emphasis on 'health gain' reflects the change in the focus of health policy from the provision of health services to the achievement of positive and meaningful health outcomes. The implication is that health policy should be less exclusively concerned with providing more and more health services and more concerned with bringing about improvements in the health status of the population. This focus has a number of implications for data collection and research on health. The first and most fundamental is that the health status of the population needs to be monitored in a consistent, on-going fashion – it is impossible to evaluate the success or otherwise of health policy from a health gain perspective if there is no means of knowing whether health gain is occurring or not. Further implications include the need for greater understanding of what determines the health status of the population and more stringent assessment of the impact of policy measures and health services on the health status of the population. From a women's health perspective, the implication is that all these other requirements be fulfilled in a gender-differentiated fashion, so that it is possible to measure and analyse women's health gain both in absolute terms and in comparison to men's.

How do the current data and research base in Ireland measure up in the light of these requirements? To answer this question, this section looks in turn at the two most widely distinguished dimensions of health status – mortality and morbidity – and for each considers both the adequacy of the available data and the extent of the analysis which has been conducted on those data. It then turns to factors affecting health status, focusing especially on research on health-related life-style in Ireland. It finally considers research on the impact of health services on health status in Ireland.

2.1 Mortality

The data

The principal source of data on mortality in Ireland is the system of death registration. Data from this source, which legally are owned by the Minister for Health and Children, are processed by the CSO to produce statistical information on deaths by age, sex, cause of death and county of residence. The series originated in 1864. There was evidence of some under-registration of deaths (and thus incompleteness in the data) as recently as the 1970s (Dean and McLoughlin 1980, Dean and Mulvihill 1972) but it is now likely that little or no under-registration occurs. Summary data from this source are published on a quarterly basis (in the Quarterly Vital Statistics Report), usually within a matter of weeks of the end of each quarter. More detailed breakdowns of the data are published annually in the Annual Vital Statistics Report, though publication of this series is now experiencing a time lag of approximately five years (the most recent published issue in the series is for the year 1994). The data are now also available in the form of a detailed database on standardised death rates by

age and by sex for all important diseases in this country. This is called the Public Health Information System (P.H.I.S.), which was commissioned by the Directors of Public Health of the Health Boards and was developed in co-operation between the Directors of Public Health and the Department of Health and Children.

Death registration data amount to an invaluable and in some respects quite detailed source of information on this crucial aspect of population health status. However, they have a number of limitations. Some of these are common to similar data systems in other countries. For example, it is difficult to achieve consistent, meaningful classifications of cause of death, simply because cause of death is often complex or difficult to determine and can be understood and classified in different ways by different observers (Prior 1985). However, as this is a generic problem in death registration data, it is not peculiar to Ireland and there is no easy means of rectifying it.

A limitation which is more peculiar to Ireland is the difficulty in disaggregating data below the county level to small area units (such as the District Electoral Division or ward, of which there are just over 3,400 in Ireland). Small area analysis of mortality patterns has become an important tool of health policy analysis in other countries and has been used in a small number of health research projects in Ireland (Johnson and Lyons, 1993 and Kelly and Sinclair, 1997). Research of this kind can attempt, for example, to assess whether there are 'mortality blackspots' in certain parts of the country and even within a particular city or county (Johnson and Lyons, 1993 and Kelly and Sinclair, 1997), and is sometimes motivated by concern for the health effects of a particular local environmental feature (such as proximity to a local source of pollution). However, the more general use of this kind of research in Ireland is hampered by the difficulty in routinely assigning the addresses of deceased persons to pre-defined small areas and thus in generating mortality data on a small area basis. This difficulty in turn reflects the absence of a precise local addressing system for dwellings in Ireland – townland addresses in rural Ireland, for example, are often imprecise and variable, and it is not uncommon for a particular dwelling to have a number of variants of its address and for none of these variants to relate to an officially recognised local area. It would be highly desirable from a health research point of view that the difficulty in coding deaths to small areas be overcome. Current work by An Post on a more precise local addressing system for dwellings is therefore to be encouraged, as this is a prerequisite for small-area coding of deaths. The CSO should also be supported and encouraged in devoting effort in the same direction as far as both death registration and birth registration data are concerned.

A further limitation in mortality data, which is particularly relevant in the case of women, relates to the coding of deaths by socio-economic group (SEG). SEG codings are based on occupation, either own occupation in the case of those who have had paid jobs or spouse's occupation in the case of those in home duties. Such information

is often inadequately returned on death registration forms, especially in the case of women whose occupation is recorded as 'housewife' and for whom full information on husband's occupation is needed to assign an SEG code. Even where full occupational details are available for married women who had paid jobs, there may be uncertainty as to whether SEG coding should be based on their own occupations or their husband's. In any event, the outcome is that classifications of deaths by SEG are often incomplete or of uncertain reliability, particularly in the case of women. As a result, the analysis of socio-economic mortality differentials among women is hampered, and the tendency is to confine analysis of such differentials to male mortality (Nolan 1990). This is an important deficiency, since it means that information on socio-economic differentials in mortality among Irish women is less complete and reliable than it should be, thus making it difficult to assess central questions concerning social equity in women's health outcomes.

Analysis of mortality data

Considerable use has been made of mortality data to establish broad trends and patterns in both male and female mortality. Generally, we know that women have a longer life expectancy than men. Ireland was exceptional among western countries in the early part of the present century in that women had no life expectancy advantage over men, a pattern which was particularly a feature of rural Ireland. This has been taken as a sign of the distinctively low status of women in rural Ireland in the early part of the present century (Kennedy 1973). In more recent decades, however, the Irish pattern has 'normalised' as Irish women's life expectancy has advanced faster than Irish men's, and the gap between the two, which now stands at just over 6 years, is within the range typical for western countries.

Most of the policy-related analysis of mortality data has focused on 'premature deaths' (understood as deaths before age 65) and their causes, and in particular on those areas of premature mortality which are particularly high in Ireland. The government discussion document *Developing a Policy for Women's Health* (1995) highlighted how coronary heart disease, cancer and accidents account for three quarters of the premature deaths among Irish women. Rates of coronary heart disease for both Irish men and women are among the highest in the European Union.

The second principal cause of death among Irish women is cancer, which accounts for approximately one-fifth of female deaths in Ireland. While there has been a decrease in mortality generally, cancer mortality has increased. *Developing a Policy for Women's Health* (1995) noted that in 1994 Irish women ranked third highest of thirteen European countries in relation to cancer deaths, while Irish men ranked ninth according to WHO statistics. Breast cancer is the most common cause of mortality from malignancy in Irish women while cancers of the lung, large bowel and stomach are the most common causes of mortality from malignancy among both women and

men. Irish women's risk of developing lung cancer was twice the EU average while breast cancer risk was 20-30 per cent above the EU average. The risk of incidence and mortality for all cancers for women in Ireland was close to the EU average while for men the risk of incidence was below the EU average but mortality was close to the average.

We do not know the reasons for higher incidence of breast cancer but we do know that 90 per cent of lung cancer is caused by smoking. Of the 6,000 deaths caused by smoking in Ireland each year, 2,000 are among women.

Maternal and infant mortality rates are also used as a measure of women's health status in a given country, though Ireland rates well on both these measures. Maternal mortality for Irish women is now below the EU average (Developing a Policy for Women's Health, 1995). The most recent analysis of the subject, reported in Jenkins et al (1996), pointed to certain deficiencies in the data collection procedures for maternal mortality and noted that a European Task Force is working on the subject of comparative mortality studies with the intention of standardising methods of data collection to facilitate comparison. While Ireland's maternal mortality rates do not seem to warrant concern because they are so low by international standards, this literature suggests that a review of data collection policies would give a more accurate picture of the rate and causes of maternal mortality.

For accidents, the third main cause of death, the main sources of data are Vital Statistics, Hospital In-patient Enquiry data (HIPE), the National Roads Authority Statistics and the European Home and Leisure Accident Surveillance System. Again, these provide scope for analysis by gender. Women in developed societies have been found to be less at risk of death from accidents (Doyal, 1995 and Lorber, 1997) and this pattern holds for Ireland also. Nonetheless, gender differences in accidental deaths have been noted, for example women seem to be more susceptible to deaths from accidental falling due to osteoporosis and living to an older age. Men on the other hand are more likely to be killed in road traffic accidents and the current rise in male suicide rates is another main cause of concern. Concern over the numbers of accidents leading to injury or death among the population generally has led to the establishment of a National Accident Forum within The Office for Health Gain (Laffoy, 1997). Laffoy noted how current sources of data on accidents do not record injuries presented to Accident and Emergency Departments of hospitals which means that information on an estimated 90 per cent of injuries is not available. To address this the Forum aims to develop an injury information system. It is important for policy that the injury information system would be designed so as to be sensitive to gender in its collection and analysis by taking account of the different types of accidental deaths noted across genders so that the data can be used to identify how gains could be made in addressing women's accident related mortality and morbidity rates.

2.2 Morbidity data

The data position on morbidity is weak in Ireland, in that there is no regular, standardised large-scale measure of morbidity in this country. Neither has there ever been a single dedicated population-wide survey of health status or morbidity at a given point in time. A number of one-off surveys on more general topics have included certain health status measures (such as the ESRI's Living in Ireland household panel survey, which has been fielded annually since 1994). Surveys with a stronger health component have been carried out on certain sub-sets of the population (such as the survey on women's reproductive health reported in Wiley and Merriman, (1996). Two major surveys on health lifestyles and attitudes were carried out in 1998 by the Centre for Health Promotion Studies in the National University of Ireland in Galway on behalf of the Health Promotion Unit of the Department of Health and Children. These were the Survey of Lifestyles, Attitudes and Nutrition (SLÁN), which was carried out on a national sample of adults aged 18+, and a survey entitled Health Behaviour in School-aged Children (HBSC) which studied children aged 9-17 years. Both these surveys contained items on general health, but their primary focus was on health risk factors and health lifestyles rather than health status or morbidity. They thus focus on such things as smoking, alcohol consumption, food and nutrition patterns, exercise and accidents.

In the absence of the necessary comprehensive data, it is not possible to say in an overall way whether illness levels in the population are rising or falling, to identify morbidity differentials between men and women or between different sub-groups within either gender. Neither is it possible to produce indicators of health status such as 'health expectancy' measures (see, e.g. the 'Disability Free Life Expectancy' measure which is being developed under the auspices of the OECD – Mathers 1997). This means that a necessary central plank in any effective system of health monitoring is missing and the task of assessing progress towards the goal of health gain is fundamentally compromised. Until a system of data collection is put in place to rectify this deficiency (such as a regular comprehensive national survey on health status), it is difficult to see how the effectiveness of current health policy can be meaningfully assessed.

Some information is available on specific illnesses. For example, a National Cancer Registry has begun to record detailed statistics on cancer-related illnesses (Comber, 1997). The Registry collects information on the process and outcome of care including stage at diagnosis, method of diagnosis, and treatment and outcome for all cancers registered. A gender-based analysis of data collected as part of the National Cancer Registry would provide valuable information on women's risk, incidence and mortality from cancer.

2.3 Gender and morbidity

A common theme running through literature on women's health is that while women live longer they experience greater levels of ill-health during their lifetime. Nathanson (1989) looked at sex differences in illness and medical care in a global context using data from various health administrations where appropriate data was available. In practice this meant that in most cases the appropriate data was only available for Britain and the US. She found that the marked increase in the differences between women and men's life expectancy in favour of women witnessed during the 20th Century was attributed to excess mortality in men. However, adult women were found to report more acute illness and associated disability and to make more physician visits, even when obstetric visits were excluded. She attributed the finding that 'men die quicker but women get sicker' to women having more illness, but in milder forms, while women have more acute illness, but men more chronic illness. Differences in morbidity varied over the life cycle. She found equality in women and men's health at the beginning and at the end of the life cycle. Illness differences were found during mid-life, described as from school entry to retirement. Men suffered greater mortality and higher rates of chronic conditions, women suffered more acute illnesses and had greater use of the health services. In 15-24 year olds, the higher mortality rate among young men was due to accidents. In the 'prime of adult life' - 24 to 65 years - health variations were most marked. Women were found to use physicians and hospital services more, even when pregnancy was excluded. Men's mortality increased due to heart disease. For those aged 65 and over, chronic illness rates for women were found to approach or even exceed those for men.

The limited data available in Ireland are at most inconclusive on this point, and to some extent contradict it, in that they indicate that gender differences in overall morbidity levels are slight or non-existent. Nolan (1991) found that in aggregate there was no difference between men and women in the extent of reported illness. While younger women reported slightly higher morbidity levels than younger men, the reverse was the case for older women and men (Nolan 1991, pp. 63-64). In the case of the elderly, Fahey and Murray (1994) likewise found that gender differentials in various indicators of morbidity varied a great deal by age-group and by specific indicator, but did not point to any consistent pattern of morbidity disadvantage for women. The preliminary report on the SLÁN survey mentioned earlier found no significant difference between men and women on perceived health (Friel et al. 1999, p. 14). Among children, according to HBSC data, boys perceived themselves as more healthy than girls, a pattern that was especially marked among 15-17 year olds (Friel et al. 1999, p. 17). In the case of mental health, Cleary (1997) found that men predominated in the Irish psychiatric hospital system, while women predominated in the community mental health services, again suggesting that while patterns of mental health and disorder differed by gender, it was difficult to point to an overall mental health disadvantage for women.

2.4 Health service utilisation

Data on health service utilisation are sometimes used as indirect indicators of morbidity, though critics of this practice have pointed out that service utilisation data should not be confounded with morbidity. Research from other countries has found that women are higher attenders at health services and are more likely to avail of ambulatory care, while 'non-attenders' at health care are predominantly male (Nathanson, 1989). In Ireland, however, Nolan (1991) did not find consistent gender differences in patterns of utilisation of health services, other than that women who had recently had a birth caused female utilisation rates to be sharply higher than men's in the mid-adult age ranges. The largest national, continuous data source on utilisation of health services is the Hospital In-Patient Enquiry (HIPE) but this has not been examined from the point of view of gender differentials in utilisation patterns.

2.5 Health lifestyles

Although data collection on overall population health status is underdeveloped in Ireland, there has been considerable research effort in the field of health-related lifestyle. A research and demonstration project, the Kilkenny Health Project, looked at coronary heart disease (CHD) and aimed to modify the behaviour and environment of the population of County Kilkenny (Shelley et al. 1991a). It noted that Irish mortality rates from CHD have been lower at all times in women and the decline in mortality from CHD has been proportionately greater in women than in men between 1950 and 1986. However, according to WHO data, Irish women ranked fifth highest in 1985 for CHD while Irish males ranked sixth highest (Shelley et al. 1991a). While declines were noted both in male and female mortality rates from CHD, Ireland has continued to rank among the highest countries for deaths from CHD with the incidence of female mortality from CHD relatively higher than that for males. Findings from the Kilkenny Project on risk factors associated with women's CHD are referred to further below.

More recently, the Survey of Lifestyle and Nutrition (SLÁN) aimed to provide a nationally representative profile of the health lifestyle patterns among Irish people as part of a needs assessment process for the Department of Health and the health boards. Using a national representative sample of 6,539 adults (aged 18+), it generated baseline information on such things as exercise patterns, smoking, alcohol consumption, other substance use and accidents, body mass index and nutrition profile, as well as providing information on general health, mental health and well-being. A separate clinical examination of one-tenth of the sample, which has not yet been reported on, is intended to measure risk factors such as total cholesterol and systemic blood pressure.

The results of the SLÁN survey (reported in Friel et al. 1999) showed rates of smoking among adults that were high and far in excess of the target anticipated for the year

2000. As many women as men now smoke, but female smokers consume fewer cigarettes per day than male smokers. Among younger women, a slightly higher proportion smoke than among young men, but again, these young women tend to smoke fewer cigarettes per day than young men. Overall, therefore, cigarette consumption is considerably lower among women than among men.

The SLÁN survey found that most other health lifestyle factors were more positive for women than for men, though in many instances these gender differences arose around quite poor overall levels. Alcohol consumption was lower for women than for men – a larger proportion of women than men were non-drinkers and among women who drank, consumption rates were lower than for men. Over one-fifth of women reported drinking more than the weekly recommended limits for alcohol, compared to over a quarter of the men. Excess weight, as measured by the Body Mass Index, was a good deal more common among men than among women. Over half the men were either overweight or obese, according to the BMI measures gathered in the SLÁN survey, compared to a third of the women. Eating and nutrition patterns also seemed to favour women, though the differential was not consistent across all nutrition indicators. Women also generally were more likely to take the minimum recommended amounts of exercise than men, though again this pattern did not hold universally across all age-groups and social classes. Women were less accident prone than men, and considerably less likely to have driven a car after drinking alcohol than men.

Broadly similar gender patterns were reported for children aged 9-17 years on the basis of the survey on Health Behaviour in School-aged Children (HBSC) (also reported in Friel et al. 1999). Slightly larger proportions of older girls smoked than older boys, but they smoked only about half the number of cigarettes per day that boys smoked. One-third of children reported having had an alcoholic drink, and this proportion rose to over four-fifths for 15-17 year olds. The incidence of alcohol consumption was markedly higher for boys than for girls. Boys also seemed to have poorer eating habits than girls – they consumed less fruit and vegetables and more of them had a high fat/high sugar diet than girls. In the case of exercise, however, boys did somewhat better than girls, especially in the mid-teenage years. On the other hand, boys were considerably more likely to have suffered accidents and injuries, particularly in connection with sport.

2.6 Conclusion

The Plan for Women's Health states that a narrowing of the gap between the health indicators for Irish women and women in the EU will be an important way of evaluating the policy. Its stated principal objective is to maximise health gain by reducing premature mortality among women so that Irish women will have a life expectancy equal to the best achieved in the EU. Action on combating individual

diseases is one means set out for achieving this. The World Health Organisation has itself set targets for all health administrations in relation to gains in women's health status and it would appear appropriate to incorporate these into health gain targets set in the Irish context. Overall however the principle of health gain in relation to women's health has not been clearly formulated to date. A data base which is more gender sensitive and inclusive of information on both mortality and morbidity, would contribute to a better understanding of women's health. Combined with further conceptualisation of the principle of health gain this should lead to the emergence of clear strategies with stated targets for gains in women's health.

Section 3

- 3.0 Social Gain
- 3.1 Women's activities and women's health
- 3.2 Domestic role
- 3.3 Women as carers
- 3.4 Women at risk of domestic violence
- 3.5 Women's reproductive role
- 3.6 Women's body image
- 3.7 Contextualising women's health

Section 3

3.0 Social gain

Sickness and death have been found to be shaped by social, cultural and economic factors, while health status in turn impacts on one's social and economic life. While health policy in Ireland has long been aware that social conditions and health are closely related, a formal incorporation of the social dimension into Irish health policy did not emerge until *Shaping a Healthier Future* (1994) included reference to 'social gain' as an objective of health policy. This in turn was prompted by the WHO's *Health For All* policy document, which, as MacDonald (1992) says, focused on the "wider causality of ill-health – moving away from narrow bio-medicine view towards a paradigm which encompasses a social, cultural and economic causality" (MacDonald, 1992, p.128). *Shaping a Healthier Future* did not itself define what is meant by 'social gain' nor did it identify indicators nor specify targets by which progress towards the goal of 'social gain' might be measured. Thus while health policy in principle now accords importance to social dimensions as a direct concern of the health system, it does not spell out in practice what this should mean.

Given the lack of clarity about the concept of what 'social gain' means, it is difficult to identify the kinds of research needed to further its implementation in regard to women. However, a number of possible dimensions to the concept can be noted, most of them having to do with the social causality of ill-health among women. In this vein, Doyal's (1995) authoritative work on women's health in a global context, *What Makes Women Sick*, looked at the major obstacles that prevent women from optimising their health. She argued:

"If the biological finality of death can only be explained in a wider social context then the complex realities of women's sickness and health must be explored in similar ways. In order to do this, traditional epidemiological methods have to be turned on their head. Instead of identifying diseases and then searching for a cause, we need to begin by identifying the major areas of activity that constitute women's lives. We can then go on to analyse the impact of these activities on their health and well-being." (1995, p.21)

3.1 Women's activities and women's health

This would be a useful framework to use so that the potential for social gain through health policy could be strategically identified. Women's activities can be difficult to define, to separate out from each other, to label and at times to relate to health or ill-health. Also, while these activities can be mapped out at the macro level, they will not be experienced in the same way by each woman on the micro level of day to day living. However, through this review it has been evident that social structures do have a bearing on health-related aspects of women's quality of life and its recurrence through the literature demands that it be given more attention in further research.

Research to date is very patchy and does not include key activities in women's lives such as paid work. We can however map out some ways in which women's social roles impact on their health and identify the basis for this. This prompts questions in relation to other activities or roles in which women engage and the end of the section will indicate what other areas could be focused on.

3.2 Domestic role

In our society where the nuclear family is the principal social arrangement, the primary social role assigned to women is the domestic role. For example in 1995, 44 per cent of all women and 56 per cent of women aged over 25 were described as being 'on home duties' by the Labour Force Survey (1995). Social policies are underwritten by this assumption that women occupy the private, domestic domain and men occupy the public, work domain. Women's work within the home is unpaid and they are assigned the dependent spouse role with the family wage or social welfare payment directed towards the male head of the household. Research has shown that there are sex inequalities in the way in which these resources come to be distributed within the household leaving women at risk of poverty (Byrne, 1991 and Cantillon, 1997).

Women's domestic role as wife, mother and carer has been found to cause them stress leading to health consequences. Wiley and Merriman (1996) found that women engaged in home duties (21.3 per cent) and those working part-time (17.3 per cent) were significantly more likely to be taking tranquillisers to cope with stress than women in other employment categories. One in five married women and mothers had taken tranquillisers at some time compared with only 7 per cent of single women and those who had no children. These suggest that the role of wife and mother are significant stressors for women. Main sources of stress mentioned by women were marital or relationship problems or family bereavement. These findings reflect those of Cleary (1997a and 1997b) who studied the development of depression among women. Cleary studied a random sample of seventy-five women in a Dublin city community to determine the prevalence of depression among women in an Irish urban setting and found the occurrence of depression to be as high as in similar settings in other countries (1997a). Over half of the women she interviewed had sought treatment for psychological difficulties and 28 per cent were currently receiving treatment (1997b).

To study the social factors involved in the development of depression Cleary (1997a) also conducted research among fifty women attending a psychiatric hospital for depression. She argued that many of the difficulties of women's lives leading to depression could ultimately be traced to the patriarchal dominance of society which circumscribed women's roles. She took a 'life-span' approach to explaining the social factors involved in the development of depression. Experiencing adversity in

childhood was found to have left women with a poor foundation in self-esteem which caused them to be vulnerable in the negotiation of later transitions and difficulties. The married women in her study were found to have married at an age when they went directly from being a daughter to being a wife, leaving little opportunity to develop an independent identity. They were also more likely to have been pregnant or mothers already when they married and to have extensive difficulties during their marriages which had predated their episode of depression. By comparison the single women in the study tended to be older when they became depressed and the depression tended to be precipitated by loss of a parent or difficulties in forming or maintaining relationships with men. She concluded that the women she studied lived in very difficult situations with low prospects of amelioration which could be a reflection of the relative powerlessness of women's lives. These findings also highlight how women's psychological well-being is compromised by the limited social roles open to them which puts them at risk of stress.

3.3 Women as carers

Women make-up the vast majority of carers of the elderly and research has shown this role to be likely to result in isolation and reduced social interaction, high levels of strain and psychological distress and compromised health status. Carers in turn have been found to have low levels of social, practical or financial support from the formal health services. (Hodgins and Kelleher, 1997) O'Donovan's (1997) research on the Home Help Scheme operated by health boards found that a gendered conceptualisation of care underlies the scheme. The assumptions made by those who initially established and now administer the scheme are that women are inherently equipped to care for the elderly, that this is an inherent component of their domestic and community role and that they neither require training nor adequate payment to work as a Home Help. This attitude to carers reflects a formal acknowledgement of a social organisation of caring which has been found to impact negatively on women's health.

It was interesting to note in the Plan for Women's Health (1997) a reference to the role of women as a resource for the health of their families and communities generally:

The consultative process highlighted the importance women attach to health - their own health, to the health of their families and to the health of their communities generally. Because women attach such a high priority to health and because of their influence on the health of their families, they are a tremendous resource for health. (1997, p.14)

However MacDonald (1992) issued a caution about formulating health policies on such a premise stating that:

Many so-called Primary Health Care programmes are 'aimed' at women, yet

whether their impact on the lives of the women is always liberating is not so clear. Sometimes their effect is to add to the already heavy burden a woman always carries in caring for the health of families. (1992, p.128)

3.4 Women at risk of domestic violence

While women are primarily assigned the domestic role, the home has been found to be a place where women have been at risk of violence in the form of mental cruelty or, the threat of or actual physical violence. An Irish study revealed that 11 per cent of women surveyed had experienced actual physical and/or sexual violence which resulted in physical injuries or mental health effects including depression and resorting to the use of alcohol or medication (Women's Aid, 1995). This report concluded that:

Violence against women in the home is a complex issue which is deeply rooted in gender based power relations. It is socially constructed and reinforced by cultural economic and social factors. Any systematic attempt to eliminate violence in the home therefore must be multi-dimensional and address the issue at different levels. (Women's Aid, 1995: xii)

3.5 Women's reproductive role

Research on women's reproductive role reveals the existence of social structures surrounding childbearing which impact negatively on women's experiences of sexuality and motherhood. Findings have shown that women's access to services, information and methods of fertility control is constrained by social attitudes towards female sexuality (Smith, 1996 and Mahon et al. 1998). Hyde (1996) found that the dominant ideology which prescribes a two parent family based on marriage as the appropriate context for childbearing, and asserts to control women's sexuality to that end, limits their capacity to manage fertility actively in line with their intentions about pregnancy. Mahon et al. (1998) found that women with a crisis pregnancy were impelled towards abortion by the social stigma attaching to motherhood outside of marriage and the incompatibility of motherhood with other roles due to an absence of state sponsored child-care and other supports. In their study of crisis pregnancy, single women who were intending to keep their babies and become mothers had to negotiate structures and norms based on the ideal of motherhood within a two-parent marriage based family. This resulted in them encountering stigma, revising their career trajectories downwards leaving them at risk of economic marginalisation, and being concerned about coping as a lone mother in a society where this was not the ideal for childbearing.

3.6 Women's body image

Women's health has also been affected by cultural ideals of beauty and body image. A socially constructed ideal body image for women has been found to cause young

women in particular to engage in unhealthy behaviours so as to pursue this ideal. Research has shown how cultural ideals of female beauty which emphasise thinness lead to young women perceiving themselves to be heavier than their actual weight and engaging in harmful weight loss strategies in the 'pursuit of thinness'. These include starting to smoke, inducing vomiting, using laxatives and using diet pills. (Ryan et al. 1998) O'Connor et al. (1997) found that while fashion conscious young women were more likely to smoke this was not the case among fashion conscious young men. Ryan et al. (1998) concluded that the long-term health risks associated with this behaviour in pursuit of thinness may outweigh those associated with female fatness and obesity.

3.7 Contextualising women's health

The picture emerging from the albeit scant research on ways in which the roles and activities women engage in can undermine their health suggests that health research should be located in the context of the broader social, cultural and economic factors structuring women's lives if measures to bring about broader social gain are to be identified. As yet many facets of women's lives have not been researched. While women are primarily engaged in home duties they are also increasingly participating in the waged labour force. There is no state provision for child-care in Ireland as a result of which women who work are often responsible for child-care arrangements while still retaining primary responsibility for domestic duties. Thus, where women engage in work outside the home this is likely to be added onto their primary role rather than replacing it, forcing women to occupy multiple social roles. At present research has not been undertaken to establish the extent to which women who work outside the home assume multiple roles and have the double burden of job and family and whether this influences their health status. Analysis of women's labour force participation has found that women are concentrated in a narrow range of jobs which are typically lower paid, lower status occupations (Cullen and Morrissey, 1987). The degree to which this profile of women's work impacts on their health has not been examined here either.

The outset of this section referred to the notion of the compartmentalisation of health and how this results in the symptoms of ill-health rather than the causes being dealt with. Earlier in relation to health gain it was argued that a true picture of women's health must be based on both mortality and morbidity statistics. To broaden out policy strategies from health gain to incorporate social gain requires a further dimension to the research agenda for women's health so that policy is adequately informed. Causes of death and illness need to be located in the context of women's social lives to address this compartmentalisation. A comprehensive picture of the various dimensions to women's social roles and activities and their capacity to shape women's health would embellish the understanding of women's health and form a basis for identifying strategies towards social gain through health policy for women.



Section 4

- 4.0 Equity
- 4.1 Equity and male-female health differences
- 4.2 Social class differences in health
- 4.3 Young, lone and single mother
- 4.4 Rurality
- 4.5 Traveller women
- 4.6 Equity: an overview

Section 4

4.0 Equity

The principle of equity in health can be defined broadly to refer to equity in health status and health outcomes or narrowly to refer to equity in access to health services. Given the growing emphasis on health status rather than health service provision as a concern of health policy, one might have expected a parallel focus in the concept of equity on health status and health outcomes. In fact, as far as the principle of equity in health is concerned, the policy focus has tended to shift in the other direction, towards a preoccupation with health service coverage and equity in access to health services and away from a direct concern with social differentials in health status. Thus, for example, From Alm-Ata to the Year 2000 (1988) defined the principle of equity as:

No one should be left out, no matter how poor or how remote. If all cannot be served, those most in need should have priority. Here is the all in health for all. Here, also, is the basis for planning services for defined populations, and for epidemiological concepts based on a population denominator that are required for, among others, determining differential needs. This principle of universal coverage may come into conflict with efforts to promote cost-effectiveness, because those most in need may be more costly to reach. (1979, p.16)

Likewise, *Shaping A Healthier Future* defined the principle of equity in health wholly in connection with access to services:

Access to healthcare should be determined by actual need for services rather than ability to pay or geographic location. Formal entitlement to service is not enough; those needing services must have them available within a reasonable time period. Furthermore the pursuit of equity must extend beyond the question of access to treatment and care and must examine variations in the health status of different groups in society and how these might be addressed. (1994, p.10)

In the broader research literature, by contrast, much of the focus is on social differentials in health status and health outcomes. This is most evident in research on social class differences in health status. Gender differentials have also attracted a certain amount of attention, though some commentators feel that this aspect of equity in health has been under-researched. For example, Nathanson (1989) looking at *Sex, Illness and Medical Care: A Review of Data, Theory and Method in a global context* made an observation about the state of research globally then that continues to apply to the Irish context today:

While sex has been used as a primary basis of more detailed classification, there has been relatively little sustained attention to the broad range of sex differences across a variety of health indices. (1989, p.46)

4.1 Equity and male-female health differences

Some reference has already been made to gender differences in various aspects of health status and health lifestyles. These generally show either that women have a considerable advantage over men (as in the case of life expectancy and many aspects of health lifestyle or health risk factors) or that they have no overall disadvantage (as in the case of general perceptions of health or other self-reported health status measures, where gender differences are weak or non-existent). However, these patterns have not been systematically examined from an equity point of view, and as a result there has been no systematic discussion of whether or in what ways they can be considered as inequitable or otherwise.

In the case of life expectancy differentials, for example, there seems to be a widespread though largely implicit view that women's advantage over men is biologically determined and 'natural', and is therefore in some sense equitable – though no attempt has been made to determine how large a differential can be considered equitable or whether a point might be reached where in principle the life expectancy gap in favour of women might become so wide as to become inequitable. In the case of gender differences in health, therefore, it is necessary first to define what 'equity' might mean before it is possible for health policy to decide what, if anything, needs to be done to promote equity in health between men and women.

4.2 Social class differences in health

The picture is more clear-cut in regard to differences in health by social class or socio-economic status, as these differences are both widespread and unambiguously inequitable. Mortality patterns show clear differentials by socio-economic status, though for reasons of limitations in the data outlined earlier, this pattern has been established only for men (Nolan 1990, Cook 1990). Johnson and Lyons (1993) set out to determine whether socio-economic factors could explain variations in mortality between small areas of Dublin. They found higher mortality in disadvantaged areas and concluded that social class is the best predictor of mortality in small areas while less affluent areas appear to suffer higher mortality than more affluent ones. The Small Area Health Research Unit (SAHRU) in Trinity College Dublin also examined the association between deprivation and morbidity as well as mortality at Community Care Level in the Eastern Health Board (Kelly and Sinclair, 1997). Initial findings from SAHRU research show that there is a concentration of deprivation in some Community Care Areas and they found a strong correlation between the deprivation score and mortality as well as between the score and low birth weight.

Both the SLÁN and HBSC surveys carried out in 1998 show that socio-economic differentials are prevalent in practically every health and health lifestyle indicator, with the higher socio-economic groups having consistent advantages over the lower, for women and girls as much as for men and boys.

Wiley and Merriman (1996), in their study of women's reproductive health, also showed strong and consistent socio-economic differentials, though in the case of their study, educational level was often a stronger axis of differentiation than socio-economic group (the better educated had better health and better health-related lifestyles than the less well-educated). Women with lower levels of education and medical card holders were least knowledgeable about who was at risk of pregnancy or infection from AIDS and how to reduce the risk (Wiley and Merriman 1996, Butler and Woods 1992). They were also less likely to attend antenatal classes, less likely to know the appropriate time intervals at which women should have a smear test and less likely to examine their breasts for breast cancer (Wiley and Merriman 1996; see also Sixsmith et al. 1997). Women in the manual classes had a much higher incidence of smoking, were more likely to express the intention to smoke during a future pregnancy and to have smoked during a previous pregnancy (Wiley and Merriman, 1996). Women on lower incomes and from lower social class backgrounds are also much more likely to have taken tranquillisers to cope with day-to-day life (Wiley and Merriman 1996). Cleary (1997b) found that women who developed depression had more childhood disadvantages including being from a family where the principal earner was unemployed, where a parent was alcoholic, where there was marital disharmony and a lack of parental care due to parental psychiatric illness. These factors were found to contribute to women having difficulties negotiating key stages in their lives which left them vulnerable to depression.

On the basis of strong and consistent evidence of substantial socio-economic differentials in women's health, Wiley and Merriman (1996) argued for an approach to women's health policy which has specific regard to the needs of disadvantaged women at greatest risk of ill-health:

A recognition of the relatively greater needs of these women would be an important first step in gaining priority status for disadvantaged women on the policy maker's agenda and would be consistent with the pursuit of the objective of equity (Wiley and Merriman 1996, p.141)

Nolan and Whelan (1997) studied the impact of unemployment on health and found it to have a significant negative effect on psychological well-being as compared with those who are at work or retired. They further found that the impact of unemployment is mediated by exposure to poverty, displaying a cumulative effect of four out of ten people suffering both unemployment and poverty exhibiting mental health problems compared to one in fourteen of those in work or retired and non-poor (Nolan and Whelan, 1997). The Kilkenny Health Project found that there were significant differences between social classes in the levels of knowledge about health and risk factors in relation to Coronary Heart Disease with the lower socio-economic classes comparing badly with other classes (Collins and Shelley, 1997). This body of

work has developed evidence which links low socio-economic status, deprivation and social inequalities with poor health status.

4.3 Young, lone and single mothers

Women with crisis pregnancies were found to be typically younger, single and without a stable relationship but did not differ from other pregnant women by occupation or educational level (Mahon et al. 1998). This reflected Hyde's (1996) findings that age, social class, stage of relationship and social circumstances were sites of difference in relation to the how single women she studied came to be pregnant. In her analysis young, working class women were most passive in managing their fertility while older women who were more secure in socio-economic terms and in established relationships had been more active in their fertility management. Single women who are pregnant were critical of their treatment by the medical profession and were less happy with the amount of time they had with the doctor than married women (Wiley and Merriman 1996). Hyde (1997) found that medical personnel made value judgements about single women's pregnancies because these threaten the social order and she argued that this mediates the medical encounter rendering women passive, taking choice and agency out of their hands and leaving the physician in a position of dominance. Spillane et al. (1996) found that first-time mothers who were single, unemployed and younger than the overall population of women giving birth, who had not booked delivery at the hospital, attended for antenatal care or who had concealed their birth were at risk of giving birth before arrival at hospital.

4.4 Rurality

Some research has described how living in a rural area had a negative impact on women's health. Family planning advice and services are harder to access for rural women (Wiley and Merriman, 1996 and Prendiville and Short, 1993) while Smith (1996) found this to be a particular problem for young women who retained a preference for a dedicated family planning service. Byrne's (1991) findings revealed how the combined factors of living in a rural area and living in poverty impact on women's health. While she found there were many depressed, demoralised and miserable people in her survey of a community in North-West Connemara, women in particular were found to be fatigued and stressed. The lack of counselling and family support services was felt by many women, particularly those whose spouses were dependent on alcohol, while potential relief in the form of participation in community activities and services for the elderly were not found to be available to them. Byrne and Owens (1996) in a study of women's lives in a community in South-West Mayo described how service depletion in rural areas has placed a severe strain on women, in particular as they have responsibility for caring for others who are young, elderly or unwell.

4.5 Traveller women

Travellers in general experience a lower standard of health and this has been related to their poor living conditions while the high rate of premature mortality among the Travelling community has been related to their social and economic disadvantage (Pavee Point, 1995; Report of the Task Force on the Travelling Community;1995 and MacLaughlin, 1995). Death from metabolic and congenital disorders is especially high among the Traveller population due to a high rate of consanguinity, or marriages between couples related to each other (MacLaughlin, 1995). MacLaughlin (1995) related this increase in consanguinity to the transition from nomadic, rural to settled, urban lifestyles whereby Travellers, having settled down, marry within a small localised community which has reduced the gene pool. Also the tendency of Travellers to marry within their own community was described as a two fold outcome of racial discrimination: the difficulties for Travellers to integrate into the settled population and, attempts by Travellers to preserve their ethnic identity. The high numbers of families in the Travelling community without a current medical card, who do not understand their entitlements to health services, has also been a factor in their poor health status (MacLaughlin, 1995, Pavee Point,1995).

A high proportion of Traveller women do not know where to go for family planning services or a cervical smear, while the number performing breast examinations was found to be low (Rigal, 1993 and Pavee Point, 1995). However, the Report of the Task Force on the Travelling Community (1995) found that over half of the Traveller women studied had a smear test in the previous five years, higher than the total population. This was related here to the higher fertility of Travellers which put them in contact with such a service and, the participation of the group in a project which included health promotion activities including arranging smear tests. Rigal (1993) found that Traveller women use different methods of contraception from those principally used by settled women. Depo-Provera is among one of the principal methods used and she noted that this has tended to be administered to women in Third World countries and ethnic minorities in Western countries despite being the subject of controversy regarding safety.

Travellers' fertility rate is much higher at 18.1 per thousand live births in 1991 as opposed to a national average of 7.4, and is particularly high among unhoused Travellers while unhoused teenage Traveller women have a markedly higher fertility rate than teenagers nationally (Report of the Task Force on the Travelling Community 1995, MacLaughlin, 1995). The average age at first pregnancy is younger among Traveller women and the average spacing between their last two children was two and a half years (Pavee Point, 1995). Traveller women were found to have a lower level of uptake and attend later for antenatal care while a large number had no post-natal check-up (Pavee Point, 1995, Report of the Task Force on the Travelling Community

1995). The incidence of still-births, infant mortality and birth difficulties is also significantly higher among Travellers, particularly those who are unhoused, related to lower levels of antenatal care, maternal malnutrition during pregnancy, recurrent pregnancies with short intervals between each one and poor accommodation and housing for Traveller mothers (Pavee Point, 1995; Report of the Task Force on the Travelling Community, 1995 and MacLaughlin, 1995).

According to the Report of the Task Force on the Travelling Community (1995) significantly more Traveller women smoke than the total population at 62 per cent compared with 28 per cent. Traveller women were also found to provide a high level of caring to people who do not live with them, but the number who described themselves as carers was found to be low. It was felt overall that there is a need to target Traveller women's health with outreach services and education which are culturally appropriate. Finally, Women's Aid (1995) found that there were specific cultural factors associated with domestic violence in the Traveller community including early age of marriage, arranged marriage, kinship marriage and large numbers of children which may increase the risk of violence and make it difficult for women to leave a violent relationship. They recommended that services be culturally sensitive to this group.

4.6 Equity: an overview

There is some lack of clarity on what the present emphasis on equity as a principle of health policy signifies. While it might be expected to direct attention to equity in health, the policy documents refer primarily to equity in access to health services, which is quite a different (and ultimately narrower) concern. Furthermore, as far as gender differences in health and usage of health services are concerned, there has been no discussion of what should be counted as equitable – to what extent can gender differences in health status (most of which come down in favour of women) be counted as equitable or otherwise, or on what basis can equity questions be assessed in that context.

Though research on social inequalities in health is not extensive in Ireland, such work as had been carried out shows quite marked differentials by socio-economic group and indicates that questions of equity across socio-economic groups are as pressing in Ireland as in other countries. Population-based studies in Ireland have shown strong evidence of a link between deprivation and disadvantage and poor health status for women and men. Findings from research reviewed here also reveal inequalities within the female population as a result of socio-economic disadvantage, single parent status, living in a rural area and membership of the ethnic minority Travelling community. This indicates the need for studies of variations in health status across a range of variables.

Section 5

- 5.0 Quality
- 5.1 Appropriateness of treatment
- 5.2 Counselling
- 5.3 Pregnancy counselling
- 5.4 Reproductive health
- 5.5 Women drug users with HIV
- 5.6 Women and health information
- 5.7 Women-friendly health services: a summary



Section 5

5.0 Quality

There are two aspects to the 'quality' of health services.

The first relates to technical quality of the treatment or care, the extent to which it is provided to the highest technical standards generally available. Although this is a fundamental aspect of quality of services, little research has been conducted into this question in Ireland and no systematic monitoring of the overall technical adequacy of services is in place, other than that which arises from internal self-regulation by the medical professionals. Consumers thus have no way of knowing what the overall level of quality is in any branch of the health services, nor how particular service providers would rate by reference to the prevailing standards in their areas. These are major gaps, and mean that knowledge about the quality of health services is seriously underdeveloped in Ireland, both from an individual consumer's point of view and from the viewpoint of health policy.

The second aspect of quality relates to consumer satisfaction, that is, the consumer's perception of the quality of the service they receive. This aspect of quality has received much more attention than the first, to the extent that 'quality of services' often tends to be equated wholly with consumer satisfaction. The interpretation of quality in these terms is excessively limited, since consumers, by virtue of their lack of technical knowledge, may be satisfied with a service which is of inferior technical quality. A technically poor service which is delivered in a friendly, accessible fashion may score high on consumer satisfaction ratings, though it might be counted as deficient and unacceptable on medical grounds.

Nevertheless, although consumer satisfaction should not be accorded excessive attention as a measure of quality, it is important. This is particularly so in the case of women, as women have higher health service utilisation rates and have been found to act as intermediaries between the health services and their families and communities. Women's perception of the quality of the health services has become synonymous with the notion of 'woman-friendly' health services and this was the term used in the Plan for Women's Health (1997). Shaping a Healthier Future (1994) described quality thus:

The consumer's perception of the quality of the service he or she receives will be greatly influenced by factors such as the efficiency with which they are organised, the courtesy shown and the physical surroundings in which they are delivered. The maintenance of quality standards in these areas is also therefore of great importance. (1994, p.11)

The concept of 'woman-friendliness' highlighted in the Plan for Women's Health included a number of dimensions: a more holistic model of health whereby the whole woman, both the physical and psychological, is treated and the context of a woman's life is taken into account by service providers; respect for women through consultation; a commitment to improving women's health and delivering services in an environment which is acceptable for women; and providing the option of a female practitioner where possible.

Certain elements of the health services have been criticised for not being sensitive to women's needs or for being 'unfriendly' to women. These arise under a number of headings.

5.1 Appropriateness of treatment

There has been criticism of the established biomedical approach to women's health on the basis that it tends to 'over-medicalise' aspects of women's health, with the result that women are channelled into drug-based medical treatments for health matters that could be dealt with by other means. Examples of this have already been mentioned, mainly relating to ways of coping with abuse, stress or mental ill-health experienced by women. Cleary (1997a) found that women suffering from depression tend to predominate in the community-based, especially general practitioner, services and are more likely to become long-term attendees because of the drug based treatment they receive. She argued that women were channelled into this type of service and contained within the system because of a lack of alternatives. Furthermore she pointed out that the discourse within this system of health care where women seek out and receive help for depression is predominantly male. She concluded that the individualising tendencies of medical practice which focus on the presenting problem rather than the structural causes are unlikely to solve many women's problems since the difficulties leading to depression could be traced back to the patriarchal dominance of society.

In their study of domestic violence Women's Aid (1995) found that while three quarters of their respondents who had been subjected to domestic violence reported that they suffered from depression, the service response was to route women into the medical management of the problem. Counselling and support were lacking, and this had the result that women were treated by General Practitioners or psychiatric hospitals which they considered inappropriate given that the underlying issue of domestic violence is not addressed. Both of these studies indicate how the narrow biomedical approach to women's health can be both inappropriate and ineffective.

5.2 Counselling

One of the major deficits of the health services noted in the Women's Health Plan (1997) was the absence of a structured counselling and complementary health service. This was perceived to be the main alternative to bio-medicine. Women's long established use of complementary medicine was described by MacFarlane (1997). As well as the work of Cleary (1997) and Women's Aid (1995) there were other occasions through the review where women sought counselling-based interventions rather than medical treatment. Byrne (1991) in her study of rural women living in poverty noted that many women felt the lack of counselling and family support services, particularly whose spouses were dependent on alcohol. The strong demand from women for the incorporation of this type of care into health policy requires more research to see what other aspects of women's health could be appropriately taken care of in a non-medical way.

5.3 Pregnancy counselling

The one area of women's health where there is a specific policy on counselling is in connection with pregnancy and more specifically, crisis pregnancy. Legislation introduced by the Department of Health (1995) regulated the dissemination of information on abortion making it available only within the context of full non-directive counselling. Mahon et al. (1998) found that this could have a negative effect on women's experiences of crisis pregnancy. They described the route to pregnancy counselling agencies as circuitous, because of uncertainty about the legal situation, lack of awareness about counselling or information provision, a fear of delays, and the cost of counselling, all of which impeded women's access to counselling. Other women were ambivalent about counselling and the requirement that they attend in order to receive information impeded some women in accessing reliable information as quickly as they would have liked. This led Mahon et al. (1998) to recommend that the availability of information only in the context of counselling should be examined. They further noted that while women seeking abortion and those contemplating adoption were targeted by counselling services, women who had decided to continue their pregnancy, despite being in need of support, did not receive such a service.

5.4 Reproductive health

As an aspect of health which is unique to women and which is surrounded by social and cultural norms and taboos, reproductive health issues are constantly being evaluated for their 'woman-friendliness'. Family planning advice has been found to be difficult to access especially for rural and younger women. Women expressed a strong preference for a female practitioner to administer reproductive health services. Dedicated family planning clinics are preferred by some because they were associated with the option of a female practitioner, confidentiality, privacy, competence and empathy. (Donovan et al. 1992; Smith, 1996; Hyde, 1997a and; Wiley and Merriman, 1997) Mahon et al. (1998) identified a range of issues which constrained women in

their use of contraception. These included perceived sanctions against sexual activity and contraceptive use among young, single women from authority figures including parents and doctors. This meant that some young women avoided attending their doctor because they worried about confidentiality and meeting disapproval from their doctor. Access to sterilisation and emergency contraception was also found to be problematic for women (Wiley and Merriman 1996; Mahon et al. 1998).

Women wanted more continuity of care in maternity services, and were found to be more satisfied with private or health centre-based than hospital-based antenatal classes. (Wiley and Merriman 1996; Carr, 1992). Single women were most critical of how they were treated which was explained in terms of a pejorative attitude to pregnancy outside of marriage (Hyde 1997, 1997b). This was found to impact negatively on breast-feeding rates as well as on women's attendance at services (Carr, 1992 and Loh et al. 1997). Women were found to lack information on the menopause (Wiley and Merriman, 1997 and Sixsmith et al. 1997) which resulted in confusion, fear and misconception and militated against women participating in preventative care (Sixsmith et al. 1997). Specific issues have been identified in relation to Traveller women in the provision of maternity, family planning and other reproductive health care and research findings have stressed the need for a culturally sensitive approach to Traveller women's health needs (Pavee Point 1995; Report of the Task Force of the Travelling Community, 1995; and Rigal, 1993 and 1997).

5.5 Women drug users with HIV

Butler and Woods (1992) criticised services for women with HIV. Both care workers and women with HIV in their study were of the view that while counselling services were adequate, women needed more practical help such as child-care, help with home duties and financial assistance. HIV positive women were found not to use the services to the same extent as men because they found access difficult due to the demands of home and motherhood.

5.6 Women and health information

The Plan for Women's Health (1997) referred to women's demands for the dissemination of information about health and health services in an accessible and appropriate format. It was noted in the Plan that the Library Association of Ireland had begun research into the provision of consumer health information in Ireland. This work has now been reported (MacDougall 1998) and includes an assessment of the demand for consumer health information in Ireland as well as current levels of access to such information. This is followed by a discussion on how to address the needs identified on the basis of a Consumer Health Information Strategy at both national and regional level which makes information locally available. The report (Well Read: Developing Consumer Health Information in Ireland, 1998) defines consumer health

information as encompassing the full range of information on health care and health issues, not including advice or diagnosis, which is available for patients, their relatives and carers, and the public.

However, O'Donovan (1997) has expressed concerns about the use of this model for disseminating information to women about their health. She noted that some commentators argue that making women more informed about health matters may facilitate them in taking control over their own health and reducing their dependence on doctors. She also referred to the alternative viewpoint which argues that this information is not value-free but the product of vested economic, social and political interests in our society. Rather than empowering women in relation to their own health, the dissemination of such medical information results in the intensification of biomedical hegemony. O'Donovan (1997) concluded that dominant understandings cannot be separated from dominant interests and by endorsing the established wisdoms of medicine, the Plan for Women's Health endorses wisdoms which do not necessarily reflect the interests of women. Thus it appears that there are particular issues relating to the provision and role of health information for women which need to be systematically explored in the interests of informing policy.

5.7 Woman-friendly health services: a summary

Much of the research on quality in women's health services has tended to take the technical quality of the services on faith and to concentrate on quality as measured by consumer satisfaction or 'women-friendliness'. While greater attention to consumer satisfaction is welcome in the health services, the assessment of quality solely in those terms is unfortunate, since it means that hard questions about the technical adequacy and standard of services are not asked. As a result, both the policy maker and the consumer are left without information which is essential for an informed approach to the health services.

In connection with the 'women-friendliness' of the health services, research has indicated what women consider to be important. Key issues include the incorporation of complementary health care and counselling services into the health care model, a more holistic approach to health; certain aspects of reproductive health services, including those arising in the case of crisis pregnancy; dissemination of health information in a way which would empower women in making informed choices about their health behaviour and care, and their sensitivity to cultural issues particularly for Traveller women. The need remains for a more structured and co-ordinated evaluation of the various components of the health services to assess quality from the perspective of woman-friendliness.

Section 6

6.0 Accountability

Section 6

6.0 Accountability

Accountability was another concept which Shaping A Healthier Future (1994) described as having a number of strands. Service providers need to be legally accountable to their clients and politically accountable by taking responsibility for achieving agreed targets. Another dimension to accountability is the need to ensure that those with decision-making powers are acceptable to the consumers of the service. Women make greater use of health services and participate in the labour force of the health sector to a greater extent than do men. However women have been found to be under-represented in the higher managerial and medical ranks which limits their influence on health policy development. Meanwhile it has been recognised that greater accountability will be achieved when a representative constituency of users contribute to decision-making.

One of the principal concerns in relation to women's health has been the level of representation of women in the health services. This is seen as integral to a greater sensitivity to gender in the implementation of health policy and the delivery of health services. Women working in health boards were found to be clustered at the bottom of the jobs hierarchy while being largely absent from the top despite making up almost three quarters of the employees (Department of Equality and Law Reform, 1994). O'Connor (1995) found that the barriers to women's promotion, and consequent participation in decision-making, lay at the level of organisation procedures and culture. A culture of hegemonic masculinity was found to exist which included such aspects as men's chances of promotion far outweighing women's, a traditional hierarchical style of management reigning, which impeded both communication with women and the identification of their competencies, while women's proper place was not seen to be in management. Changes in relation to equal opportunity initiatives, training, promotional paths, interviews, organisational culture and strategies for combining paid work and family responsibilities were all recommended so as to create conditions which would increase women's participation at higher levels in the organisation.

This research which gives a valuable insight into barriers to women's promotion in the health services was confined to the Administrative, Nursing and Paramedical areas at senior and middle level of two Health Boards. A more general gender audit of the health services is needed to locate where women are within the overall services, in order to assist in developing policies or targets for increasing women's overall participation in the health services. Women's location within the medical profession is particularly important given that as consumers women want to be able to attend a female practitioner.

Section 7

7.0 Conclusion – Research For women's health policy



Section 7

7.0 Conclusion – research for women’s health policy

Though there has been considerable development in health policy in Ireland in recent years, this has not been matched by corresponding development in the official approach to research on health. There has been no official assessment of the adequacy of existing research for policy purposes and no official statement of the research which is needed in the future to guide or monitor the new approaches to health policy.

This review set out to fill this gap in connection with women’s health. Its purpose has been to describe the extent of research on women’s health in Ireland and assess its adequacy as a basis for policy.

Distinguishing between data collection and data analysis as components of research, the findings of the review can be summarised thus:

- There are some areas of women’s health on which we do not have any data. The absence of comprehensive data on health status and morbidity is a particular gap.
- In other areas data are collected but the data collection methods need to be gender proofed to ensure they are capable of revealing accurately the situation regarding women.
- There are further areas where data are collected which could be informative about women’s health but these data have not been analysed or otherwise used for policy purposes.
- There are some areas where available data have been analysed with regard to women and have provided revealing insights for policy makers.

Research on women’s health emerges as fragmented and further data collection and analysis are required so that policy can be informed by a comprehensive knowledge base.

In collecting and analysing data on women’s health it is important to have regard to the increasing evidence that biomedical knowledge of ill-health is derived from research based on a standard of male criterion which can overlook gender differences in antecedents to ill-health, diagnosis, treatments and health outcomes.

While women live longer they also experience more ill health and it is particularly important for women’s health policy to be informed by a well designed, gender sensitive database capable of describing morbidity as well as mortality health trends.

Equity is also important. The design and collection of health data relating to mortality and morbidity needs to be amenable to analysis for both inter-gender and intra-gender health variations across a range of variables.

Research which looks at the areas of activity in women's lives and their impact on women's health needs to be sensitive to the differing needs and experiences of women in various social locations including socio-economic status, age, marital status, region and ethnicity.

The review illustrated how health policy and practice can be underwritten by gender assumptions. Any review of health policy to assess its sensitivity to the issue of gender or research into gender differences in health needs to pay attention to this.

Attention to women's perceptions of the quality of the health service in the past has been criticised for two main limitations. The first is a tendency to focus on reproductive health services exclusively and the second is to focus on services within the biomedical model to the exclusion of other alternative models of health care in which women in particular have been interested. This highlights the need for more information about women's perceptions of general health services and their demand for the incorporation of other models of health care into current services.

In relation to the accountability of health services, the research commissioned by the Midland and Mid-Western Health Boards (O'Connor, 1995) provided a very insightful account to women's participation in health services which in itself would function quite well as a basis for policy. This would be further enhanced if a more general gender audit of the health services were conducted.

More generally, structures supporting health research with a gender focus need to be put in place and the activities of agencies engaging in health research, in particular the Health Research Board, should be examined in relation to how inclusive their research brief is of gender.

Finally, methods of data collection and analysis in the area of health needs to be capable of revealing women's attitudes to health in a system which has consistently been found to be dominated by a male discourse. Social research on women has recently been responsive to the arguments of women's' studies practitioners that research methods need to be sensitive to the structural inequalities in society which may render women's experiences invisible when traditional, positivistic research methods are used.

Bibliographies

Annotated bibliography
Subject based bibliography
Reference bibliography

Select Annotated Bibliography of Research on Women's Health in Ireland

Butler, Shane and Woods, Marguerite, 1992. *Drugs, HIV and Ireland: Responses to Women in Dublin* in Dorn, N., Henderson, S. and South, N. (Eds) *AIDS: Women, Drugs and Social Care*. London: Falmer Press.

Butler and Woods described primary qualitative research undertaken with carers for women with HIV and women who were HIV positive to ascertain their views regarding the needs of HIV positive women, the resources available to meet those needs, and the appropriateness of training and support systems available to the carers.

The research concluded that the burden of HIV rather than being randomly distributed bore most heavily on those from a lower socio-economic background. Both care workers and women with HIV were of the view that the counselling services were adequate but they needed more practical help such as child-care, help with home duties and financial assistance.

It was found that women with HIV did not take care of themselves to the extent that they should because of the tendency for women generally to put the care of their children or partner before their own well-being.

Byrne, Anne, 1991. *North-West Connemara: A Baseline Study of Poverty*. FORUM North and West Connemara Rural Project Ltd. Galway.

Byrne conducted a household survey among the population of north-west Connemara to collect quantitative data on the extent of poverty and, qualitative data on the nature of poverty. The study focused on low-income households and selected a sample from the list of GMS medical card holders in the study area.

The survey found a large volume of sub-standard privately owned accommodation among the housing stock of this group. Poor infrastructure in the area was seen as being a major impediment to improving quality of life.

The use of community welfare and voluntary organisations for basic household necessities was taken by Byrne as an indicator of the uneven distribution of income within households. The need to travel to Galway for many basic health care services was described as one of the greatest single problems facing the study area. Services for the elderly were found to be in need of co-ordination, many were found to be lonely but unable to travel due to lack of services and more home helps were said to be needed to help maintain an elderly presence in the community.

Carr, Patricia, 1992. *Labour Relations: Mothers and Hospital Procedures* Sociological Association of Ireland 2: 20-41.

Carr compared the birth experiences of two groups of mothers: one group who had attended ante-natal classes in the hospital setting and a second group who had attended ante-natal classes outside the hospital setting delivered by what she described as an alternative group interested in improving services for women.

She argued that pregnant women make use of the information they learn in ante-natal classes during the course of labour.

Her focus was on how these two groups of women coped with giving birth and with breastfeeding in an institutional setting (the hospital). She was a participant observer of both sets of classes. The hospital classes were described as similar to a classroom setting, given by a nurse and a physiotherapist who sat at the top of the room. She also attended a reunion class after the birth. The other classes were run in a health centre and were likened to a discussion group, giving more in-depth knowledge because they were of longer duration, and also providing women with access to a library. Semi-structured interviews were also carried out with participants of both classes after the birth.

She argued that what she described as the “rules of childbirth” (1989:20) emerging from antenatal classes could be enabling rather than constraining for women. She contrasted this with the argument that unequal power relations exist between medical personnel and pregnant women based on gender, that is that male doctors try to control female bodies. Rather she argued that examining gender relations is not enough and that the social context in which birth occurs and the resources women bring to the hospital must also be examined.

Women in the alternative group were given detailed information about the process of labour and breastfeeding. This provided them with knowledge which they could use to actively participate in managing their birthing experiences and negotiating breastfeeding. Women who were mothers already were further enabled to express their views and preferences during childbirth in hospital. Carr put forward the hypothesis that antenatal classes run by the hospital reproduce the social structures of the hospital and in turn reproduce structures of domination.

Cleary, Anne, 1997a. *Gender Differences in Mental Health in Ireland* in Cleary and Treacy, (Eds) *The Sociology of Health and Illness*. Dublin: University College Dublin Press.

Gender differences in relation to mental health data are examined here to look at how mental illness is experienced differently by women and men. An analysis of hospital

in-patient and out-patient data revealed a gender differential in terms of diagnosis and positioning within the mental health and hospital landscape. Men were found to predominate in the Irish hospital system, a pattern identified over a long time-frame. Women in contrast were found to predominate in the community-based, especially general practitioner, services.

However women were found to be contained within this system, and to be channelled into this type of service because of a lack of alternatives. This has led to women being more likely to become long-term attendees because they usually receive drug based treatment.

Cleary went on to examine the notion that depression among women is the outcome of stresses related to their role in society. Depressed women were described as having had more serious difficulties both in their past and present lives. On its own this vulnerability was not found to produce distress but depression may result when other factors are presents. Thus she put forward a tentative explanation for depression embracing both women and men that “depression is a condition to which people are likely to succumb when role loss is substantial” (203).

She concluded that there is a gender pattern in psychiatric service usage both at hospital and community level in Ireland with men predominating in the hospital system and women in community services. Cleary closely links this pattern to diagnosis with women and men predominating in different diagnostic categories and different areas of what she calls the mental health landscape.

Cleary, Anne, 1997. *Madness and Mental Health in Irish Women*. *Women and Irish Society*. Byrne and Leonard (Eds). Blackstaff, Belfast. 233 - 250.

Cleary undertook a qualitative study of depression among women in Ireland. This had two aims: to establish the prevalence of depression among women in an urban Irish setting, and to investigate social and psychological factors associated with its development. The study involved a comparison between a group of 50 women attending a district psychiatric hospital and 54 women from a Dublin city community who had been found to show minimal or no symptoms.

She concluded that adversity in childhood left women with a poor foundation in self-esteem which caused them to be vulnerable in the negotiation of later transitions and difficulties. It was necessary to look at the context in which depression is experienced for women. Many of the difficulties of the lives of women's lives could be traced back to the patriarchal dominance of society. There are reasons why individual women become depressed which are related to the meaning of events and experiences for each woman.

By drawing together research on hospital in-patient statistics, out-patient statistics

and a community study of the experience of depression by women living in one area of Dublin, she concluded that there are gender differences in certain diagnostic categories with women dominating for depressive disorders and men for alcoholism and also that there is a gendered pattern of service presentation.

Codd et al, 1994. Screening for Breast Cancer in Ireland: the Eccles Breast Screening Programme. *European Journal of Cancer Prevention* Vol. 3 Supplement 1 21-28.

The pilot programme targeted women aged 50-65 years living in Dublin city and county and counties Cavan and Monaghan. The main problem encountered by the programme was the identification of a comprehensive register of women living in these areas which was acknowledged as the main problem facing the establishment of the programme on a national level. The programme was successful in detecting a higher rate of cancers which were non-invasive than would be seen in referral practice populations.

Department of Health Promotion Studies & Patricia McCarthy and Associates, 1995. *Health Service Provision For The Travelling Community in Ireland. Report of the Task Force of the Travelling Community, Dept of Equality and Law Reform.*

This survey involved in-depth interviews with 200 Travellers in Galway and Dublin. It transpired that all respondents bar two were women which is indicative of the central role of Traveller women in interaction with health services.

The survey again revealed the poor facilities, services and conditions Travellers live with. Substantial proportions of respondents had no toilet facilities (20%), bath or shower (40%) or electricity (32%), while over a quarter had only shared cold water supply.

It also noted that only a small number of doctors provide services to Travellers with the result that many Travellers in an area will be registered with the same doctor. Travellers also reported difficulties getting a doctor to call out to an illness and so the tendency was to present at hospital Emergency Departments which could be interpreted as misuse.

Travellers were found to be reluctant to visit health centres and it was noted that the desirable increase in PHN input should be on an outreach basis.

It was felt overall that there is a need to target Traveller women's health with outreach services and education which are culturally appropriate.

Department of Health & Children, (1999) Survey of Lifestyles, Attitudes and Nutrition (SLAN) and Health Behaviour in School-aged Children.

The first ever Irish National Health and Lifestyle surveys was commissioned by the Department of Health & Children in 1998. The survey was carried out by the Centre for Health Promotion Studies, NUI, Galway.

A total of 6,539 adults and 8,497 school-aged children were the sample group. Data were obtained through questionnaires. Topics included general health, smoking, alcohol, food and nutrition exercise and accidents.

Results indicated that with regard to smoking, 33% of 15-17 year olds were regular smokers and 49% of children have smoked at least one cigarette. Smoking was slightly higher among males (32%) than females (31%) but when further categorised by age the youngest female age group exhibited a significantly higher rate (40%). Overall, 31% of adults are regular or occasional cigarette smokers.

With regard to alcohol consumption it appeared that most adults now drink alcohol. 27% of males and 21% of females were found to consume more than the recommended weekly unit allowance of alcohol consumption. Some 26% of males over 55 years reported having at least one alcoholic drink every day and 22% of adults admitted to driving after consuming two or more alcoholic drinks. In this survey 29% of children reported having had a drink in the last month.

In terms of nutrition 32% of respondents reported a body mass index classifiable as overweight with 10% classifiable as obese. Some 35% of 15-17 year old females believed they needed to loose weight and 8% of all children in the sample reported being on a weight reducing diet. 64% of respondents reported consuming the recommended quantities of fruit and vegetables per day.

The survey also revealed that 42% of adults engaged in some form of regular exercise however it further found that one third of those aged over 55 years took no exercise at all in a regular week.

Donovan, Aislinn, Ryan, Jerome and Donovan, William, 1992. Why Choose a Family Planning Clinic. FORUM: 53-55.

Donovan et al. (1992) surveyed 100 women attending a female GP at a family planning centre to identify who used Family Planning Clinics (FPCs) and why they choose an FPC in preference to attending their GP. Three main factors emerged in their analysis: whether the patient was a GMS patient or a private patient, their usual GP and age.

Having no GP or having a GP who was not 'sympathetic, competent or interested' were the two main reasons women attended the FPC for contraception. Privacy and anonymity was next in line of importance followed by the clinic being seen as a specialised service.

Their findings showed that 18-25 year olds were the largest age-group in attendance at the FPC which indicated that younger women have a preference for FPCs.

[European Institute of Women's Health \(1999\): Dementia Care Challenges for an Ageing Europe.](#)

The European Institute of Women's Health recognises the serious problems posed by Alzheimer's disease and other dementias to European Member States. Dementia is a particular problem for women who are at increasing risk of the disorder as they age, and who are also primarily responsible for the care of dementia patients.

The Institute has undertaken a cross-country comparison of policies and practices regarding dementia with project partners from Belgium, Germany, Ireland, Italy, Luxembourg, Netherlands, Sweden and the U.K.

This report is intended to provide a profile of dementia, its prevalence now and in the future, its economic and social impact, as well as an overview of national policies and care arrangements and recommendations for the future.

The challenge facing Europe on the eve of the millennium lies in developing an interdisciplinary combination of medical, clinical, social, economic, governmental and personal approaches to those with dementia and their families.

[Flynn, Mary, 1997. Fear of Fatness and adolescent girls: implications for obesity prevention. Proceedings of the Nutrition Society. 56, 305-317.](#)

Concern has emerged about excessive dieting among young women in the pursuit of thinness among nutritionists working in the Irish context. Writing on this issue in 1997 Flynn, a nutritionist in the Dublin Institute of Technology, described the emergence of fatness phobia among adolescent girls in developed societies despite the prevalence of overweight and obesity. She argued that this 'fear of fatness' has led to inappropriate dieting and weight-loss behaviours which may constitute a far greater threat to young women's health than obesity.

She discussed smoking as a weight-loss strategy for adolescent girls and emphasised the worrying implications of this tendency in light of findings which show that weight gain on smoking cessation is greater for women than men. She explained that

adolescent girls fear the immediate possibility of weight gain far more than the remote likelihood of serious disease and premature death from smoking related illnesses. She concluded that the link with smoking represents the most overwhelming reason for urgent and effective action to address the issue of fatness.

Hodgins, Margaret and Kelleher, Cecily, 1997. *Health and Well-being in Social-Care Workers* in Barry et al, (Eds) *Women's Studies Review: Women and Health*. NUIG Women's Studies Centre, Galway.

Hodgins and Kelleher undertook a discussion of 'Health and Well-being in Social Care Workers' based on findings of both international studies and Irish studies with an emphasis on the latter. They say that social care can include medical care but is chiefly characterised by personal and social services, and that it is usually provided by family members, primarily women. They identify three issues that arise consistently in research on carers: One - the mental and physical health of carers is compromised by this work; Two - care is unshared by relatives; Three - carers receive inadequate back-up or support services from formal health services.

Care within families and communities entails considerable hard work, physical strain and emotional resources as well as long hours with one study reporting an average of a 58 hour week for carers of the elderly.

They reported evidence of an absence of support for carers.

To alleviate the conditions of informal carers they suggest that health boards should be mandated to provide Home Help Services and funded to develop this service; the assumption that informal carers are qualified to perform the duties of a home-help should be examined; types and grades of social care workers should be examined to clarify and develop appropriate pay scales and conditions. Community supports including respite workers and day care centres should be put in place for those who decide to provide care in the family.

Hyde, Abbey, 1996. *Unmarried Pregnant Women's Accounts of Their Contraceptive Practices: A Qualitative Analysis*. *Sociological Association of Ireland* 6: 179-211.

Hyde conducted qualitative interviews with 51 pregnant women attending one antenatal clinic all of whom were unmarried and becoming mothers for the first time. Her analysis sought to understand women's subjective experiences of their pregnancy and to locate these within wider social processes. Part of her research focused on the participants contraceptive practices during the lead-up to their pregnancy.

There were 7 different categories to describe contraceptive practices. One - 'Fertility

denial' (it won't happen to me) This group were younger, had not completed education and were not working. Two - 'Destiny dependence' (if it happens, it happens) Again these were younger, without Leaving cert., unemployed or in unstable employment but in a stable relationship. Three - 'Progressive remissive' had been regular users of contraceptives but less regular at the time of getting pregnant. They were of average age with Leaving cert and in a stable relationship when they became pregnant. Four 'Occasional or intermittent risk-taking'. Five 'Calculated risk-taking; Six - Pro-active fertility management' and, Seven 'Contraceptive failure or misuse group.

Hyde noted throughout the study that age, social class, stage of relationship and social circumstances were sites of differences between these groups who had become pregnant in various ways. She argued that the variation reflects women's exposure to conflicting patriarchal discourses which influence women to different degrees.

She argued that discourses around childbearing have different nuances for different themes, norms relating to age were more significant for some women (older rather than adolescent) while those around gender relations (stable relationship rather than single) were more influential for others.

Hyde, Abbey, 1997. *The Medicalisation of Childbearing Norms: Encounters between unmarried pregnant women and medical personnel in an Irish context in Cleary and Treacy (Eds) The Sociology of Health and Illness Dublin: University College Dublin Press.*

Hyde (1997) reported findings from a qualitative study of 51 unmarried women's experiences of pregnancy.

Hyde conducted qualitative interviews with 51 pregnant women attending one antenatal clinic all of whom were unmarried and becoming mothers for the first time. Her analysis sought to understand women's subjective experiences of their pregnancy, and to locate these within wider social processes. This paper discussed respondents encounters with medical personnel and how their behaviour reflected and reinforced social norms about the appropriate timing and context for childbearing.

Hyde concluded that the practice of some medical personnel who make value judgements about pregnancies which threaten the social order mediate the medical encounter and mean that medicine plays a part in the maintenance of social arrangements for childbearing.

Jenkins, DM, Carr C, Stanley J, O'Dwyer T., 1996. Maternal Mortality in the Irish Republic, 1989 - 1991. *Irish Medical Journal* July/August Vol. 89, No.4.

The most recent analysis of maternal mortality was undertaken by Jenkins et al. (1996) who noted that the last published report of Maternal Deaths in the Republic of Ireland had produced triennial reports until it lapsed in 1981.

They looked at maternal mortality in Ireland between 1989 and 1991 examining the number and causes of maternal mortality during the period. Their method of identifying the maternal deaths were through Death Certificates, Coroners' Reports and Hospital Annual Reports. They noted that autopsies were either not done or not available in 10 of the 19 cases of maternal death studied and described this as unsatisfactory. They found a higher than expected number of cerebrovascular accidents in the group. They argued that the lack of facilities to terminate a pregnancy did not appear to have influenced the rate of maternal mortality due to obstetric causes. They attributed the reduction in deaths in part to the dramatic fall in Irish fertility rates and large family sizes among most women, with the exception of Traveller women. They concluded that the definition of maternal deaths should be extended to include all those deaths during or within one year of completion of pregnancy. It is noteworthy that in their analysis of the care received by women they did not refer to 'avoidable factors' because they were concerned that given the small number of cases involved "medico-legal utilisation would follow publication" (1996, p.140).

Loh, N., Kelleher C., Long S. and Loftus B., 1995. Can We Increase Breast Feeding Rates?. *Irish Medical Journal* 90: 100-101.

The study of Breast Feeding rates looked at whether an intervention, namely providing pregnant women with a sheet illustrating eight positive aspects of breast feeding at an antenatal visit in the late stages of pregnancy, would have an effect on breast feeding rates. The prospective study, which also included a control group, found that when interviewed 48 hours after delivery an almost significantly higher number of women in the intervention group went on to breast feed than had in the control group.

Mac Farlane, Anne, 1997. The Changing Role of Women As Health Workers in Ireland. in Barry et al. (Eds) *Women's Studies Review: Women and Health*. NUIG Women's Studies Centre: Galway.

MacFarlane (1997) studied 'medical pluralism' in the Irish context - that is conventional medicine alongside traditional folk practices and contemporary 'alternative' medicine and found women to be the principal providers of all types of health care and, in the case of traditional and alternative medicine, as providers of knowledge also. She found evidence of women's responsibility for the maintenance

and, in the case of illness, restoration of the health of their families. She discussed the notion of a 'clinical iceberg' which she said "refers to the fact that people who seek medical care represent the tip of the iceberg of illness experiences because the majority of physical complaints do not reach medical services" (1997, p.17). In this way women were said to address the health care needs of the large group of those with medical problems who do not present to the health services.

MacLaughlin, Jim, 1995. *Travellers And Ireland: Whose Country, Whose History?* Cork: Cork University Press.

MacLaughlin's study of Travellers in Ireland involved secondary analysis on both official statistics and primary research to present a picture of where Travellers are located in Irish society.

Travellers were found to have a much higher fertility rate. Unhoused teenage Traveller women have a markedly higher fertility rate than teenagers nationally.

The high rate of premature mortality among the Travelling community was related to their social and economic disadvantage. MacLaughlin noted that death from metabolic and congenital disorders is especially high among the Traveller population. This was the outcome of a high rate of consanguinity, or marriages between couples related to each other, which contributed to genetic disorders among Traveller children, a cause of both morbidity and premature mortality.

Travellers who live in the most difficult conditions of roadside settlements were said to have even higher mortality rates than settled Travellers. The two types of accident which Travellers in these sites are more exposed to are road traffic accidents and fires due to inadequate fire-fighting equipment.

Mahon, Evelyn, Conlon Catherine, and Dillon Lucy, 1998. *Women and Crisis Pregnancy*. Dublin: Government Publications, The Stationery Office.

The aims of the study were - to identify factors associated with and processes leading to a crisis pregnancy; - to examine how women arrive at decisions regarding different outcomes of a crisis pregnancy; - to look at pregnant women's use of contraceptive, medical and counselling services; - to outline the factors which should guide the future development of family planning and related services. The study included qualitative in-depth interviews with women seeking abortion (94) or who had an abortion in the past (10); women with a crisis pregnancy who were anticipating single, lone motherhood (34); women with a crisis pregnancy who were contemplating adoption (11)¹. There was also a quantitative component to the study whereby a closed questionnaire was administered to 2,053 women in ante-natal clinics.

¹In total the study involved qualitative interviews with a much bigger sample as women with non-crisis pregnancies were also included. The overall number of interviews conducted were 353. This comprised 104 interviews with women seeking abortion, 11 with women contemplating abortion and 238 women who were continuing with their pregnancy and becoming mothers

They found that the majority of women who have a crisis pregnancy continue their pregnancy while the numbers of women seeking abortion was found to have increased with time. While the rate of abortions represented 8.5% of all conceptions, the proportion of non-marital conceptions ending in abortion was 25% as compared with 2% of marital conceptions.

Issues were identified that constrain women in their use of contraception. These included perceived sanctions against sexual activity and contraceptive use among young, single women. Women feared that being prepared with contraception would be construed by partners as being prepared for sex. Access to sterilisation and emergency contraception was also found to be problematic for women.

Use of pregnancy counselling services was by three different routes - a) self-referral to a British clinic (29 out of 88); b) contact with doctors in Ireland before travelling (21 in all but 7 for pregnancy test only, 14 had counselling and were given information on abortion); c) contact with pregnancy counselling agency before travelling (36 out of 88).

They described factors influencing the decisions of those women who decided to have an abortion. These related to women's roles as daughters, students or workers, prospective mothers, partners or ex-partners and in some cases as mothers already. They concluded that "a woman frames the competing demands, she determines that it is impossible to go ahead with the pregnancy, except by hurting others, or by not being able to afford to have a child in the future, so she makes her decision [to have an abortion]" (1998: 526).

Women contemplating adoption were found to have rejected abortion because of their moral viewpoint, financial reasons and becoming aware of the option of adoption. The women were in residential accommodation where they received on-going counselling. This group were found to feel ambiguous about the decision they were making. On-going counselling was found to be helpful to women contemplating adoption.

Women who intended to become lone mothers were described as doing so, conscious that the dominant model for having a child is marriage. Women were found to worry about disclosing the pregnancy to parents though most parents emerged as supportive and this support was found to be a key factor in women coping with the crisis pregnancy. Women were found to have revised their career trajectories downwards in response to the anticipated demands of motherhood which was related to an absence of support structures for mothers in education, training or work.

The report concluded that economic marginalisation and considerable social stigma are still experienced by many lone mothers.

McElwee, Niall and Lalor, Kevin, 1997. *Prostitution in Waterford City: A Contemporary Analysis*. Waterford: StreetSmart Press.

This study was commissioned by the Good Shepherd Sisters of Waterford, in collaboration with the Waterford Institute of Technology and the Dublin Institute of Technology. Its objectives were to enumerate the incidence of prostitution in Waterford City and to identify possible service requirements for this particular population. It became apparent that prostitution is a very hidden activity in Waterford - many potential respondents refused to participate in the study. Ultimately a total of six in-depth interviews were conducted.

The participants were aged between seventeen and thirty-one years, the majority were single and two were mothers. All participants reported that they had suffered some form of sexual abuse. Five out of the six interviewees stated that they were currently involved in the consumption of illegal drugs. Half of those interviewed had contracted some form of STD. 33% had been 'in trouble' with the Gardai, 33% had, as children, been placed in the care of the local health board, while 50% stated that they had at some point received professional counselling for psychological problems.

In light of their findings, and in consultation with social service providers and the Waterford Gardai, McElwee and Lalor (1997) recommend the establishment of a Women's Health Project with adequate funding and qualified staff along the lines of the one operating in Dublin

Milner, M. and Barry-Kinsella, C., 1992. *Changing characteristics of Irish menopausal women seeking assistance*. *Irish Medical Journal* 85: 54 -56.

Milner and Barry-Kinsella (1992) reported on the first year audit of the Menopause Clinic at the Rotunda Hospital in Dublin, described as a balanced working relationship with those in primary care, who in the main will initiate treatment and utilise our service for difficult or unusual problems.

The audit revealed difficulties relating to how the clinic was used in its initial stages but saw these being resolved in accordance with the clinic's stated aims by the second year. The first group were found to have significantly more social problems particularly alcoholism which the authors argued were best dealt by GP services so as the treatment takes account of the woman's background environment. The second group had less social problems which the authors interpreted as more appropriate menopause related referral.

O'Connor, Aideen and O'Hare, Aileen, 1987. *Gender Differences in Treated Mental Illness in the Republic of Ireland* in Curtin et al. (Eds) *Gender in Irish Society*. University Press: Galway.

This study looked at gender differences in treated mental illness rates in the Republic of Ireland. Contrary to trends in both Britain and the United States, it was found that Irish resident rates in psychiatric hospitals, and admission rates to all forms of psychiatric treatment show a higher proportion of male rather than female patients. They concluded that, given the issues raised by this study, further in-depth analyses of gender, class and rural/urban differences in the area of treated mental health illnesses are required. An examination of the case loads faced by GPs is also recommended in order to assess the extent to which they are handling cases of psychiatric and emotional disturbance in addition to community studies with the aim of identifying individuals using other sources of non-medical help, or receiving no help at all.

They suggested that certain gender-specific characteristics among males in rural areas can render them vulnerable to institutionalisation in psychiatric hospitals or dependent on out-patient psychiatric services, once mental illness, usually schizophrenia, is judged to be present. The authors suggested that women, particularly mothers, with a large number of role obligations are less likely than their male counterparts to seek help for symptoms of depression, and may well delay doing so until late in their family life-cycle. The authors uncovered a trend among rural general practitioners to act as treatment agents themselves, only filtering some of their patients through to further, more specialist services, whilst maintaining others, women more so than men, at the primary level of care.

They concluded that, given the issues raised by this study, further in-depth analyses of gender, class and rural/urban differences in the area of treated mental health illnesses are required. An examination of the caseloads faced by GPs is also recommended in order to assess the extent to which they are handling cases of psychiatric and emotional disturbance, in addition to community studies with the aim of identifying individuals using other sources of non-medical help, or receiving no help at all.

O'Connor, Anne Marie, 1994. *The Health Needs of Women Working in Prostitution in the Republic of Ireland*. University College Dublin/Eastern Health Board: Dublin.

This study was commissioned by EUROPAP and funded by the Women's Health Project which provides health services for women working in prostitution and are part of the Eastern Health Board. The study used qualitative methodology.

Eighteen interviews were conducted with prostitutes working in Dublin, interviews were also conducted with health professionals working with prostitutes and

documentary analysis was also conducted. None of the women interviewed were actually married at the time of the study. In almost all cases partners knew of the work these women were engaged in, however all women stated that they were working independently of any male protector or 'pimp'. A number of the women interviewed mentioned the worry and stress involved in attempting to keep the nature of their work hidden from other family members, particularly in the case of the 83% of participants who had children of their own.

All of the women stated that they started this form of work for financial reasons - three women needing money for alcohol, drugs, gambling reasons respectively. Almost half (44%) of the participants had been sexually abused as children or teenagers. Over half (55%) of the women discussed suffering violent acts including broken bones and strangulation at the hands of their clients, suffering from cold-related general health problems including asthma, chest infections, bronchitis and pneumonia. Many problems related to nerves and stress. One third said they used painkillers, while 17% took valium or anti-depressants.

In the area of sexual health, the majority of participants have regular checks for Sexual Transmitted Diseases and 89% had been tested for HIV.

In examining the attitudes of women working in prostitution towards health workers, the large majority of women interviewed felt unable to reveal their profession to their own GP or hospital staff - it was only at the WHP.

In conclusion, among all participants, levels of awareness and confidence in using health services varied. Most of the women who took part in this study availed of the services offered by the WHP. However it must be noted that many women working in different types of prostitution and particularly in certain areas of Dublin are isolated, and have little motivation to seek out any of the facilities that the health services may provide for them.

O'Connor, Emer, Friel, Sharon and Kelleher, Cecily, 1997. Fashion Consciousness as a Social Influence on Lifestyle Behaviour in Young Irish Adults. *Health Promotion International* 12: 135-139.

A 1997 study by the Health Promotion Unit in University College Galway set out to examine the influence of fashion as portrayed in the media on health-related behaviour in adolescence.

To explore this they conducted a street survey with a cross-section of young adult women and men aged 15-30 to ascertain their knowledge and use of the print and visual media and conducted a similar study with a sample of patients with eating

disorders attending three different psychiatric units. They recommended that the interrelationship between the three factors of smoking, fashion consciousness and dietary behaviour be acknowledged and incorporated in health promotion strategies.

O'Connor, Pat, 1995. *Barriers to Women's Promotion in the Midland and Mid-Western Health Boards*. Midland and Mid-Western Health Boards, Longford/Dublin.

O'Connor was commissioned by the Midland and Mid-Western Health Board to conduct a study to ascertain the views and advice of women on their perceptions to the barriers to promotion in the Boards' employment and how this can be removed. Almost three quarters of the health boards employees are women. Chances of promotion improved once women reached the middle of the hierarchy but remained lower than men's. Women were found to express anger and bewilderment at the way in which characteristics that were traditionally fostered in women worked against their career development. Women welcomed initiatives being taken by the Boards to address inequalities of opportunity including carrying out the study, appointing an Equality Officer. Culture of hegemonic masculinity existed with the Board which had created the barriers to women's promotion.

O'Donovan, Orla, 1997. *Contesting Concepts of Care: The Case of the Home Help in Cleary, and Treacy (Eds) The Sociology of Health and Illness*. Dublin: University College Dublin Press.

O'Donovan (1997) undertook an analysis of the concept of care underlying health boards use of home help staff to provide care to elderly dependent members of the community. Health boards are described as being opposed to the provision of training to home-helpers on the grounds that it would undermine the voluntarist nature of the care given which they presume to be motivated by a strong emotional commitment rather than having any economic motivation. O'Donovan concludes that the service is both a reflection of the oppression of women by the patriarchal welfare state and an example of the lack of commitment to resourcing community-based services to older people in Ireland.

O'Donovan, Orla, 1997. *The Plan for Women's Health and the Politics of Knowledge: A Brief Commentary in Barry et al (Eds) Women's Studies Review: Women and Health*. NUIG Women's Studies Centre: Galway.

O'Donovan assessed the commitment in the Plan for Women's Health to undertake initiatives to disseminate information about the health services and the health services and information to support the development of healthy lifestyles. She notes that some commentators argue that making women more informed about health matters may facilitate them in taking control over their own health and reducing their dependence on

doctors. The other viewpoint she noted is that which argues that this information is not value-free but the product of vested economic, social and political interests in our society.

Prendiville, Walter and Short, Mary, 1993. A review of family planning in Ireland. *The British Journal of Family Planning* 19: 246-247.

Prendiville and Short (1993) carried out a review of family planning in Ireland and concluded that there is a large variation in the provision of family planning services throughout the country. They argued that the influence of the Catholic church is responsible for the failure of family planning services here to become aligned with services throughout Europe. Dublin was described as being well served by family planning clinics. However they found that sterilisation was more accessible in Cork or Galway than in Dublin. The role of General Practitioners in providing contraception was described as significant though they cited evidence of low levels of awareness among those attending their GP of the family planning services they provide.

Primary Health Care For Travellers Project, 1995. *Analysis of Baseline Questionnaire*, Pavee Point and Eastern Health Board, 1995.

The Primary Health Care For Travellers Project is a partnership between the Eastern Health Board and Pavee Point.

The project undertook a Baseline Survey of the health problems and needs of Travellers to provide information on disease pattern and utilisation of services, to inform policy making at health board level, to ensure culturally appropriate health services are developed, to inform the Traveller community of the findings regarding their health and illness experiences and, to enable Travellers participate in the planning process.

The survey included a section specific to women's health. Women were found to attend late for antenatal care. Two thirds of women had no post-natal check-up. The average age at first pregnancy for the group was 19 years and the average spacing between their last two children was two and a half years. The GP was the most frequently used source of family planning.

Women were found to have spent on average six and a half years at school. The changes women sought to the health services were more information appropriate to the needs of Travellers, more time to listen to Travellers and reduced waiting lists.

Rigal, Jocelyne, 1993. *The Emergence of Fertility Control Among Irish Travellers*. *Irish Journal of Sociology*, Vol 3, 95 - 108.

Rigal described her research as an attempt to complement quantitative information

documenting a rise in fertility control among traveller women, with qualitative data in order to situate the phenomenon in its cultural context. She noted that younger Traveller women were discussing fertility control with their husbands. Younger Traveller women used contraception early in their reproductive lives whereas older women used it because they already had a large family.

Sources of information on family planning were found to be hospital consultants at postpartum examinations, centres where women were attending training, the mobile clinic run by the health board and social workers. Intra-uterine devices, the contraceptive pill and the injection of Depo-Provera were methods used. She also noted instances of contraceptive pill failure among Traveller women and an ambivalence among Traveller women towards contraception which she related to a traditional passivity towards their reproductive life.

Rigal, Jocelyne, 1997. 'Family Planning for Irish Travelling Women: Gender Ethnicity and Professionalism at Work' In Byrne and Leonard (Eds) *Women and Irish Society: A Sociological Reader*. Beyond the Pale Publications, Belfast.

This paper is further analysis of Rigal's qualitative study of Traveller Women's use of contraception based on unstructured interviews and participants observation.

Rigal argued that in the contraceptive counselling she encountered between the settled health professional woman and the Traveller women, cultural conflict arose. She further argued that the cultural conflict around contraception between the nurse and the women and the unequal power relationship between the two protagonists, provided the opportunity for the professional to contribute to the social control of Traveller women by not informing them sufficiently so as to empower them and, by subscribing to stereotyped ideology.

Ryan, Yvonne, Gibney, Michael J. and Flynn, Mary, 1998. *The Pursuit of Thinness: a study of Dublin schoolgirls aged 15 years*. In *International Journal of Obesity*. 22, 486-488.

Ryan et al., (1998) undertook a study of 420 14-17 year olds to compare their actual weight with their perceptions of their weight and to assess their body weight concerns and slimming practices. In all 59% of the group were not happy with their weight and more than two thirds of them had previously tried to lose weight. While dieting (79%) and exercising (80%) were the most commonly used methods of weight loss used, 19% reported smoking, 15% induced vomiting, 5% used laxatives and 4% used diet pills. They concluded that the long-term health risks associated with the weight control strategies engaged in by young women may out-weigh those associated with female fatness.

The Saffron Initiative (1998) :The Saffron Report on Women's Lifetime Health Needs.

The Saffron Initiative was established in 1997 to identify opportunities for improving the health of women in the second half of their lives.

The aims of the initiative are to:

Provide appropriate information on health for women

Influence policy changes; Encourage health professionals, voluntary bodies and the media to take a more pro-active role in promoting health awareness in this age group.

The Saffron Initiative is chaired by Dr. Maire Geoghegan Quinn and the Medical and Nursing Professions as well as voluntary bodies.

A questionnaire was designed by Dr. Joe Durkin, of the Department of Health Economics, U.C.D. and the survey was conducted by the ESRI.

The survey examined life time health needs of women, knowledge and attitude to menopause and sequelae to the menopause and management of same.

While almost all of the women (74.5%) surveyed were aware of menopause, 66% felt that nothing can be done about it. The majority of women preferred to source their information directly from their G.P's although at present, the greatest source of information was through the written word.

Just over half the women surveyed were aware that osteoporosis was a sequelae of the menopause and were aware of dieting and exercise management yet few were knowledgeable of the value of HRT in preventing osteoporosis.

Only one quarter of the women surveyed were aware of increased risk of cardiovascular disease associated with the menopause. In terms of disease perceptions, women placed breast cancer and stroke as the most worrisome and the most difficult to cope with.

Sixsmith, Jane, McCarthy, Emer and Shryane, Eithne, 1997. Women's Attitudes to the Menopause, HRT, Breast Cancer and Mammography Screening in Barry et al (Eds). Women's Studies Review: Women and Health. Galway: NUIG Women's Studies Centre.

Sixsmith et al., (1997) looked at women's knowledge beliefs and attitudes in relation to the Menopause, HRT, Breast Cancer and Mammography Screening among a group of 50-65 year old women.

Firstly, their findings showed that the media followed by doctors were the main source

of information for this group of women. Women were found to be unclear about the risk factors for breast cancer and to hold a strong fear of detection which combined to reduce their likelihood of attending for mammography screening.

As regards the role of HRT as a health promotion tool, women were deficient in their knowledge of the increased susceptibility of post menopausal women to osteoporosis and cardiovascular disease as well as the role HRT could play in reducing these risks. They identified the GP as ideally placed to provide this information to facilitate women's decision making and enable them make real choices.

Smith, Mary, 1996. Why young women in Dublin choose family planning centres for their contraceptive needs.. *The British Journal of Family Planning* 22: 145 - 150.

Smith (1996) looked at why young women in Dublin choose family planning centres for their contraceptive needs.

The main factors she found were a preference for a female GP in particular for smear tests and an emphasis on privacy and confidentiality which she found stressed by young, unmarried women in particular. Smith (1996) argued that GPs need to be pro-active in family planning service provision by informing women they do provide this service.

Spillane H, Khalil G, Turner M., 1996. Babies Born Before Arrival at the Coombe Women's Hospital, Dublin. *Irish Medical Journal* March/April Vol. 89, No.2.

Spillane et al. (1996) conducted an analysis of factors contributing to babies being born before arrival at hospital (where this was unplanned) in light of its association with increased perinatal mortality. Their higher rate of prematurity was found to be a factor in this while these babies were also found to have a higher admission rate to the special care baby unit most commonly for hypothermia. Head injury and hypothermia as reasons for admission to the unit were unique to babies born before arrival.

Their analysis of maternal characteristics divided the mothers into two categories. The first group were fourteen first-time mothers who were single, unemployed and younger than the overall population of women giving birth. These women had not booked delivery at the hospital or attended for antenatal care while one third of them had concealed their birth. Of the five babies who died four were born to women from this group. The second group of ninety-two women were already mothers and a higher incidence of four or more births was found among this group than among the overall population of women giving birth. It was noted that many of these multiparous women choose not to attend antenatal classes and furthermore there was also evidence to suggest that some of them had delayed coming into hospital after the onset of labour. While the study argues that social factors play a major role in giving birth before

arrival, their evidence only supports this in relation to the first much smaller group. To reduce the incidence of birth before arrival the authors suggest women recognising and knowing the signs of labour, planning how they will travel and making arrangements for the care of other children well in advance.

Turner, M.J., Flannelly, G.M., Wingfield, M., Rasmussen, M.J., Ryan, R., Cullen, S., Maguire, R. and Stronge, J.M., 1991. The miscarriage clinic: an audit of the first year. *British Journal of Obstetrics and Gynecology* 98: 306-308.

Turner et al. (1991) reported on a miscarriage clinic established in the Coombe Women's Hospital in 1989. The practice of holding an outpatient clinic dedicated to miscarriage follow-up and separate to clinics attended by mothers with healthy babies seemed to be good practice. The women who attended the clinic were found to report symptoms consistent with a grief reaction and the paper concluded that all who attended found the counselling beneficial.

Wiley, Miriam and Merriman, Brian, 1996. *Women and Health Care in Ireland*. Dublin: Oak Tree Press.

This research was described as a response to the absence of a national data source on the knowledge, attitudes and behaviours of Irish women towards their health-care needs. A nationally representative sample of 3,000 women aged between 18 and 60 was surveyed on the areas of nutrition, sex education, sexually transmitted diseases, family planning, maternity leave, hospital services for mothers, breast feeding, parenting skills, gynaecology, family size and lifestyles.

The following is a brief resume of results

Substance use and abuse

Smoking - 29% of women smoke regularly, with the highest proportion among those aged 30-34 years. The report concluded that due to the personal risks from smoking and its adverse effects on birth outcome, a targeted and strategic programme to reduce its incidence among women is necessary.

Alcohol

While the survey showed that almost 80% of women aged 18 to 60 do drink alcohol, this was found to vary by age and medical card status. They concluded that there is a need for targeted strategic programmes to address alcohol misuse among women pointing in particular to the figure of 58% intending to stop drinking during a previous pregnancy which they considered needs improving.

Tranquillisers

The survey found that almost 15% of women generally had used tranquillisers to cope with stress in the past.

Sex education

The receipt and adequacy of sex education, together with the perceived risk of pregnancy, was found to be significantly related to employment status with women engaged in home duties the least informed overall reflecting their older age profile. Overall it was found that women who had received sex education were most likely to give correct information regarding the risk of pregnancy. They concluded that sex education and information on how to reduce the risk of pregnancy and of contacting the AIDS virus are elementary and essential and recommended targeting information programmes at those whose current levels of information are least adequate.

Family planning

One third of sexually active respondents described family planning advice as inaccessible with more rural women expressing this view than urban women while women in the North Eastern and Western Health Boards were more likely to say that the advice was inaccessible to them. General Practitioners, health centres and family planning clinics were the most frequently used and preferred sources of information on family planning.

Gynaecological health issues

Findings included that 65% of women had ever had a smear test performed, 45% considered that one should be taken every year while 31% had undergone the test within the previous twelve months.

Antenatal care

As regards antenatal care, over half of the mothers studied attended public hospital care, with 26% attending privately and 9% attending semi-private clinics. Higher professional women were more likely to attend private clinics while women from unskilled manual group were more likely to attend public hospital clinics. Single women were less happy with the amount of time they had with the doctor than married women. Three out of four women were of the opinion that tests should be available to determine any abnormality in the baby prior to birth.

Antenatal classes

Of those mothers studied, 31% had attended antenatal classes during their last pregnancy. First-time mothers were most likely to attend antenatal classes. There was significant variation in attendance at antenatal classes between health board area which the authors noted may be an indication of availability as well as preference. Private classes received the highest rating followed by health centre based classes with hospital classes rating third.

More generally “serious and pervasive gaps” were found by Wiley and Merriman (1997) in the information available to many women concerning the maintenance and advancement of good physical, mental and reproductive health. This was particularly marked among women at greatest risk of disadvantage including those with low levels of education and unemployed women. Again they pointed to the need for policies to have specific regard to the needs of disadvantaged women at the greatest risk of ill-health. They argued that in order to pursue the objective of equity, policies on women’s health should have specific regard to the needs of disadvantaged women at most risk of ill-health.

Women’s Aid, 1995. *Making the Links: Towards an integrated strategy for the elimination of violence in intimate relationships with men.* Dublin.

This study examined the extent of violence against women in domestic relationships, women’s level of contact with services around domestic violence and, the response of professionals to domestic violence. A random sample of 1,483 women which yielded a response of 679 women. This was supplemented by an Area Based Study which was conducted in a mixed housing area with a population of approximately 200,000. This involved surveys with women in doctor’s surgeries, group interviews and individual in-depth interviews with women who had been subjected to domestic violence.

The report found the prevalence of violence against women in the home to be extensive with 18 percent of women reporting that they had been subjected to mental cruelty or the threat of or actual physical violence. Actual physical violence and/or sexual violence had been experienced by 11 percent of the women surveyed.

Systematic health related differences between women from different class backgrounds must be included in a discussion of the ill-health effects of domestic violence and called for further research on the class related health effects of violence against women.

The absence of counselling and support resulted in women being treated by General Practitioners or psychiatric hospitals which were thought to be inappropriate given that they do not address the underlying issue of domestic violence.

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Designed at Language