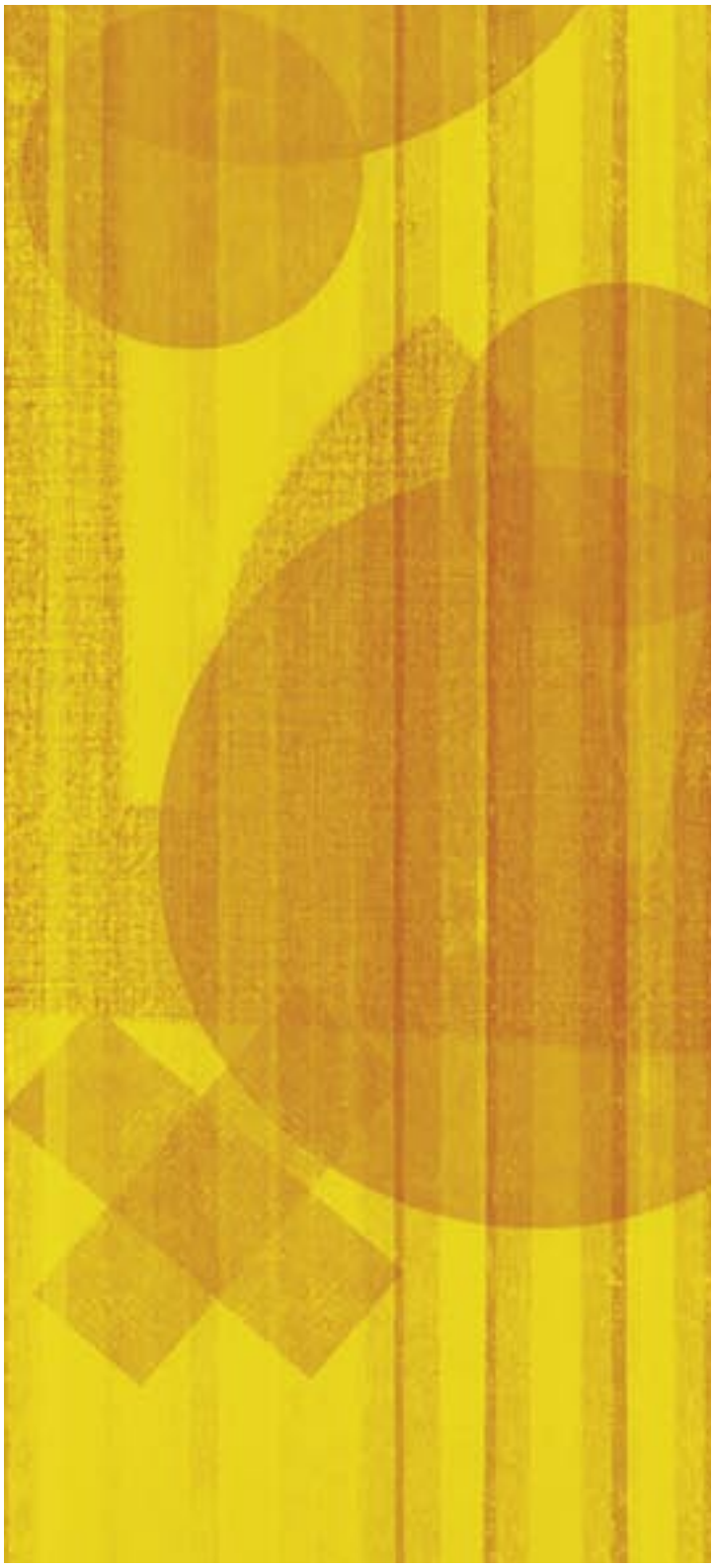
Integrating the Gender Perspective in Irish Health Policy: A Case Study



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

WORLD HEALTH ORGANIZATION
EUROPE

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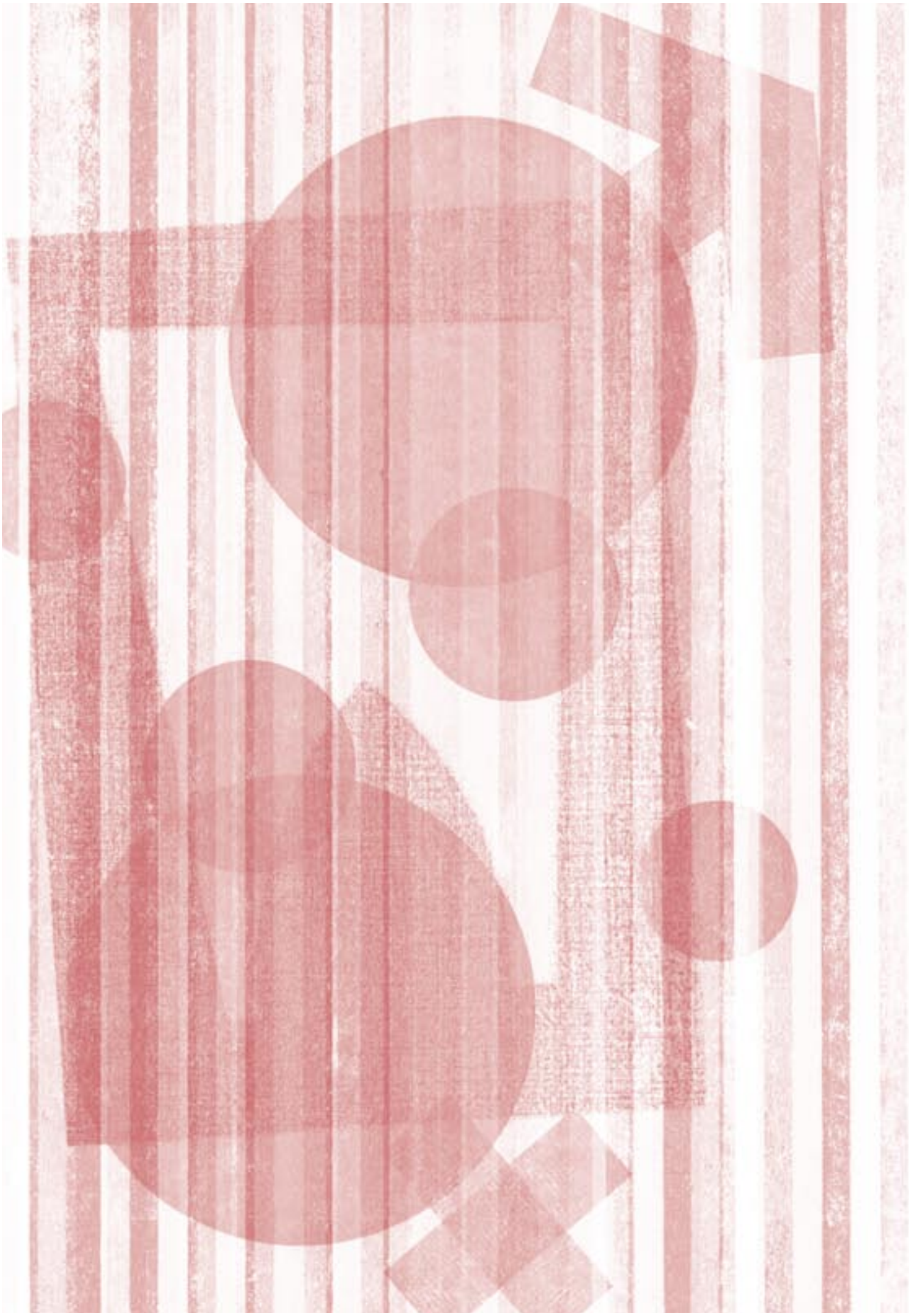

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Background

In late 2003, the Women's Health Council (WHC) was invited by the World Health Organisation's Regional Office for Europe (WHO) to take part in an international project aimed at examining the extent to which gender is taken into account in contemporary health policy. The project was spear-headed by the Gender Mainstreaming Programme of the WHO Regional Office for Europe (GEM/EURO), which aims to support Member States in the gender mainstreaming of health policies.

Ensuring that men and women are given equal opportunities to realise their potential for health is an important goal of the WHO. A crucial strategy to achieve this goal is the gender mainstreaming of national health policies. This entails integrating attention to sex and gender differences in all stages of health policy development: problem definition and agenda setting; policy design; decision-making; policy implementation and monitoring.

Six countries were invited to conduct a case study with the aim of performing a gender analysis of a national health policy in their country:

- Ireland
- The Netherlands
- Croatia
- Turkey
- Kyrgyzstan
- Tajikistan

Each country aimed to identify one national health policy or program in an area that is relevant for a gender analysis. Along with representatives from Croatia and the Netherlands, the WHC identified the National Cardiovascular Health Strategy as the key document to be used for the case study.

Participants in the project attended two Planning Meetings, held in the WHO offices, Copenhagen, Denmark on 26th to 27th of February 2004 and on 26th to 28th May 2004 respectively.

The aim of the project activity was to produce:

1. Country specific reports on the case study, prepared by the country teams.

2. A tool kit (report) with recommendations to support the development of gender sensitive health policies. The toolkit is to be prepared by GEM/EURO in cooperation with the country teams and published by the WHO.

Introduction

One of the goals of the WHO is to ensure that men and women are given equal opportunities to realise their potential for health. This fits well with the remit of the Women's Health Council in working towards the maximum health and social gain for women, and is directly related to the Council's core principle of equity. The gender mainstreaming of national health policies is a crucial strategy in achieving equal opportunities and reducing inequalities in health between men and women. The purpose of this project was to move towards mainstreaming gender within health policy and strategy by carrying out a gender analysis of one national health policy and examining the extent to which gender has been included in it.

The WHC identified Ireland's cardiovascular health policy as an ideal area for a gender sensitive health policy study. The Irish National Cardiovascular Health Strategy *Building Healthier Hearts* (Department of Health & Children Cardiovascular Health Strategy Group, 1999) is the key document here. Cardiovascular disease is the single largest cause of death among women and men in Ireland, representing 40% of all deaths in 2001 (Department of Health & Children, 2002). In addition, the WHC felt that cardiovascular health is an area that could benefit greatly from the incorporation of a gender perspective. Over their lifetimes women are as affected as men by the disease, and have high rates of the disease at older ages. In spite of this, however, heart disease has traditionally been thought of as typical to men. This is probably because men are more likely than women to die prematurely (under the age of 65) from the disease (Codd, 2001). It may also be explained by the historical lack of clinical research focusing on or including women's cardiovascular health. Women can have quite different symptoms of disease than men, something the literature describes as women's 'atypical' experience of heart disease, with men's symptoms being perceived as 'normal'. The WHC recently prepared and published a report on *Women and Cardiovascular Health* in Ireland. This research drew attention to significant gender bias in current thinking about cardiovascular disease, and found gaps in both knowledge and in the provision of services to women[1]. The growing evidence about the impact of gender on cardiovascular health provides the rationale for ensuring that the national cardiovascular health strategy is gender sensitive and that gender is built in from the development stages of the document.

This case study aimed to describe the extent to which gender was included in the national cardiovascular health policy and its follow-up reports, and to assess the extent to which gender was taken into account in the development of the strategy.

The aims of this report are:

- To describe the case study and results
- To make recommendations for future work/ policy options for Ireland and the WHO

1 *Further details of the WHC's findings regarding gender differences in cardiovascular health can be found in Annex 1 to this report, and on the WHC website at* http://www.whc.ie

Methodology

The key focus of the study was the original cardiovascular health strategy document *Building Healthier Hearts* (Department of Health & Children, Cardiovascular Health Strategy Group, 1999). Two follow-up reports on the strategy were also analysed, namely the *Heart Health Task Force First Progress Report July 1999-June 2001* (Heart Health Task Force, 2001) and *Ireland's Changing Heart; Second Report on the Implementation of the Cardiovascular Health Strategy 1999-2002* (Heart Health Task Force, 2003). Together, these documents present national policy on prevention, management and service provisions for cardiovascular health in Ireland. The reports were analysed with reference to the outline matrix and guidelines provided by the Gender Mainstreaming Programme of the WHO Regional Office for Europe (GEM). Content analysis was used to examine the Strategy and Progress Reports from a gender perspective. The use and non-use of the words 'gender', 'male', 'female', 'equality', 'equity' and other related words were noted, and the implications of this use/non-use were drawn out (see Annex 2).

Epidemiological and other research data on cardiovascular health for Ireland were key sources in identifying the significance of the use/non-use of gender-related terms in the documents analysed. Sources drawn upon included the data mentioned in the Cardiovascular Health Strategy reports themselves, the Irish National Health and Lifestyle surveys (SLÁN) (Kelleher et al., 2003, Friel et al., 1999), Eurostat statistics (Eurostat, 2002), material produced by the Irish Heart Foundation (Codd, 2001), and data from the Central Statistics Office. These sources covered material that would have been available during the time the Strategy and Progress Reports were developed, as well as statistics not used in these reports. Reference was also made to the WHC's recently published *Women and Cardiovascular Health* report (Women's Health Council, 2003), which drew on international research studies in the area. In order to set the context for the study, Ireland's national gender policy and its gender and health policy were also explored.

The National Heart Health Advisor, Dr Emer Shelley, was interviewed as part of the study in order to answer some of the questions left after the analysis of the Strategy documents, and in particular to expand on the process of developing the Cardiovascular Strategy. The Interview guide used for the interview is attached in Annex 3. The findings of a conference held by the WHC in connection with the Health Promotion Unit of the Department of Health & Children on *Women, Disadvantage and Cardiovascular Disease: Policy Implications* were also used to feed into this study. The conference was held on 22nd April 2004, and included contributions from the international research community, statutory and voluntary agencies within the Republic of Ireland, as well as those responsible for policy implementation. During the day, cutting edge international research findings were presented and a number of inter-sectoral discussions took place. The proceedings are available on the WHC website (*http://www.whc.ie*). The recommendations made at the conference informed the recommendations made in the present report.

The timeframe presented a distinct limitation to the present study. Work on the case study was initiated in February 2004 and the deadline for final country reports was June of the same year. If more time had been available, there are many other documents on heart health that could have been included, for example Health Board heart health documents, Health Promotion Department heart health materials (including the *Handy Guides* series), additional reports drawn up by the Heart Health Task Force and by the Advisory Forum on Cardiovascular Health, as well as materials from two other conferences on heart health held in Ireland during the EU Presidency. Time limitations also meant that only one interview was possible – interviewing additional stakeholders, for example staff of Heartwatch the general practice prevention programme or from other stakeholder groups, might have produced other interesting findings.

The Broader Context

A. Irish Policies on Gender Equality

International commitments on gender:

The Irish government is a signatory to the United Nations Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) since 1985. In addition, in line with its obligation arising from the Platform for Action of the United Nations Beijing Conference on Women, the Irish Government has produced a draft National Action Plan for Women. All of the international commitments made under the Beijing Agreement have not, as yet, been given full recognition by Irish law however. Women's health was identified as an area for action in Ireland's commitments in the Government Report to the United Nations under the 1995 Beijing Platform for Action (Department of Justice Equality & Law Reform, 2002), and individual chapters on both men's and women's health are included in the most recent Irish national health strategy (Department of Health & Children, 2001). The hosting by the Women's Health Council of a National Forum of stakeholders to chart future action was identified by the Department of Justice Equality & Law Reform as an anti-discrimination measure in Ireland's most recent report to the UN on eliminating discrimination against women (Department of Justice, Equality & Law Reform, 2003).

Ireland is also a signatory to the EC (Amsterdam) Treaty 1999. Article 2 of the Treaty states that the promotion of equality between men and women is a task of the European Community, and Article 13 provides for the incorporation of the EU equality directives. The treaty also states that:

> *'In all its activities the Community shall aim to eliminate inequalities and to promote equality between men and women.'*

Ireland participates in a number of EU committees on gender equality, including the High Level Group on Gender Mainstreaming; the Advisory Committee on Equality between Women and Men, and the Management Committee of the Programme relating to the EU Gender Equality Programme, 2001-2005. Ireland is also represented on the Council of Europe Committee for Equality between Women and Men (CDEG).

Gender Policy in Ireland

One of the first documents addressing the concept of 'equality proofing' in Ireland was *Equality Proofing Issues* published by the National Economic and Social Forum in 1996. It focused particularly on women, people with disabilities and Travellers, although recognising that other groups such as the long-term unemployed, and older people, also suffer from disadvantage. The report stated that:

> *'Equality of opportunity and equality of participation are vital steps to the achievement of greater equality for all individuals and marginalised groups in our society; seeking to achieve equality of outcome in employment and in the provision of goods and services by the public and private sectors should also be a central policy aim.'*

Many of the recommendations made by the National Economic and Social Forum in this report have now been implemented. These included introducing legislation prohibiting discrimination and the establishment of an Equality Authority. Some progress has also been made towards the goal of putting equality proofing procedures in place to address the impact of Government policies and programmes, although this is certainly an area that the Women's Health Council considers as needing more attention.

Equality Legislation

Equality is formally set out in legislation in Ireland under the terms of the Employment Equality Act, 1998 and the Equal Status Act, 2000. These outlaw discrimination in employment, vocational training, advertising, collective agreements, the provision of goods and services and other opportunities to which the public generally have access on nine distinct grounds. These are:

- Gender
- Marital status
- Family status
- Age
- Disability
- Race
- Sexual orientation
- Religious belief
- Membership of the Travelling Community

Discrimination is described in legislation as the treatment of a person in a less favourable way than another person is, has been or would be treated on any of the above grounds.

The Equal Status Act 2000 enabled Ireland to ratify the UN Convention on the Elimination of all Forms of Racial Discrimination and to lift our reserve on the UN Convention on the Elimination of all Forms of Discrimination against Women.

Department of Justice, Equality & Law Reform

Much of the work on gender equality and proofing in Ireland has been carried out under the aegis of the Department of Justice, Equality & Law Reform. In 1999, the Department of Justice, Equality & Law Reform published a report on *Gender Proofing and the European Structural Funds*. Its specific focus was on women 'because women continue to be disadvantaged as a group'. The report described gender proofing as a mainstreaming approach to gender equality, which has, at its heart, a concern that the target group should participate in the policy-making process.

NDP Gender Equality Unit

The NDP Gender Equality Unit provides an advisory, training and information service on issues relating to gender and the National Development Plan (NDP). It was established to support all implementing Departments and delivery agencies to meet the equal opportunity objective in their programmes, measures and initiatives. It also provides assistance to the Department of Justice, Equality & Law Reform in carrying out Gender Impact Assessments of policy proposals drawn up in the context of the Plan. In total, funding of Ir£4 million was allocated from the Plan for this purpose. The Unit's website contains information on mainstreaming of equality at policy level and has a databank of gender disaggregated statistics on areas covered by the National Development Plan. It can be found at: *http://www.irlgov.ie/justice/equality/gender.*

National Development Plan:

The National Development Plan 1994-1999 took an important first step towards gender proofing policies by requiring participation rates on particular programmes to be recorded by gender. However, gaps still existed which prevented gender proofing from being fully implemented in policy:

- It was unclear what criteria were to be used to assess the gender relevance of funded programmes and initiatives
- The emphasis was on equality of opportunity rather than equality of outcome
- The National Development Plan only related to structural programmes so data was only collected on gender in a limited number of 'relevant' programmes. From this, the impression was that gender issues were only relevant to human resources, training and local development issues; gender was not addressed in wider policy areas such as transport, tourism, agriculture or energy policy.

According to the NDP Gender Equality Unit, the new National Development Plan 2000-2006 should go about addressing some of these issues:

> *'It is Government policy that the National Development Plan 2000-2006 which involves the spending of over Ir£40 billion should support the achievement of equal opportunities between men and women. The goal of gender equality covers the whole Plan including infrastructure and productive investment as well as the regional, human resources and peace programmes. The Plan provides that project selection criteria must have regard to the equal opportunities objective.'* [2]

Gender Impact Assessment Guidelines for the National Development Plan 2000-2006:

A set of Gender Impact Assessment Guidelines was adopted by the Cabinet in March 2000, which stated that the following steps must be completed with respect to almost every area of expenditure under the National Development Plan:

1. The current position of women and men in the area that the expenditure activity will address must be outlined.
2. The factors leading to women and men being affected differentially in the area to be addressed by the expenditure activity must also be covered.
3. Ways in which the factors leading to women or men being affected differentially could be addressed and changed should also be explored.

Programme for Prosperity and Fairness

The *Programme for Prosperity and Fairness*, published by the Department of the Taoiseach in February 2000, also contains a commitment to equality proofing.

Objectives identified in the Programme relating to equality included:

- The development of an effective equality infrastructure to support the achievement of equality objectives in the nine categories covered by equality legislation.
- Ensuring that the necessary institutional structures are in place and that they are enabled to play their role in eliminating discrimination and promoting equality.
- The development of arrangements, including administrative procedures, for mainstreaming equality issues.
- Providing a range of supports for groups experiencing disadvantage and inequality.

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2 *Communication from Deirdre Blake of the NDP Gender Equality Unit, 04.05.01.*

Monitoring of outcomes from an equality perspective was one of the key requirements for equality proofing under the Programme. Gender equality, mainstreaming gender equality and the importance of collecting disaggregated data are specifically mentioned in this regard. Issues around pay differentials between men and women, and measures tackling gender segregation in the labour market are also covered in the Programme (Department of the Taoiseach, 2000).

Gaps:

While the foundations for gender proofing of policy in Ireland have been laid, much remains to be done in order to ensure equality between the sexes, particularly in the area of health. The following barriers must be resolved in order to fully achieve this aim:

- Lack of sufficient funding to promote gender mainstreaming – insufficient investment in the development of a body of expertise across the policy making system which would enable gender mainstreaming to be fully and properly implemented.
- Need for comprehensive collection of gender disaggregated data, in order to make the situations of both men and women clear.
- More attention should be paid to the monitoring of gender equality within Irish national health policy. Specific targets should be developed, and time scales for their achievement and indicators of progress should be set.

B. Irish National Policy on Gender and Health

Gender Specific Health Policy in Ireland

In 1993, the Second Commission on the Status of Women recommended that the Department of Health should respond to the concern that women's health needs were not always being met by publishing a policy document specifically on women's health.

A discussion document, *Developing a Policy for Women's Health* was published by the Department of Health in June 1995. It looked at the health services from women's point of view and analysed the health status of women living in Ireland. It examined mortality and morbidity rates among women living in Ireland and identified ways of preventing premature mortality and increasing health and social gain for women. The priorities suggested in the document were:

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

(Department of Health, 1995)

The discussion document was used as the basis of a wide-ranging public consultation with organisations and individual women in 1995-6. This consultation process on women's health was initiated at national level on 30th June 1995, when a conference on the

subject was held in Dublin by the Department of Health. Consultation at regional and local level was organised by Health Boards, in collaboration with the National Women's Council of Ireland (NWCI), the national representative organisation for women and women's groups in Ireland. Out of this consultation process a women's health plan was drawn up.

The Plan for Women's Health 1997-1999

The Plan for Women's Health 1997-1999 was the first specific policy aimed at taking gender considerations into account in health policy in Ireland. With its publication in 1997 by the Department of Health, Ireland became only the second country internationally, after Australia, to have a national policy specifically dealing with women's health.

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

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

(Department of Health, 1997)

The Plan comprised a mix of affirmations of support for existing government strategies, broad aspirations for the development of women's health services and specific recommendations. For the most part, however, it did not contain timeframes for implementation or measures for the monitoring and evaluation of actions. Without indicators of success, accurate costing or explicit ring-fenced funding the Plan read as aspirational rather than as a blueprint for targeted action (Women's Health Council, 2002).

Since the Plan's timeframe ran out in 1999, no further government policy has been put in place specifically aimed at women's health. Instead, sections on women's and men's health have been included in mainstream national health strategy and policy documents, for example in *Quality and Fairness; A Health System for You Health Strategy* (Department of Health & Children, 2001) and in the *National Health Promotion Strategy 2000-2005* (Department of Health & Children, 2000).

The Women's Health Council

One of the recommendations in the Plan was that a Women's Health Council be set up as 'a centre of expertise on women's health issues, to foster research into women's health, evaluate the success of this Plan in improving women's health and advise the Minister for Health on women's issues generally.'

The Women's Health Council is a statutory body established in 1997 to advise the Minister for Health and Children on all aspects of women's health. The mission of the Women's Health Council is to inform and influence the development of health policy to ensure the maximum health and social gain for women in Ireland. Its membership is representative of a wide range of expertise and interest in women's health.

The Women's Health Council has five functions detailed in its Statutory Instruments:

1. Advising the Minister for Health and Children on all aspects of women's health
2. Assisting the development of national and regional policies and strategies designed to increase health gain and social gain for women.
3. Developing expertise on women's health within the health services.
4. Liaising with other relevant international bodies which have similar functions as the Council.

5. Advising other Government Ministers at their request.

The work of the Women's Health Council is guided by three principles:

- Equity based on diversity – the need to develop flexible and accessible services which respond equitably to the diverse needs and situations of women
- Quality in the provision and delivery of health services to all women throughout their lives
- Relevance to women's health needs

In carrying out its statutory functions, the Women's Health Council has adopted the WHO definition of health, a measure reiterated in the Department of Health's *Quality and Fairness* document (2001). This definition states that:

> *'Health is a state of complete physical, mental and social well being.'*

Men's Health Policy

The first specific mention of men's health was made in the National Health Strategy, *Quality and Fairness*, published by the Department of Health & Children in 2001. The Strategy called for a policy on men's health and health promotion to be developed. The *National Health Promotion Strategy 2000-2005* also identified the development of a national plan for men's health as an important initiative. Research carried out in the North Eastern Health Board in 2001 indicated a need to raise awareness about men's health issues and to encourage men to actively seek screening and to seek timely medical help. The Department of Health & Children have taken the lead role in beginning to prepare a policy for men's health in partnership with the health boards and other agencies. Work commenced on the development of this policy in January 2004, when a consultation meeting was convened in association with the relevant stakeholders.

Men's Health Forum

The Men's Health Forum in Ireland (MHFI) is an important stakeholder in this process. It is a voluntary network of individuals and organisations, men and women, working to collate the key concerns relating to men's health on the island of Ireland and to increase understanding of these issues. The mission of the MHFI is to promote, influence and enhance all aspects of the health and well-being of men and boys on the island of Ireland.

Its principal objectives are:

- the advancement of the education of the general public in all matters relating to men's health and in particular, but not exclusively, by providing information, commissioning and disseminating research, and providing education on men's health and associated issues to health professionals and the general public;
- the preservation and protection of men's health.

The Forum recognises the right of everyone to good health regardless of age, gender, sexual orientation, disability, race, culture, religious or political affiliations.

In January 2004 the Forum published *Men's Health in Ireland*, a comprehensive overview of key statistics on men's health on the island of Ireland. Key findings of the report included the fact that men in Ireland die, on average, nearly six years younger than women do, and have higher death rates at all ages, and for all leading causes of death (McEvoy & Richardson, 2004). Evidence of sex differences in the incidence, symptoms, and prognosis of a wide range of health problems were documented. The report also noted that men engage in a range of risk behaviours that can be seriously hazardous to their health and that many men do not seek help for any health problems they may be experiencing unless prompted to do so by female relatives/spouses.

National Planning Forum on Women's Health

The National Planning Forum for Women's Health was established in 2002 in the period following the publication of the Women's Health Council position paper *Promoting Women's Health*. The position paper critically reviewed the *Plan for Women's Health 1997-99* and made proposals to focus the women's health agenda for the 21st century. Central among the proposals was a new orientation to ensure gender equity in health services and initiatives. This gender mainstreaming approach marked a departure from the previous emphasis on a national plan specific to women's (or men's) health.

This approach meant that rather than specifically focusing on women's health alone, the Forum explored the significance of integrating a gender dimension into policies, programmes and projects at national and regional level. It confirmed the need to integrate a gender dimension into policy-making at a high level. However, while work is continuing on the inclusion of a gender dimension in health planning and delivery, the Forum recommended that this should take place alongside positive actions or women/men-only actions, as part of a twin-track approach to mainstreaming gender considerations across health policy. The Forum considered this measure necessary in light of the timescale needed to properly establish and evaluate gender mainstreaming protocols.

The Forum identified gender impact assessment as a new and urgent need in gender mainstreaming strategies in health policy, planning and programmes. The availability of data on sex differences in health risks, health policies and health outcomes was given particular attention as a mode of quantifying the rationale for gender impact assessment. The Forum recommended having the maximum feasible volume of gender disaggregated data in all spheres of health policy and programmes of research, promotion, care and treatment. Once gendered data becomes available, it will be possible to form gender-specific programme/service/activity targets for programmes in quantifiable terms of users/patients/activity rates/plans.

The difficulty in making the 'business case' for application of gender policies in the health services in the absence of gender disaggregated data was noted by Forum members. Performance indicators were viewed as crucial in delivering a more responsive and effective health service to the entirety of populations served. Paradoxically, in the absence of gender disaggregated data, performance indicators are difficult to construct. Forum participants expected performance indicators for gender to be present, or in development, at this significant moment of health service restructuring and publications of health service reviews. At the time of the Forum's discussions, there was no evidence to confirm that such a development process was occurring, despite Ireland's commitment to gender mainstreaming.

In its final report, submitted to the Minister for Health and Children in June 2004, the Forum insisted on the importance of gender impact assessment, gendered performance indicators and gender-disaggregated data to advance the increased consideration of gender in health policy. This was integrally linked to the need for Performance Indicators in the gender and health field. However, it is not possible to have Performance Indicators without gender disaggregated data being available as a first step in the gender impact assessment process.

Getting Inside Men's Health

Since the substantive work for the present Case Study was carried out, further work has been done on developing a policy for men's health in Ireland. On 1st December 2004, a comprehensive report on men's health in Ireland was launched by Mr Seán Power T.D., Minister of State at the Department of Health & Children. The report, entitled *Getting Inside Men's Health*, presents the findings of a three year research

study on men's health, funded by the Health Promotion Unit, Department of Health & Children, and carried out in the South Eastern Health Board. The report was commissioned to inform the development of a national policy for men's health in Ireland and its launch coincided with the first National Conference on Men's Health in Ireland, *Men's Health – Asking The Questions*.

In total 570 men participated in the interviews, focus groups and survey elements of the *Getting Inside Men's Health* research. Issues explored with the men included the levels of health consciousness among men and their knowledge of fundamental health issues; the preventative health ethos among Irish men; men's relationship with their GP; women's affect on men's health; how men cope with illness; alcohol; risk taking behaviour; emotional/mental health issues; the effect of fatherhood on men's health.

Overall, the researcher noted that men tend not to be health conscious or proactive about their health, have poor knowledge of health issues and are often afraid to ask for help. Further issues highlighted by the *Getting Inside Men's Health* report were that:

- less than half of men surveyed knew the function of the prostate gland, while over a third were not aware of some of the most common prostate cancer symptoms.
- the lack of preventative health ethos amongst Irish men meant that just one in five drinkers monitored their own alcohol consumption and a mere one in seven men aged 18-29 reported practising Testicular Self Examinations monthly.
- over half of the men surveyed expressed varying degrees of reluctance to attending their GP, with attendance for many, simply being incongruous with 'being a man'.
- the omnipresence of alcohol in men's health with half of those consuming over 50 units per week (i.e. over twice the recommended maximum limit), considered themselves to be 'moderate' drinkers.
- young men appeared indifferent to the risks of unsafe sex, and were willing to divest responsibility for contraception use to their female partners.
- three out of four men surveyed adopted strategies of 'avoidance' or 'silence' in the way that they managed themselves through an emotional or mental health issue.
- two-thirds of all fathers took fewer risks with their health on becoming a father.
- women continued to have an overall positive impact on men's health.

(Richardson, 2004)

The research and the *Men's Health – Asking The Questions* conference will both be used to inform the development of a national policy for men's health in Ireland.

As these developments took place after the work for the present Case Study had been carried out however, unfortunately it was not possible to include their findings in the analysis that follows.

Results

The Integration of Attention to Gender in Cardiovascular Health Policy

The Cardiovascular Health Strategy

The Cardiovascular Health Strategy Group was established by the then Minister for Health and Children, Mr. Brian Cowen, T.D., in March 1998:

> *'...to develop a strategic approach to reduce avoidable death and illness caused by cardiovascular disease. The Group will engage in a wide-ranging consultation process and make recommendations on the development and implementation of an integrated strategy to improve cardiovascular health.'*

The establishment of the Cardiovascular Health Strategy Group was part of an overall initiative on cardiovascular health and cardiac services announced by the Minister in January 1998. The Group was made up of twelve members, six men and six women, mainly working in the field of health. It included cardiologists, a GP, a nurse, a hospital manager, a specialist in public health medicine, a professor and a manager of health promotion, a co-ordinator of cardiac rehabilitation, and three civil servants from the Department of Health & Children. The establishment of the Cardiovascular Health Strategy Group to investigate heart health in Ireland and develop a policy to deal with the high levels of mortality was an innovative move at the time.

Policy Context

The national health strategy, *Shaping a Healthier Future* set out the principles and provided direction for the development of the strategy for cardiovascular health (Department of Health, 1994). It stressed the importance of equity of access to health care, the provision of a high quality service and of accountability. In line with *Shaping a Healthier Future* the recommendations of the Cardiovascular Health Strategy Group were guided by the following basic principles:

- Health and Social Gain
- Equity of Access
- Quality
- Effectiveness and Efficiency
- Accountability and Audit

Working Methods

As part of its brief to develop a national policy on cardiovascular health, the Group engaged in a consultation process that aimed to include stakeholder groups in the area of cardiovascular health. Written submissions were invited, and representatives from many relevant organisations met with the Group. In addition, members of the Group made a number of site visits. Questionnaires were circulated to hospitals caring for patients with cardiac problems inquiring about the type and volume of diagnostic and treatment services provided and about the level of cardiology staffing. An Implementation Group was established within the Department of Health & Children in order to facilitate the work of the Strategy Group and the implementation of its recommendations.

The two Progress Reports were produced by the Heart Health Task Force, the group set up to review the objectives proposed and to monitor the implementation of the recommendations contained in the Strategy. The Task Force was made up of a total of twenty-nine members, seven women and twenty-two men. Members were drawn from several government departments, including Health & Children; Finance; Social, Community & Family Affairs; Education & Science; Tourism, Sport & Recreation; also CEOs of Health Boards, representatives from relevant voluntary sector organisations, and trade union, employer, public and academic interests.

The Strategy

Building Healthier Hearts, the Irish National Strategy on Cardiovascular Health, was published in July 1999 by the Department of Health & Children. The full report contained 150 pages of text, complete with 211 recommendations and full references. In all, the document contained ten chapters. The first five set out the background to the Strategy and relevant issues around cardiovascular disease in Ireland. The next five chapters set out the situation for each sector with a role in cardiovascular disease management. The 211 recommendations made by the Group were divided into four areas:

1. Standardise care in the pre-hospital and hospital settings across health boards
2. Establish a protocol for appropriate primary care
3. Ensure an effective surveillance system
4. Expand or put in place settings-based health promotion programmes

The two Progress Reports, *Heart Health Task Force First Progress Report July 1999-June 2001* and *Ireland's Changing Heart; Second Report on the Implementation of the Cardiovascular Health Strategy 1999-2002*, were structured in much the same way as the original strategy document. *Heart Health Task Force First Progress Report July 1999-June 2001* contained 44 pages of text including appendices, and focused solely on setting out progress on each of the recommendations in the two years since the Strategy was launched. *Ireland's Changing Heart* was a more substantial document, with a total of 128 pages broken into similar chapter headings as the original *Building Healthier Hearts* document.

Gender analysis of the Irish National Strategy for cardiovascular health: Findings

Both *Building Healthier Hearts* and *Ireland's Changing Heart* included detailed gender disaggregated data on many of the important variables in the area of heart health. For example, *Building Healthier Hearts* presented detailed gender specific data on mortality and morbidity rates of cardiovascular disease in Ireland and in the different regions in the country in chapter 4. The report noted, for example, that in 1997 cardiovascular disease was the main cause of death for men under the age of 65 and the second highest cause of death in women under 65. It also noted that death rates were 16% and 15% lower in men and women respectively in 1991-1993 compared to 1970-1972. *Ireland's Changing Heart* provided updated figures for these variables and also presented detailed gender disaggregated data on people discharged with a diagnosis of coronary heart disease (CHD) and on surgical procedures for CHD in a series of tables and graphs in chapter 2. The *Heart Health Task Force First Progress Report* was a less detailed document, but in describing the NICO anti-smoking campaign it demonstrated that health promotion initiatives were

based on the gender-disaggregated research data available. The NICO anti-smoking campaign was developed in response to the increased prevalence of smoking among teenage girls and young women in Ireland at the time.

In spite of the amount of gender disaggregated data available, however, content analysis of the *Building Healthier Hearts* document, together with its two follow-up reports, revealed that the Irish cardiovascular health strategy did not appear to have been developed with gender in mind (full analysis is included in Annex 2). No references to gender were included in any of the recommendations made in the reports and the language used was gender neutral for the most part. In the text, 'men' and 'women' were replaced by 'patients', 'clients', 'individuals' and 'consumers'.

The Appendices of the *Heart Health Task Force First Progress Report July 1999-June 2001* included a summary of the actions taken as a result of the recommendations made in *Building Healthier Hearts*. This showed clearly that gender was not a consideration in the recommendations. The only section that made any reference to gender was the NICO anti-smoking campaign, and that was specifically targeted at young women alone.

The second progress report, *Ireland's Changing Heart*, seemed to have concentrated more on socio-economic than gender considerations, focusing on inequalities due to social class rather than due to gender. Although 'Reducing Inequalities' was identified as a future challenge for the Strategy, it referred to inequalities caused by poverty and not by gender. 'Targeting disadvantage' was a goal within health promotion, but this referred to 'disadvantaged communities', 'people on low incomes', 'people from disadvantaged areas', 'Travellers', 'asylum seekers', 'disadvantaged people' with no reference to gender.

The interview with the National Heart Health Advisor confirmed that gender was not a concept that was systematically taken into account in developing the Strategy and that gender experts had not been involved in the development of the Strategy. It emerged from the interview that geographical access rather than gender considerations was at the heart of the commitment to 'Equity of Access' presented in the *Building Healthier Hearts* document. The lack of services for cardiovascular health available in Ireland at the time should be taken into account in this regard. At the time the policy was developed, service provision in Ireland was relatively poor for both women and men and there was considerable variation in service provision across different regions in Ireland – access to services was particularly bad in the Western region. This meant that the most pressing need from the point of view of the policy-makers was geographic equity and improving service provision generally, and this was reflected in the original strategy document, and hence in the progress reports. The Cardiovascular Strategy was an innovative document at the time, particularly in respect to the holistic approach it took to cardiovascular health service provision. As well as addressing the acute care needs of cardiovascular patients, the Strategy also addressed needs in the primary care and rehabilitation areas, something that had not previously been done in Ireland.

A breakdown of the results is presented in the Matrix below. Full analysis is included in the Annex 2 to this report.

Matrix for reporting results of assessment of the attention to gender considerations in the development of specific health policies

Title of the policy: Building Healthier Hearts (1999)

	Gender considerations included	Enabling factors	Gender considerations not included	Barriers
Objectives	'Equity' was one of the factors the Cardiovascular Health Strategy Group was expected to take into account on advising on services.	Principles set out in *Shaping a Healthier Future* (National Health Strategy, 1994) included Equity of Access. Thus *Building Healthier Hearts* stated that "Access to services should be on the basis of need. Patients should not be restricted in their access to a service because of their income or ability to pay, or because of their place of residence, gender or age" (p10).	Gender was not built in to the Strategy as a baseline measure. Rather it was one of a range of factors (including income, place of residence and age) that had to be considered.	Seems to have been a lack of awareness of the importance of gender as a determinant of health at the time (late 1990s).
Stages of policy development • **Problem Description**	Referred to CVD as an important cause of sickness and death "in Irish men and women" (p14). No specific reference to gender. Concern at the time was with equity of access to services and with expanding a previously underdeveloped cardiovascular health service base.	Strategy presents rich gender-specific information on mortality and morbidity rates and detailed discussion of the health service structures put in place to deal with the disease. E.g. The majority of the data presented in Chapters 4 (Cardiovascular Diseases in Ireland) & 5 (Health Promotion) were broken down according to gender.	Strategy document made no attempt to debunk the common notion of cardiovascular disease as a mainly male phenomenon. E.g. Male symptoms are quoted as being the norm: "In the typical history, there has been severe and sustained chest pain or discomfort" (p15). Women may not experience chest pain, but rather a range of conditions such as neck, shoulder or abdominal discomfort, dysponea, fatigue, nausea or vomiting. Gender disaggregated data not available for all variables discussed.	Gaps still exist in the availability of gender-specific research/data in the area of cardiovascular health. Lack of awareness of women's experiences of CVD (perhaps also partly explained by the lack of research/data). Lack of awareness of the importance of gender as a determinant of health.
• **Planning**	Gender is not included in any consistent way, although differences between men and women are noted in some places. E.g. "In a 1992 study of Irish CCUs it was shown that…men received thrombolytic treatment more often than women…" (p95). "HIPE data show lower provision of angiography, PTCA and CABG for women compared to men. This may be partly accounted for by lower need for these procedures in women compared to men, particularly in younger age groups. It is recognised that women have higher in-hospital mortality than men after AMI even after adjustment has been made for age and other baseline characteristics. At least some of these differences are likely to reflect the sub-optimal treatment of women compared to men" (p105).	Gender-disaggregated data seems to be available for most of the variables relating to services (e.g. mortality, treatment rates, hospitalisation rates etc).	Although many of the chapters contained detailed data on the different experiences of women and men around cardiovascular health and health services, the implications of these differences were not drawn out. **No references to gender/gender differences were included in any of the recommendations made in the Strategy.**	Lack of awareness of the importance of gender as a determinant of health.
• **Implementation**	No	N/A	No specific reference to gender in any of the implementation measures put forward in the document.	Lack of awareness of the importance of gender as a determinant of health.
• **Monitoring**	Not explicitly	Gender differences were referred to in the text of the Strategy in a number of chapters, and Chapter 5 referred to the need for health impact assessment to be carried out when other government departments & agencies are formulating policy. It would thus only be one step further to introduce the notion of gender impact assessment for future policy in the area.	No specific reference to ensuring gender-proofing of data and research on the area of cardiovascular health was included.	Lack of awareness of the importance of gender as a determinant of health.
Process Characteristics • **Gender experts included in policy development**	No	The Cardiovascular Health Strategy Group was balanced according to gender – 6 men and 6 women.	Submissions were invited from key stakeholders but existing gender-based groups (e.g. the National Women's Council of Ireland) were not included.	The Cardiovascular Health Strategy Group was made up of mainly medical personnel. Lack of awareness of the importance of gender as a determinant of health.

Matrix for reporting results of assessment of the attention to gender considerations in the development of specific health policies

Title of the policy: Heart Health Task Force First Progress Report July 1999-June 2001 (2001)

	Gender considerations included	Enabling factors	Gender considerations not included	Barriers
Objectives	No	*Building Healthier Hearts* contained a commitment to 'equity of access'.	Report aimed solely at presenting progress made on implementing the recommendations of the *Building Healthier Hearts* report.	Recommendations in *Building Healthier Hearts* did not contain any specific reference to gender, therefore this report did not either.
Stages of policy development • **Problem Description**	No specific reference to gender.	A National Conference for stakeholders was held in Dublin Castle on 5th Nov. 1999, to discuss the *Building Healthier Hearts* report. 'Eliminating equalities' was one of the workshop topics on the day but it is not clear if gender inequalities were specifically mentioned.	As for *Building Healthier Hearts* report.	As above
• **Planning**	No	N/A	As for *Building Healthier Hearts* report.	As above
• **Implementation**	NICO anti-smoking campaign – 'Given the concern about the increased prevalence of smoking among teenage girls and young women, a special component of the Break the Habit campaign was developed during 2000 to target teenage girls and was partly funded by the Strategy.' (p15).	Gender specific data was presented to provide a rationale for the campaign: • by the age of 15 years more girls smoke than boys • girls are less likely to quit when they are addicted • by the age of 17, 40% of girls (28% of boys) from low income backgrounds are smokers.	No specific reference to gender in any other implementation measures.	Since *Building Healthier Hearts* did not contain any specific reference to gender, therefore overall this report did not either.
• **Monitoring**	No	N/A	No reference to ensuring that gender was a concern when monitoring progress in the area.	As above – lack of emphasis on gender in the original Strategy document meant that it was not a concern for the progress report either.
Process Characteristics • **Gender experts**	No	N/A	Gender balance of the Heart Health Task Force was not as even as that of the Cardiovascular Health Strategy Group.	N/A

Matrix for reporting results of assessment of the attention to gender considerations in the development of specific health policies

Title of the policy: Ireland's Changing Heart; Second Report on the Implementation of the Cardiovascular Health Strategy 1999-2002 (2003)

	Gender considerations included	Enabling factors	Gender considerations not included	Barriers
Objectives	No specific commitment to 'equity' in this report, but it presumed that the principles set out in the other documents were applied here too. No specific reference to gender.	*Building Healthier Hearts* stated that "Patients should not be restricted in their access to a service because of their income or ability to pay, or because of their place of residence, gender or age" (p10).	As with the *Building Healthier Hearts* document, gender was not built in to *Ireland's Changing Heart* as a baseline measure.	Lack of emphasis on gender in the original Strategy document meant that it was not a priority for this progress report either.
Stages of policy development • **Problem Description**	No specific reference to gender.	Presents gender-specific information on mortality and morbidity rates – the majority of the data presented in Ch. 2 (Epidemiology of cardiovascular diseases in Ireland) is gender disaggregated. Some gender-specific information is also presented in Ch.4 (Health Promotion). E.g. Under Diet and Nutrition, the report noted that in 2001/2002 the focus of the National Healthy Eating Campaign 'was specifically on heart health and aimed to raise awareness among women in particular' (p50).	Gender disaggregated data not presented for all variables discussed, e.g. prescriptions, overweight, physical activity, alcohol, blood pressure, schools, targeting disadvantage etc. In some cases this information would have been available from the SLÁN study. Section on Inequalities under *Implications of Changing Epidemiology*, but focuses on inequalities due to social class rather than due to gender: '…in the south of Ireland death rates from circulatory diseases were almost three times higher in the semi- and unskilled working classes compared to professionals' (p27). Report also noted that 'the prevalence of heart failure in the oldest age groups has increased greatly' but did not note the implications this has for women, who live longer than men. There was no information on men's needs in relation to healthy eating, in spite of the fact that *Building Healthier Hearts* had noted that 'one in three young unskilled males frequently ate fried food' (1999: 55) and that 'Groups in need of nutrition advice and support are likely to be young men, those in manual occupations, those on low incomes and disadvantaged minorities'.	Gender-specific research/ data still not available for all variables. Continuing lack of recognition of the importance of gender as a determinant of health.
• **Planning**	No	In Ch.4 (Health Promotion), under 'Resources and their Management' the report states that the findings of health and lifestyle surveys of the population (e.g. SLÁN) to be used 'for planning and evaluation of health promotion interventions' (p44). There is no specific reference to the gender differences noted in the SLÁN study, however.	No references to gender/gender differences were included.	Continuing lack of recognition of the importance of gender as a determinant of health. Lack of emphasis on gender in the original Strategy document.
• **Implementation**	No	'The first three years of implementing the Cardiovascular Health Strategy has seen a substantial increase in cardiology prevention and treatment services. Through the implementation of the Strategy, these services are already making a difference, providing more accessible, equitable, better quality care for patients with cardiac conditions' (p103). No reference to gender considerations, however. 'Reduce Inequalities' and 'Equitable Access to Services' put forward as key challenges facing the future implementation of the Cardiovascular Health Strategy (p104).	No specific reference to gender in any of the implementation measures put forward in the document. No explicit mention made of reducing inequalities between men and women or of ensuring the men and women have equal access to services.	As above.
• **Monitoring**	Not explicitly.	N/A	Ch. 10 includes a section on "The Way Forward: Monitoring, Evaluation and Consultation" but within this there is no specific reference to ensuring gender-proofing of data and research on the area of cardiovascular health was included.	As above.
Process Characteristics • **Gender experts included**	No	N/A	Gender balance of the Heart Health Task Force was not as even as that of the Cardiovascular Health Strategy Group.	Continuing lack of recognition of the importance of gender.

Discussion & Conclusions

The *Building Healthier Hearts* Strategy document and its two follow up reports are valuable resources in considering patterns of cardiovascular disease in Ireland. They present rich gender-specific information on mortality and morbidity rates from the disease and detailed discussion of the health service structures put in place to deal with the disease. As this is a retrospective study of the Strategy, it is important to note the context in which it was developed. At the time, cardiovascular health services in Ireland were relatively undeveloped, with wide variation in service provision in different areas of the country. This meant that geographical equity of access to services was the over-riding concern of policy-makers at the time.

The overall conclusion reached after completing the content analysis, however, was that the Strategy was limited in its consideration of gender. Although many of the sections of the reports contained detailed data on the different experiences of women and men around cardiovascular health and health services, the implications of these differences were not drawn out in the Strategy. No references to gender were included in any of the recommendations. This meant that there was a significant gap between the information regarding gender differences presented in the documents and the practical recommendations made in Ireland's Cardiovascular Health Strategy.

In addition, gaps in gender-specific information were also found to exist in some areas of the strategy, suggesting that further gender-specific and gender-disaggregated research is required in Ireland. A significant cause for concern here was the neglect of women's experience of the symptoms of cardiovascular disease. The report focused almost exclusively on 'chest pain' to the neglect of any of the range of conditions women can experience as indicators of the disease, such as neck, shoulder or abdominal discomfort, dysponea, fatigue, nausea or vomiting (MacSheridan, 2001; Bedinghaus, 2001). Sections on 'Information Systems, Audit and Research' were included in all three reports, but no specific reference was made to ensuring that data and research on the area of cardiovascular health were gender-proofed/sensitive.

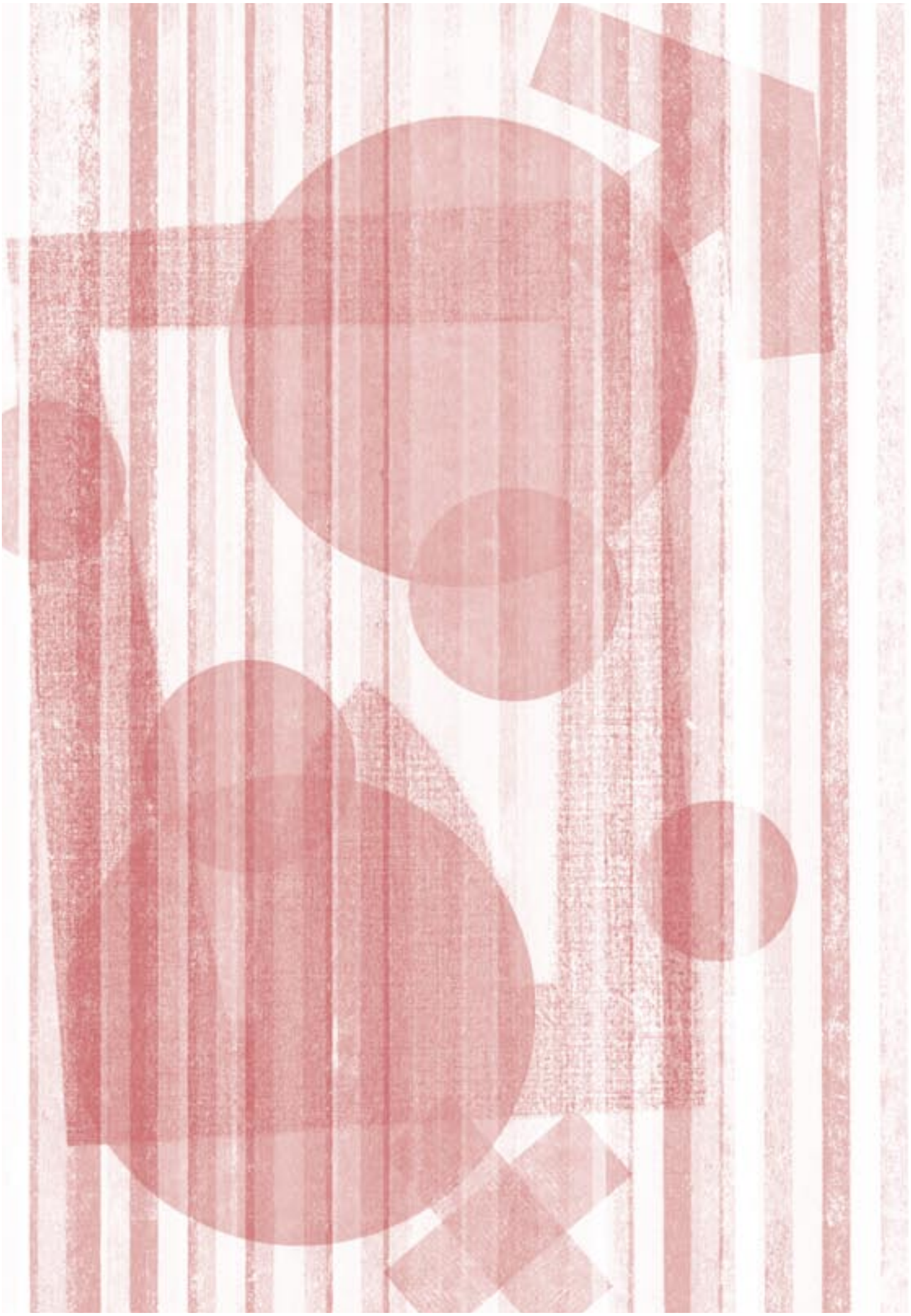
The fact that gender was not a baseline concern for either of the Progress Reports is probably a reflection of the lack of emphasis on gender in the original *Building Healthier Hearts* document. It demonstrates the importance of building in gender from the beginning of the policy/strategy development – if gender is not included in the initial strategy document then it is unlikely to be an issue for any follow-up actions or reports.

There are reasons for optimism, however. The Cardiovascular Strategy in Ireland is not set in stone, but seems to be quite flexible and open to improvement. The National Heart Health Advisor recently announced that a new Cardiovascular Health strategy is currently in development, presenting a key opportunity for the findings of the present study to be incorporated into policy making in a meaningful way. In line with other areas of health policy in Ireland, the focus of the new Cardiovascular Strategy may be on inequalities in health, particularly those related to socio-economic concerns. This being the case, it will be important to point out the 'gendered face' of poverty, and again draw attention to the need to include the gender dimension in developing policy. In addition, both *Building Healthier Hearts* and *Ireland's Changing Heart* referred to the need for health impact assessment to be carried out when formulating policy, so it would only be one step further to introduce the notion of gender impact assessment for future policy in the area.

Since the original cardiovascular health strategy document was developed and published, work on the area of gender and health has greatly expanded. The Women's Health Council and colleagues in the area of men's health are working to promote gendered notions of health and will continue to contribute to raising awareness in the area. The Women's Health Council has fed the findings of its *Women and Cardiovascular Health* report and of the *Women, Disadvantage and Cardiovascular Disease: Policy Implications* conference into the Department of Health & Children and to key relevant stakeholders in the area. The Council recently contributed to a document being produced for the EU Council of Ministers, and pointed out the importance of including gender in cardiovascular health policy. The Council stated that:

> *'Recent international research found gender to have a significant biological and social effect on the incidence of cardiovascular disease across the life course. An inverse relationship was also found to exist between disadvantage and cardiovascular disease... The importance of gender and the different patterns of risk for men and women across the life-course should be taken into account in addressing cardiovascular disease including early life influences. An inter-sectoral approach using gender sensitive polices is required to address the link between cardiovascular disease and disadvantage.'*

It is hoped that all of this work, together with an increased awareness overall of the importance of mainstreaming gender within health policy, will lead to an improved situation in the future. The work of the WHO in developing a tool kit for gender mainstreaming will make a substantial and much-needed contribution towards this goal.



Recommendations

To the Irish Government:

1. It is essential that gender is recognised as a health determinant that is as significant as social origin, economic situation and ethnic origin. In order to achieve maximum efficiency, policy/strategy/programmes must be developed, implemented and evaluated in a gender sensitive manner.

2. Effective targets and timetables for mandatory action on gender mainstreaming must be clearly established. Gender mainstreaming measures already endorsed by Government must be fully resourced and implemented across all government departments/agencies without delay. Responsibility for driving and implementing gender mainstreaming must be positioned at senior Governmental/Departmental/managerial levels.

3. Attention must be paid to gender equity in relation to the prevention, treatment and management of cardiovascular disease. Measures must be put in place to increase awareness about the incidence of cardiovascular disease among women, for both women themselves and their physicians. Appropriate gender sensitive diagnostic measures should be introduced.

4. All research should be carried out in a gender sensitive manner and results should be fully disaggregated by gender.

To the WHO:

1. The WHO should encourage Governments to recognise gender as a cross-cutting variable that underlies all other social and health issues, such as disadvantage or ethnic/social origins.

2. More work is required to develop effective tools for the implementation of gendered policies. Since Gender Mainstreaming has the ability to transform systems rather than tailor them to individual circumstances, work is necessary to connect this process to communities on the ground.

3. The gender balance of sampling frames within clinical research on cardiovascular disease nationally and internationally needs to be addressed so that data can be gathered to inform gender specific prevention, detection, treatment and rehabilitation programmes. All research should be carried out in a gender sensitive manner and its results should be fully disaggregated by gender.

Annexes

Annex 1. Gender Differences in Cardiovascular Health

The WHC recently carried out a piece of work on *Women and Cardiovascular Health*. This research drew attention to significant gender bias in current thinking about cardiovascular disease, and found gaps in both knowledge and in the provision of services to women. Despite the numbers of women dying from cardiovascular disease every year, it has traditionally been thought of as a disease typical to men. The problem seems to stem from the different manifestations of the disease in men and women, and from the historical lack of clinical research focusing on women's cardiovascular health. The literature consistently refers to women's 'atypical' experience of heart disease, with men's symptoms being perceived as 'normal'.

Gender bias

Research has largely concentrated on men and on manifestations of the disease among men. This concentration on male subjects is likely to have been due to this historical tendency in medicine to see the male body as 'normal' and to assume that data collected with regard to male subjects could be extended to women. The American Medical Association asserted that:

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

This situation meant that women were, for the most part, ignored in research on cardiovascular disease (The Lancet, 2003). The possibility of pregnancy, or other co-existing medical conditions, was one reason given for excluding women from clinical trials (Thaul and Hotra, 1993).

A recent analysis of thirty systematic reviews on the area of cardiovascular health held in the Cochrane Library, confirmed that women are largely ignored in clinical trials (Johnson et al., 2003). Women comprised only 27% of the total pooled population of the 258 relevant trials. One hundred and ninety six (196) of the 258 trials included men and women, but of these only 33% examined outcomes by gender. Where gender-based analysis was present, 20% reported significant differences in cardiovascular outcomes by gender. The researchers concluded that, in future, all clinical trials relating to the treatment of cardiovascular disease should include significantly more female participants, and that gender-based analysis must be carried out.

The neglect of women in clinical trials and the lack of gendered analysis of research in the area has had serious implications for women's cardiovascular health. Perhaps most significantly, the manifestations of cardiovascular disease in women were not fully recognised until recently. This led to the under-diagnosis of cardiovascular disease in women, resulting in avoidably high rates of mortality. Laher asserted that:

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

This assertion has been borne out by the findings of a number of studies, both in Ireland and abroad. Bedinghaus (2001) found that when women present with myocardial infarction they are more likely than men to be misdiagnosed, and they are also more likely to die of their first infarction. A survey of eighteen medical practices in England that explored differences in treatment for men and women with ischaemic heart disease, found that the results suggested a systematic bias towards men compared with women in terms of secondary prevention of ischaemic heart disease (Hippisley-Cox et al., 2001). Women with angina were found to be less likely to be referred to a specialist or to have revascularisation than men, and in secondary care further inequalities were found in investigation and use of drug treatment. Among patients with ischaemic heart disease, it was also found that women were less likely than men to have their risk factors (body mass index, smoking, blood pressure) recorded (Hippisley-Cox et al., 2001). Most recently, an article published in the *Irish Medical Times* (Hurley, 2003) reported on a study carried out by Vittinghoff et al in the United States. The study, of 2763 post-menopausal women with serious heart disease, found that doctors often fail to prescribe aspirin, beta blockers and cholesterol lowering drugs to the women, in spite of the fact that these drugs have been shown to prevent further heart attacks or other heart trouble. Beta blockers, which slow the heart rate, were only being taken by one-third of women who should have been taking them, only half the women who qualified for them were taking cholesterol lowering drugs, and although all women who had suffered a heart attack should have been prescribed aspirin only 80% actually had been (Vittinghoff et al., 2003).

In Ireland, *HIPE* database information showed that among patients with ischaemic heart disease and/or acute myocardial infarction, hospitalisation rates for males were found to be roughly double that for females (Codd, 2001). The findings of a recent study carried out at health board level suggested that access to secondary preventative therapy is not equitable across regions, gender and age in Ireland (Bennett et al., 2002). Bennett et al (2002) found that men were more likely to receive any secondary preventative therapy, except statins, than females, and that younger patients were more likely to receive the majority of secondary preventative therapies, particularly aspirin, statins and beta-blockers. Given the time lag in the development of cardiovascular disease among women, the implication of these findings is that women are doubly disadvantaged.

Commentators have suggested that the different and often less aggressive handling of coronary episodes in women may be related to the different symptoms of heart disease among women, in particular the greater frequency of non-coronary chest pain. It may also be due to women's tendency to be 10 years older than men when first presenting with cardiovascular disease or up to 20 years older at the time of myocardial infarction (Hines, 2001). Attention must be paid to medical teaching around cardiovascular disease, and the notion that prevalence is lower in women in particular must be challenged. At present, MacSheridan has asserted that this assumption means that doctors are less likely to consider a diagnosis of cardiovascular disease in the female patients, and that both they and their patients may not be sufficiently educated to recognise and respond to symptoms (2001).

Women's 'atypical' experience:

Studies have shown that women and their health care providers are not always sufficiently aware or educated about female risk of developing cardiovascular disease. Bedinghaus (2001) suggested that because public campaigns have emphasised breast cancer risks in the effort to promote mammography screening, many women are more afraid of breast cancer than of cardiovascular disease. In fact, research has shown that more women die as a result of cardiovascular disease than as a result of breast cancer – one study in the United States found that although one in 28 women die of breast cancer, one in two women die

of cardiovascular disease (Mosca, 2002). Part of the problem may be that while the risk factors are the same, heart disease has been found to manifest itself in different ways in women and men.

It has been found that the generally accepted warning signs for cardiovascular difficulties may not necessarily be present in women with the disease. For example, women may not present with the chest pain that is the generally accepted symptom of heart disease (Laher, 2001). Instead, women with ischaemic heart disease or myocardial infarction may present with symptoms such as neck, shoulder or abdominal discomfort, dysponea, fatigue, nausea or vomiting (MacSheridan, 2001; Bedinghaus, 2001). In the case of angina, while the classic symptoms occur in both sexes, angina is more likely in women than in men to occur at rest, during sleep, or during periods of mental stress (MacSheridan, 2001).

It is important to educate both women and their doctors about these differences, and to promote awareness of the risks of cardiovascular disease among women. This last point is particularly important, given that women have also been found to have symptoms for a longer period than do men before presenting for evaluation, perhaps for the most part because they are not sufficiently aware of either their risk for heart disease (MacSheridan, 2001) or of the symptoms, either typical or 'atypical' (Laher, 2001).

Age difference:

Although there is no marked difference between men and women in the proportion of all deaths accounted for by cardiovascular diseases, Codd noted that:

> *'The difference lies in the fact that for males less than 65 years, ischaemic heart disease is the most common cause of death. For females less that 65 years, deaths from cancer exceed those from IHD' (2001: 13).*

There is a difference in the peak ages at which heart disease is most likely to affect women and men. Research in Ireland from the *HIPE (Hospital In-Patient Enquiry)* database, showed that in 1999 while the peak age range for hospitalisation of males with ischaemic heart disease and/or acute myocardial infarction was 60 to 74 years, that for women was 65 to 79 years (Codd, 2001). This means that men tend to develop the disease earlier than women, and research has also found that men are more likely than women to die prematurely (before 65 years) from heart disease. Women are on average 10 years older than their male counterparts when they develop heart disease, and the incidence of heart attack, or myocardial infarction, among women has been found to lag behind that of men by up to 20 years (Laher, 2001). The incidence of cardiovascular disease was found to increase more steeply with age in women, so that the rates of the disease among men and women almost converge between the ages of 85 and 94 years (Kannel, 2002).

Although women are less likely to die prematurely from the disease, their longer lifespans mean that they are more likely to live with the disease for longer. This could have serious implications for health services. Health policy and services will need to take account of the growing numbers of older women at risk in the population, and of the additional complications that may be present among these older patients. Laher (2001), for example, has suggested that older women may have other diseases such as arthritis or osteoporosis that could mask symptoms, so it will be particularly important to ensure that doctors are fully aware of the symptoms of cardiovascular disease among women.

As a result of its research, the Women's Health Council strongly asserted that attention must be paid to gender equity in relation to the prevention, treatment and management of cardiovascular disease.

Annex 2. Detailed Analysis: Cardiovascular Health Strategy Reports

Building Healthier Hearts; The Report of the Cardiovascular Health Strategy Group

Overall, gender did not seem to have been included in any meaningful way in the recommendations made in the *Building Healthier Hearts* report.

Chapters 4 & 5 were both good sources of gender disaggregated data, but the implications of the differences found between men and women in the data were not drawn out and no reference to gender was included in any of the recommendations made at the end of each chapter.

Foreword

This chapter presented an overview of the situation with regard to cardiovascular disease in Ireland, and a summary of the work of the Cardiovascular Health Strategy Group.

Chapter 1: The Cardiovascular Health Strategy Group

This chapter set out the terms of reference, background and membership of the Cardiovascular Health Strategy Group. The Group was made up of twelve members, six men and six women, mainly working in the field of health.

Other than the reference to gender under 'equity of access', no mention of gender was made in Chapter 1 of the report.

Chapter 2: Overview of Cardiovascular Disease

Chapter 2 gave an overview of the different manifestations of cardiovascular disease and the epidemiological or population pattern of the disease internationally. It included descriptions of the main forms of cardiovascular diseases, including cardiac arrest, angina pectoris, acute myocardial infarction, heart failure, cerebrovascular disease (such as stroke) and diabetes mellitus.

Differences according to gender were not included for all sections although the report did note the following:

> *"Angina in middle age is more than twice as common in men as in women...In those over the age of 75 the prevalence is similar in men and women." (p15).*

> *"The World Health Organisation MONICA (Monitoring Trends and Determinants in Cardiovascular Disease) registers found that 28 day mortality in the mid-1980s in those aged 35 to 64 years ranged from 31% to 81%, with a mean of 49% for men and 54% for women" (p15).*

> *"The Framingham Heart Study found that once heart failure had developed only 25% of men and 38% of women were alive after 5 years" (p16).*

The implications of these findings were not drawn out however, and no further mention of gender differences in cardiovascular disease was made in the recommendations section of the chapter.

Chapter 3:
Overview of Management and Prevention

Chapter 3 reviewed the causes and prevention of cardiovascular disease and the treatment and rehabilitation of patients with coronary heart disease (CHD), the most common form of the disease.

The chapter looked at factors which alter the risk of cardiovascular disease, such as diet, physical inactivity, overweight, cigarette smoking, genetic factors, psychosocial factors (stress) and socio-economic group. Although sex was mentioned in Figure 3.1 as a personal characteristic associated with increased risk of future coronary heart disease, it was not elaborated upon any further.

Prevention measures, including lowering cholesterol, hypertension and the prevalence of smoking, were discussed, again with no reference to gender or possible gender differences. The report did note the need for "special attention…to promote health in disadvantaged groups, with low income or low levels of education" (p24) but with no reference to gender.

Similarly for the sections on diagnostic procedures, drug treatments, cardiac interventions, cardiac surgery, angioplasty, and cardiac rehabilitation, gender did not arise as an issue to be taken into account. Rather 'patients' were referred to and the assumption seemed to be that each procedure worked equally well for men and women. Mention was made of 'randomised clinical trials' of drugs and of 'research…on new techniques to improve blood supply to the heart muscle' but it was unclear if the research included women and men or not. This is an important point given the historical neglect of women in clinical trials and medical research.

The evidence presented in this chapter generally referred to 'patients', 'population' and 'people' and very little mention was made of men and women or to possible differences between them. It is unclear if this was because the research drawn upon did not present gender disaggregated data or because the report itself was gender blind.

Chapter 4:
Cardiovascular Diseases in Ireland

Chapter 4 presented patterns of cardiovascular disease and the associated risk factors in Ireland. It contained detailed gender specific data on mortality and morbidity rates of cardiovascular disease in Ireland and in the different regions in the country. The report noted, for example, that in 1997 cardiovascular disease was the main cause of death for men under the age of 65 and the second highest cause of death in women under 65. It also noted that death rates were 16% and 15% lower in men and women respectively in 1991-1993 compared to 1970-1972. With regard to morbidity, the report noted that the largest number of bed days was recorded for women aged 75 or more (77,853), followed by men under 65 (77,301) and men in the 65 to 74 age group (75,433).

The report also included gender specific data on the different interventions (treatments) for heart disease, such as angiograms, CABG, PTCA and heart transplants. It recorded that 'arteriography, PTCA and CABG are substantially lower in women than in men' and suggested that this was perhaps due to 'lower levels of need compared with men', particularly in the younger age groups. Similarly, the number of heart transplants was substantially higher among men, with 41 heart transplants in men compared to 11 female cases. Prescription rates for cardiac drugs were found to be very similar for men and women at all ages up to the age of 75, but for those over the age of 75, rates were slightly higher among women.

Some gender specific data were also included for risk factors for Cardiovascular Disease. Sections on blood pressure, smoking, diet, blood cholesterol levels, body mass index and physical activity were included, with gender specific information included in all except diet. Although gender differences were noted in most areas, no comment/analysis was made and no reference was made to them in the recommendations at the end of the chapter.

Overall, the data presented in Chapter 4 were found to have been broken down according to gender. While some details were lacking, the data presented were generally useful in considering the incidence and prevalence of cardiovascular disease in males and females in Ireland. The implications of many of the findings presented were not drawn out, however, and were not included in the recommendations. Gender differences were noted but not acted upon – suggesting that they were not considered a priority.

Chapter 5: Health Promotion

Chapter 5 outlined health promotion structures as they stood in 1999 and public health strategies. It also contained gender-specific data and statistics.

There was no reference of any kind to gender in the first three sections: Introduction, Successful Health Promotion Strategies, and Structures and Funding for Health Promotion.

Section 5.4 'Health Promotion Policy in Ireland' paragraph 5.4.1 'Policies and Strategies' referred to the 'Developing a Policy on Women's Health' discussion paper, and noted that smoking was identified as a priority issue for Irish women. No reference was made to men as a population group in particular need of health promotion activities, but women were referred to as a 'Priority Population Group' as set out in the National Health Promotion Strategy.

National targets, drawn from all national health and health promotion strategies were presented in section 5.4.2, but no reference to gender was included in any of them. Although gender disaggregated data was available for some of the targets mentioned (e.g. smoking), the particular needs of men and women were not drawn out and the targets were thus very much gender blind.

Nothing in section 5.5 on 'Public Policy and Supportive Environments'.

The recommendation section referred to the need for health impact assessment to be carried out when other government departments and agencies are formulating policy – but contained no mention of the need for gender impact assessment.

Section 5.6 looked at 'Health Promotion Interventions in Ireland'. Nothing was mentioned on gender under 'the Mass Media' or 'Overview of interventions in settings' but the report noted under 'The School' that "Health behaviour differs considerably between schools, with variations related to gender and class" (p49). This point was not referred to again, however, and was not included in the recommendations for that section. Within 'The Workplace' a similar point was noted: "Women perceive more practical barriers to change [lifestyles], and men of all ages exhibit least disposition to change" (p50), but again, this point was not drawn out in the recommendations or analysed any further.

No gender considerations were noted in the section on 'The Community'.

Within the section on 'The Health Services' a whole paragraph was devoted to the health promotion opportunities that arise for those providing services to pregnant women: "There is substantial scope for extension of evidence-based health promotion initiatives for women during pregnancy" (p51) – in particular

around smoking cessation "given the detrimental effects of smoking on the foetus and the high prevalence of smoking among young women". The only other population group mentioned in the section was older people and there was no reference to the particular health promotion needs of men or to other groups of men or women. Only 'older people' and 'pregnant women' were specifically included in the recommendations.

Under section 5.7 on smoking, some good gender disaggregated data was included, mainly from the SLÁN report. Findings from SLÁN (1999) indicated that the incidence of cigarette smoking was highest in the 18 to 34 year age group (men 38%, women 40%) and lowest in those aged 55 or over (men 22%, women 18%). Cigarette smoking was similar (36%-38%) in men and women in social classes 3 to 6 compared 25% of men and 28% in women in social classes 1 and 2. By the age of 15 to 17 years, it was found that one third of boys and girls were regular smokers. The report went on to note that submissions to the Cardiovascular Health Strategy Group expressed concern about the perceived high prevalence of smoking among women and young people, especially among girls. Nothing seems to have come up in submissions about boys or older men smoking, although this point was not noted in the report. As with previous sections, although gender disaggregated data were presented in the body of the report, none of the findings were referred to in the recommendations, which were resolutely gender neutral (all were aimed at 'adults', 'children' 'parents', 'teachers' or 'minors' and not specifically gender proofed).

A similar situation existed with regard to 'Diet and Nutrition'. The report contained some reference to gender and made some attempt to examine diet by gender – noting, for example, that 'one in three young unskilled males frequently ate fried food' (p55) and that 'Groups in need of nutrition advice and support are likely to be young men, those in manual occupations, those on low incomes and disadvantaged minorities'. However, these findings did not appear to have been used in formulating the recommendations, none of which made any reference to gender or to the various and differing needs of particular groups of men and women. Gender considerations were not mentioned in the sections on 'Food Policy and Dietary Guidelines', and although 'special target groups' were mentioned in the section on Current Activities in health promotion, gender was not specifically alluded to. None of the recommendations were gender proofed or gender specific.

The section on 'Body Mass Index' included some gender-specific data – according to the SLÁN report published in 1999 "Twelve percent of men and 9% of women over 18 were classified as obese. A further 40% of men and one quarter of women were in the overweight category" (p57). None of the recommendations made reference to the particular needs of men and women around overweight issues, however, and no recommendations focused on the needs of men around reducing weight.

The section on 'Physical Activity' also contained a lot of gender disaggregated data on participation in sport and exercise. According to the National Survey of Involvement in Sport, participation in activity was higher among men, 77%, than among women, 71%. The reasons for being active were also found to differ for men and women: "Men were involved for enjoyment, including the competitive element of sport. Women were active primarily for health reasons" (p58). Similarly, the Happy Heart Survey carried out in 1994 found that activity levels were lowest in women from social classes 4-6. The Department of Education's 'Targeting Sporting Change in Ireland' report (1997) included one specific reference to gender in its recommendations: 'Special reference is made to the need to encourage young girls to participate in sport' – no reference is made to particular needs among men or other groups of women, however. One of the recommendations in the present report made specific reference to gender:

"National sporting organisations should provide facilities and establish targets for participation in recreational sports by men and women, young and old" (p59).

Some gender specific data was mentioned in the section on alcohol: "SLÁN found that 27% of men and 21% of women consumed more than the recommended sensible limits for alcohol. In the 18 to 34 year age group over one third of males and one quarter of females reported consuming over those limits" (p60). No gender-specific recommendations were made drawing on this information, however.

Nothing gender-specific on 'Blood Pressure' or recommendations.

Gender was not mentioned in the section on 'Evaluation' – it mentioned 'people from disadvantaged groups, such as those on low incomes, the long-term unemployed and Travellers' (p61) but nothing on gender.

Overall in Chapter 5, gendered information was cited in most sections, but these were not specifically referred to in the recommendations. The different needs and health behaviours of women and men were noted but these did not seem to have formed the basis for the recommendations, which were overwhelmingly gender neutral/blind.

Chapter 6: Primary Care

Chapter 6 looked at the situation in primary care. It initially looked at the development of General Practice in Ireland, and then went on to examine prevention in General Practice in Ireland, prevention at a population level, and priorities for prevention. At no point in these sections were specific needs according to gender referred to. The language used was generally gender blind, referring to 'patients', 'subjects' and 'the consumer'.

The need for continuing education for GPs and practice nurses was mentioned, but there was no indication of whether or not this training was to be gender proofed, to include gender-specific needs in relation to cardiovascular disease. The WHC, in its recent *Women and Cardiovascular Health* report, identified a similar need but stressed that training should focus on the specific needs of women and men. This would help to ensure that health service providers as well as men and women are all aware of the different manifestations of heart disease and risk factors in each.

The report then moved on to looking at the high-risk strategy, risk assessment in other locations, and secondary prevention. None of the recommendations in these sections referred to the need to take gender into account, a need that has been made clear by research carried out subsequently. According to the report "Risk is assessed by questioning about family history of premature cardiovascular disease and the person's own past history of risk factors, symptoms or disease. Current levels of risk factors are assessed by questioning about diet and exercise habits, and by measurement of height, weight, blood pressure and blood cholesterol levels" (p70). A study carried out recently in England, however, found that among patients with ischaemic heart disease, women were less likely than men to have their risk factors, such as body mass index, smoking, and blood pressure, recorded (Hippisley-Cox et al., 2001). Although the section on secondary prevention mentioned that "There is evidence that the full range of secondary prevention measures are not implemented for many patients" (p74), it did not mention the need to ensure that men and women receive equal treatment. This is an important omission, given that a study of 2763 post-menopausal women with serious heart disease in the United States in 2003 found that doctors often failed to prescribe aspirin, beta blockers and cholesterol lowering drugs to the women.

Beta blockers were only being taken by one-third of women who should have been taking them, only half the women who qualified for them were taking cholesterol lowering drugs, and although all women who had suffered a heart attack should have been prescribed aspirin only 80% actually had been (Vittinghoff et al., 2003).

Specific conditions that increase risk of cardiovascular disease were then examined in the report, including diabetes, health behaviours, raised blood pressure and raised blood cholesterol. Again, few references were made to gender considerations when discussing these subjects, and none of the recommendations included any reference to gender. Under 'Health behaviours' for example, the discussion on smoking noted that "Substantially higher cessation rates have been achieved by AMI survivors (36%) and by healthy men who have been identified as being at high risk of cardiovascular disease (21%)" (p76). The report failed to draw out the implications of this statement, however, and did not consider the notion that men and women may require different strategies to aid them in giving up smoking. Research subsequently commissioned by the Office of Tobacco Control in Ireland found that women are more likely to try to quit smoking than are men, but that men have more successful quitting results (Office of Tobacco Control and TNS mrbi, 2003). Commenting on the research, Dr. Michael Boland, Chairperson of the OCT, stated that:

> *"there needs to be a concentrated and focused effort by all of those interested in women's health to develop effective smoking cessation programmes specifically for women".*

With regard to blood pressure and high cholesterol, the report included some gender-specific data:

> *"One in five men aged 50 to 69 years and one in four women in that age group had been treated at some time for raised blood pressure" (p78).*

> *"Thirty per cent of those surveyed in Offaly had had their cholesterol measured; this was nearly twice as frequent in men as in women…In the Happy Heart Survey, 38% of participants had had a cholesterol check – 42% of men and 33% of women" (p78).*

Again these findings were not commented upon or included in the recommendations.

Finally, treatment of cardiovascular disease was discussed, including treatment of patients with chronic conditions, and treatment of acute cardiovascular conditions. As expected, no reference to the particular needs of women and men were included in these sections and the recommendations made were gender neutral.

Overall, while some gender specific data was included in the chapter, the implications for differences between men and women were not drawn out in any meaningful way and again gender neutral language was used in formulating the recommendations. There was no reference in any of the recommendations to the specific needs of women and men regarding primary care, prevention, secondary prevention or treatment of cardiovascular disease.

Chapter 7: Pre-hospital Care

Chapter 7 dealt with pre-hospital services for those with a suspected acute coronary event. It included sections on early access to emergency medical services, early CPR, early defibrillation, advanced cardiac life support, and pre-hospital thrombolysis. It did not

contain any mention of gender considerations, perhaps because the evidence drawn upon did not include gender as a baseline measure. No account was taken of the different manifestations cardiovascular disease can have in women and men although it has been found that the generally accepted warning signs for cardiovascular difficulties may not necessarily be present in women with the disease. For example, women may not present with the chest pain that is the generally accepted symptom of heart disease. Instead, women with ischaemic heart disease or myocardial infarction may present with symptoms such as neck, shoulder or abdominal discomfort, dysponea, fatigue, nausea or vomiting (MacSheridan, 2001; Bedinghaus, 2001). In the case of angina, while the classic symptoms occur in both sexes, angina is more likely in women than in men to occur at rest, during sleep, or during periods of mental stress (MacSheridan, 2001). These findings have important implications for service provision, as women and their health service providers may not recognise so called 'atypical' symptoms and thus treatment may not take place within the recommended timeframes. It is therefore essential that such recommendations such as the following include references to gender and take into account gender differences in the experience of cardiovascular disease:

> *"A public education campaign should be undertaken to raise awareness of the symptoms of AMI and of the need to take urgent and appropriate action"*
>
> and:
>
> *"Education should be provided to patients and their relatives as to the appropriate response to ischaemic symptoms not relieved by their usual treatment for angina" (p86).*

Chapter 8: Hospital Services

Chapter 8 addressed hospital medical services for CHD. The introduction re-iterated the commitment to 'equity, quality of service and accountability'.

Under the heading 'Treatment of Acute Cardiac Conditions', the report discussed both aspirin therapy and thrombolysis. Although no gender-based statistics were presented for aspirin therapy, for thrombolysis the report noted that:

> *"In a 1992 study of Irish CCUs it was shown that only 35% of patients with confirmed myocardial infarction received thrombolysis...men received thrombolytic treatment more often than women..." (p95).*

The recommendations following the section did not make any further reference to this finding, however.

Similarly, although the section on 'Management of Heart Failure' noted that "The occurrence of the condition is profoundly influenced by age, reaching a prevalence of approximately 1 in 10 of those aged 75 years and over" (p96), it did not note the particular implications this might have for women, who have longer lifespans than men.

Under 'Secondary Prevention' the report again noted that "There is evidence that secondary prevention is inadequately managed in an important proportion of patients in Ireland" (p97), it did not mention that research has found women to be particularly likely not to receive such therapies (see above). The report also seemed to presume that women and men have the same needs around secondary prevention, and assumed that the same strategies would work for both. No evidence was given that this is indeed the case, however.

One reference to gender was made in the section on 'Modification of Patient's Risk Factors', under the heading 'Lipid Abnormalities'. The report stated that:

> *"Reductions in deaths from coronary artery disease and in the incidence of AMI have been shown in patients with established CHD and elevated or average cholesterol levels, as well as in men with hypercholesterolaemia without overt coronary disease" (p98).*

No reference was made to women and the finding was not included as the basis for any of the recommendations.

No reference was made to gender considerations in the section on 'Prophylactic Drug Treatment', 'Coronary Care Units', 'Cardiac Investigation Areas and Facilities', 'Invasive Angiographic Facilities', 'Percutaneous Transluminal Coronary Angioplasty' or 'Intracardiac Electrophysiological Studies and Pacing'.

Under the heading 'Cardiology Services: Access and Co-ordination', the emphasis was on geographical equality of access to services, and no mention was made of ensuring that access was not restricted by any other factors, such as gender. Although the report recommended that:

> *"National protocols should be developed for the application of evidence-based treatments such as aspirin and for secondary prevention, including the use of prophylactic drug therapy" (p104).*

there was no mention of the need to ensure the protocols were gender-proofed – a distinct need, given the research quoted above that showed women were less likely to receive any of the treatments mentioned.

This section went on to note the gender differences in treatment rates:

> *"HIPE data show lower provision of angiography, PTCA and CABG for women compared to men. This may be partly accounted for by lower need for these procedures in women compared to men, particularly in younger age groups. It is recognised that women have higher in-hospital mortality than men after AMI even after adjustment has been made for age and other baseline characteristics.*
>
> *At least some of these differences are likely to reflect the sub-optimal treatment of women compared to men" (p105).*

This was a very important point, as it had significant implications for women's mortality rates. However, it was not followed up in any way in the recommendations, and any opportunity to build gender equality of treatment into the strategy was thus lost.

The sections on 'Patients with Special Needs' and 'Staffing Requirements' made no reference to gender whatsoever.

The final section on 'Audit in Cardiology' noted that "The lack of basic information needs to be remedied" (p108), but no mention was made of including gender as a baseline measure in any of the registers and information systems proposed.

There was no specific reference to gender made in the recommendations or in the section on implementation at the end of the chapter, but equality of treatment was implicitly included in the following implementation measure:

"Hospital managers...should establish systems to ensure that all patients with cardiovascular disease benefit from evidence-based acute care and secondary prevention" (p109).

Chapter 9: Cardiac Rehabilitation

Chapter 9 reviewed cardiac rehabilitation services.

In quoting evidence on the effectiveness of cardiac rehabilitation after acute myocardial infarction (AMI), the report noted the gaps in research:

"The cardiac rehabilitation trials were...limited to a predominantly male population under 70 years of age. The survival benefits among women and elderly patients enrolled in cardiac rehabilitation have not yet been determined, although the physiological benefits of exercise are similar in both sexes across a broad age range in both normal, healthy individuals and those with CHD" (p114).

In the section on 'Benefits in Specific Populations', the report included paragraphs on women, elderly, children, heart failure and cardiac transplantation, but nothing on men. The paragraph on women noted that:

"Although exercise training in healthy women and healthy elderly persons yields significant improvements in functional capacity, the benefits of exercise rehabilitation in both women and elderly patients with CHD have been less well studied. In one study women who were enrolled in cardiac rehabilitation demonstrated a greater coronary risk profile than did the men in that programme. Women, including Irish women, have been shown to gain physiological benefits from exercise training comparable to age-matched men in similar programmes" (p116).

The paragraph on the elderly quoted research that showed that:

"...elderly women were referred to cardiac rehabilitation programmes less frequently than men, despite similar clinical profiles and apparently similar need" (p116).

No explanations were suggested for these findings, however, and neither were used as the basis for any of the recommendations.

The strategies put forward under 'Risk Factor Modification' were not examined with regard to gender to assess, for example, whether men and women had different needs in relation to nutrition counselling or smoking cessation. Similarly, no references to gender specific needs were made in relation to the psychological aspects of rehabilitation, to vocational assessment and counselling, or to compliance.

Women were briefly mentioned in the section on 'Programme Structure', where the report noted that:

"It may not be necessary for all patients to be exposed to every aspect of the rehabilitation programme. Selective focus on factors where specific advice and intervention are perceived necessary can be valuable. This may be important for women and certain ethnic groups who may find the standard exercise programme unappealing or even intimidating" (p121).

No reasons were given as to why women (and not men) might find parts of the programme 'unappealing' or 'intimidating', however.

The report noted that the profile of patients who attended rehabilitation programmes at the time was uneven: 'At present many programmes provide a service to younger patients (under 70 years), particularly males, who have had an AMI or CABG'. However, the report did not specifically include gender as a criterion for expanding service provision: 'Programmes should be expanded to include older patients and patients with other conditions, such as angina and heart failure, who may have additional health problems, such as musculoskeletal disorders' (p123). This was in spite the fact that the report had previously noted that 'In terms of demography, patients are increasingly likely to present at an older age and a focus on older populations brings with it a larger proportion of female patients than was previously enrolled in structured programmes' (p123).

Gender was not referred to in any of the recommendations at the end of the chapter.

Chapter 10: Information Systems and Audit

In Chapter 10 information systems, audit and research were considered.

No specific reference to ensuring that data and research on the area of cardiovascular health is gender-proofed was included in the chapter. Topics covered focused on mortality and morbidity data, registers (e.g. population-based, coronary care, and investigations and interventions), health surveys, audit and research.

Under 'Coronary Care Registers' the report noted some gender-based findings:

> *'Hospital-based AMI registers have examined trends in outcome and have shown gender differences in short term survival, with higher mortality in women, even after adjusting for their older age when hospitalised'*
>
> *'The use of thrombolysis has been extensively studied, showing under-utilisation, particularly in women and in older patients' (p131).*

Also gender was included as a significant characteristic under 'Registers of Investigations and Interventions':

> *'A register can compare the use of investigations and procedures according to patient characteristics, including clinical criteria, gender, residence, place of care and outcome' (p131).*

As with all of the other chapters, however, no reference was made to gender in the recommendations at the end of the report.

Overall, therefore, while the report did make reference to gender-disaggregated data and in places drew on research that noted differences between men and women with regard to cardiovascular health, as a strategy it remained gender blind in making recommendations. Gender, and the need to put different measures in place to effectively meet women's and men's needs, were absent from the recommendations. The language used in the recommendations, which form the basis of Ireland's National Cardiovascular Health Strategy, was gender neutral for the most part – 'men' and 'women' are replaced by 'patients', 'clients', 'individuals' and 'consumers'. Even in the chapter on 'Information Systems and Audit', gender is not a defining characteristic and the importance of ensuring that data is gender-proofed is not explicitly acknowledged at any point. Gender based differences in the cardiovascular health of the Irish population were noted in the report, but no action was taken as a consequence of this knowledge.

Heart Health Task Force Progress Report July 1999-June 2001 (First Implementation Report)

In the two years following the publication of *Building Healthier Hearts*, government allocated an additional €34.3 million to fund the implementation of its recommendations.

Section 2: 'Overview of Epidemiology of Cardiovascular Diseases in Ireland'

Disaggregated data is produced but there is not much gender-based analysis of the material presented. There is no particular emphasis on the needs of women and men. Gender specific analysis is present in only one sentence: "the prevalence of heart failure in the oldest age groups has increased greatly, particularly in women" (p6).

Section 3: 'The Cardiovascular Health Strategy – Building Healthier Hearts'

No gender-specific material included – merely summarises information on the *Building Healthier Hearts* strategy.

Section 4: 'Structures for implementing the cardiovascular health strategy'

Ministerial Group

chaired by the Minister for Health and Children

Joint Oireachtais Committee on Health and Children

Heart Health Task Force

responsibility for reviewing short, medium and long term objectives proposed – implementing the multisectoral recommendations contained in the Strategy (7 women of 29 members)

Advisory Forum on Cardiovascular Health

advises the Task Force and the Department of Health & Children on prioritisation of the recommendations and on best practice in cardiovascular disease prevention, detection, treatment and rehabilitation (8 women of 17 members)

Regional cardiovascular committees

at health board level

Inter-divisional Working Group on Cardiovascular Health

within the Department of Health & Children

National Conference for stakeholders was held in Dublin Castle on 5th November 1999, to discuss the *Building Healthier Hearts* report. 'Eliminating equalities' was one of the workshop topics on the day – but it is not clear from the report if gender inequalities were specifically mentioned here. There was no other reference to gender, either at the conference or in this section of the report.

Section 5: 'Funding allocated to the cardiovascular health strategy'

Total of €34.28 million allocated by Government for the implementation of the strategy.

No part of this section made any reference to gender – although the commitment to 'equity, quality and accountability' was re-iterated as a principle that should be sustained.

Section 6: 'Progress to date'

'The Strategy recognises that intensive efforts will be required to prevent cardiovascular disease at a population level' (p13). It also mentions the importance of 'attention to disadvantaged communities' (p13).

Health Promotion – National Initiatives

Describes media campaigns:

a. Ireland Needs a Change of Heart campaign – 'to address the entire community but with particular emphasis on social classes 5 and 6' (p14). Phase 1 of the campaign was around raising public awareness of high rates of heart disease in Ireland and of the lifestyle factors which increase its risk. Phase 2 concentrated on promoting physical activity and the key audiences were identified as 'older people, young people and those who are sedentary' (p14). No mention of gender.

b. NICO campaign – 'Given the concern about the increased prevalence of smoking among teenage girls and young women, a special component of the Break the Habit campaign was developed during 2000 to target teenage girls and was partly funded by the Strategy' (p15). Gender specific data was presented to provide a rationale for the campaign, including:

- by the age of 15 years more girls smoke than boys
- girls are less likely to quit when they are addicted
- by the age of 17, 40% of girls (28% of boys) from low income backgrounds are smokers:

'The NICO campaign concentrates on issues which are more immediately important to young women, such as their appearance. The simple message of this campaign is that smokers are less attractive and its uses a range of 'anti-cosmetics' presented by a character called 'NICO'. The NICO campaign uses TV, radio, and outdoor advertising and highlights the unappealing aspects of smoking' (p15).

Nothing further is presented in the section on gender and no reference is made to men's needs in relation to smoking.

No reference to gender is made in any of the following sections in the chapter:

Health Promotion

Regional Initiatives

Multisectoral Dimension to Health Promotion

Primary Care

National Initiatives

Regional Initiatives

Pre-hospital Services

National Initiatives

Regional Initiatives: 'The most disadvantages in gaining access to early intervention and treatment…are those resident in rural communities due to the fact that they are furthest away from hospital services' (p23)

Hospital Services

National Initiatives

Regional Initiatives
(mentions 'chest pain assessment facilities' p25)

Cardiac Rehabilitation

National Initiatives

Regional Initiatives
[no reference to special needs of women and older people, even though these were signposted in the first report]

Information Systems, Audit & Evaluation

National Initiatives

Regional Initiatives

Protocols

Research

Staffing

Section 7:
'Priority Services Areas for 2001'

Similarly no mention of gender was made under any of the headings in this chapter (same as the headings above)

Appendices

Included a summary of the actions taken as a result of the recommendations made in *Building Healthier Hearts*. The only section resulting from the recommendations that made any reference to gender was the NICO campaign, and that was specifically targeted at young women alone, rather than considering the needs of young women and young men.

Ireland's Changing Heart; Second Report on Implementation of the Cardiovascular Health Strategy July 1999-September 2002

Minister's Foreword

By September 2002, the Government had allocated €45 million to fund the implementation of the Cardiovascular Strategy. It allocated €9 million additional funding in 2003.

> *'Inequalities in death rates from cardiovascular disease, with substantially higher rates in those with the lowest levels of education and material resources, present major challenges to us as a society.'*

Chapter 1:
Introduction

Second progress report fulfilled the requirement on the Heart Health Task Force 'to monitor the Cardiovascular Health Strategy's implementation in accordance with the principles set out in *Building Healthier Hearts*' (p19)

A mid term review (original 5 year timeframe of the Strategy)

Overview and description of the services that developed through the implementation process

Chapter 2:
Epidemiology of cardiovascular diseases in Ireland

Gender disaggregated data (often including graphs or tables) was presented under all of the following headings:

Life Expectancy

European comparison, no specific figures were included for Irish men and women.

Trends in Cardiovascular Mortality

e.g. 'Since the early 1980s, CHD death rates have decreased by 24% and 26% in Irish men and women respectively in the 75 to 79 year age group' (p25)

Hospital Discharges

Less specific information was included by gender here, but men and women were mentioned e.g. 'Hospital discharges with a diagnosis of CHD increased between 1996 and 2001 in all age groups, in men and in women... The in-hospital mortality rate decreased from 5.9% to 3.7%, with reductions seen in all age groups, in men and in women' (p25).

Investigations and Interventions

'Overall the number of investigations increased from 5216 to 7974 between 1996 and 2001. The increase was seen across the age spectrum, in men and in women' (p26). Detailed gender disaggregated data on people discharged with a diagnosis of CHD and on surgical procedures for CHD were presented in table format.

Cerebrovascular disease

e.g. 'Death rates from stroke for Irish men under the age of 65 are very similar to the EU average, though tending to be slightly higher that the EU average in Irish women (Tables 12a & 12b).' And 'There was a reduction in the hospital discharge rate with a diagnosis of stroke in men but a substantial increase in women, reflecting the high incidence rate of stroke in older age and the higher proportions of women surviving to old age (Table 11)' (p26).

No or very little gender disaggregated data was presented on the following areas:

Prescriptions

No gender disaggregated data was included on the numbers of men and women being prescribed medicines for CHD.

Risk Factors for Cardiovascular Disease

A very short section; no specific reference to men's and women's risk factors.

Implications of Changing Epidemiology

No specific mention of gender in this section. The section did include a section on inequalities, but focused on inequalities due to social class rather than due to gender: 'It is of particular concern that the decrease in cardiovascular mortality has been unequal in different social groups...in the south of Ireland death rates from circulatory diseases were almost three times higher in the semi- and unskilled working classes compared to professionals' (p27). No discussion was included drawing out the implications of changing epidemiology for women and men either, e.g. the report noted that 'the prevalence of heart failure in the oldest age groups has increased greatly' but did not note the implications this has for women, who are represented in higher numbers than men in the oldest age groups.

Chapter 3:
Background, Structures and Funding

Summarised information on the *Building Healthier Hearts* strategy – no gender-specific material included.

Chapter 4:
Health Promotion

No gender experts were named as key players in implementing the health promotion recommendations of *Building Healthier Hearts*.

Resources and their Management

Findings of health and lifestyle surveys of the population (e.g. SLÁN) to be used 'for planning and evaluation of health promotion interventions' (p44). No specific mention of gender.

Intersectoral Working

No reference to gender.

National Awareness Campaign – Ireland needs a Change of Heart

'A mass media campaign was developed to address the entire community but with particular emphasis on social classes 5 and 6 (those with the lowest levels of education, skills and material resources)' (p45). Campaign was outlined in the first Progress Report, Second Progress Report included 'Impact of Ireland needs a Change of Heart'. No reference to gender.

Smoking

Report outlined Fiscal Measures, Legislation, Education (including the NICO campaign discussed in the First Progress Report), and some of the regional initiatives undertaken in the area. Apart from the section on the NICO campaign, no reference was made to the different needs of women and men in relation to smoking prevention and no mention was made of gender/sex-specific smoking cessation/health promotion programmes.

Diet and Nutrition

Under National Initiatives, the report noted that in 2001/2002 the focus of the National Healthy Eating Campaign 'was specifically on heart health and aimed to raise awareness among women in particular' (p50). There was no information on men's needs in relation to healthy eating, in spite of the fact that *Building Healthier Hearts* had noted that 'one in three young unskilled males frequently ate fried food' (1999: 55) and that 'Groups in need of nutrition advice and support are likely to be young men, those in manual occupations, those on low incomes and disadvantaged minorities'.

Overweight

No breakdown of rates of overweight/obesity was given by gender. Section included details of a 'Men's Healthy Weight Programme' run in the North Western Health Board Area for men aged over 30 years of age. No mention of women's needs.

Physical Activity

A lot of information was presented on specific initiatives established in the area of physical activity, but no details were given on the specific needs of different age groups by gender. The report did not note that some groups, particularly teenage girls and older women, are more sedentary than others, although this information was available from the SLÁN survey at the time.

GP Exercise Referral

Report on pilot projects set up in the Mid Western and Southern Health Boards – no reference to gender concerns in developing/implementing the programmes. A National Framework for Developing General Practice Exercise Referral in Ireland was launched in October 2002 – gender experts did not appear to have been included on the Working Group that developed the Framework, however.

Alcohol

Report on measures undertaken in relation to reducing the level of alcohol related problem and to promote moderation. No gender-specific data was included – no reference to the incidence of problem drinking among women and men; no reference to the particular needs of women and men around alcohol use; no reference to different ways of targeting women and men with regard to alcohol consumption etc.

Blood Pressure

No reference to gender.

Workplace

Within the 'Healthcare setting' the report mentioned that 'There is a focus on men's health, involving consultation and an ongoing series of seminars' (p58). Within 'Settings outside the Health Sector' the report mentioned research carried out by the Southern Health Board on a project with two groups of workers, one predominantly male and one predominantly female. No details of the findings were given, however, so there was no opportunity to consider the different needs of men and women in the workplace.

Health Promoting Hospitals

'Research to assess the factors affecting smoking cessation after discharge from an acute hospital has been commissioned with funding from the Strategy. International studies indicate factors such as diagnosis, gender, age, level of smoking and nicotine dependence, attitudes to smoking cessation and social support can influence success rates after a hospital episode. This research proposal will identify predictive factors in an Irish context and will inform smoking cessation services in the hospital setting in the future' (p60). No other mention of gender.

Schools

No reference to gender based needs – 'children' only referred to.

Targeting Disadvantage

'Disadvantaged communities', 'people on low incomes', 'people from disadvantaged areas', 'Travellers', 'asylum seekers', 'disadvantaged people'. No reference to gender, or to the fact that women are disproportionally represented among disadvantaged groups in Irish society (cf. WHC 'Women, Disadvantage and Health' report published in 2003).

Evidence-based Practice and Evaluation

No specific reference to gender only to 'population groups'. No reference to including gender as a baseline measure for evaluating the effectiveness of services.

Chapter 5:
Primary Care

Heartwatch

A structured programme of secondary prevention of cardiovascular disease in general practice in Ireland. Patients are eligible for inclusion if they have a proven history of M.I./CABG/PTCA. Patients are offered lifestyle advice as well as monitoring of risk factors and medication. No mention was made of any gender considerations, not even male/female participation rate.

Secondary Prevention Programmes piloted in the SEHB and NEHB

The only reference to gender made in the section is in regard to the SEHB programme which noted a 76% male participation rate.

Care of Patients with Diabetes

No gender considerations mentioned.

Nicotine Replacement Therapy

No gender considerations mentioned.

Community Health Promotion

Gender disaggregated data was not consistently presented for all of the programmes presented in the report. Nothing under the WHB's Community Dietetic Service or the health board wide Being Well programme; MHB's Smoking Cessation Clinic noted that males were more likely than females to refuse the opportunity to see a smoking cessation facilitator. The latter example would suggest that some strategies may have different appeal for women and men; this has important implications for service delivery.

Other Initiatives

Nothing gender specific.

Linkages with Hospital Services

No reference to gender.

Chapter 6:
Pre-Hospital Care

Nothing at all in this chapter about gender/no references to gender.

Chapter 7:
Hospital Services

No gender considerations were taken into account in this section at all in spite of research evidence (quoted in the WHC report 'Women and Cardiovascular Health' published in 2003) of gender differences in access to services, rates of treatment etc. Little or no reference to any gender-disaggregated data was made in this chapter.

Chapter 8:
Cardiac Rehabilitation

No mention of gender was made in this section in spite of the fact that *Building Healthier Hearts* noted lower attendance rates among women and older people. Report mentioned an audit of Cardiac Rehabilitation carried out in the ERHA (p90) and said that the data was to be analysed in relation to gender (among other variables), but then the findings made no reference to gender (e.g. 'Two thirds of patients availed of the invitation to cardiac rehab' – no gender breakdown).

Chapter 9:
Information Systems, Audit and Research

Nothing specifically included in this section on gender. This is perhaps unsurprising, since gender considerations were not built in to the original strategy document.

Chapter 10:
Future Challenges in Implementing the Cardiovascular Health Strategy

> *'The first three years of implementing the Cardiovascular Health Strategy has seen a substantial increase in cardiology prevention and treatment services. Through the implementation of the Strategy, these services are already making a difference, providing more accessible, equitable, better quality care for patients with cardiac conditions' (p103).*

Future Challenges

> *'Ireland's Changing Heart set out to describe developments arising from the implementation of the Cardiovascular Health Strategy, based on information received from health boards and other relevant organisations' (p104).*

Key challenges facing the future implementation of the Cardiovascular Health Strategy:

- Improve population health
- Reduce inequalities
- Equitable access to services – '...to meet the needs of the growing numbers of older people...'
- Improve the quality of services

No mention was made of reducing inequalities between men and women or of ensuring that men and women have equal access to services. Gender was not included in the recommendations of the original *Building Healthier Hearts* document, so it was not included in this Progress report either.

Improve Population Health

The report mentioned critical issues at strategic level, one of which was '...developing health impact assessment. Policies, strategies and legislation originating from non-health sectors can impact directly or indirectly on the health of the population. It is essential that all relevant policies and strategies undergo a comprehensive process of 'health proofing' to ensure that they have a positive impact on the physical, mental and social well-being of the population' (p105). No mention of gender but it would be only one step further from this to introduce gender impact assessment and gender proofing of policies as well.

Reducing Inequalities

Focused on the links between poverty and ill health, e.g. 'Population surveys have shown smoking prevalence to be approximately twice as high in men and women in the unskilled social class compared to the professional and managerial class' (p105). No mention of gender or of the particular vulnerability of women to poverty/ disadvantage.

Equitable Access to Services

No reference to gender considerations. The report did note that 'The changing epidemiology of cardiovascular disease has major implications for the provision of cardiology services and of other health and social services for older people...Continued implementation of the Cardiovascular Health Strategy must take into account the increasing numbers of people living into older age with chronic cardiovascular disease' (p107). The report did not mention the higher proportion of women who make up the older population in Ireland and their particular needs, however.

Improve the Quality of Services

Nothing on gender, although it did mention that a Research Strategy was being prepared by the Advisory Forum on Cardiovascular Health.

The Way Forward: Monitoring, Evaluation and Consultation

Nothing on gender.

Annex 3. Interview Topic Guide

What were the obstacles for paying attention to women's and men's needs in the Cardiovascular Health Strategy?

Was gender recognised as a relevant variable in developing the Strategy? Were any gender experts involved?

Commitment to 'equity of access'?

Did the consultation process raise any specific gender-based health issues?

Were the submissions to the Cardiovascular Task Force's consultation process balanced in terms of gender or did they focus on one gender more than the other?

Ireland's Changing Heart contains a lot of information on the various programmes and schemes set up as a result of *Building Healthier Hearts*, for example the 'Heartwatch' programme. Is it a requirement that male and female participation rates be monitored in all these programmes? Is there any gender breakdown of participation rates in these programmes available?

Could the Strategy be made more gender sensitive? Would the Department/Heart Health Task Force have specific needs in relation to providing a gendered strategy?

Examples of gender-sensitive cardiovascular policy from elsewhere?

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Notes