Women, Disadvantage and Health
A Position Paper of The Women’s Health Council

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The Women’s Health Council

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. Following a recommendation in the Report of the Second Commission on the Status of Women (1993), the national Plan for Women’s Health 1997-1999 was published in 1997. 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 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 Instrument:

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 to 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’.
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1 Introduction
In modern Irish society, good health is recognised as fundamental to a person’s life experience. In exploring how best to promote and maintain good health, factors which go beyond the availability of medical services must be explored. People’s health is determined not only by their physical make-up, but also by a range of social factors. This means that while hereditary factors may go some way towards explaining a person’s health, the socio-economic and cultural environment in which an individual lives is also crucial. Health is a product of whether or not a person has sufficient income, adequate housing, and social or community bonds and support, in addition to her/his behaviour, diet and lifestyle. The inability of certain individuals, as a result of inadequate income and resources, to have a standard of living regarded as acceptable by society can clearly have an adverse effect on their health.

In order to adequately capture its multi-faceted nature, the Women’s Health Council has adopted the World Health Organisation (WHO)’s definition of health:

‘A state of complete physical, mental and social well being, and not merely the absence of disease or infirmity’ (WHO, 1948)

This definition of health has also been adopted by the Irish Government, in the most recent health strategy Quality and Fairness (2001). The Strategy expands on the WHO definition, to state that health is:

‘A resource for everyday life, not the objective of living; it is a positive concept emphasising social and physical resources as well as physical and mental capacity’ (Department of Health & Children, 2001:15).

In his Foreword to the document, the Minister for Health and Children, Micheál Martin T.D., reiterated the fundamental importance of health:

‘In every aspect of every individual’s life, health is pivotal… It is a prerequisite to the achievement of wholeseness and fulfillment in adult life… Health is also crucial to Ireland as a nation. Our health care system must reflect our national values: our concerns for equity, our commitment to diversity, our determination to end poverty and disadvantage.’

The Irish government has pledged to uphold Article 12 of the International Covenant on Economic, Social and Cultural Rights to recognise the right of everyone to enjoy the highest attainable standard of physical and mental health. In signing up to this covenant Ireland has committed itself to enabling and assisting all its population to live healthy lives, and the government is required to attempt to address health inequalities. The Programme for Prosperity and Fairness (2000) went some way towards this goal by aiming to tackle some of the existing health inequalities. The Programme aimed to improve access to quality healthcare services in order to strengthen social inclusion and cohesion, and also to monitor socio-economic inequalities stating that

‘resources will be allocated to health research as part of a comprehensive approach to ensuring adequate medium and long term planning of health provision’ (2000).
The recent *Programme for Government* (2002), the *Review of the National Anti-Poverty Strategy* (2002) and the *National Action Plan against Poverty and Social Exclusion* (2003) all include references to health, but contain no specific reference to women’s health. The commitment to the social model of health and the development of a specific target is, however, a welcome development within the context of the National Anti-Poverty Strategy:

‘to reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10% for circulatory diseases, cancers and injuries and poisoning by 2007’ (Office of Social Inclusion, 2003).

In addition, the Women’s Health Council understands the commitment in the *Programme for Government* to bringing ‘the targeting of health inequalities to the fore in health policy’ and to providing ‘a high-quality and accessible health service for all’ to encompass this vital area. Improved health status for women translates as improved health status for everyone. A Government committed to the implementation of the recent Health Strategy can be expected to prioritise both quality and fairness on that basis.

**Poverty and Inequality in Ireland**

Ireland’s economic progress has been outstanding in recent years, with national income per head above the average for the European Union (Department of Social & Family Affairs, 2002). Unemployment levels fell over from 12% in 1996 to about 4% in 2002 while the numbers in consistent poverty fell from 15.1% to 6.2% over the same period (Department of Social & Family Affairs, 2002). In a recent Annual Report, the United Nations ranked Ireland in the top 20 countries in the world based on Gross Domestic Product (GDP), education levels, adult literacy and life expectancy (United Nations, 2001).

In spite of these statistics, research has clearly shown that the benefits of this recent economic boom have not been evenly distributed across Irish society. The income gap between rich and poor is now wider than ever (Eurostat, 2002b). A recent Combat Poverty report characterised Ireland as ‘a low-tax, low-spending welfare state that is heavily focused on a means-tested benefits and primarily financed through taxation’ (Timonen, 2003). In 2001 some 21.9% of the population had incomes which put them in the category of ‘at risk of poverty’. This figure represents a steady rise from 1994, when it was 15.6% (Office of Social Inclusion, 2003). The richest twenty per cent of the population in this country now receives 5.3 times more income than those in the least well off category, giving Ireland one of the widest gaps between rich and poor in Europe (Eurostat, 2003). In addition, the gap between those on social welfare and the rest of society has grown, as rises in social welfare payments have lagged behind income from work and property, so those relying on social welfare payments have been increasingly likely to experience a larger gap in relation to average income. It is also clear that the gap between men and women has widened, with 23% of women now at risk of falling below the 60% poverty line in comparison with 19% of men.
When considering the notion of graduated and widespread disadvantage, women in Irish society are one of the groups whose needs particularly necessitate attention. Research in the area of poverty has shown not only that Irish women are at an increased risk of poverty compared to men, but also that some groups of Irish women experience higher levels of disadvantage relative to others. This is a long-standing situation. One of the seminal pieces of work on women and poverty was carried out in 1989 by Daly, and, worryingly, many of the situations she described almost fifteen years ago are still causing concern today.

It is to be hoped that decisive action will be taken as soon as possible to address the situation, so that Daly’s work will not hold true in another fifteen years time. Within the 2002 review of the National Anti-Poverty Strategy, the Government aimed to eliminate consistent poverty and set specific targets in relation to the provision of income support sufficient to avoid poverty. These targets were reiterated in the recently published *National Action Plan against Poverty and Social Exclusion 2003-2005*, and work is ongoing to try and achieve them. There is a need, however, for an increased emphasis on gender-sensitivity in the area, and concern has also been expressed, by the European Commission among others, about the lack of emphasis on income inequalities (Hanan, 2002). Both of these factors have implications for the health and well-being of women in Irish society.
2 Poverty, Exclusion and Disadvantage in Ireland
The concepts of poverty and disadvantage are often used interchangeably to refer to the processes, the condition and the consequences by which certain individuals or groups of individuals find themselves marginalised and unable to participate equally in wider society. Exclusion/social exclusion is the process by which these groups, including the long-term unemployed, early school leavers, lone parents, etc., are driven to the margins of society where they have few opportunities to improve their position. These groups can generally be characterised by their lack of power and their inability to access decision-making structures.

**Absolute and Relative Poverty**

Poverty can be defined in absolute or relative terms. An absolute definition is based on whether an individual has the basic essentials for survival – food, water, clothing and shelter. Relative poverty, in contrast, considers the ability of a person to participate in society and to have access to resources and opportunities that are the norm for other people in society. The concept of relative poverty is generally accepted as more appropriate for measuring poverty in the Irish context.

**The National Anti-Poverty Strategy**

The National Anti-Poverty Strategy (NAPS) adopted a relative definition of poverty:

‘...people are living in poverty if their income and resources (material, cultural and social) are so inadequate as to preclude them from having an adequate standard of living which is regarded as acceptable by Irish Society generally’ (1997).

The NAPS emphasised the social dimension of poverty, highlighting the isolation, powerlessness and social exclusion that are associated with the experience of living in poverty. In the revised NAPS, launched in 2002, the Government set targets for poverty reduction across a number of areas: income, education, employment, health, and housing. It also recognised the needs of a range of vulnerable groups, including children, women, older people, vulnerable urban and rural dwellers, people with disabilities and ethnic minority groups. This was first time that health specific targets were included in the overall anti-poverty strategy. The targets are both specific and general:

1. Specific targets aim to reduce the gaps in mortality between rich and poor. For example, the strategy aims to achieve a 10% reduction in the gap in life expectancy between the Traveller community and the general population by 2007.

2. General targets aim to assess public policy in terms of health inequalities. For example, a series of social indicators have been identified for the purposes of monitoring and evaluating the implementation of the National Anti-Poverty Strategy and the EU led action plans against poverty.
The acceptance and adoption of the concept of relative poverty at a national level is important as it broadens the focus from a purely monetary based definition of income poverty. The NAPS adopted a broad definition of poverty to include five areas:

- income
- employment
- education
- health
- housing/accommodation.

The need for the adoption of a broad approach to tackling poverty is supported through the ongoing work of projects like the National Women’s Council of Ireland’s (NWCI) *Framing the Future*. This project sought to build a profile of the role and activities of the women’s community and voluntary sector nationally. It and other similar projects, found that women have a broader experience of poverty than income adequacy/inadequacy. Other common issues that arose within these projects included educational disadvantage, isolation, lack of childcare and an absence of adequate public services such as health care or transport.

Relative poverty is measured by looking at both relative income levels and relative levels of disadvantage. Three relative income levels are used, based on 40%, 50% and 60% of average household income. Average household income is calculated based on a detailed longitudinal panel survey undertaken on a regular basis by the Economic and Social Research Institute (ESRI). A non monetary index of deprivation, for example adequate heating, or arrears on rent, is also used to assess the extent to which someone is denied the opportunity to have or to do something that is the norm in society (CPA, 2000).

**Consistent Poverty**

The official Irish government indicator of poverty/disadvantage remains consistent poverty (NAPS, 1997). Consistent poverty is relative income poverty combined with the lack of basic items such as a warm coat, sufficient food, adequate heating, etc. The percentage of people living in consistent poverty is the proportion of the total population living on a lower than normal income and lacking certain basic essential items, thereby experiencing a lower standard of living than the rest of society. The target under the current *Programme for Prosperity and Fairness* is to reduce the numbers of ‘consistently poor’ to below 2% and if possible eliminate ‘consistent poverty’ under the current definition.

The most recent data available on income poverty in Ireland is from the 2000 Living in Ireland Survey, carried out by the ESRI. This survey found that approximately 6% of the Irish population (200,000 people) were living below 60% of the average income of €173 per week, and experiencing deprivation. This finding represents a continuing decline on the 1998 and the 1984 data, which found that 8% and 15.5% of the population respectively experienced consistent poverty. A recent study by the ESRI (Nolan et al., 2002) also showed that deprivation levels, as measured by a variety of non-monetary indicators declined substantially after 1994 and continued to fall up to 2000. In 2000, for example, 3% of respondents said they could afford to buy only second-hand rather than new clothing, which compared with a figure of 10% in 1994. A decline in family poverty and unemployment were the main reasons for this improvement in the number of people living in consistent poverty. It is also likely that the increase in the number of women working in the paid labour force contributed to the decline. Women’s labour force participation increased substantially over this period, from a participation rate of 39% in the 1994 Labour Force Survey to around 49% in the 2002 Quarterly National Household Survey (Central Statistics Office, 2003).

Relative poverty, in contrast, has increased over the same sixteen-year period. In 2000 22% of the population had incomes below 60% of the median, while the comparable figures for 1998 and 1994 were 20% and 15.6% respectively. The main reason for this increase in poverty was the higher risk for those reliant on social welfare – most notably pensioners and lone parents. These contrasting trends indicate that while the deprivation experienced by those on low incomes declined as their real incomes grew and they got more work, their relative position deteriorated as the general living standards of the rest of society improved.

The gap between rich and poor has grown over the last decade even as the general standard of living and levels of employment have risen. This means that even though Ireland has become increasingly wealthy over the past decade, it has also become more unequal. Recent research findings from the Combat Poverty Agency show that Ireland currently has one of the highest levels of income inequality in the European Union (Nolan et al., 2000).
In view of these figures, it is clear that certain household types remain at high risk of poverty. The most recent information available identifies single adult households, lone parents and larger families as high-risk groups. Households headed by a person who is unemployed, who is ill or disabled and who is working in the home – in each instance mainly women – are also at higher risk of falling into poverty. It is also the case that people who are homeless and ethnic minority groups, including Travellers, experience high levels of poverty. Child poverty is also high in Ireland by European standards. The statistics currently available support this view with the following series of findings:

- There is an 11% risk of poverty for households with member who is ill or disabled.
- 50% of lone parents are living in poverty.
- 35% of all people experiencing poverty are engaged in home duties (mostly women).

(Callan et al., 1999)

Disadvantage

Disadvantage is a much broader concept than poverty. The concept of disadvantage is one of generalised deprivation and exclusion from ordinary living conditions, due to a lack of resources. The term can be applied on both an individual and an area basis. The concept is based on the recognition that individuals have physical, emotional, social and cultural needs. It recognises the multi-dimensional nature of poverty and considers it in terms of the lack of some basic needs and the complex consequences this can have on individuals' lives.

Disadvantage is both the symptom and the manifestation of poverty, exclusion and discrimination. Disadvantage by its nature is rarely related to a single issue, recognising as it does the multiple and interrelated concerns of individuals and communities. The concept of disadvantage was used for the purposes of this paper because it is all-embracing, and focuses on all the various needs of an individual or community. Its adoption also overrides any issues and debates that might take place about which definition of poverty should be used. The multi-dimensional nature of disadvantage also links with, and complements, the broad definition of health ‘as resource for everyday life, encompassing social and personal resources as well as physical and mental capacities’ adopted in this paper.
3 The Links Between Disadvantage and Health
While research on social inequalities in health is neither extensive nor exhaustive, it is conclusive in making a clear link between disadvantage, deprivation and poor health status for women and men. The link between health and socio-economic status is indisputable. Research has shown that as a general rule people with higher paid occupations tended to have fewer health problems and longer life expectancies, while men and woman in lower income groups were more at risk of illness throughout their lives (Barry et al., 2001). Mortality patterns also clearly show differentials by occupational class, and by association socio-economic status, although limitations in the available data have meant that that this has only been clearly established to date for men (Balanda and Wilde, 2001). Inequalities in health are also evident in indicators such as life expectancy, and rates of sickness (morbidity). Another important factor in an Irish context is geographical remoteness – the ease and ability with which an individual can gain access to the necessary health services (NESF, 2002).

The link between health and socio-economic status in Ireland is unequivocal based on the findings of a number of large-scale population surveys in Ireland, particularly the national Survey of Lifestyle, Attitudes and Nutrition (SLÁN) and the Health Behaviour in School-Aged Children (HBSC) survey, carried out in 1998 and again in 2002. In each case, the SLÁN survey found those individuals from social classes 5 (semi-skilled) and 6 (unskilled) to be more likely to participate in behaviours that could adversely affect their health (Friel et al., 1999; Kelleher et al., 2003). Income levels in particular represent one of the most significant contributions to a person's experience of health and economic impoverishment is most often synonymous with poor health (Lynch et al., 2000). As long ago as 1984 the ESRI found that poor and disadvantaged people have a lower life expectancy than do those from higher socio-economic groups together with lower levels of self esteem, less confidence, and higher levels of psychological distress than those classified as non-poor (Department of Social Community and Family Affairs and Combat Poverty Agency, 1999).

Socio-economic differentials are prevalent for practically every health and health lifestyle indicator in Ireland. Higher socio-economic groups have consistent advantages over lower, for women and girls as much as for men and boys. Strong links were also made in some of the studies between health and levels of education, where people with a better education had better health and better health related lifestyles than those who were less well educated. Traveller women, one of the most disadvantaged groups in Irish society, were found to have a life expectancy twelve years lower than other Irish women, with fewer than a third of expectant Traveller mothers found to have attended hospital half-way through their pregnancies (Pavee Point, 1999).
Women and Disadvantage/Poverty

One of the first pieces of work to note women’s particular vulnerability to poverty was Mary Daly’s *Women and Poverty*, published in conjunction with Combat Poverty in 1989. In spite of the economic boom in Ireland in intervening years, the situation does not seem to have changed hugely since Daly’s seminal work was published. Data collected in 1994 showed not only that Irish women were at an increased risk of poverty compared to men, but also that some groups of Irish women experienced higher levels of disadvantage than others. The follow up report, based on 1997 data, showed that the risk of poverty for these groups had increased (Callan et al., 1999). The groups identified as most ‘at risk’ of poverty in Ireland included single adult households, lone parents and larger families, households headed by a person who is unemployed, who is ill or disabled and/or who is working in the home, the homeless, and ethnic minority groups, including Travellers. This was largely due to the high risk of poverty for single adult households – mainly headed by women – and households headed by someone working full-time in the home – again, chiefly women. Female headed households facing a 24% risk of poverty compared to a 17% risk for male headed households (Callan et al., 1999).

In 1989, Daly wrote about the difficulties raised by ‘population changes including increasing marital breakdown, more children being reared by one parent families and growing numbers of elderly women’ and she also expressed concern about the ‘increased reliance on women’s unpaid work, as public spending on services, especially health services, is cut back’. It is alarming to note that so much of her work still has resonance today – consider for example her statement that:

*The property boom in Dublin… made fortunes for some people, while at the same time placing the price of a home beyond the reach of many, particularly the young* (Daly, 1989).

Similarly, Daly’s *Charter of changes necessary to reduce poverty among women* remains largely relevant today:

1. Access to an adequate, independent income for all women
2. Full sharing of family responsibilities and workloads between men and women
3. Adequate provision for children and all families with children, including state-funded childcare facilities
4. Adequate and accessible health, education and training, housing, legal and transport services
5. Adequate funding for local women’s projects
6. Action to deal with unemployment and to create work opportunities that are well paid and that can accommodate workers’ family-related responsibilities
7. Legislative and political changes to improve the economic and social position of women.

(Daly, 1989)
4 Women, Disadvantage and Health
Socio-economic status is clearly one of the key factors affecting health and inequalities in health. Nolan has argued that the relationship between material deprivation and health outcomes is crucial (Nolan et al., 2000), a statement that has particularly significant implications for women. The Women’s Health Council’s report *Promoting Women’s Health; A population investment for Ireland’s future* (2002) identified disadvantaged women’s needs as one of the specific topics in women’s health proposed for priority action:

‘The needs of disadvantaged women have constituted a priority for the WHC in all its documents and submissions to date. It is clear that inequalities exist in relation to health in Irish society, those who live in poverty are subject to poorer or bad health, and women have a critical influence in relation to family and social support as well as to their own direct health needs. The WHC supports any initiative at policy, community, or health service level that addresses this situation of disadvantage, by reducing social inequality, promoting well-being, providing support for improvement in lifestyle and health practices and providing equitable access to healthcare’ (Women’s Health Council, 2002a).

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

In spite of this it is still almost impossible to say with any certainty how many women are disadvantaged, and in turn to gauge the extent of any health inequalities that may exist. The exact extent of health inequalities between the rich and the poor is conventionally assessed by examining mortality rates by occupation, with occupation considered as a measure of working conditions and socio-economic status. While this methodology may provide a reasonable estimation for the male population, it is not always suitable for assessing the situation of women. The coding of deaths according to socio-economic status can be particularly problematic since women ‘engaged in home duties’ are often coded according to their husband’s occupation. Within households the division of resources and living standards may not always be equal, so portraying the household as an income-sharing unit may mask significant inequalities between household members. Women’s true socio-economic status thus may not be accurately identified using their husband/partner’s occupation, making it difficult to gain an authentic picture of inequalities in Irish society (Conlon, 1999). It is also the case that women’s occupations are often missing from official statistics and where data does exist it shows that women tend to be concentrated into a limited number of occupational categories.
Reliance on mortality as a measure of health is also problematical because mortality is a singular, objective concept while health is subjective, complex and multidimensional. The Chief Medical Officers Report in 1999 acknowledged that research was urgently required to establish the extent of health inequality in Ireland and its complex causes. The recent commitment to adapt existing data systems to enable disaggregation of data on health access and outcomes across the National Anti-Poverty Strategy target groups is therefore a welcome development. It is particularly useful since the data is to be monitored and reported at national level, thereby drawing further attention to the extent and nature of inequalities that exist. The Combat Poverty Agency, in a recent study, identified a number of possible health indicators related to mortality, quality of life, healthy lifestyles, children’s health, mental health and access to services. These may in time provide a useful future direction in terms of obtaining a more accurate assessment of the extent and nature of health inequalities (Palmer and Rahman, 2002). The Women’s Health Council has also previously called for an improved information base on health to be developed, with improvements to be made in the collection and analysis of data on mortality and more especially on morbidity in order to better assess the health status of the population. The Council also recommended the disaggregation of all data along the lines of the nine grounds outlined in the Employment Equality Act 1998 and the Equal Status Act 2000; these are gender, marital status, age, disability, race, sexual orientation, religious belief, and membership of the Traveller community (Women’s Health Council, 2002b).

In the absence of reliable data it is difficult to accurately assess the extent and nature of health inequalities between men and women. It is clear, however, that more women than men experience poverty and disadvantage, and therefore it is reasonable to assume that women also experience more health inequalities than do men. Poverty and disadvantage in Ireland are not only widespread among women, but also graduated, affecting different groups in different ways, and some groups more than others. As Barry et al (2001) found, while women tend to live longer than men, women on lower incomes remain more likely to die at a younger age than those in better-off groups (Barry et al., 2001). It is also the case that women, because of their multiple roles within society, are generally regarded as a key link in health awareness and provision generally.

The particular circumstances, needs and roles of women regarding health have been recognised by Government in a number of policy documents published in the last ten years. These documents include Developing a Policy for Women’s Health (1995), A Plan for Women’s Health (1997-1999), both published by the Department of Health, and also the Women’s Health Council’s own Promoting women’s health: A population investment for Ireland’s future, launched by the Minister for Health in September 2002.
Women as One of the Most Disadvantaged Groups within Irish Society

Although income levels and socio-economic status are only partial indicators of disadvantage, they are a reasonable proxy in the absence of an alternative, given that they are among the key factors affecting health and inequalities in health in Ireland. From a poverty and disadvantage perspective, the concentration of women in low paid employment is a key issue. If eligibility for a medical card is used as an indicator of low income, there were about 1.2 million people (30% of the population) covered by a medical card at the end of 2001. Almost 56% of these were female (NESF 2002). In real terms, this means that in 2001 there were at least 672,000 women in Ireland living on low incomes. This group of women is clearly an ‘at risk’ group.

Specific Groups of Disadvantaged Women in Irish Society

The concept of disadvantaged women is a broad one which can be broken down further into a number of more specific groups each with their own particular needs and issues. It is disturbing to note that almost fifteen years since the publication of Daly’s Women and Poverty, many of the groups of vulnerable women she pointed out remain at risk of poverty today (Daly, 1989). In 1989, Daly pointed to women in ‘minorities’, women in the home, lone parents, and older women as groups in particular need. Not only are all of these groups of women still at risk, but further groups of women have emerged and been identified as being at a particular disadvantage in Ireland in the twenty-first century. These groups are examined in more detail in the sections that follow.

Carers

The Women’s Health Council’s report Women – The Picture of Health indicated that women form the vast majority of carers of the elderly (Conlon, 1999), a statement which has been borne out in recent studies of carers in both the South Eastern (Lane et al., 2000) and Western Health Boards (O’Neill and Evans, 1999).

This concentration of women in caring roles is at least partly due to the fact that social policies are still underwritten with the assumption that it is part of the role of women in society to assume caring responsibilities for others. The policy of community care outlined in Shaping a Healthier Future (Department of Health, 1994), with its emphasis on care for dependent groups being provided in the home by family members, had obvious implications for women and their health status. Similarly, the new Health Strategy document Quality and Fairness, with its aim of reconfiguring the primary healthcare system, places:

‘...a stronger emphasis on the community setting and emphasises the vital role individuals, families, communities and other sectors have in helping everyone to achieve their full health potential.’ (Department of Health and Children, 2001: 51)
In spite of society’s reliance on them, carers have been found to receive little social, practical or financial support from formal health services, despite their common experience of isolation, reduced social interaction, high levels of strain and psychological distress, and compromised health status (Conlon, 1999). The Western Health Board study found that many carers devoted all their time to their caring role, and described themselves as being ‘on call twenty-four hours a day’. Carers were also found to have significant worries about financial matters and to experience a range of negative physical (e.g. exhaustion), psychological (not enough privacy or time to themselves), social (did not get out or see friends and family as often as they would like) and financial consequences arising from their caring duties (Neufeld et al., 2002; O’Neill and Evans, 1999).

Women with Disabilities

At present there is a sustained lack of data on the situation of women with disabilities in Ireland. It has, however, been shown that there are consistently higher unemployment levels among people with disabilities, and households headed by a person with a disability or by someone who is ill have a 28% risk of poverty. The risk of poverty is heightened since in order to take up employment outside the home people with disabilities often incur added costs – transport and insurance costs, for example, may be higher than for people without disabilities. It has also been shown that there are also significant additional costs associated with having and living with a disability, for example, to pay for special foods or medication (National Disability Authority, 2001).

Women with disabilities face a range of difficulties on a daily basis which put their health and well-being under strain. Social exclusion is common in a situation where everyday participation in society and routine interaction with others is impeded by inaccessible buildings and services. Such inaccessibility may also mean that women with disabilities experience particular difficulty in obtaining basic health services. This can be due to architectural barriers but also due to the inaccessibility of medical equipment, such as examination tables, and transport to and from appointments.

As well as the physical difficulties, women with disabilities also face other barriers in accessing adequate and appropriate health services. For example, sexuality and reproductive health issues have not been given the same attention for women with disabilities as they have for other women or for men with disabilities (Thierry, 1998). Thierry (op. cit.) stated that women with disabilities are often treated as if they are asexual, and leading to a situation where women with disabilities are significantly less likely to have reproductive health checks, such as pelvic examinations, than are women without disabilities. Secondary conditions, the additional physical or mental health conditions that occur more frequently among people who already have a primary disabling condition, are also a serious concern for women with disabilities. The most frequently mentioned secondary conditions among women with disabilities include pain, osteoporosis, chronic bladder infections, fatigue, depression, and trouble with weight management (Thierry, 1998). Moreover, violence against women with a disability is more hidden than that against women without disabilities, while refuges and other support services for women who experience violence are not always adequately adapted to suit the needs of women with disabilities.
Older Women

Of the 11% of the total population in Ireland aged over 65 years in 2000, 53% were women (CSO, 2002). The 2000 Living in Ireland Survey found that, on average, income levels for the over 65s were 15% less than those of people under 65 years of age. Older women were found to be at particular risk of poverty, with elderly households headed by a female 2.5 times more likely to be poor than non-elderly households. On a European level, the average income of women aged 65 and over was found to be some 10% below that of men in the same age group and some 20% less than the average for people under 65 (Winqvist, 2002). In all EU member states the average income of women aged 65 and over living alone was significantly less than that of those living in households with other people. In Ireland, these women’s average income was found to be 40 to 50% below the average of people under 65. In fact, in Ireland the risk of poverty among women aged 65 and older compared to that of men in the same age group was particularly marked, so that the proportion of women over 65 with income below 60% of the median was over 10% higher than for men (Winqvist, 2002). This can be partly attributed to the fact that levels of social protection for older Irish people living alone are the lowest in the EU, with close links established between old age, poverty, living alone, and working in agriculture in particular.

Women are especially susceptible to poverty in older age because of their longer life expectancy than men and the increased levels of poor health associated with older age. Looking at mortality data it would seem, for example, that women are more susceptible to deaths from accidental falling due to osteoporosis and living to an older age (Conlon, 1999). Women are also prone to economic hardship later in life due to the numbers working in the home. If women withdraw from the labour market to work full time in the home, or take up part-time posts in order to fulfill family duties, this may lead to a situation where they will lack adequate retirement benefits and will not, for example, qualify for the higher State contributory pension (Wamala and Agren, 2002). This is particularly pertinent for women in Ireland affected by the ‘marriage bar’ who had to give up their jobs on marriage. This legislation was lifted in the 1970s with Ireland’s entry into the European Union and the introduction of the equality legislation, but many older women are still suffering the after effects. It is for this reason that the National Women’s Council of Ireland has called on the government to fully recognise the value of women’s unpaid work in the home in its provision of pensions to the over 65s:

‘Pension levels are determined by the years spent in paid employment and as women have tended to work in sectors where occupational pensions are not the norm, the penalty for years spent engaged in caring work becomes very evident. Many older women remain dependent now either on non-contributory old age pensions or on reduced rate contributory pensions because they looked after their families and were not entitled to pension credits for this work’ (National Women’s Council of Ireland, 2002).
Homeless Women

The most recent World Health Report stated that:

‘The most extreme health impact of housing is found among the poorest sectors of societies… Lack of affordable housing for low-income households may mean diverting family resources from expenditure on food, education or health towards housing needs’ (WHO, 2002).

Focus Ireland has estimated that there are at least 6000 homeless people in Ireland at any given time. The organisation suggested that these numbers are likely to persist because of the shortage of suitable emergency and permanent accommodation available in this country at present. Housing waiting lists rose from 15,000 to nearly 54,000 people between 1999 and 2001, with on average only 12,000 houses becoming available each year. The figures for homelessness are only estimates, and therefore probably conservative as they do not include what Focus Ireland termed the ‘hidden homeless’. This group is made up of families or individuals involuntarily sharing with relatives or friends, those in insecure accommodation or those living in housing that is woefully inadequate.

It is impossible to say what percentage of homeless people are female, as there is no definitive gender breakdown available for the data. It has been found, however, that homeless women face increased risks to their health than do both the general population and their male counterparts. Health problems appear to be magnified among women living out of home, and they and their children face a range of health needs and risks which are often overlooked. A recent research study carried out on behalf of the Royal College of Surgeons of Ireland and the Children’s Research Centre in Trinity College Dublin, stated that ‘homeless women are often insufficiently represented in studies of homelessness’ (Smith et al., 2001). One hundred homeless women participated in the study, most of whom, it was found, were young mothers with low levels of educational and skills achievements. The study found ‘very high levels of physical and psychological conditions’ in the sample population, as well as ‘very high levels of physical and sexual abuse’ and high levels of drug misuse. The homeless women interviewed were found to use health services quite frequently, but in spite of this reported confusion about GMS service entitlement and access, and many of their complaints remained untreated.

The relatively small amount of research specifically examining homeless women has found a definite link between domestic violence and homelessness (National Women’s Council of Ireland, 2000). In Carlson’s study of homeless women with children living in hostels, the majority reported that they had left home to escape violence or sexual abuse (Carlson, 1990).

Women who Misuse Drugs

The National Drug Treatment Reporting System (NDTRS), the national epidemiological database on drug misuse administered by the Health Research Board, has consistently found high rates of social deprivation among treated drug misusers (O’Brien, 2001). As Mayock and Moran pointed out:
‘Over the past two decades research in Ireland has consistently demonstrated a link between concentrations of drug use and various indicators of poverty and social exclusion, including unemployment, poor housing, one-parent families and low educational attainment’ (Mayock and Moran, 2001).

Although the numbers of women misusing drugs are generally lower than the numbers of men misusing – currently the male-female ratio in Ireland is 73-27 (Moran et al., 2001) – they are still a significant socially excluded group which experiences considerable health inequalities. Research has found that women in Ireland are more likely to suffer negative consequences from drug use than men; for example, women were more likely to report weight loss and abscesses than men, and they were also more likely to report mental health problems such as depression, suicidal tendencies, isolation and anxiety. A study carried out in the Merchants’ Quay Project, a Dublin voluntary agency providing services to drug users, found that women who presented for treatment were in general younger than men, and were more likely to have a sexual partner who was an injecting drug user, to report recent sharing of injecting paraphernalia and to have a medical card (Geoghegan et al. 1999, quoted in Moran et al., 2001). Moran et al. suggested that with the proportion of women in the drug using population increasing over time, these findings present serious health implications. Health promotion activities must be undertaken in relation to female drug misusers.

The misuse of drugs and/or alcohol can be used as a coping strategy by women being subjected to domestic violence. Research has shown that up to seventy per cent of women who misuse drugs have experienced violence, and that that female drug users are more likely than men to have been victims of sexual or physical abuse (Hedrich, 2000). However, these women may not have access to services designed to respond appropriately to them, such as specialised women’s refuges. Instead they may end up sleeping rough, or placed in bed and breakfast accommodation or emergency hostels for homeless women. Treatment services may be similarly inappropriate for such women, as a predominantly male environment may be very off-putting for them. Dunne (1994), in a study exploring the needs of fifty female drug users, found that ‘women-only support groups’ were most frequently mentioned when the women were asked what services were most important to them. This was followed by welfare, one-to-one counselling, crèche facilities, relaxation and parenting skills (quoted in Farrell, 2001).

Hedrich (2000) found that women drug users were perceived to be a hidden or hard to reach population and that they were in general under-represented as clients of drug services. She put forward two explanations for this:

‘...that societal expectations of appropriate gender behaviour make it more difficult for women to admit and seek help for problem drug use; and that services are inappropriate to women’s needs.’
The stigma attached to women who use drugs has been found to be greater than that for men, and this can inhibit their contact with drugs services – for example, women fear that seeking help for drug use could lead to their children being taken into care. Research has also shown that women continue to be the primary carers for children, a factor that might also limit their opportunities to seek help for drug use. In Ireland among drug users seeking treatment, 8.4% of women were lone parents compared to 0.8% of men (NFP Ireland, 1999 quoted in Hedrich, 2000). A recent study found that providing childcare facilities in drug treatment services not only made it easier for women to attend, but also communicated to women that the agency was sympathetic to and accepting of women drug users with children (Moran, 1999).

Although the National Drugs Strategy aims to provide an integrated response to the problems posed by drug misuse, and supports general initiatives to tackle social exclusion, additional measures must be put in place to deal with the particular needs of women who misuse drugs.

Traveller Women

Travellers are one of the most disadvantaged groups within Irish society with regard to socio-economic status and health inequalities. Many Travellers live in intolerable circumstances, and overall Travellers as a group have a much lower standard of health than the settled community, with different and significantly worse health and disease problems (Pavee Point, 1995). Infant mortality among Travellers is almost three times the national average, and only 1% of Travellers live to 60 years of age (Fay, 2002). Traveller women are particularly susceptible to poor health, and on average live almost 12 years less than settled women (Fay, 2002).

According to the Task Force on the Travelling Community (1995), Traveller women have higher fertility rates than the national average, with a rate of 18.1 per 1000 live births in 1991 compared to the national average of 7.4 per 1000. In particular, the Task Force noted that unhoused Traveller teenaged girls have markedly higher fertility rates than teenagers nationally. This is significant, not least because the incidence of still births, infant mortality and birth difficulties were found to be significantly higher among Travellers, and particularly among the non-settled Traveller community (Pavee Point, 1995). This finding was related to the existence of lower levels of antenatal care, maternal malnutrition during pregnancy, recurrent pregnancies with short intervals between each, and poor accommodation and housing for Traveller mothers. In general, Traveller women had a lower level of uptake and attended later for antenatal care, and a large number did not have any post-natal check-up (Department of Health Promotion Studies and Patricia McCarthy & Associates, 1995). Similarly, Traveller women’s ability to access information on preventative health care, such as screening, as well as sexual health care was found to be poor with a subsequently low take up of these services (National Traveller Women’s Forum and Pavee Point Travellers Centre, 2002).
Poverty and disadvantage hit Traveller women particularly hard, as they generally have the primary responsibility for taking care of the family. The accommodation they live in and lack of access to basic facilities, such as running water, have a negative impact on both the women’s health and the health of their families (National Traveller Women’s Forum and Pavee Point Travellers Centre, 2002). In their role as primary carer for the family, Traveller women generally take on the role of negotiator with the service providers and health professions, acting as a bridge between their families and health and other services and service providers. This means that it tends to be Traveller women who have the experience of direct discrimination from the health services, for example being refused services or being treated poorly, as well as extensive experience of indirect discrimination in dealing with both their own and their families’ poor health and the lack of health provision to meet their needs (National Traveller Women’s Forum and Pavee Point Travellers Centre, 2002).

The distinct and unmet needs of Traveller women are particularly obvious when examining the provision of services for those who have been subjected to domestic violence. Accessing refuges can be especially difficult for Traveller women, as they often have many children whom refuges will not be able to cater for, particularly teenaged sons. Without supportive accommodation available, Traveller women may not feel they can leave the home and access help. Added to this is the lack of culturally sensitive support services, and especially a lack of Traveller women working in services for those who have been subjected to domestic violence. Pavee Point and the National Traveller Women’s Forum (2002) have suggested that the employment of Traveller women as health service providers should be explored and implemented by Health Boards as a matter of some importance. This would include funding Health Boards to train and employ Traveller women as primary health care workers. This would go some way towards rectifying the problems around the lack of user-friendly, culturally appropriate information and services available to Traveller women.

As with all disadvantaged groups, the importance of the medical card cannot be overestimated for many Travellers. Poor health status, combined with larger than average families, means that access to free health care is a necessity for many. It has been suggested that it is partly fear of losing the benefits provided by a medical card that prevents some Traveller women from accessing employment and training opportunities. As a response to this concern, Pavee Point and the National Traveller Women’s Forum (2002) have proposed that the Traveller community retain their medical cards for five years after taking up employment, with a review at the end of the five year period.

The National Traveller Health Strategy, prepared in response to the recommendations made by the Task Force on the Travelling Community and published by the Department of Health and Children in 2002, goes some way towards tackling Traveller health needs. As well as providing for the establishment of a Traveller Health Advisory Committee in the Department of Health and for a Traveller Health Unit in each Health Board, the Strategy also made the following recommendations:
• Culturally sensitive training to be prepared in consultation with Traveller organisations and provided for all Health Board staff in contact with the Travelling community.

• Planning and provision of health services relating to Travellers to be carried out in partnership with the Travelling community.

• Emphasis to be placed on building a community development approach incorporating a permanent role for peer led services and the development of new roles for Travellers within the health services as planners, service providers and promoters, as appropriate.

• Health research on Travellers’ health needs to be encouraged, including a Traveller Needs Assessment and Health Status Study to update the last survey of Travellers Health Status published in 1987, and a working group on Traveller Ethics and Research to be established.

• Health education programmes to be developed, covering ante and post natal care, peer-led educational and awareness programmes on and greater access to family planning and sexual health services.

• Emphasis on equality proofing (or ‘Traveller-proofing’) of all services provided at both national and regional levels. (Department of Health and Children, 2002)

The Women’s Health Council endorses the recommendations laid out in the National Traveller Health Strategy, with the proviso that they be implemented in a gender sensitive manner, to take into account the differing health needs of women and men.

Asylum Seeker/Refugee Women

There is a great deal of confusion about the use of the terms ‘refugee’ and ‘asylum seeker’. A female refugee, as defined by the 1951 Geneva Convention, is a person who has been forced to leave her country due to well founded fear of persecution, and who is unable to return to her country of origin for reasons related to her race, religion, nationality, membership of a particular social groups or political opinion. Ireland has a legal responsibility to determine who is a refugee and to extend the necessary protection to such a person. Once a particular woman is recognised as a refugee she has virtually the same rights as an Irish citizen. An asylum seeker is a person seeking to be recognised by the 1951 Convention. An asylum seeker has a legal entitlement to stay in the state while her application is being processed. In Ireland, refugees/asylum seekers are dealt with in legislation under the 1996 Refugee Act. The provisions of this Act, implemented in 2000, provide for the independent assessment of asylum claims. The Act offers additional protection to women in that it distinguishes between the needs of male and female refugees.

Asylum seekers are currently catered for in Ireland under a system of ‘direct provision’. Under the scheme, asylum seekers are accommodated on a full board basis in communal centres, and they receive €19.10 per adult and €9.50 per child per week plus child benefit (National Consultative Committee on Racism & Interculturalism, 2002). In practice, direct provision means that asylum
seekers are not allowed to work or study, there is no specific provision made for mothers with babies or young children, and they cannot generally cook for themselves (Irish Refugee Council, 2003). The payments made to asylum seekers, which were unacceptably low even when they were established in 1996, were frozen in 1999 and are now seen by many as a direct cause of increased poverty and social exclusion (Irish Refugee Council, 2003).

Asylum seeking families, many of whom are headed by women, under direct provision in Ireland face extreme levels of income poverty which typically place them well below the 20% poverty line. This lack of resources can mean that such families do not even have the resources to ensure an adequate diet, leading to a range of negative effects on their health. A recent study of refugee families in Ireland, carried out by the Irish Refugee Council (2001), found extreme levels of deprivation among its sample population. The study found malnutrition amongst expectant mothers, ill health related to diet amongst babies, and weight loss amongst children. Poor health among children had a doubly negative effect on their parents, since as well as worrying about their children’s health, adults were also found to be going hungry in order to ration their available resources in an effort to provide for the needs of children and babies. The food provided in hostels under ‘direct provision’ was found to be inadequate to meet the needs of respondents, especially pregnant women and babies (Fanning et al., 2001). The great majority of survey respondents on direct provision (92%) stated that they considered it necessary to buy extra food to supplement the food provided in the hostel for themselves and their children. More than two-thirds (69%) stated they were unable to afford to purchase this extra food.

For women asylum seekers/refugees not in direct provision or looking for private accommodation, the key issues included saving a contribution for a deposit, racism from landlords and difficulties in getting advice and support in making the transition from direct provision to community living (Irish Refugee Council, 2001).

Current health provision for women asylum seekers is on the same basis as for Irish Nationals. They are entitled to a medical card to ensure access to health services and prescriptions free of charge. They are also entitled to exceptional needs payments and a voluntary medical screening. There are still issues that may restrict the ability of women to access particular services, however. In some cultures women would not seek support from male practitioner so additional female health workers and female interpreters may be needed. Furthermore, many of the women arriving to seek asylum in Ireland have suffered serious human rights abuses and may also have been separated from partners and/or dependent children. As a result, they may have additional physical and psychological health needs, and they may also require social supports. In this regard, Murphy-Lawless and Kennedy refer to the concept of cultural competency:

‘...the capacity of providers to effectively identify the health practices and behaviours of diverse populations and to thereby intervene and educate across cultural and language barriers’ (Murphy-Lawless and Kennedy, 2002).
The British Medical Association has put together a list of the particular difficulties of female asylum seekers around healthcare, which in some circumstances may also be relevant to ethnic minority women arriving in Ireland:

- Screening and health promotion programmes tend to have a low uptake among refugee women. Female asylum seekers should be offered appropriate sexual healthcare, family planning, and maternity care that is sensitive to their culture. They should be offered a choice as to the gender of the healthcare professional and interpreter.

- Female asylum seekers are less likely than males to speak English or to be literate but it is important to speak with them directly, using an independent interpreter rather than a family member. They are more likely than men to report poor health or depression. They may be lonely and isolated but often welcome the opportunity to belong to a group, where they may benefit from the contact and support.

- One specific problem for healthcare professionals to be aware of is female genital mutilation. In the UK, it is most common among women from Eritrea, Ethiopia and Somalia, and has been found to affect sexual health and childbirth. The BMA has accordingly issued guidelines for doctors with the request that ‘as appropriate, female and male asylum seekers should be educated on the dangers of FGM and made aware that it is unacceptable and illegal in [the UK].’

(British Medical Association, 2002)

Due to their continued role as primary caregiver in the family, women refugees/asylum seekers newly arriving in Ireland may face difficulties over and above those of their male counterparts. Neufeld et al., for example, suggest that women are affected disproportionately by the stress suffered by families on migration to a different country:

‘All family members experience acculturative stress. However, as cultural and intergenerational mediators, women are expected to uphold cultural traditions and gender roles while assuming increased responsibility for caregiving in the absence of relatives who would usually assist…’

(Neufeld et al., 2002).

Murphy-Lawless and Kennedy (2002), in their study of the maternity needs of refugee and asylum seeking women in Ireland, discovered a similar situation. They found that women migrating to Ireland carried a greater burden than did men in the same position, as women were ‘most commonly responsible for children and for filling the gaps of a wider traditional support structure which is fractured by migration’. The ICCL in their 2000 study also commented on the additional strain placed on women by their role as primary caregiver within the family. The paramount issue for the women who contributed to this study was the lack of culturally sensitive translation facilities available to women, while the need for all statutory services to distribute good explanatory information leaflets was also identified (ICCL Women’s Committee, 2000).
Taking up this theme, Murphy-Lawless and Kennedy identified a number of models of best practice for meeting the maternity healthcare needs of asylum-seeking and refugee women, some of which could be expanded and adapted to take the needs of other non-pregnant groups of women migrating to Ireland into account as well. These included:

- **The Primary Health Care Project for Travellers** is a model already in existence in Ireland which could be adapted and extended. In a similar vein, the Maternity Alliance pilot project in the UK is exploring a pilot project to employ women who have already been through the asylum process from the particular ethnic communities to be link workers for pregnant asylum seekers.

- **The Ethnic Care Provision Group in Northern Ireland’s Eastern Health & Social Services Board** is designing a handbook for healthcare professionals to deal with the varied information and specialist needs of non-nationals, under headings such as nationality, special considerations, diet, fasting, modesty, language and interpreters.

- **Telephone services such as Language Line** should be freely used. This is a London based company which provides its interpretation service to healthcare workers seven days a week, twenty-four hours a day. Interpreters have training in confidentiality and in health care and service provision issues.

- **Community Mothers Programmes** – some Dublin community care clinics are organising special mother and baby mornings, which as well as helping to meet the healthcare needs of women also perform a social function, so that women in similar situations have a structured way of meeting and forming support networks.

- **The provision of advocates** is seen as valuable for ethnic minorities, as interpreters or advocates can enable people to present their needs about services most fully. Access Ireland, a refugee integration project with a special focus on health and well-being issues, has just finished running a six-month pilot training programme in Cultural Mediation Skills, funded by European Refugee Fund through the Department of Justice and the Northern Area Health Board which could prove valuable in this regard. The aim of the training was to equip the mediators to act as link workers within the health and social services, supporting staff in delivering culturally sensitive services and making links with members of the minority ethnic community who might otherwise be hard to reach because of cultural and linguistic differences.

- **Equality proofing** must be undertaken on a wide scale to prevent any form of institutionalised discrimination, and health professionals and other people working in the health services should undertake race relations training to help them deal in a more positive way with the needs of women of various ethnic backgrounds.

(*Murphy-Lawless and Kennedy, 2002*)
Lone Parents

There has been a substantial rise in the number of lone parent families in Ireland since the early 1980s, with increases in both the numbers of marital separations and the number of births outside marriage. The vast majority of lone parent families are headed by women, who have been found to face a higher than average risk of poverty (Combat Poverty Agency, 2000). The 1996 Census found a total of 128,000 lone parent families, defined as a non-cohabiting parent living with at least one child of any age, in this country. More than four in five of these families were headed by women. Similarly, ninety-one per cent of the 2,326 lone parents with children under fifteen years identified in the 1997 Labour Force Survey were found to be female (Fahey and Russell, 2001). The ESRI estimated in the year 2000 that one in every four women raising children or managing households on their own would experience poverty – despite our economic boom and a growth rate of eight per cent at the time (Nolan et al., 2002).

Research has previously suggested that lone parents are more likely than their married counterparts to come from socially disadvantaged backgrounds, and to experience social problems including poverty, homelessness, and poor educational achievement (Leane and Kiely, 1997). Flanagan and Richardson’s (1992) study of non-marital births in the National Maternity Hospital suggests that their ‘average social class’ was skilled manual and McCashin’s (1996) qualitative study of fifty-three lone mothers showed that forty-six per cent had primary education or less. Education has been described in a study published by the ESRI as ‘the variable that is most likely to capture information on individuals’ social background prior to becoming lone parents. The study found that ‘lone mothers of all three types (unmarried, separated and widowed) have lower educational attainment than married/cohabiting mothers’ (Fahey and Russell, 2001). The National Women’s Council of Ireland (NWCI, 2000) has found that lone parents generally have low levels of educational attainment and related levels of employment status, with the majority of lone parents relying on social welfare payments as their main source of income. Lone mothers have also been found to be over-represented in local authority rented housing and in the private rented sector (Fahey and Russell, 2001).

Lone mothers are particularly ‘invisible’ within data currently being collected, for example Labour Force statistics, as the majority work full-time in the home rather than in the paid labour force.

Fahey and Russell (2001) found that between forty and fifty per cent of lone mothers were of ‘unknown’ social class for this reason. Among the remainder, lone parents were found to have a somewhat lower social class profile than married mothers, with fewer located in the higher professional/managerial class and more located in the semi-skilled and unskilled manual classes.

Apart from the generally lower levels of educational attainment among lone mothers, other barriers to employment have been cited by lone parents. Chief among these has to be the difficulty of accessing childcare, and in particular the absence of comprehensive state supported childcare (Fahey and Russell, 2001). This lack means that lone mothers are often reliant on informal sources of support to provide childcare, or they may be faced with a situation in which most of their wages go towards paying for the costs of private childcare. The emotional needs of children and the loss of secondary benefits, such as rent allowance, were also cited by lone parents as barriers to employment.
Fahey and Russell (2001) recommended that the following measures be developed and put in place to increase lone parents' chances of becoming fully independent of social welfare:

- Programmes to improve skills and educational deficits of lone parents.
- Affordable childcare.

Women Living in Rural Areas

The widely dispersed and hidden nature of rural poverty makes it difficult to tackle. The particular disadvantage faced by women living in rural areas was noted in the 1999 White Paper on Rural Development, which stated that:

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

Service depletion in rural areas may place more severe strain on women, as they often have responsibility for caring for others (children, young people, older people, and the sick). Often services just do not exist for women in rural areas and potential relief, such as participation in community activities, is not always readily open to women because of their caring responsibilities and issues around transport in rural areas. Wiley and Merriman (1996) found that living in a rural area had a negative impact on women’s health. This finding was borne out by a study of women who attended Symptomatic Breast Clinics carried out on behalf of the Women’s Health Council (Kennedy et al., 2000). Under the heading ‘treatment issues’, the women interviewed expressed great concern about the lack of radiotherapy and chemotherapy services available locally to them. Having to travel to access these services not only caused the women stress, it also had the effect of cutting them off from immediate support from their families at a point when such support was badly needed. The women interviewed also raised issues about the need to organise childcare while they were away. One of the key recommendations of the report was that women on low incomes who did not have a medical card should be enabled to reclaim travel costs incurred when accessing treatments from their Health Board.

The negative impact on women’s health of living in a rural area was further reinforced by the findings of a report produced by the National Cancer Registry. The study found regional variation in cancer treatment services, with only 24 per cent of women with breast cancer in the Western Health Board area receiving radiotherapy, compared with 42 per cent who live in the Eastern Regional Health Authority area (National Cancer Registry Ireland, 2003). At least part of the reason for the variation is explained by the uneven availability of radiotherapy services in the State.
Up to now Ireland’s two radiotherapy units have been based in Dublin and Cork, which had obvious implications for those not living in their vicinities. However, a new report has recommended that four radiation treatment centres be set up, two in the eastern region and one each in Cork and Galway (Expert Working Group on Radiation Oncology Services, 2003). If the Government decides to implement the expert group's proposals, the Women’s Health Council strongly recommends that the needs of women travelling to access cancer treatment services be fully addressed. This would have to include the provision of transport and of support services, such as childcare and respite services for Carers. If such needs are not taken into account, the result will be further inequity in the system.

A recent study on provision of counselling services for Irish women carried out on behalf of the Women’s Health Council found that the rural women sampled were further away from key services, had less access to transport, were less likely to be in employment outside the home and were more likely to be eligible for a medical card (Batt and Nic Gabhainn, 2002). This lack of counselling and support services in rural areas may act as a contributory factor to social exclusion. The Report of the Advisory Committee on the Role of Women in Agriculture (2000) clearly recognised this issue when it stated that:

‘…unless positive action is taken to afford rural women access to core services, the social exclusion of rural women will not be redressed’ (Department of Agriculture Food and Rural Development, 2000).

Lesbian Women

The Combat Poverty Agency’s report on poverty among lesbians and gay men showed that ‘discrimination and prejudice result in lesbians and gay men being disadvantaged and excluded from full participation in society’ (Gay & Lesbian Equality Network and Nexus Research Co-operative, 1995). The survey results clearly showed significant cumulative and interlocking processes of discrimination operating in key economic and social areas which increase the risk of poverty for lesbians and gay men – one fifth (21%) of respondents were living in poverty. Additionally, almost one-third of those who took part in the study reported being effectively homeless at some stage in their lives, many experienced bullying, harassment in the workplace or violence, and many reported that their job opportunities were severely narrowed through fear of discrimination. The vulnerability of lesbians and gay men was similarly noted in the NAPS report Sharing in Progress:

‘While homosexuality in itself does not necessarily place one at risk of poverty, the impact, experience and perception of discrimination may limit the full participation of gay men and lesbians in society, and may in some cases place them at risk of poverty’ (Government of Ireland, 1997: 71-72).

Such discrimination, on top of the burden of being financially less well-off, may also place lesbians at risk of poorer health. Although there is a dearth of knowledge surrounding lesbians’ health and health seeking behaviours in the Irish context, what little research exists in the international arena suggests that compared with heterosexual women, lesbians have higher rates of risk behaviours/
factors that put them at increased danger for poor health. For example, higher rates of smoking and alcohol use have been found among lesbians, and these women were also found to have a greater prevalence of overweight, and higher use of mental health services (Diamant and Wold, 2003, Spinks et al., 2000, Fethers et al., 2000). It is speculated in the literature that factors such as living in a largely homophobic society, internalised homophobia, fear of coming out, discrimination experiences, and the chronic stress associated with being a member of a stigmatised minority group may be responsible for the poorer mental health often experienced by lesbians. Suicidal ideation is a common manifestation of this poorer mental health, and it has been found to be particularly common among younger lesbians (Diamant and Wold, 2003; Spinks et al., 2000; Bagley and D'Augelli, 2000; Matthews et al., 2002).

When the opinions of lesbians were sought during the consultative process which preceded the publication of the Plan for women's health (op. cit.), the most serious health issue identified by them was the negative attitudes which they encountered when seeking care from the health services. This is clearly a serious issue, as research has shown that such negative experiences and interactions both discouraged many lesbians and gay men from seeking needed medical care (Diamant and Wold, 2003) or caused them to hide their sexual orientation from various service providers because of fear of prejudice and discrimination (Rose, 1998). Both factors have lead to a situation where lesbians are effectively invisible within the health care setting and thus often their needs are not appropriately met.

The particular situation of lesbians has been noted in official documents on health in Ireland. Lesbians were identified as a group of ‘women with special needs’ in the Plan for women’s health (op. cit.). The Plan stated that there is an onus on health personnel to be informed about lesbian health issues and to ensure that sexual orientation is not a barrier in accessing services. In order for these aims to be achieved, it will be necessary to provide education and training for staff members so that they are fully aware of, and sensitive, to the issues involved. Ways of ensuring that a non-discriminatory health care setting are to ensure that health care providers ask questions/take histories in an open and accepting manner which does not assume heterosexuality (Spinks et al, op cit). Similarly it has been suggested that an effective way of conveying a message of welcome and acceptance is through including lesbian and gay friendly literature or posters in waiting rooms (Rose, 1998).

The most recent health promotion strategy published by the Government (Department of Health & Children, 2000) also noted the particular needs of lesbians and gay men, and stated that ‘considerable progress’ had been made in the area of health promotion interventions for these groups. The Strategy recommended research into the health and lifestyle behaviour of lesbian and gay groups within the population; prioritisation of health promotion programmes; and working in partnership with lesbians and gay men to develop and adapt health promotion programmes to meet their particular needs. The Women's Health Council would recommend that the aims of the Strategy be implemented in full in order to address the needs of lesbians living in Ireland.
5 Impact of Multiple Roles on Disadvantaged Women’s Health
As the Women’s Health Council pointed out in *Promoting women’s health; A population investment for Ireland’s future*, women living in Ireland in the 21st century are expected to perform multiple roles in society. Together with participating in the labour market, women continue to perform their traditional roles as mothers, wives and carers (Women’s Health Council, 2002a). Murphy-Lawless (2002), in her interviews with women living in the north inner city in Dublin, found that a multiplicity of tasks characterised their everyday lives. Within three basic roles of carer, earner and life-giver, women spoke of their roles as mothers, wives, grandmothers, aunts, sisters, neighbours, workers, counsellors, community activists, anti-drugs activists, trainers and trainees (Murphy-Lawless, 2002). Research conducted in other countries has provided similar findings. In fact, Wamala and Agren found that in all industrialised countries women ‘retain the primary responsibility for domestic tasks, even though many women participate in the labour market’ (2002: 164).

The adverse effects on health of the stress which these multiple roles and competing responsibilities produce has been documented in previous Irish research. The role of wife and mother, for example, has been shown to be a significant stressor for women. Wiley and Merriman (1996) found that one in five married women and mothers had taken tranquillisers at some time, compared to only 7% of single women and those who had no children. Shire pointed out that the burden of this ‘Superwoman syndrome’ may fall particularly heavily on women from less well off backgrounds:

‘...women [in lower socioeconomic classes] must often work at multiple low-wage jobs to support their families, yet they are expected to retain the same functions of motherhood as non-working mothers do… The stress of trying to fill an impossible array of roles contributes significantly to poor health outcomes, whether directly (e.g. through compromised immune system) or indirectly (e.g. by smoking to alleviate stress)’ (Shire, 2002: 51).

The difficulty of achieving a balance between the demands of the family and work outside the home can be especially hard for women who have children, and can be a significant cause of stress for them. In this regard, the issue of parental leave is particularly relevant for women – it has been found that 84 per cent of those taking parental leave are women (Carmichael, 2002). Unlike in other EU countries such as Austria, Finland, Germany, and Sweden, where parents receive more than 18 weeks’ leave on a paid basis, in Ireland parental leave is unpaid and must generally be taken in a single block of 14 consecutive weeks (National Women’s Council of Ireland, 2002, Carmichael, 2002). It is recommended that parental leave be increased and remunerated in line with other EU countries, a move which would benefit disadvantaged women since unpaid parental leave currently impacts most heavily on them and reinforces the gap in incomes between men and women generally. In order to address the expectation that women are in the main responsible for childcare, it would also be important to ensure that parental leave and other ‘work-life balance’ measures are also available to fathers.
Women also take on a significant role in maintaining the health of their families and negotiating with service providers to take care of the family’s health needs. Shire (op. cit) noted that women are often responsible for family’s physician visits, for medication follow-through and for family diet, for example. Where poverty is an issue in the family, the burden of limited resources has been found to fall particularly heavily on women, who generally put the needs of their families before any needs of their own. It is widely known, for example, that when food is scarce women will cut back on their own allowance in favour of feeding the children (Polakoff and Gregory, 2002, McIntyre et al., 2003). Similarly, it has been found that women in low income situations have to make choices about whether to attend to their own health needs or to use their scarce resources to pay for the needs of their children instead (National Women’s Council of Ireland, 2002). In one study, the cost of a visit to a GP was found to be a barrier to people accessing services when ill and also to them availing of health screening, such as smear tests. This was particularly the case when the family’s income was just above the cut off point for medical cards (Cherry Orchard Concerned & Active Citizens Group, 1999).

As mentioned above, in the sections on Traveller women and on Asylum seeker and Refugee women, the burden of multiple roles can fall particularly heavily on those who also have cultural or other issues to deal with in Irish society. Traveller women, for example, often act as ‘go-between’ for their families and healthcare services and the settled community, a role which has been found to leave them open to higher levels of both direct and indirect discrimination in society. In their study of migrant women, Neufeld et al (2002) found in their study of immigrant women in Canada that the strain of their multiple roles was exacerbated by issues of immigration and inadequate language skills. For immigrant women

‘…migration can alter profoundly the structure of the social network and social interaction patterns in ways that affect caregivers’ access to support… relatives who would normally provide support to the family caregiver may not be available’ (Neufeld et al., 2002).

In addition, while migrant women may need work outside the home in order to meet the financial needs of themselves and their families, they are likely to run into barriers in spite of any professional qualifications they may have achieved in their countries of origin. Neufeld et al (op. cit.) found that a lack of recognition of foreign professional qualifications, combined with language difficulties meant that the range of employment open to the women they studied was extremely limited. In fact, most of the immigrant women they spoke with were found to work in ‘low-paying jobs that were inconsistent with their qualifications and failed to meet their expectations’.

It is impossible to consider the health impacts of poverty on women without considering their families, since women are more likely to include social relationships in their definitions of health, and to assess their own behaviour in terms of the health of others. Any analysis and recommendations made in relation to women, disadvantage and health, must therefore make reference to the multiple roles that women have within the home, the workplace, the social welfare system, together with their family situation and also the wider societal expectations placed on women (NWCI, 2000). It is only in this way that the real-life experience of disadvantaged women can be adequately captured and supported.
6 Recommendations
This position paper has outlined the particularly disadvantaged and unequal situation of women in Irish society, both in comparison to men and to the rest of Europe. It has demonstrated that, when considering notions of graduated and widespread disadvantage, women in Irish society are one of the groups whose needs particularly necessitate attention.

Research has shown that Irish women are at an increased risk of poverty compared to men, and also that some groups of Irish women experience higher levels of disadvantage relative to others. This is a long-standing situation. One of the seminal pieces of work on women and poverty was carried out in 1989 by Daly, and, worryingly, many of the situations she described almost fifteen years ago are still causing concern today. It is to be hoped that decisive action will be taken as soon as possible to address the situation, so that Daly’s work will not hold true in another fifteen years’ time.

The recommendations being presented by the Women’s Health Council have been grouped according to the Council’s four working areas: research, personal and community development, policy and legislation, and health service delivery.

A Research

Better Health Related Data Collection

• All data must be disaggregated along the lines of the nine grounds outlined in the Employment Equality Act 1998 and the Equal Status Act 2000. These are gender, marital status, age, disability, race, sexual orientation, religious belief, and membership of the Traveller community.

• The collection and analysis of data on mortality and, more especially, on morbidity should be developed in order to better assess the health status of the population and in order to better measure progress in achieving health and social gain for women.

• Data collection must be undertaken in such a way that it is possible to undertake analysis by gender across different socio-economic groups, but also in such a way that it is possible to be able to examine data held in the various databases by social class (rather than by occupation/socio-economic groups) and by gender. This would help to ensure that the status of individual women is fully analysed. Information systems should be developed or improved in this regard.

• Innovative methods of data collection should be developed to ensure that data are collected from all members of society, and in particular from previously ‘invisible’ women such as Travellers, the homeless, women with disabilities, lesbians, and groups such as asylum seekers and refugees.
• Currently health inequality indicators used in Ireland tend to focus on male economic status (male income level, male employment status and position as head of household) thus obscuring the economic position of diverse groups of women who may also be experiencing profound social and economic deprivation. There is scope to build on the work of the Combat Poverty Agency and develop a more broad reaching range of health based social inclusion indicators.

B Personal & Community Development

Workplace Improvements
• Conditions in the paid workforce must be improved in order to take the multiple roles of women into account. In attempting to make the workforce more ‘family friendly’ and provide a better work-life balance, attention should be paid to ensuring that schemes are gender proofed to facilitate men’s as well as women’s participation in both work and family life. Improvements should be made in the area of parental leave, to ensure that it is paid, extended to a level comparable to other EU countries, and available to both parents.

Healthy Community Initiatives
• It is important that community education approaches to supporting healthier lifestyles are promoted in order to fully take the needs of disadvantaged women into account. Some examples of good practice in the area are identified in the Women’s Health Council’s recently published Community Involvement for Women’s Health: Mechanisms for Primary Care Services report (Women’s Health Council, 2003).

Childcare
• The availability of affordable childcare is critical for women living in disadvantage as without it they will be unable to engage/re-engage in wider society. Childcare would help to combat social exclusion among women through providing them with a very real choice to return to work after having children. It is therefore essential that a substantial proportion of the resources available under the National Childcare Programme be targeted at the provision of these services.
• All health care services and labour market programmes should include childcare provision, to ensure effectiveness and accessibility to all women. Provision of childcare facilities within drug treatment services, for example, would help reduce stigma and encourage more women drug misusers to attend for treatment.
• Childcare should not just be linked to services for women – ‘family friendly’ policies should apply to men as well, and childcare facilities should be made available for fathers as well as mothers.
Additional Supports

- There is a need for increased support to be provided for Carers by the formal health services. Innovative forms of respite care should be provided, to allow carers a chance to participate more fully in society/live less isolated lives. This would contribute to improving carers’ mental health and reducing the burden on them both physically and mentally. Financial support for Carers should also be improved, as should awareness and take-up of the Carer’s Allowance.

C Policy & Legislation

Gender Sensitive Policy

- All policies, strategies and government initiatives should address the area of gender, in order to ensure that the needs of both women and men are targeted.
- Equity must be about more than access to health services; a broader focus must be adopted if the needs of disadvantaged women are to be met.

Income and Resources

- Disadvantaged women have a variety of social, educational and health needs and thus the multi-dimensional nature of their problem must be recognised. Their needs should be targeted in a more multi-sectoral and integrated way through the development of enhanced linkages between the various different service providers.
- A universal health care system should be developed where need, and not means, defines access.
- With the existing private/public health care divide, public health resources should not be used to supplement private care.

Medical Card

- Eligibility for the medical card should be widened by increasing the income threshold for adults and children, as promised in the Government Health Strategy.
- Medical cards should be introduced for all children. This would both improve children’s health and indirectly contribute to women’s health through increasing the amount of household income available for lower income families.
- Women on low incomes who do not have a medical card should be enabled to reclaim travel costs incurred when accessing treatments from their Health Board.
Review and Implement

- The recommendations made by the National Traveller Health Strategy (2002) should be implemented in full and in a gender sensitive manner.
- The system of direct provision and current levels of payments made to asylum seekers should be reviewed.
- The means-test for the Carer’s Allowance should be abolished.

Health Service Delivery

Appropriate, Equality Proofed and Culturally Sensitive Services

- Female healthcare staff should be available to women attending health services, and women should feel safe when attending health care or other treatment services. In some cases this may be achieved by ensuring privacy or separation from male clients.
- Care should be taken to offer female asylum seekers appropriate healthcare, sexual healthcare, family planning, and maternity care that is sensitive to their culture. Additional female health workers and female interpreters may be needed.
- Refuges and other services for women who have been subjected to violence must be equality proofed, in line with the nine grounds laid out in the Equal Status Act 2000, to ensure that they are accessible to all. This should include ensuring that services are adapted to address the needs of women with a disability, as well as ensuring that culturally sensitive support services are available for Traveller women and women from diverse ethnic backgrounds, such as asylum seekers and refugees.
- The Primary Health Care Project for Travellers should be adapted and extended to asylum seeking/refugee groups. Women from ethnic communities who have already been through the asylum process could be employed as link workers for other women seeking asylum.
- Advocates should be provided for women from ethnic minorities, to enable them to present their needs about services most fully.
- A lack of attention to sexuality and reproductive health issues for women with disabilities has been identified, as have continuing barriers to health services. These should be tackled, and training should be provided for health personnel to raise awareness about disability issues and to ensure that the needs of women with disabilities are not neglected in the future.
Training

- Sensitivity training for health care staff and professionals must be put into place in a wide range of areas, to raise awareness around the particular needs of the most disadvantaged groups of women in society.
- Anti-discrimination training should be provided by Health Boards in relation to a number of disadvantaged groups including Travellers, asylum seekers and refugees, lesbians, and women with disabilities.
- Cultural training is also required for those working in health care, to address the needs of Travellers and women from diverse ethnic groups now settling in Ireland. A handbook could be developed to deal with the varied information and specialist needs of these women, under headings such as nationality, special considerations, diet, fasting, modesty, language and interpreters.

Information and Consultation

- Care must be taken with the language used in providing information to the variously disadvantaged groups in society. Issues around literacy and language differences must be dealt with, and the need to provide non-written information in some cases must be taken into account.
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