

The report of

# The Gender Equity Project

What the “gender duty” provision  
of the Equality Act 2006 will mean  
for the health for men



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**by Surinder Sharma**  
**National Director of Equality and Human Rights**  
**Department of Health**

I am delighted to provide the foreword for this report which addresses this hugely important area of healthcare which has for too long been neglected. Equality, fair treatment and valuing diversity lie at the heart of the Department's drive to improve the health of the nation. In the Equality and Human Rights Group we actively promote innovative approaches to embedding these principles in our day-to-day work.

The Department of Health was pleased to support and fund the Gender Equity Project. The Government has made a manifesto commitment to put equality at the very heart of public service delivery, and projects such as this embody precisely this aim. I too, would like to add my personal commitment to gender equality in the delivery of healthcare services.

The Gender Equity Project is a welcome contribution to putting gender-sensitive service provision on the map, and in working towards reducing health inequalities.

I very warmly welcome the continued involvement and partnership-working between the Equality and Human Rights Group, the Men's Health Forum, and the Essex Primary Care Research Network in addressing men's health inequalities. I would also like to thank Bradford City Teaching PCT, Epping Forest PCT, South Worcestershire PCT, Southwark PCT and Uttlesford PCT for their valuable contributions.

I really value the partnerships that my team and the Men's Health Forum have developed to launch this key report at a national conference. The report will inform the Equality and Human Rights Group in the Department of Health, in preparation for the Gender Equality Duty.

It is equally important for NHS organisations to start to think about making a real difference in terms of health inequalities and access to healthcare, and this report will go a long way towards developing that thinking in a creative and imaginative way, to ensure that we provide appropriate and tailored healthcare services, which benefit all of our communities.

by **Peter Baker**  
**Chief Executive**  
**Men's Health Forum**

**T**he Men's Health Forum (MHF) has consistently held the view that in order to achieve the improvements to the health of men and boys that are so clearly needed, it will be necessary for health providers at local and national level to develop a "gender-sensitive" approach to statistical analysis, needs assessment, policy development and service provision. Arguments in favour of this approach are made in the MHF's over-arching policy document, *Getting It Sorted*<sup>1</sup>. Among its recommendations, this document proposes that local health planning should "address men's health issues as part of a consideration of gender as a determinant of health".

This is an idea whose time has come. The "gender duty" introduced by the Equality Act 2006 is intended to achieve a cultural change that will put the recognition of gender at the heart of policy-making and service provision across the public sector. The Gender Equity Project represents a serious attempt to get to grips with the reality of this idea in relation to health and within the context of the day-to-day business of PCTs – and indeed, of other NHS bodies.

The recommendations in *Getting It Sorted* are, naturally, couched in terms of the pressing need to improve the health of men and boys – and the Gender Equity Project concentrated largely on this same issue. It is beyond doubt however, that a gender-sensitive approach would also benefit the health of women and girls. There are a number of important female-specific health issues that require greater attention, as well as health issues affecting both sexes where women's particular needs are overlooked.

The Gender Equity Project was initiated by the MHF but would have been impossible without the support of the various partners whose involvement is explained in the text. In particular, the management and organisation of the project was shared with the Essex Primary Care Research Network without whose support the project could not have gone ahead and whose commitment to, and financial support for, this extremely important initiative is gratefully acknowledged. The project was largely funded by the Department of Health and it is immensely encouraging to us that the Department has shown such a willingness to embrace the spirit of the new legislation. This augers well for the potential achievement of the step change in male health that the MHF has long hoped to see.

**G**ender is a key determinant of health status. It is a central element in how effectively people use particular services and in the likelihood of particular health outcomes. The resulting inequalities affect both sexes in specific instances – but the health of men in particular is widely accepted as being poorer than it need be.

The Equality Act 2006 – which takes effect in spring 2007 – imposes a duty (the “gender duty”) on all public bodies (including health bodies) to take gender into account when planning and delivering local and national services. In effect, health organisations will have to work towards the achievement of more equitable use of services and more equal health outcomes between men and women.

The Gender Equity Project (GEP) explored the present state of knowledge and understanding of gender issues within primary care trusts (PCTs), and considered the likely impact of the new legislation. It also sought to find ways of ensuring that the gender duty is implemented as effectively and efficiently as possible within the NHS. The GEP had three component parts:

- 1 A survey of all English PCTs to establish the existing state of knowledge about gender issues, and the level of understanding and preparedness for the implementation of the gender duty.**
- 2 A “case study” of one particular aspect of current service provision within each of five PCTs who had a pre-existing commitment to tackling gender inequalities.**

- 3 A series of interviews with each of these five PCTs exploring the motivation for their commitment to the achievement of gender equity; the benefits to their PCT of having such a commitment; and the obstacles that they had encountered.**

The findings of the GEP indicate that the gender duty will address a pressing need, at least as far as health provision is concerned:

- ▶ The national survey suggested that PCTs have not, by any means, been as sensitive to this issue in the past as the new legislation intends they should be in the future.**
- ▶ The case studies confirmed that an individual’s gender makes a significant difference to the way he or she uses services, and to the outcomes that he or she might expect.**
- ▶ The interviews with the five PCTs revealed that they share a number of concerns about levels of understanding of this issue among their peers.**

Overall, the findings suggested that there may be a lack of both commitment and capacity to tackle gender inequalities in any wholehearted way. There is also a shortage of expertise in working specifically with men.

Five recommendations emerged from the project, incorporating the following eight specific courses of action that should be incorporated into national guidance for PCTs and other health bodies as they take on their new responsibilities.

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- 1 All datasets in regular use at both national and local level should be routinely collected, presented and considered in a form that is disaggregated by gender.**

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  - 2 Data made available to the general public (e.g. in media releases, information material, annual reports and so on) should also always be broken down by gender.**

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  - 3 Strategic Health Authorities should appoint a "Gender Lead" with responsibility to see that gender inequalities are tackled effectively.**

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  - 4 A model training programme should be developed that incorporates a programme for senior managers capable of being "cascaded down". The training programme should be backed up by an online resource aimed at NHS staff at all levels.**

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  - 5 An online searchable central database of good practice should be developed – preferably in advance of the implementation of the gender duty.**

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  - 6 PCTs should establish standing advisory groups of men and women whose role is to comment on local policy and practice from a "gendered" viewpoint.**

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  - 7 The Department of Health should establish an advisory group with a membership drawn from organisations with expertise in tackling gender inequalities. This group should have a brief to advise on policy and practice, and to scrutinise the implementation the gender duty.**

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  - 8 PCTs should be encouraged to review all existing local targets and wherever possible to re-write them in a form that is disaggregated by gender. Likewise PCTs should be encouraged to express all future targets in this way.**

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**O**ver the past few years there has been an increasing recognition of gender as a central determinant of health status. In 2003 the Department of Health (DH) published guidance for mental health practitioners on effective working with women<sup>2</sup> that recognised gender as an important and relevant factor in that particular field. That guidance suggested there was “a strong evidence base” for “the need for gender sensitive and gender specific services”. In the same year the Gender and Health Partnership – a coalition of individuals and organisations concerned with the health of women and men – organised the first Gender and Health Summit. This landmark conference confirmed the commitment of the partner organisations to press the case for taking gender into account in policy-making and service provision<sup>3</sup>. The following year saw the publication of the MHF report, *Getting It Sorted*, which made a serious attempt to look at how best to incorporate the specific needs of men into policy-making at both national and local levels.

2004 also saw the publication of *National Standards, Local Action*<sup>4</sup>, the planning guidance for The NHS Improvement Plan. *National Standards, Local Action* marked a shift from the pre-existing approach of national health targets. This new, more flexible, approach aimed to “create more headroom for PCTs [Primary Care Trusts] to set local targets in response to local needs and priorities”. In order to establish a framework for these local targets, National Standards, Local Action outlined seven key underpinning principles for local decision-making. The third of these principles was that targets should be set in such a way that they “deliver equity”. In seeking to achieve this objective, PCTs were

advised that they would need to demonstrate that they:

*... have taken account of different needs and inequalities within the local population in respect of area, socio-economic group, ethnicity, gender, disability, age, faith and sexual orientation ...*

The appearance of the word “gender” in this list was significant. There had been very few previous DH documents in which gender had been formally recognised as intrinsic to the group of population characteristics that are associated with unequal health status. Certainly no previous examples had been so explicitly linked to a requirement for action.

Finally – and most importantly – in the Queen’s Speech in November 2004, the Government re-affirmed its long-standing commitment to introduce a statutory duty on all public bodies to prohibit sex discrimination in the exercise of public functions and “to promote equality of opportunity between men and women”. The subsequent Equality Bill was introduced into parliament in May 2005 and received Royal Assent in February 2006.

The Equality Act 2006 (as it now is) also included provision to amalgamate the UK’s various existing equality agencies into a single new Commission for Equality and Human Rights (CEHR), and made discrimination on grounds of religion or belief unlawful. Its importance here however, is in its establishment of an unequivocal commitment to achieve gender-equitable policy-making and service provision. This element of the Equality Act takes effect from 6th April 2007 and has become known as the ‘gender duty’. This latter term is the one that will

be used throughout this report to refer to this provision of the Equality Act. At time of writing the final and precise detail about what public authorities will need to do in order to comply with the new duty is still being formulated, but they will certainly have to have Gender Equality Schemes in place by the effective date and thenceforward will need to ensure that all major developments in policy and services are subject to a “gender impact assessment”.

It is crucial to note that the clear intention of the gender duty is to achieve differences in outcomes – not just differences in processes. Also, the onus will be on public authorities to be pro-active in tackling and eliminating discrimination, rather than relying on individual complainants to draw attention to inequalities, as has been the case with some anti-discrimination legislation in the past. In essence, the NHS as a whole will, from April 2007 onwards, need consistently to address the following questions, which are drawn from the Equal Opportunities Commission’s draft Code of Practice for the new legislation:

***Is there any evidence that women and men have different needs, experiences, concerns or priorities in relation to the issues addressed by the policy?***

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***Of those affected by the policy, what proportion are men and what women?***

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***If more women (or men) are likely to be affected by the policy, is that appropriate and consistent with the objective of the policy?***

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***Could the policy unintentionally disadvantage people of one sex or the other? It is essential to consider not just the intended consequences but also any unintended consequences and barriers that might prevent the policy being effective for one sex or the other.***

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# A note about definitions

## “Equality” and “equity”

There is often confusion about the different meanings of the terms “equality” and “equity” and their opposites “inequality” and “inequity”. There is some overlap between these terms and they may be used interchangeably in some contexts but they are not synonymous. Throughout this report we have tried to adhere to the commonly accepted principles that underlie the numerous official and academic definitions of the two words and the differences of emphasis between them. In essence, this is to say that an inequality is a straightforward measure of difference and does not necessarily reflect an injustice or a situation capable of change – although of course it very well may do. An inequity, on the other hand implies a potential lack of fairness, and it is often the case that the imbalance could be redressed by using resources in a different way. The key point is that resources delivered equitably are resources delivered on the basis of demonstrable need. The following passage from the World Health Organisation’s “Health Promotion Glossary” is written in the context of global health development but it summarises the key ideas nicely:

*The WHO global strategy of achieving Health For All is fundamentally directed towards achieving greater equity in health between and within populations . . . This implies that all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal lifestyle*

*choices. Inequities occur as a consequence of differences of opportunity which result for example in unequal access to health services, nutritious food, adequate housing and so on. In such cases inequalities in health status arise as a consequence of inequities in opportunities in life.*

## “Sex” and “gender”

The official or academic difference of definition between “sex” and “gender” is more distinct than that between “equity” and “equality”. It is undoubtedly the case however, that in common usage and indeed in many official documents, the two words are frequently used interchangeably. This is so much the case that it is almost reaching the point that it is unhelpful to insist on marking the difference. Nevertheless, throughout this document we have tried to stick to the accepted distinction between the two terms – although this is not always possible where we are quoting from other sources or where a term already in common use has adopted the “wrong” usage. The passage below from the World Health Organisation’s “Madrid Statement” on gender equity in health sums up the difference:

*The word “gender” is used to define those characteristics of women and men that are socially constructed, while “sex” refers to those that are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men.*

In other words, a person’s sex is a simple biological fact but his or her gender is a function of the behaviours, attitudes, values and beliefs that a particular cultural group considers appropriate for males and females on the basis of that biological fact.

# The present position

**G**ender inequalities in access to health provision and in take-up of services are commonplace. There are also very significant inequalities between men and women in disease incidence and health outcomes. In the case of health outcomes, biological and physiological differences between the sexes make some variations inevitable but it is commonly accepted that these factors alone often do not amount to a satisfactory explanation. Although mortality rates are a blunt instrument for measuring the experience of health and well-being, the ultimate consequence of all these inequities and inequalities is that men are more likely to die than women at all ages. A paper considering the evidence specifically in relation to mortality rates concluded that:

*... comparison of international variation in sex differences in mortality shows, that even if the biological make-up of women gives them a mortality advantage, it is not sufficient to explain today's variation in developed countries<sup>5</sup>.*

The paper adds that "social, environmental and behavioural factors play an important role" in explaining the sex differences in mortality rates. These groups of factors, of course, include both the way health services are provided, and the way men use them. Such factors are susceptible of change. Even "behavioural factors", which seem the most intractable, can, once they are recognised, be taken account of in policy-making and in the planning of service provision.

A range of examples which demonstrate the present position is given in the two sections below.

## Access to services and take-up of services

- ▶ **Men are much less likely to visit their GP than women. Under the age of 45, men visit their GP only half as often as women. It is only in the elderly that the gap narrows significantly – and even then women see their GP measurably more frequently than men.**

Office for National Statistics.  
*General Household Survey 2003.*

- ▶ **Despite the much higher prevalence of overweight in men, men are massively under-represented in weight management programmes in primary care. For example, only 26% of participants in the national primary care "Counterweight" intervention are men, and only 12% participation by men was achieved in a pilot partnership programme involving "Slimming World". Men are also much less likely to have their weight routinely recorded by their GP.**

Men's Health Forum. *Hazardous Waist? Tackling the epidemic of excess weight in men.* 2005.

- ▶ **Chlamydia infection is equally prevalent in both sexes but the most recent figures from the National Chlamydia Screening Programme show that only 17% of those screened opportunistically are men.**

Department of Health. *Annual report of the National Chlamydia Screening Programme in England 2004/5.* 2006.

- ▶ The pilot programme for the National Bowel Cancer Screening Programme to be launched in 2006, offered voluntary screening to almost half a million people. It achieved much lower take-up among men (52% of eligible men compared to 61% of eligible women)<sup>1</sup>. The death rate for colorectal cancer is 24.7 per 100,000 in men compared with 14.7 per 100,000 in women<sup>2</sup>.

<sup>1</sup> Department of Health. *Evaluation of the UK Colorectal Cancer Screening Pilot: Final Report*. 2003.

<sup>2</sup> Cancer Research UK. [www.cancerresearchuk.org/statistics](http://www.cancerresearchuk.org/statistics)

- ▶ A study of patients using NHS smoking cessation services during a six month period in 2002 found that of 107,000 people setting themselves a "quit date" only 46,000 were men compared to 61,000 women<sup>1</sup>. This is despite the fact that 28% of men smoke compared to 24% of women<sup>2</sup>.

<sup>1</sup> Department of Health statistical press release. *Statistics on smoking cessation in England, April to September 2002*.

<sup>2</sup> Office for National Statistics. *General Household Survey 2003*.

## Disease incidence and health outcomes

- ▶ Average male life expectancy is about five years lower than average female life expectancy (75.7 years against 80.4 years). The gap is greater in lower social classes.

Office for National Statistics. *Health Statistics Quarterly No. 26*. 2005.

- ▶ Men are twice as likely as women both to develop, and to die from, the ten most common cancers affecting both sexes.

Men's Health Forum. *National Men's Health Week 2004 Briefing Paper: Men and Cancer*

- ▶ Men (65.4%) are significantly more likely than women (55.5%) to be overweight or obese<sup>1</sup>. Men are consequently much more likely than women to suffer from the co-morbidities of overweight and obesity including cancer (see above), coronary heart disease and metabolic syndrome (24.6% of men, 17.8% of women<sup>2</sup>).

<sup>1</sup> Department of Health. *Health Survey for England 2003*

<sup>2</sup> Villegas et al. *Prevalence of the Metabolic Syndrome in Middle-aged Men and Women*. *Diabetes Care* 26. 2003.

- ▶ **Three times more men than women die from suicide.**

Department of Health. *National Suicide Prevention Strategy for England*. 2002

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- ▶ **Pedestrian accidents are the leading cause of accidental death and serious injury to children. Boys are twice as likely to be killed or seriously injured in this way than girls.**

Child Accident Prevention Trust. *Child Pedestrians Factsheet*. [www.capt.org.uk](http://www.capt.org.uk)

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- ▶ **In 2004, 2110 boys died under the age of five from all causes compared to 1710 girls<sup>1</sup>. 60% of sudden infant deaths occur in boys<sup>2</sup>.**

<sup>1</sup> Office for National Statistics. *Population Trends 121*. 2005.

<sup>2</sup> Office for National Statistics. *Health Statistics Quarterly*. 1999.

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Although it is not the primary concern of this report, it is important to point out that there are also significant areas of concern in relation to both service provision and health outcome, where disadvantage is experienced disproportionately by women. These inequities and inequalities are no less important than those that have an impact on men and it is not the intention of this report to imply otherwise. The general principles for improvement that have been identified as a consequence of the GEP will, if equally applied, contribute equally to the improvement of the health of both sexes.

# Project structure and organisation

**T**he gender duty affects all areas of public policy and provision (i.e. not only health policy and provision) but, as we have seen, it has arrived at a particularly favourable time for the development of policy and practice within the field of health. In order to inform the debate about gender equality in health, and with the intention of assisting in the development of a useful knowledge base, the Men's Health Forum decided in 2005 to initiate a project that would:

- ▶ **Give some indication of the present state of knowledge and commitment within PCTs in relation to the achievement of gender-equitable policies and services**

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- ▶ **Begin to identify and disseminate good practice**

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- ▶ **Explore some of the motivating factors, and identify some of the obstacles, within a group of PCTs that had already demonstrated a willingness to tackle gender inequalities**

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- ▶ **Contribute towards the development of a "template" for conducting gender equity audits**

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Five PCTs were recruited to participate in the project. These "partner PCTs" were already known to have a particular interest in developing "male friendly" services – and therefore already to have thought about some of the issues associated with delivering services that take the issue of gender into account. The partner PCTs exhibited a broad range of geographical and demographic characteristics including rural, urban and suburban areas; areas of differing economic

status; and, in two cases, significant black and minority ethnic (BME) communities. Two of the PCTs (asterisked) are among the DH's "Spearhead" group of PCTs that are in the bottom fifth nationally for particular markers of health inequalities and where particular efforts are being made to tackle the associated problems. The five PCTs were:

- ▶ **Bradford City Teaching PCT\***

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- ▶ **Epping Forest PCT**

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- ▶ **South Worcestershire PCT**

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- ▶ **Southwark PCT\***

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- ▶ **Uttlesford (Essex) PCT**

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A sixth PCT, Airedale (Yorkshire), was also involved in the project at the outset but subsequently had to withdraw because of a shortage of staff time to undertake the case study.

It is acknowledged incidentally, that the responsibilities and administrative structure of all PCTs, including those involved in the GEP, will have changed by the time this report is disseminated. It is also acknowledged that the internal pressures associated with planning for the forthcoming changes to PCTs, which happened to coincide with the GEP, did not create a particularly conducive climate. This enhances the gratitude of the MHF for the willingness of the partner PCTs to take part in the GEP so constructively. As will be seen, despite this unhelpful circumstance, the GEP has nevertheless produced useful and generalisable information and outcomes that will be transferable to the new primary care organisations.

The GEP was managed by a project management group including a representative from each of the MHF, the DH, the EPCRN, and each partner PCT. Although the partner PCTs each had an established interest in men's health, they were all also interested in the issue of gender equality more broadly. Nevertheless it was recognised as important to ensure that the GEP took specific account of the implications of its findings for the health of women, and the Pennell Initiative for Women's Health (now incorporated into Help the Aged) was invited to join the management group to ensure that this happened. The Equal Opportunities Commission (EOC) was also represented on the management group because of its formal interest in the progress and implementation of the gender duty. The management group was chaired by Professor Alan White of the Centre for Men's Health at Leeds Metropolitan University and Chair of the MHF. The GEP was funded by the DH in partnership with the Essex Primary Care Research Network (EPCRN) with additional contributions in kind from the latter organisation and the MHF.

A part-time Project Co-ordinator was employed to work on the GEP for eight months from October 2005 until June 2006. The Co-ordinator was employed by, and based at, Tendring PCT in Essex, for whose support the MHF is extremely grateful.

A full list of members of the GEP management group is given at Appendix 1 and brief pen pictures of the partner PCTs are given at Appendix 2.

The GEP had three practical elements:

- ① **A "snapshot" survey of all English PCTs to establish the existing state of knowledge about gender equity; and the level of understanding and preparedness for the implementation of the gender duty.**

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- ② **A "case study" of one particular aspect of current service provision within each of the partner PCTs. These case studies had two objectives. First, to examine the service for equity; second to enable an exchange of views among the partner PCTs that would shed light on the generalities arising from their shared experiences.**

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- ③ **A series of interviews with each partner PCT exploring the motivation for their commitment to the achievement of gender equity; the benefits to their PCT of having such a commitment; and the obstacles that they had encountered. The objective of the interviews was to identify lessons that were generalisable to all PCTs.**

Each of these elements of the GEP will be described separately in the three sections that follow.

# National “snapshot” survey

## Process and methodology

It was decided that the survey should take place online for ease of completion and to encourage participation. The intention was that the questionnaire should be as brief as possible, consistent with meeting its obvious objective of obtaining relevant information. All planning and development of the survey took place in partnership with members of the GEP group. A draft of the questionnaire was piloted in each of the partner PCTs, where it was completed by a senior member of staff who had not previously seen it. Ten questions were developed in total. Nine of the questions required “tick box” responses. At the end of the survey, there was an “open-ended” question inviting PCTs to submit examples of good local practice.

It was agreed that the invitation to participate should, by preference, be sent directly to Directors of Public Health (DPHs) in order to ensure that the responses had maximum authority. In the event however, gaining access to a contact list of DPHs across 302 PCTs proved to be difficult. Indeed it was not possible to obtain an e-mail address of any kind for some PCTs. Of the 279 invitations that were sent, 155 were sent directly to DPHs and 124 were sent to PCT “enquiries” email addresses with a request that the e-mail be forwarded to the DPH.

The survey questionnaire was posted online on February 1st 2006. The e-mails of invitation to participate were sent on the same day.

## Results of the survey

55 responses were received by the initial closing date (a response rate of 20%). Following a reminder e-mail, a further 34 responses were received. In total therefore, 89 responses were received, giving a response rate of 32%. It should be borne in mind when looking at the tables below that, in all probability, those PCTs who responded to the survey are those more likely to have an interest in gender equity issues. In other words, the survey may present a more positive view than is actually the case.

The questions in the questionnaire were relatively straightforward, so the results are presented here with little comment. A fundamental observation however, is that few respondent PCTs were able to state with confidence that they consistently account for gender differences when formulating policy and/or designing services (Tables 1 and 2). This however, is precisely what PCTs will be required to do after April 2007 – and indeed, arguably, are already expected to do by *National Standards, Local Action*.

This point is emphasised by the survey findings in relation to local data usage (Tables 5, 6 and 7) which demonstrate that only a minority of PCTs always examine gender disaggregated data during decision-making processes. Clearly, such a fundamental absence makes gender equitable planning and provision virtually impossible.

Question 9 in the survey offered respondents who did not routinely use gender disaggregated data the opportunity to explain in more detail why that was the case. Only two PCTs took up this invitation in any detail but both gave the same explanation – that the problem lay with the Quality and Outcomes Framework (QOF):

**“The increased use of primary care data – through QOF – has increased our knowledge of local needs but has reduced the proportion of time we look at data disaggregated by gender”**

**“Data that is easily accessible to the PCT is in line with GMS contract and Quality and Outcomes Framework which do not require gender specific information.”**

The question about preparedness for the introduction of the gender duty (Table 4) has clearly been overtaken by events but it is perhaps, not entirely encouraging for the future implementation of the duty that at the time the Equality Act was receiving Royal Assent and its implementation timetable was well established, 13% of respondents were still not even aware of its existence.

**Table 1: 89 responses**

**Does your PCT consciously take into account the differences in health needs, behaviours and attitudes between men and women when developing public health policy?**

Always	19	22%
Often	31	35%
Sometimes	28	31%
Rarely or never	4	4%
Not sure / don't know	7	8%

**Table 2: 84 responses**

**Does your PCT seek consciously to ensure that the services your PCT provides or commissions are delivered in such a way that they are used by men and women in direct proportion to differences in needs?**

Always	12	14%
Often	22	26%
Sometimes	39	46%
Rarely or never	6	7%
Not sure / don't know	6	7%

**Table 3: 81 responses**

**Is your PCT aware of the obligation to deliver improved health equity (including improved gender equity) contained in National Standards, Local Action?**

Yes, our PCT is fully aware of this obligation	58	72%
Our PCT takes account of this obligation but it is not our highest priority	20	24%
No, our PCT is not aware of this obligation	3	4%

**Table 4: 79 responses**

**Is your PCT aware of the “gender duty” (GD) in the Equality Bill that will be placed on all public sector bodies from 2007 to “promote equality of opportunity between men and women”?**

Yes, our PCT is aware of the GD and is preparing for its implementation	31	39%
Our PCT is aware of the GD but has not yet begun to plan for its implementation	38	48%
No, our PCT is not aware of the GD	10	13%

**Table 5: 78 responses**

**Please consider HEART DISEASE as an example area of service provision; to what extent are the data used by your PCT in planning and decision-making routinely examined in a form that is disaggregated by gender?**

Always	23	30%
More than half the time	22	28%
Less than half the time	12	15%
Never	5	6%
Not sure / don't know	16	21%

**Table 6: 78 responses**

Please consider **CANCER** as an example area of service provision; to what extent are the data used by your PCT in planning and decision-making routinely examined in a form that is disaggregated by gender?

Always	24	31%
More than half the time	23	29%
Less than half the time	12	15%
Never	3	4%
Not sure / don't know	16	21%

**Table 7: 77 responses**

Please consider **DIABETES** as an example area of service provision; to what extent are the data used by your PCT in planning and decision-making routinely examined in a form that is disaggregated by gender?

Always	15	19%
More than half the time	18	23%
Less than half the time	16	21%
Never	6	8%
Not sure / don't know	22	29%

**Table 8: 89 responses**

If you have answered "never" or "less than half the time" to any of the preceding questions, why is this?

Answered "always" or "More than half the time" to all preceding questions	32	36%
Data not routinely collected in a form easily disaggregated by gender	17	19%
No demand for gender disaggregated data in the planning process	15	17%
Lack of capacity to disaggregate the data by gender	16	18%
Other reason (please specify)	9	10%

In addition to the online questionnaire, a brief search of PCT websites was undertaken in order to examine whether locally-set targets are generally sensitive to the issue of gender as a determinant of health status. In common with practically all national health targets of recent years, it was clear that local targets tend to be expressed in "gender-unaware" terms – i.e. targets might be differentiated by age, social class or ethnicity but almost never are differences between men and women taken into account.

# Case studies in the five partner PCTs

## Process and methodology

The GEP management group met first in January 2005. Each PCT subsequently identified a specific area of provision within which it would undertake a small scale case study in relation to gender equity in service provision. The group then held a day-long event in June of the same year, at which each PCT reported on its findings. After all the presentations had been completed, the group members debated their various experiences in order to identify common themes, and to share learning and thoughts on the best way to make progress.

The case studies are summarised below. Again, little additional comment is necessary. It is clear that there are important differences by gender in terms of disease incidence, attitude to services, and use of services. The PCTs largely chose to conduct their case studies in areas where men are disadvantaged in one way or another (that being the more common circumstance anyway as we have already seen) but even so, examples of the particular needs of women also emerge. The important inter-relationship between men's and women's health can also be seen in the Uttlesford PCT case study where it is observed that if men are twice as likely to suffer a heart attack, then women, by and large, are twice as likely to become carers.

## Bradford City Teaching PCT

Bradford City Teaching PCT decided to conduct a statistical analysis of secondary data held by the PCT to identify any differences in experience and outcomes between men and women. This was the broadest in scope of the five case studies and was made possible by the availability of a group of medical students on

a public health placement who undertook the audit as part of their course work. As well as providing a case study for the GEP, the data analysis also formed the basis of a report for the PCT "to inform its commissioning and provision of gender sensitive services".

It is not possible to present all the findings in this report but it is noteworthy that very distinct gender differences in disease patterns, risk factors and service use were observed. Some summarised examples of the findings from the study are as follows:

- ▶ **All but one of the ten disease areas examined exhibited different levels of incidence between men and women – with each sex at greater risk of some particular conditions.**

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- ▶ **The only condition with equal incidence rates overall was cancer. All four cancers examined in more detail however (skin cancer, colo-rectal cancer, stomach cancer and lung cancer) had significantly higher mortality rates for men. [Author's note: rates overall are equalised by the dominance of sex-specific (or largely sex-specific) cancers (e.g. cervical cancer, breast cancer) as causes of morbidity and mortality in women].**

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- ▶ **Men were twice as likely to be regular smokers.**

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- ▶ **Under the age of 65 women were very much more likely to attend GP surgeries (between the ages of 25 and 34, women were almost three times as likely as men to see their GP). If evening visits to GPs are considered separately however, then men are more likely to attend than women in many age groups.**

- ▶ Under the age of 55, men were much more likely to attend A&E. After that age, the pattern reversed, with women in particular, far more likely to be seen at A&E over the age of 85.

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## Epping Forest PCT

Epping Forest PCT had previously recognised that there are health inequalities that vary by gender, with men often adversely affected. As a consequence, the PCT undertook three small-scale studies aimed at establishing whether any male-specific services had developed locally in response to the resulting need; and exploring some of the reasons why men might be less willing to use existing services.

- ▶ A qualitative study interviewed groups of male hairdressers, police officers and builders about their attitudes to personal health. The study suggested that men would be prepared to attend for a check up if given an appointment and time; men would like to be able to drop in for a health "MOT" in a setting convenient to them (i.e. not necessarily a GP surgery); that men wouldn't mind who they saw for a check-up (i.e. doctor or nurse) as long as that person had the necessary knowledge and skills; and that more health education at school would be useful.
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- ▶ A telephone audit of all GPs in the PCT established that there were no specific "Well Man" clinics. All the practices at the time had Well Woman clinics running regularly. When asked if a specific appointment could be made for a men's health check, one practice said it could not be done by a nurse and required an appointment with the GP.
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- ▶ A randomised trial of 300 men aged 25 – 45 registered with a particular general practice was undertaken. One group was given invitations for a check-up with date and time of appointments; a second group was asked to make their own appointment; and a third group was offered open access. Just over half of the men given a specific date and time attended the surgery but the other two groups were less likely to take up the offer of a check-up. The exception was older men, who were likely to use the open access route.
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An audit of hospital admissions completed in 2004 suggested that proportionately more males than females are admitted to hospital for general surgery, general medicine, critical care and paediatrics.

## South Worcestershire PCT

The South Worcestershire case study is still in progress at time of writing. It is investigating a conclusion reached previously within the PCT that more elderly men than elderly women are in the "high-risk" group for hospital admission (that is, typically, a patient aged 65 or over who has two or more emergency admissions in a 12 month period). In particular it is known that men aged 75 – 84 are more likely than women to have multiple admissions.

The case study is qualitative and aims to explore the patient's experience of healthcare provision and to explore elderly men's knowledge of the availability of community support services – particularly those services provided by the voluntary sector. The case study will use a "discovery interview" technique which allows patients to share

their personal stories with those professionals involved in the care pathway. This should enable both parties to understand more about the needs and experiences of the other and ultimately to help develop services which take more account of the patient's circumstances, attitudes and behaviours – in this case, from a gender-specific perspective.

## Southwark PCT

Southwark PCT carried out two case studies. The first examined the use of smoking cessation services, the second considered the incidence of heart failure within the PCT area and looked at the use of related services.

### Case study 1: smoking cessation services

This small study aimed to investigate the reasons why current smoking cessation services in Southwark are either not taken up or, when they are taken up, not adhered to, by “disadvantaged” groups of users. The study involved an analysis of relevant data, and an examination of the relationship between gender and individual circumstances in relation to service use. This latter part of the case study involved five focus groups for potential and existing service users in particular sections of the community (pregnant women and parents of young children; male manual workers; young people; existing smoking cessation service users; and unemployed people).

The analysis of the data found that women were proportionately more likely to use smoking cessation services than men; 55% of smokers in Southwark are male but men make up only 38% of smoking cessation service users. There were no significant differences

between men and women who used the service, in terms of their success rates (61% of women and 62% of men succeed in quitting). These findings will inform future plans for the development of the smoking cessation service.

### Case Study 2: heart failure incidence and service use

Heart failure accounts for 5% of hospital admissions in Southwark, of which 75% are unplanned. Age standardised admission rates are much higher in men (146/100,00 compared with 90/100,000 for women). Rates for both men and women are markedly higher than for London as a whole. Admission rates via A&E are higher in women (87% against 83% for men). Actual numbers of males and females hospitalised for heart failure are roughly equal (there being more women than men in the older age group where heart failure is more common) but men make up 79% of patients referred to the heart failure clinic, suggesting there may be inequity of access to this service for women.

## Uttlesford PCT

The Uttlesford case study aimed to explore the use of care pathways by patients who had suffered a heart attack (MI = myocardial infarction). The study also sought to determine the adequacy of service provision, as perceived by patients and their carers, both during emergency admission and following discharge from hospital.

The methodology was to conduct an observational, retrospective study using both quantitative and qualitative information. All patients who had suffered an MI three months, twelve months or twenty-four months previously were invited to participate

in the study. Patients of nine of the eleven practices covered by Uttlesford Primary Care Trust were included. The interviews (with patients and their carers) for the qualitative element of the study were conducted by a Cardiac Community Liaison Nurse and took place at the patient's home. The main findings were:

- ▶ **In line with national data, the incidence of MI is about twice as high in men. It follows that a greater proportion of women than men are carers.**

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- ▶ **Men are proportionately more likely to be referred for further investigation post-MI and proportionately more likely to be referred for revascularisation procedures.**

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- ▶ **Women are significantly less likely than men to comply with their post-MI medication regime (64% women comply, compared with 87% of men).**

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- ▶ **Women are less likely to be offered places on cardiac rehabilitation programmes.**

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- ▶ **Perhaps surprisingly, male carers may have access to more social support than female carers.**

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# Interviews with the five partner PCTs

**D**uring January and February 2006 each PCT representative was visited and interviewed about his or her experiences in relation to the case study in order to establish key principles for exploring the relationship between gender and policy-making within PCTs. Interviewees were also asked about knowledge and understanding of gender issues in their PCT in general.

Each interview was audio-taped and the key points from each interview are presented in a standardised, summarised format below. It should be noted that some of the “Suggestions for Improvement” in the boxes below relate to local circumstances, others are directed at PCTs more generally. Where the comments are locally specific, this has been made clear in the context.

## Bradford City Teaching PCT

### What were the reasons for participating in the Gender Equity Project?

- ▶ The PCT has an established interest in men’s health and in gender as a determinant of health status.

### What difficulties were experienced?

- ▶ Gender is not generally considered when commissioning services. There is therefore not a very sophisticated understanding of the issue.
- ▶ Lack of capacity was not a great problem during the case study as a group of eight medical students was available to work on the project. More generally, capacity is a very important issue – this piece of work could not be replicated or added to. In terms of data, the PCT has good health information services which collect high levels of data and provide a very strong overview of the health inequalities locally. The students were able to interrogate this data for information about gender – although there remain plenty of other questions to be asked in this context.

### Suggestions for improvement:

- ▶ There is still plenty of scope for this issue to be considered in greater detail locally. The commitment exists to do so.
- ▶ There may be a need for PCTs to have a specific member of staff who has responsibility for actually developing gender sensitive services. That person would then be able to become knowledgeable enough to understand the issues and to communicate that understanding within the PCT.
- ▶ Nationally it is necessary to formulate health policy in a more gender sensitive manner and to undertake more research with a focus to the link between disease incidence and gender.
- ▶ In respect of men it is necessary to find ways of making services more accessible and responsive e.g. providing services in community settings.

**Epping Forest PCT****What were the reasons for participating in the Gender Equity Project?**

- ▶ The health of men is increasingly recognised as a problem both locally and nationally. It is under-researched – this means there is a weak evidence base for practice.

**What difficulties were experienced?**

- ▶ Lack of capacity.
- ▶ Link between codes used in General Practice and those used in hospital based database are not reliable as they have different coding systems.
- ▶ Data collected in General Practice are not yet sophisticated enough to be gender sensitive, and hence the Quality and Outcomes Framework (QOF) data that is requested from GPs by the PCT for funding reasons is not disaggregated by gender. There is very good data on diabetes patients and pre-school immunisation for example, but it is not possible to consider any of it in relation to gender.

**Suggestion for improvement:**

- ▶ Audit systems should be made more sensitive to gender issues. Systems should be developed to monitor reasons for admission to hospital in relation to gender.
- ▶ Data quality within primary care must be improved in relation to gender.
- ▶ Examining “patient pathways” may be a key area for improving knowledge about the relationship between gender and use of services.
- ▶ Training and education of health professionals is crucial in order to encourage setting up gender sensitive services.

**South Worcestershire PCT****What were the reasons for participating in the Gender Equity Project?**

- ▶ The PCT is interested in maximising its efficiency as both a commissioner and provider of services.

**What difficulties have been experienced?**

- ▶ There is limited awareness in regards to the gender work in the PCT.
- ▶ When the NHS is dealing with a lot of uncertainties, it is difficult to persuade people of the importance of something as apparently highly specific as the achievement of gender equality.
- ▶ Locally, because of the possibilities of redundancies, the network of interest in the issue that has been established might break up in the near future.
- ▶ Present circumstances are not conducive to creating an atmosphere of enterprise initiatives, or taking on something new and additional.

**Suggestion for improvement:**

- ▶ Consultation is needed before equity audit commences.
- ▶ It is important to estimate the local prevalence of risk factors that are likely to affect disease and health across the PCT, e.g. a gendered analysis of data relating to older people
- ▶ Must raise awareness among health professionals and health organisations of gender inequalities.
- ▶ New and developing knowledge must be embedded in strategies.
- ▶ Health promotion teams may need help to understand the issues.
- ▶ Best practice guidelines for PCTs are needed, as is effective dissemination of “what works”.

**Southwark PCT****What were the reasons for participating in the Gender Equity Project?**

- ▶ The PCT recognises the importance of addressing gender issues if health inequalities are to be reduced. A major men’s health programme was developed in response to local analyses which showed lower male life expectancy.

**What difficulties were experienced?**

- ▶ The absence of ethnicity and gender codes for key data sets, for example ethnicity for mortality and birth files and ethnicity and gender for QMAS. If gender issues are to be properly addressed, it is important not to exclude the transgender community.
- ▶ Mortality and life expectancy are long-term indicators that may not be sensitive to short term monitoring. Reliable proxy indicators need to be agreed for monitoring progress.

**Suggestion for improvement:**

- ▶ Primary care and front line staff to be offered training on making specific services more “gender friendly”, including opening times.
- ▶ Strengthening engagement with the local voluntary sector and local community groups to promote access to health and health improvement services.
- ▶ Better understanding of the wider and more specific drivers leading to gender inequity. Develop methods to target health promotion campaigns precisely in a cost effective way.
- ▶ Where shown to be appropriate, strengthen community-based provision, including outreach services, to help make services more accessible to different populations. Work in partnership with other organisations to raise the equality profile.
- ▶ Continued support for the London Health Observatory to lobby for changes in the way that ethnicity and gender data is collected and made available.

**Uttlesford PCT****What are the reasons for participating in the Gender Equity Project?**

- ▶ PCT's interest in what the gender duty will mean in practice.
- 

**What difficulties have been experienced?**

- ▶ Gender has never been considered as one of the major determinants of health in the PCT, consequently it is difficult to change the way in which people look at the data.
  - ▶ Much of the data needed to plan for improvement is not available in a gender disaggregated form.
  - ▶ Gender disaggregated data is available from the London Health Observatory and National Statistics but is not up to date.
  - ▶ The lack of gender sensitive data in the system makes it difficult for the public health team to show the importance of gender equity audit and how it can be beneficial in the circumstances.
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**Suggestion for improvement:**

- ▶ To develop professional and academic support for the case that audit by gender is valuable to PCTs.
  - ▶ Key decision-makers need to be convinced.
  - ▶ Good guidance is needed about how best to analyse and use clinical data in seeking to achieve gender equity.
  - ▶ The need for much more work in this area and for robust recommendations about how to proceed.
-

# Conclusions

**T**his has been the first study of its kind. It provides a baseline understanding of how widely and how effectively PCTs have been able to apply the notion of gender equity in policy-making and service provision in the past. It also enables informed speculation on the likely impact of the gender duty in the immediate future.

The gender duty has the potential to bring about recognition of gender as a primary element in the determination of individual and population health status. The implementation of the new duty however, coincides with a time of significant change in the organisation of NHS planning and service delivery. This has advantages and disadvantages. On the one hand, the new structures offer an opportunity to cement gender-equitable provision into mainstream thinking. On the other hand, it must be recognised that the time and resources demanded by the reconfiguration may limit the capacity to give due attention to this new responsibility. The findings of this report demonstrate that the issue is a genuinely important one and suggest that the gender duty has addressed a pressing need, at least as far as health provision is concerned.

► **The case studies confirm that an individual's gender makes a significant difference to the way he or she uses services, and to the outcomes that he or she might expect. Gender is not, of course, the only variable of this kind – but it is a fundamental and crucial one.**

► **The national survey suggests that PCTs have not, by any means, been as sensitive to this issue in the past as the**

**new legislation intends they should be in the future. In particular the failure in many cases routinely to use gender disaggregated data means that provision of gender-equitable services has been – at best – significantly hampered.**

► **The interviews with the partner PCTs (a group that has made particular efforts to be concerned about gender) reveal that they share a number of concerns about levels of understanding of this issue among their peers. They wonder whether the commitment will be there – and indeed whether the issue is even regarded within their peer group as one that matters.**

In the wider context therefore, the GEP's findings can be seen as throwing up a serious challenge. It is plain that some extremely hard work will be necessary to ensure that this issue is taken seriously. Indeed, it is for this reason that we have stopped short of offering a "template" for gender equity audit – it is clear that a broader base of expertise and understanding needs to be developed before such audits can be conducted effectively. The problem that emerges consistently from the national survey and the opinions of our partner PCTs is that of attributes perceived to be missing. Recognition of the issue; expertise in working specifically with men; commitment to tackling the problem and the capacity to do so – all these need to improve. In light of this, the recommendations that follow concentrate deliberately on very straightforward, workable and pragmatic ideas that are intended to build capacity without requiring significant commitment of resources.

# Recommendations

## 1 Collection, analysis and use of data

It is clearly impossible to make planning decisions that seek to achieve gender equitable objectives without the relevant data – indeed without the right data it is also impossible to evaluate the effectiveness of existing services and policies. It is therefore of central importance that from now onwards, data should be routinely collected, presented and considered in gender-disaggregated form at PCT level. The NHS should actively ensure that all datasets in regular use at all levels are required to conform to this fundamental principle. At a local level, it should also be a matter of routine that data made available to the wider public (e.g. in media releases, public information material, annual reports etc) should be presented in a way that enables local people to consider the differences between men and women. This will help facilitate the education and engagement of service users, which in turn will contribute to the wider cultural change that the gender duty element of the Equality Act is aiming to achieve.

## 2 Developing local commitment

All the partner PCTs drew attention to the need to convince clinical, public health and management colleagues of the importance of taking gender equity seriously. The consensus (borne out by the MHF's experience over the years) seems to be that many people working in the NHS do not easily recognise the link between gender and health status or service use. Against this background, it is hard to see from where the impetus will come to get seriously to grips with the spirit of the new legislation. Indeed, if these attitudes prevail, it may be that many NHS organisations will inevitably tend toward the lowest level response ("box ticking").

As a solution, some of our partner PCTs

favoured a named employee with specific responsibility for championing gender as an issue. In 2003, in *Getting It Sorted* the MHF suggested that each PCT should have a member of staff with dedicated responsibility for men's health. While such an approach would undoubtedly be helpful, it may be unrealistic to expect all local NHS organisations to find the resources to take on such an idea at this stage. It is clear, however, that hearts and minds do need to be won. It is therefore recommended, as a starting point, that Strategic Health Authorities appoint a "gender lead". More widely, a model training programme should be developed that incorporates both an online resource aimed at NHS staff at all levels and – where there is sufficient local interest – a training event for senior managers that has the potential subsequently to be "cascaded down" at a local level.

## 3 Good practice

The results of our survey suggest that examples of good practice in this field are few and far between. This applies both to practical initiatives designed to redress gender inequities directly and probably also to the more theoretical business of developing population-level policy that seeks to bring about change in the longer term. For several years the MHF maintained a well-used searchable online database of local projects which targeted men. Resource shortages meant that this database is now out of date but the MHF is still approached on a regular basis by people who want to be put in touch with others who share their objectives. This suggests a model for a similar central database of good practice in the development of gender equitable policy and local assessment frameworks. Learning from the experience of others has benefits wider

than the simple replication of good quality work, important though that is. The MHF's experience was that a central database – and the links it facilitates – encourages new ideas, promotes debate and professional growth, and enhances the overall capacity for effective policy and practice. It is recommended that the Department of Health consider establishing such a database in the very near future – preferably in advance of the implementation of the gender duty.

#### 4 Seeking the views of stakeholders

In practice, the gender duty will require public sector bodies both to consult and inform stakeholders about their overarching Gender Equality Scheme (GES) and their individual Gender Impact Assessments (GIAs) of particular policies and services. The question of stakeholder involvement did not form part of the GEP but the recurring concerns about levels of commitment suggest that this element of the new legislation – which on the face of it may appear to be of lower priority – may well fail to receive the attention it deserves. The MHF has undertaken other research which has suggested a degree of generalised disengagement between men and the NHS. The requirements of the gender duty may offer the opportunity to “kick start” a process of seeking men's views about the way services are provided – and ultimately contribute to the development of services that are more sensitive to men's needs and attitudes. Such a process would potentially have benefits far beyond the requirements of the new legislation.

It is recommended that PCTs set up formal consultation processes with men (e.g. a standing advisory group). Such a group could be established by seeking nominations of men from existing patient groups and service user organisations, or perhaps by approaching

other representative organisations that have significant numbers of male members. (This concept is not limited to men. A similar structure could be established to seek the views of female service users and women from the local community).

It is further recommended, at a national level, that the DH institute an advisory group specifically to address the issue of gender equality. Such a group could be established in partnership with the MHF and equivalent women's health organisations. Among other functions, this group should hold a specific brief to contribute to the development of thinking around GESs. It could also ensure that GIAs are conducted appropriately by taking on a scrutiny role at a strategic, national level.

#### 5 Local targets

As a result of the shift of emphasis in recent years away from nationally-set targets outlined in the “Background” section of this report, most PCTs have now developed local targets that reflect local population needs. These targets vary from area to area and relate to a range of clinical, public health and service delivery functions. Such targets appear in Local Delivery Plans and in a wide variety of other specifically local strategic documents. The (admittedly limited) search of local targets that was undertaken as part of the GEP suggested that such targets rarely take account of the differences in patterns of service use or health outcome between men and women.

It is recommended that PCTs review all existing targets of this kind and consider re-writing them to take account of gender differences. This relatively simple exercise could be undertaken whether or not the targets relate to services or policies that fall

within the requirements for gender impact assessment under the new legislation. It is strongly recommended that PCTs express all future local targets in gender disaggregated terms, even where the statistics, circumstances and objectives for men and women are considered to be identical. This would have the effect of sharpening thinking on this matter and, like the preceding recommendations, would contribute to the wider cultural change that the new gender duty is intended to achieve.

## Summary recommendations for the Department of Health and NHS

All of the above recommendations contain specific suggestions for action by the DH or for action within the NHS as a sector. It is worth summarising these in a more succinct form:

- 1 All datasets in regular use at both national and local level should be routinely collected, presented and considered in a form that is disaggregated by gender.
- 2 Data made available to the general public (e.g. in media releases, information material, annual reports and so on) should also always be broken down by gender.
- 3 Strategic Health Authorities should appoint a "Gender Lead" with responsibility to see that gender inequalities are tackled effectively.
- 4 A model training programme should be developed that incorporates a programme for senior managers capable of being "cascaded down". The training programme should be backed up by an online resource aimed at NHS staff at all levels.
- 5 An online searchable central database of good practice should be developed – preferably in advance of the implementation of the gender duty.
- 6 PCTs should establish standing advisory groups of men and women whose role is to comment on local policy and practice from a "gendered" viewpoint.
- 7 The DH should establish an advisory group with a membership drawn from organisations with expertise in tackling gender inequalities. This group should have a brief to advise on policy and practice, and to scrutinise the implementation of the gender duty.
- 8 PCTs should be encouraged to review all existing local targets and wherever possible to re-write them in a form that is disaggregated by gender. Likewise PCTs should be encouraged to express all future targets in this way.

# Appendices

## Appendix 1

### **Gender Equity Project Management Group membership**

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**Anna D'Agostino**

Minority Ethnic Elders Falls Prevention Project  
Officer, Help the Aged

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**Veronica Chan**

Gender Equity Project Co-ordinator  
Gender Equity Project  
(employed by Tendring PCT)

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**Kuljit Dhillon**

Head of Legislation and Gender Equality  
Policy Equality and Human Rights Group,  
Department of Health

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**Lowri Griffiths**

Gender Equality Duty Manager  
Equal Opportunities Commission

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**Caroline Gunnell**

Research Governance Co-ordinator  
Epping Forest PCT

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**Dr John Hockey**

Clinical Governance Project Officer  
Uttlesford PCT

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**Oksana Hoile**

Head of Research and Development  
Essex Primary Care Research Network

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**Meryl Johnson-Mair**

Corporate Public and Patient Involvement &  
Diversity Manager  
South Worcestershire PCT

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**Jin Lim**

Public Health Specialist  
Southwark PCT

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**Ralph Saunders**

Acting Assistant Director of Health  
Inequalities Bradford City Teaching PCT

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**Caroline Skinner**

Health Development Advisor,  
Uttlesford PCT

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**Professor Alan White**

Professor of Men's Health  
Leeds Metropolitan University

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**David Wilkins**

Policy Officer  
Men's Health Forum

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## Appendix 2

### Brief pen-pictures of the partner PCTs

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#### Bradford City Teaching PCT

Bradford City Teaching PCT is one of four PCTs in the Bradford Metropolitan District and covers a geographical area of 12 square miles. It has 41 GP practices and a population of about 150,000. It includes the most deprived areas of the city. It has the city's highest prevalence of coronary heart disease and diabetes mellitus, and the lowest life expectancy for both males and females in the district.

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#### Epping Forest PCT

Epping Forest PCT serves a population of around 120,000 people, across 12 major towns and villages. The PCT works with 19 GP practices and serves a mixture of urban and rural areas. The majority of people are relatively well off by national standards, although there are some areas where income is lower.

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#### South Worcestershire PCT

South Worcestershire PCT serves a population of around 284,000; 18% of the population is aged under 16. 18% of the population is aged over 65.

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#### Southwark PCT

Southwark serves a population of around 245,000 in London Borough of the same name. Southwark is the 17th most deprived local authority area in England. Its population is young and ethnically diverse with 52% white British and 16% black African.

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#### Uttlesford PCT

Uttlesford Primary Care Trust has 76,600 patients registered with 45 Principal GPs in 11 practices. Uttlesford falls within the 10% of least deprived local authorities in England with an unemployment rate of 0.9% in 2002.

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## Appendix 3

### Interview questions and prompts

- 1 What were your reasons for participating in the Gender Equity Project? (professional or personal reason?)

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- 2 What were the main weaknesses and strengths of the local case study?

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- 3 What difficulties and barriers did you experience in the process of the case study? e.g. data collection; the amount of information available and where and when it can be found; format of information; capacity; priority.

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- 4 What have you learnt from the case study? Can you suggest 5 areas for improvement?

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- 5 What were the limitations of your case study?

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- 6 What do you think about the level of knowledge, interest, and the skills and insights of your colleagues in relation to gender issues?

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- 7 What issues will emerge in the longer run?

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- 8 How might gender sensitive services be further encouraged at your PCT and what are the main constraints that need to be overcome?

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- 9 What do you want us to include in the final report?

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## References

<sup>1</sup> Wilkins D and Baker P, *Getting It Sorted: a Policy Programme for Men's Health* (Men's Health Forum, London 2004)

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<sup>3</sup> See: Gender and Health Partnership, *Gender sensitivity: the new public sector duty in healthcare* (Gender and Health Partnership, London 2005). Available from the Equal Opportunities Commission.

<sup>4</sup> Department of Health, *National Standards, Local Action* (Department of Health, London 2004)

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## The report of **The Gender Equity Project**

What the "gender duty" provision of the Equality Act 2006 will mean for the health for men

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The mission of the Men's Health Forum (MHF) is to provide an independent and authoritative voice for male health and to tackle the issues affecting the health and well-being of boys and men in England and Wales. Our vision is a future in which all boys and men in England and Wales have an equal opportunity to attain the highest possible level of health and well-being.

**We aim to achieve this through:**

- ▶ **Policy development**
- ▶ **Research**
- ▶ **Providing information services**
- ▶ **Stimulating professional and public debate**
- ▶ **Working with MPs and Government**
- ▶ **Developing innovative and imaginative projects**
- ▶ **Professional training**
- ▶ **Collaborating with the widest possible range of interested organisations and individuals**
- ▶ **Organising the annual National Men's Health Week**

The Men's Health Forum (MHF) makes comparisons between men's and women's health only when it is unavoidably necessary to do so. We do not advocate shifting attention away from female health or re-allocating resources from women to men. Moreover we do not believe that women's health should function as a "gold standard" for men's health – the MHF is committed to improved health for both men and women.

The Forum's mission, vision, values and beliefs statement can be read in full at: [www.menshealthforum.org.uk](http://www.menshealthforum.org.uk).

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