Making a difference for women and men including transsexual people
‘The NHS in Scotland faces many challenges in delivering appropriate and accessible health services to an increasingly diverse population. Key among these is ensuring that our policies and procedures support our staff to deliver the highest quality clinical care to all the people of Scotland.

Whatever the individual circumstances of people’s lives – their gender, age, ethnicity, disability, sexual orientation, mental health, economic or other circumstances - the NHS must provide them with access to the right health services for their needs. We developed our Fair For All approach, in partnership with Scotland’s Equality Commissions and others, to support local NHS services respond sensitively and flexibly to the needs of the people they serve.

The NHS welcomed the Gender Equality Duty as a way of demonstrating our commitment to meeting the different needs of women and men, including transsexuals, and to overcoming the gender health inequalities which exist across Scotland.

The Fair for All – Gender partnership between the NHS Scotland and the Equal Opportunities Commission was launched following the Health Department’s work to pilot the Gender Equality Duty. This raised important issues about how the Health Department and NHS Boards would meet the challenge of ensuring gender equality across all their policies and functions – from gender sensitive service delivery to issues of procurement and employment. This guidance provides useful information, resources and examples of good practice in response to these challenges.

Our Fair for All – Gender partnership demonstrates our commitment to working together to tackle gender health inequalities and to promote the benefits of diversity across Scottish society; not because the law says we have to, but because it is the right thing to do. The moral case is unquestionable and, as our experience across NHS Scotland proves, so is the business case. The Gender Equality Duty is about achieving real outcomes for men and women across Scotland, and we believe this guidance will support NHS Scotland achieve real outcomes as it tackles Scotland’s historic gender health inequalities’.

Dr Kevin Woods  
Head of Scottish Executive Health Department and Chief Executive of NHS Scotland  

Mr John Wilkes  
Director, EOC Scotland
Introduction

Section 1

1.1 Fair For All - The Wider Challenge
This guidance has been developed by Fair For All – Gender to provide information that will be helpful to national, special and territorial NHS Scotland health boards in understanding how to meet the needs of the Gender Equality Duty.

The purpose of the Gender Equality Duty is to bring about change. This guidance is to assist the NHS in Scotland in achieving outcomes and improvements in the way services and functions are delivered, which will benefit women and men, including transsexual people.

The aim of this specific health service guidance is to provide a clear, concise and practical tool to help staff in health boards tasked with implementing the GED to meet the requirements of the duty. It will focus mainly on service delivery. The guidance should be used in line with the Equal Opportunities Commission’s Scottish Code of Practice which can be found on the Commission’s website and covers the legal requirements of the duty: www.eoc.org.uk/fairforallgender

Fair For All – Gender is a partnership project between the Equal Opportunities Commission Scotland and the Scottish Executive Health Department’s Fair For All initiative. Fair For All – Gender adds to the existing Fair For All initiative strands and it builds on significant existing gender and health work undertaken in Scotland. Fair For All - Gender is supported by the additional strands of:

- Age
- Disability
- Race (The National Resource Centre for Ethnic Minority Health)
- Religion and Belief
- Sexual Orientation

The challenge, as outlined in Our National Health: A plan for action, a plan for change (SEHD: 2000)

“We want to work with the NHS to ensure that a patient focus is embedded in the culture. To make this happen we will ensure that listening, understanding and acting on the views of local communities, patients and carers is given the same priority as clinical standards and financial performance.”

And the challenge as outlined by Kevin Woods, Head of Department and Chief Executive, NHS Scotland (June 2006) is:

“We need to ensure that delivering patient services that are fair for all is more than a bureaucratic process of developing Equality Schemes:

“_The Gender Equality Duty is about achieving real outcomes for women and men across Scotland._”
to effect real change, equity and equality must be at the heart of our service, embedded in, for example, our clinical priorities of cancer, CHD and mental health and in our health improvement agenda.”

Health boards may want to embrace the learning from the race and disability duties when preparing to implement the Gender Equality Duty. Additional areas that could be taken into consideration in preparation for the duty are gender impact assessment, equal pay policies, consultation with gender organisations and hidden groups, multiple identity issues and the design and delivery of services that meet the different needs of men and women. All of these topics are described in detail throughout this guidance.

1.2 Setting Priorities for NHS Scotland’s Equality Approach
It is useful to consider setting gender priorities on 2 levels; nationally and locally.

Firstly the NHS in Scotland is working towards a “whole system” approach to its work on equality and diversity, from Health Department planning to service delivery. Delivering patient services that are fair for all is more than just a process of developing equality schemes: to effect real change equity and equality must be embedded in our national priorities of cancer, CHD and mental health.

This whole system approach, which will assess all stages of the delivery of a clinical service, will start in 2007/2008 with cancer and will focus on patient outcomes. It will not only be more understandable to staff and patients, it should also more readily support the planning and delivery of accessible, patient-focussed services.

Therefore Cancer, CHD/Stroke and Mental Health should be included as priorities in your Gender Equality Scheme.

Additionally Domestic Violence and Equal Pay are existing national priorities, which should also be reflected in your Disability Equality Schemes.

Local consultation with gender stakeholders may highlight other priorities that are important for your NHS Board to achieve gender equality. These should be included as local priorities.

1.3 Single Equality Schemes
Some health boards may produce a combined equality scheme in anticipation of a Single Equality Approach. This format is acceptable as long as the evidence and actions of the gender equality scheme are shown, are clearly identifiable and easily accessible.

An advantage in producing a Single Equality Scheme is that it may allow for better recognition of the complexities of people’s identities. Interactions between women and men’s age, sexual orientation or disability for example, may lead to multiple and complex discrimination. A single scheme to address multiple inequalities might better capture the work that is needed to tackle persistent problems of multiple discrimination, such as bullying or harassment faced by women and men who are gay, lesbian or transgender. However, this approach is not without its challenges.

For information on the commonalities and differences between the 3 duties, you may wish to refer to the document ‘Bringing Equality to Scotland: The Three Public Sector Duties’, which can be found at www.eoc.org.uk/fairforallgender

1.4 National and Special Health Boards
Some health boards do not provide services directly to patients, but instead to the rest of the NHS in Scotland, and these boards will need to illustrate these differences in their Gender Equality Schemes. National health boards may want to consult with staff, stakeholders and diversity groups within staff groups. Local level structures which could be utilised for consulting on gender equality priorities include Public Partnership Forums.

National health boards are in an excellent position to provide tools and information to support territorial health boards to meet their duties more effectively.

1.5 Leadership
For the Gender Equality Duty to be successful, leadership support at senior level is essential. As well as commitment, there needs to be competence and an understanding of gender issues in the health mainstreaming process.

Explanation of Terms:

**Equality** - is about creating a fairer society where everyone can participate and has the opportunity to fulfill their potential. It is mostly backed by legislation designed to address unfair discrimination and resulting inequalities based on membership of a particular group.

**Diversity** - the recognition and valuing of difference in its broadest sense. It is about creating a culture and practices that recognise, respect, value and harness difference for the benefit of patients, carers, members of the public and members of staff.
It is important at this level, that gender equality is not seen as a bolt-on, but as an integral part of a health board’s policy and planning process.

Many health boards employ specialist equality staff to steer the process of implementing overall equality; other health boards make equality part of an individual’s responsibilities. One of the best ways to inspire confidence is to ensure commitment from the highest level. This could be demonstrated by the Chief Executive endorsing a Gender Action Plan, emphasising commitment and active participation of the board in making it work.

One of the ways we have supported NHS boards to deliver on the duty is to ask them to nominate staff as Gender Equality Duty leads to exchange experiences, share good practice and offer support as part of a Gender Equality Duty Network. These leads should not be expected to take all responsibility for the successful implementation of the duty. This will need ownership, action and a culture change across the organisation as a whole. Senior people or teams with major strategic or management responsibility supported by key staff should contribute to gender equality change across a health board.

Reporting on progress to senior management teams, Patient Focus and Public Involvement Designated Directors or Chief Executives should help increase the understanding that gender equality can and should be a core part of the business, policy development and service delivery objectives, not just a minor issue or a small part of human resources work.

**Explanation of Terms:**

**Gender** - refers to roles, attitudes, values and behaviours given to women and men by society. These characteristics can vary depending on which society we live in. For example, traditionally, a gender role would suggest that women should look after children, while men continue to go to work.

**Sex** - refers to how we are born, the biological and physical differences between men and women. People are born male and female, learn to be girls and boys and grow into women and men.
2.1 Who is this Guidance for?
This guidance provides information relevant to Policy Makers, Commissioners, HR departments, Workforce Planners, Service Designers, GED Nominated leads, Chief Executives, Patient Focus and Public Involvement Designated Directors.

2.2 How can this Guidance help?
This guidance identifies why the health sector in Scotland needs to take action on gender equality, what the benefits are and what needs to be done to meet the duty. By following this guidance and applying it appropriately, positive steps can be taken to deliver gender equality for staff and service users.

The guidance is relevant to all functions of a health board and not limited to policy development. The Gender Equality Duty (GED) includes all staff at every level and all services and functions where girls and boys, women and men, including transsexual people, are involved. It also covers territorial, special and national health boards as well as services that are funded by health boards.

General GED guidance from the Equal Opportunities Commission (EOC) on employment, gender impact assessment, procurement and transsexual people in the workplace will also be provided on their website.

The guidance in this current state is not a final document; it will be reviewed and changed over the following months where appropriate. Updates will be available on the website: www.eoc.org.uk/fairforallgender

2.3 What is the Gender Equality Duty?
The Gender Equality Duty (GED) is the most important change to sex equality legislation in the past 30 years. Under existing law, a person who feels that they have been treated unfairly must take a case to an employment tribunal or sheriff court. When the GED comes into force in April 2007, the responsibility is on public sector employers, including health boards, to ensure they are actively promoting gender equality.

Under the GED, the NHS in Scotland will be expected to eliminate unlawful discrimination and take steps to actively promote equality between women and men through the work that it does. By taking into account
legal provision, and it is not a new concept. However, it is important to note that the GED is not only about ensuring equal opportunities for women and men but also about promoting equality in all aspects of life. The GED can help health boards achieve their aims and aspirations and promote equality in the workforce. The specific duties of the GED are designed to support progress in delivering the general duty. The specific duties support progress in delivering the general duty. A public authority must:

- Prepare and publish a Gender Equality Scheme showing how it intends to fulfil the general and specific duties, containing gender equality objectives (priorities)
- Consult employees, service users, stakeholders (including trade unions)
- Take into account any information it considers relevant
- Ensure that the scheme sets out the actions the health board has taken or intends to take to:
  - Gather information on the effect of its policies and practices on men and women, in terms of employment, services and performance of its functions
  - Use the information to review the implementation of the equality scheme objectives
  - Assess the impact of its current and future policies and practices on gender equality and use this information to inform planning and delivery
  - Ensure implementation of the gender equality scheme objectives
  - Review and revise the scheme at least every 3 years
  - Report on progress annually
  - Develop and publish an Equal Pay Policy Statement and report on progress within 3 years

Further reading on what the duty requires can be found in the Scottish Code of Practice at www.eoc.org.uk/fairforallgender

Explanation of Terms:

Gender Equality Objectives - are set by health boards where they aim to promote gender equality between women and men and remove discrimination and harassment. For instance, promoting flexible working for man or ensuring public transport is more accessible for women. These must include national priorities set by NHS Scotland of cancer, mental health and coronary heart disease.
Section 3
Gender and Health -
What is it all about?

3.1 Why have a duty?
3.2 Why Gender matters
3.3 Key facts
3.4 Women and Gender
3.5 Men and Gender
3.6 Health Inequalities, things to consider when setting gender equality priorities
3.7 What the Gender Equality Duty could help the NHS in Scotland look like

How can this Guidance help?

2.5 Timetable - Gender Equality Duty
6th April 2007
Gender Equality Duty comes into force
29th June 2007
Health boards to have produced a Gender Equality Scheme
28th September 2007
Equal Pay Statement to be published by organisations with 150+ staff

Key requirements in developing a scheme and preparing for the duty include:
- Awareness raising
- Training
- Data and evidence gathering
- Consultation

These requirements are covered in more detail in Section 4 and 5 of the guidance. Health boards should be considering now what preparatory work is required to help them develop a high quality scheme.

Explanation of Terms:
Duty - a mandatory and legal obligation to do something. For example, the general duty to eliminate sex discrimination and promote gender equality.
Action Plan - a 3-year plan of how a health board intends to promote gender equality and mainstream it into all of its policies and functions
Gender Mainstreaming - making sure gender issues are built into the business planning and procedures of an organisation or health board. It is about an approach to integrating gender considerations into all facets of work. It involves ensuring that gender views and attention to the goal of gender equality, are central to all activities - policy development, research, advocacy, dialogue, legislation, resource allocation, and planning, implementation and monitoring of programmes and projects.

Key points to remember:
- Evidence and data collection: break down information by gender
- Raise awareness of the Gender Equality Duty, ensure that staff understand ‘gender’
- Gender Impact Assess policies, legislation and services continuously
- Keep the needs of transsexual people in mind

“Although a great deal has been achieved already, there is still a long way to go to deliver full gender equality for all.”

Pictured Right:
Laura DiMichele, Human Resources Admin Assistant, NHS Forth Valley
3.1 Why have a duty?
Men and women, boys and girls, staff and service users, have different needs and uses of the health service in Scotland, which was traditionally based on a ‘one size fits all’ model. By taking into account these different needs, the quality of health services will improve for everyone. Since the NHS in Scotland is a major employer, the duty should improve work practices also.

The duty will help address key issues including patient satisfaction rates and the late diagnosis of key illnesses. Although a great deal has been achieved already, there is still a long way to go to deliver full gender equality for all.

3.2 Why Gender Matters
There are many differences in patterns of health, differences in respect to certain types of illness and in how health services are used by women and men. When trying to understand this, it is useful to be aware of the difference between sex and gender.

Sex refers to the biological differences between men and women that are universal. We are born as boy or girl and grow into man and woman. With gender, health differences occur as a result of the social impact on being either a man or woman. Social influences can change and can vary within and between cultures. For example, men consume more alcohol than women and need to be treated differently than women for resulting illnesses. There is also a difference in alcohol consumption amounts; women are generally physically smaller so the ‘safe’ consumption amount must be lower.

Overall, men have higher death rates than women from all major causes of death, but largely from suicides, drug related poisonings, lung cancer and heart disease. There is less of a difference between women and men in death rates for strokes, most cancers, respiratory or infectious diseases. However, women are more likely than men to be diagnosed with mental health illness. Women and men also have many other health differences, from reproductive health to genetic and metabolic differences that can influence the diagnosis of many diseases.

The variation of life expectancy between women and men, and the resulting number of older women living in poverty and ill health highlights the case for a better understanding of the relationship between gender and biology in health outcomes. Resulting illnesses are likely to increase unless action is taken to combat obesity, addictions, lack of exercise and poor diet.

Meeting the different needs of women and men, including transsexual people, means gender equality must be considered at all stages of planning and designing of services, policy development, implementation and monitoring and when assessing the impact of services, policies and functions. It follows on through to recruitment and management of staff, training, delivery of care, audit and evaluation.

3.3 Key facts
Some health differences between women and men are:

**Biological:**
- Men typically develop heart disease 10 years earlier than women
- Man to woman infection with HIV is more than twice as efficient as woman to man infection
- Women are around 2.7 times more likely than men to develop an autoimmune disease such as diabetes.

**Gender:**
- Men are more likely than women to commit suicide
- Boys are twice as likely as girls to be killed or seriously injured in pedestrian road accidents
- Life expectancy for women in Scotland is the lowest in the EU and for men, the second lowest
- Men are more likely than women to die of injuries, but women are more likely to die of injuries sustained in the home
- Women are more likely to suffer from anxiety or depression
- The gap between women’s and men’s smoking rates is changing, with more young girls taking up the habit than boys.

3.4 Women and Gender
Women are more likely than men to report practical problems in accessing services. They are more likely to have caring responsibilities, for example, or to have transport problems (Doyal et al, 2003). But there are also some medical conditions that they under-report.

**Example:** In a study in the West of Scotland people were asked to describe likely ‘candidates’ for heart problems. All described men. When they talked about ‘unlikely’ people who had problems they also described men. Women remained invisible when people spoke about heart disease.
Some women can be seen as more ‘involved’ in healthcare services; they see their doctor more often than men and feel they are more knowledgeable about the range of healthcare services available to them.

However, there are many women who do not access health care services. The experience of being treated unequally, or discriminated against acts as a pathway into poor health for many women. In particular, in relation to poor mental health and as a result of gender based violence.

Women are more likely to be on a low income and suffer the consequences for health. Retired women and lone women are most at risk of poverty and average incomes of women in work are lower. Women take major responsibility for domestic labour and for the care of children and older people. Domestic work can have a negative impact on both physical and mental health: 1 in 5 of women spend over 50 hours a week caring for someone living with them and caring responsibilities are a risk factor associated with possible mental ill health.

After a cardiac episode, women have difficulty with male-orientated “getting back to normal” rehabilitation. Going back to ‘house work’ may not be an inspirational goal.

Example: The sexual health of young people in Scotland is poor. It is likely that an increase in risky sexual behaviour has contributed to sexual health outcomes such as STIs and unintended pregnancy among young people. Young people, in particular young women under the age of 20, bear the burden of sexually transmitted infections. Health boards may want to consider how to involve more young women in their sexual health services.

How the NHS is improving services for women
Women’s Mental Health Demonstration Project

The Women’s Mental Health Demonstration Project (WMHP) aimed to develop a social, gender sensitive model of care for women presenting within primary care services with mild to moderate mental health difficulties. Based on best practice from the UK and beyond, it aimed to influence wider mainstream policy and practice also. The evaluation indicated that brief interventions, if composed of empowerment and advocacy and underpinned by a broad understanding of the links between life circumstances and health, were found to make women feel more able to deal with their lives. Many women had used primary care services for mental health issues in the past but had not been asked about key underlying factors, for example, abuse and financial circumstances. NHSGGC is continuing to mainstream the implications of this learning.

NHS Greater Glasgow and Clyde

3.5 Men and Gender

Men are reluctant to seek medical services generally. To be powerful, men are required to appear invulnerable, to take risks, to be independent and not ask for help. A man can easily feel that once he starts to take care of his health he also somehow stops being a man.

It may be necessary for health boards to think of ways to encourage more men to visit GP practices or medical centres, and to provide new services aimed specifically at men, who in the past have been reluctant to visit health services.

It may be useful to ask men for feedback on the suitability of particular services and the extent that they meet their particular needs and address some of the barriers they face such as practical issues of men’s long working hours and service opening times.

Men remain more likely than women to die prematurely from occupational diseases and injuries. Socialisation of men makes them more likely to smoke, drink excessively, drive dangerously and have unsafe sex.
Some male roles may involve more risk-taking:

Example: There is a growing awareness that the risk-taking behaviour of young men has a substantial impact on life expectancy rates. Research in the Highland region of Scotland suggests that not only the high accident rate among young men is attributable to their willingness to take risks, but also a large proportion of early deaths among men in their 50s and 60s are a result of earlier “health-damaging brushes with risk” for example, drink-driving and dangerous work environments.

Health services may want to encourage men into services where these issues can be explored.

Health boards also need to consider how they can address any health differences to achieve good health for both women and men.

Example: Discussions with groups of Scottish men suggested a widespread endorsement of the view that men are reluctant to seek help, particularly younger men. Men seeking help was more acceptable when it was seen to be a means to preserve or restore an aspect of masculinity (e.g. working as a fire-fighter or maintaining a sexual performance or function).

Some methods to encourage men to visit health services could be:

- Providing availability on an appointment system which is open after normal working hours, avoiding the pitfalls of a drop-in service and also allowing for more comprehensive assessments to be planned.
- Publicising a men’s service through poster displays, newspaper and radio advertisements, invitations could be sent out from GP practices at staged intervals. This would allow for a more sustainable service to be developed as appointments not filled through other means could be filled by sending out letters of invite.

Example: Perth and Kinross Council is working with health partners to promote a proactive approach to health for men in this area including offering testing. Testing offered to men at their workplace and other venues, includes blood pressure, body mass index, blood sugar etc.

3.6 Health Inequalities - things to consider when setting gender equality priorities

Older People

Health boards might want to focus attention on the different needs of men and women and their expectations of what public services can deliver and aim to dispel the notion that older men and women lead the same lives and are equally well catered for by “one-size-fits-all” services.
Gender and Health - What is it all about?

Violence against Women – domestic abuse
There is a substantial amount of research which links women’s experience of child sexual abuse and domestic violence with long term mental illness and also with physical and sexual health problems (WHO, 2005). Although domestic abuse does happen to some men, the majority of this abuse happens to women. Health boards need to ensure they are providing services that are proportionate to the needs of their region and that meet the particular needs of women and men.

In Scotland in 2005/06, police returned details of 45,796 incidents of domestic abuse. In 87% of cases where the information was recorded, the victim was female and the perpetrator male (Scottish Executive September 2006).

One American study found that 83% of people living in poverty had been physically or sexually assaulted in their lifetimes (Bassuk, et al 1998, in Belle and Doucet, 2003).

Incidents of violence against women are known to be under reported and there is a need to provide health services specifically for women who are victims of violence or domestic abuse as well as ensuring that mainstream services are accessible.

How an NHS board is improving services for women
In NHS Greater Glasgow and Clyde, there is a dedicated project to support midwives in identifying & responding to abuse which has been very successful in changing practice. They have implemented routine enquiry of domestic abuse at the booking visit in maternity services since 2005 which has been well received by women.

In the evaluation interviews, 94% thought it acceptable & appropriate to ask directly about abuse at the booking visit.

NHS Greater Glasgow and Clyde

Treating people equally, differently
Among people who reported chest pain to a GP in the West of Scotland, after controlling for type of pain, men were significantly more likely than women to receive a provisional diagnosis of Coronary Heart Disease (CHD). Unless health boards take into account the different needs of women and men, and the way women with CHD present, are unlikely to be treated in the most effective way, leaving more people at risk.

How does the duty affect single sex services?
Single sex services can meet a variety of needs which would be difficult or impossible to deliver in a mixed-sex setting. Amongst women’s organisations this includes women-only spaces, personal development, high service-user involvement, good peer support, delivery of complex services and accessing women who are traditionally “hard to reach”. They are lawful where there is a clear need to preserve decency or privacy, such as a women’s refuge. However, this is a complex area of law with a number of exemptions.

The law in this area does not change under the gender duty. The duty does not mean that single sex services should be cut, or that services should be provided on the same scale for both men and women. For example, because women make up the majority of victims of domestic violence and rape it would not be appropriate for a local council to fund or provide refuge services on an equal basis for men and for women. More information on this issue is available in the Scottish Code of Practice

www.eoc.org.uk/fairforallgender

Health Service Responses
It is unlikely that health promotion campaigns which do not take account of gender will be as successful as they could be, given that smoking, food, weight and body image and alcohol consumption have all been so closely linked to ideals of masculinity and femininity.

Key points to remember:
• Evidence and data collection: break down information by gender
• Raise awareness of the Gender Equality Duty, ensure that staff understand “gender”
• Gender Impact Assess policies, legislation and services continuously
• Keep the needs of transsexual people in mind

3.7 What the Gender Equality Duty could help the NHS in Scotland look like
• All NHS Scotland staff feel valued and respected for who they are, and for the skills that they bring to their work.
• Everyone, whether patients, carers, members of staff or members of the public, experiences an NHS in Scotland, which is free from all forms of discrimination, harassment or intimidation.
• A health service in Scotland where boys, girls, women and men including transsexual people, can access services that meet their individual needs.
• Each NHS board aims to be an excellent employer, challenging negative behaviour and reinforcing positive attitudes to gender equality.
• Barriers to women and men accessing health services in Scotland are recognised and removed.
• The NHS recognises and provides services that meet needs of ‘hard to reach’ or hidden/silenced groups of women and men in Scotland including victims of domestic violence.

Key points to remember:
• Evidence and data collection: break down information by gender
• Raise awareness of the Gender Equality Duty, ensure that staff understand “gender”
• Gender Impact Assess policies, legislation and services continuously
• Keep the needs of transsexual people in mind
4.1 Diagram step by step to developing your Gender Equality Scheme

4.2 What is a Gender Equality Scheme?

4.3 What is a Gender Action Plan?

4.4 Developing your Gender Equality Scheme

4.5 Gender Equality Awareness Raising

4.6 Consultation

4.7 Data Collection and Evidence

4.8 Gender Impact Assessment

“Gender Impact Assessment is not just about developing a scheme every 3 years. It is a continuous practice to embed gender equality into everything a health board undertakes.”

Pictured Right:
Robert Cameron, Domestic Help, NHS Fife
4.2 What is a Gender Equality Scheme?
The Gender Equality Duty requires that health boards produce a Gender Equality Scheme. A Gender Equality Scheme is an overarching document that contains a three year set of objectives for a health board’s work to eliminate discrimination and promote equality between women and men. It must show how these objectives have been prioritised, through evidence gathering and consultation.

A gender equality scheme should identify:

- A health board’s gender equality objectives, and what evidence has been used to develop these objectives
- How a health board will gather information to monitor change in terms of both employment and service delivery
- How staff, service users and unions are consulted in setting objectives
- How the impact of the organisation’s policies and practices on gender equality are assessed
- What action is to be taken to meet objectives over the next three years
- How progress will be monitored.

Indicators of effective practice that might be included within a scheme are:

- Evidence of commitment to gender equality from senior management, from board members to porters and staff throughout the health board
- Evidence of the link to corporate priorities and business plans
- Identified lead staff members with clear responsibilities for taking action
- Resources made available where needed, e.g. for consultation or information-gathering
- Measurable indicators of progress including timescales
- Measures to build the capacity of the health board to meet the duty (for example training, or internal quality assurance processes)
- Separate action plans for individual departments, where relevant
- Details of how gender impact assessment will be incorporated into future planning
- Details of how the health board will ensure the duty is met in procurement and partnership work.

4.3 What is a Gender Action Plan?
An Action Plan takes the objectives set out in the Gender Equality Scheme and shows how they will be delivered, resourced and monitored. It ensures objectives will be achieved within 3 years and allows managers to ensure they can report on progress annually.

A health board must consult with staff, service users and stakeholders to decide on the most important and suitable objectives to be contained in the Action Plan. The Plan needs to be outcomes focussed, less about processes. Action Plans can be designed in a number of ways to fit with existing service planning mechanisms and should cover each function of a health board.

The Action Plan will need to have clear objectives towards promoting gender equality with steps for achievement and a realistic timetable for meeting the objectives. It will also need to indicate responsibilities for implementing the various aspects of the Action Plan and give a clear indication of the specific outcomes it hopes to achieve.

Information gathered both from consultation and from a health board’s own data should dictate the more important actions that need to be taken to make improvements towards gender equality.

It is also recommended that the action plan be divided into separate sections where different teams (individuals) have responsibility for action.

An Action Plan could include:

- Proposals for issues found to be high priority during assessment of present functions and policies
- Proposals for addressing disparities in service evident from involvement with staff and service users
- Plans for monitoring all policies and functions where implications for gender equality have been identified
- Proposals for carrying out gender impact assessments, with timescales for completion
The requirements within the duty do not set out a fixed list of activities that health boards have to undertake. Boards are expected to set their own priorities and action plans to respond to different cultural, social and geographical needs. The aim is better public services for all and to achieve this, health boards will be expected to research and respond to the different and specific needs of the people they serve. This could include looking at the demographic profiles of the people that live in a region who use or may use your services and include NHS national clinical priorities for equality – cancer, mental health and CHD.

The Gender Equality Scheme can be embedded within another strategic document such as an Annual Report, a Strategy Plan or a health board’s Corporate Plan.

4.4 Developing your Gender Equality Scheme

The Gender Equality Duty means that public bodies such as the NHS in Scotland will need to identify major issues for gender equality in their services, employment and policy making. It is not about assuming that all women or all men have the same needs, they simply don’t, it is about making an effort to find out the specific needs and circumstances of different groups of girls and boys and women and men, including transsexual people.

In order to make a policy as effective as it can be for as many people as possible, it is necessary to know which members of society will be affected and how. This means looking at what you already know about your staff and service users, and investigating what you don’t know and taking action based on your findings.

The effect of the duty should be to ensure that gender equality is being recognised and incorporated into all relevant policies, employment practices and service design at every level of health boards in Scotland.

When developing GED schemes, health boards may need to ask:

- What are the issues about gender that a health board needs help with?
- Why is gender important to a board?
- Is gender taken into consideration daily and in every situation it might impact upon?
- What should gender equality look like for a health board?
- What positive difference would it make to a health board?
- Do spending priorities reflect the different needs of women and men?
- How can national equality priorities like cancer, CHD and mental health be implemented?

Each health board is likely to start from a different point in terms of gender information and planning. Regardless, the most important fact is that health boards, whatever their starting points, try to continuously improve their policies and practices in order to achieve real visible change to the health of women and men year on year in Scotland.

Health boards might not be able to take action to improve all of their functions in a single 3-year cycle of the gender equality scheme, but boards have a continuing duty of improvement, which means prioritising functions with the most relevance to gender equality. Fulfilling GED requirements will depend on continuous improvement being made against evidence based and reasonable priorities.

When beginning work on the GED initially, it is important to start assessing where your health board stands in terms of gender equality. A first action, before beginning work would be to set priorities, then to identify what information already exists in terms of gender data and decide what other information may be needed to provide a more detailed picture of the gender position within a health board.

To ensure there is a good understanding of the meaning of gender and gender equality, it is vital to raise awareness by informing all staff from top level down of the reasons why gender is important and that it is about women and men, including transsexual people across all aspects of a health board.

Explanation of Terms:

Policy - an umbrella term for everything we do: Legislation, Strategies, Services and Functions

Due Regard - this concept is based on ‘proportionality’ and ‘relevance’. It is the weight given to gender equality, which should be proportionate to its relevance to a particular function. The greater the relevance of the function to the duty, then the greater the regard that should be paid to it.

Gender Disaggregated Data - information that has been collated and analysed by gender, for example making sure that the results of patient satisfaction surveys at a hospital include a question about whether a patient is male or female. The results of the survey would highlight any differences between men’s and women’s satisfaction with their treatment.
4.5 Gender Equality Awareness Raising
It is important to remember that gender equality is every staff member’s responsibility and it is recommended that all health board staff should have some understanding of the GED. Staff should understand what gender equality means for their work and for their health board’s priority goals.

It is of key importance to get gender equality training right for staff. Training should be targeted and focussed, include some elements of gender equality legislation as well as training about issues for transsexual people who may be staff or service users. All staff will need to understand the full meaning of gender equality in order to work effectively.

4.6 Consultation
The specific duties require health boards to consult employees, service users and trade unions, as well as any stakeholders likely to have an interest in the development of the scheme. Consulting before producing a Gender Equality Scheme and Action Plan will be essential to the process of prioritising steps in the plan and reviewing outcomes and is a legal requirement under the specific duties of the GED.

By consulting, you will be able to:

• Build up a better understanding of the most important issues to achieve gender equality in a board’s work
• Gather evidence to use in setting priorities and to support the gender impact assessment process
• Get feedback on initial thinking around objectives and priorities
• Develop greater ownership of gender equality objectives and priorities
• Improve accountability to staff, service users and the general public
• Change traditional processes that excluded one gender over another

It is the board’s responsibility to select priorities for action in consultation with service users, employees and stakeholders, taking into account all relevant information and the information on page 4 on national and local priorities.

It is also important to ensure that the consultation gives adequate attention to issues of gender equality and that any questions are structured to record outcomes in such a way as to bring out any potential differences in views between girls and boys, women and men, including transsexual people, or between groups of women and men, for example, disability groups.

Providing the right environment so that women and men can fully take part in a consultation process, in order to get a full picture of their concerns is vital. Some women may be less likely to speak out at a traditional public meeting if they do not feel sufficiently confident, if their community discourages women taking up public roles, or if there are language barriers.

Where one gender has been under-represented or disadvantaged in a policy area, service or employment issue, health boards may need to make special efforts to encourage their participation. An example of this might be fathers who previously were not included in discussions on children’s services. There may also be particular barriers to participation where a minority group has experienced multiple disadvantages, for example, on the grounds of ethnicity and sexual orientation - health boards may wish to consult such groups in a single-sex or issue-specific environment.

You may want to consider that focussed consultation with the transsexual community be conducted separately, although they should also be actively encouraged to participate in mainstream consultation processes.

Some external groups that may be consulted with are:

• Immigrants
• Homeless people
• Those in care / sheltered housing
• Men’s Health groups
• Black Minority Ethnic groups
• Community groups
• Transsexual groups
• Sexual Health groups
• Asylum seekers
• Travellers
• Violence against Women groups
• Trade Union representatives
• Women’s health groups
• Lesbian Gay and bisexual groups
• Learning difficulty groups
• Patient groups
What do you need to do?

4.7 Data Collection and Evidence

Health boards will need to set evidence-based gender equality objectives. It is important that gathering information should be one of the first steps in the journey of implementing the gender equality duty and in setting an evidence based objective.

It is also worth noting the three national clinical priorities of cancer, mental health and coronary heart disease and ensuring that gender disaggregated data is compiled for these priorities.

It is important to:

• Identify what data is already being collected and undertake additional data collection if this is insufficient.
• Look at how data is collected, what questions are being asked and response rates.
• Look at how the data or information is analysed and if it is broken down appropriately to provide the right information that you need.

Data indicating unequal outcomes should form the basis of choosing priorities in a scheme; some health boards may already collect data on women and men, including transsexual people, but not develop it appropriately. Sometimes information is not disaggregated by gender or other equality strands, which would allow for a greater understanding of individual needs and circumstances.

It is appropriate to ensure confidentiality for staff and services users and to explain that collecting this data is important to help understand their needs in order to provide better services.

It would be useful to look at national statistics and research as a baseline for information gathering, but also to look at internal data. It is valuable to acknowledge information from other sources such as prison services, police, domestic abuse organisations, sexual violence help groups, as well as employment and poverty information.

If data and research is undertaken in a gender sensitive manner then it is more likely to lead to improved treatment outcomes.

Example: If few men are accessing flexible working policies, relative to the proportion of female staff that do, a health board may want to take more steps to support more men to work flexibly. It would be useful to gather information on reasons why men don’t adopt such a policy.

Here are a list of possible categories for data collection:

• differences in how women and men access and use services, barriers in access, and satisfaction rates
• any information on who is not using services when they might be expected to do so and why?
• service outcomes broken down by gender, e.g. referral times for specific health conditions, employment rates after training
• balance of men and women in key decision-making areas, including public appointments and in the consultation process
• the gender profile of staff – data on recruitment, promotion, the distribution of women and men in the workforce by seniority and by types of work (‘vertical and horizontal segregation’), flexible working take-up rates, an analysis of training opportunities, appraisals, grievance and disciplinary procedures, reasons for leaving and redundancy.

This data also needs to be analysed for part-time staff, and those with caring responsibilities, as women are disproportionately represented in those groups. Where relevant, external organisations providing services under contract should be asked for similar information on their staff.

• barriers to staff progression
• the extent and causes of any gender pay gap for full-time and part-time staff, including the impact of occupational segregation, of discrimination and of women’s disproportionate share of caring responsibilities
• the prevalence of harassment and sexual harassment of staff and service users, the number of formal complaints and the outcome of complaints
• return rates of women on maternity leave and whether they are returning to jobs at the same level of responsibility and pay
• issues and barriers affecting transsexual staff and potential staff.
• Analysis of ill health and disease using gender sensitive approaches
• Analysis of service delivery issues using gender sensitive approaches

4.8 Gender Impact Assessment

One of the specific duties of the GED is to conduct Gender Impact Assessment (GIA) to provide an understanding of the impact that policies and services may have on women and men, including transsexual people to ensure they are not disadvantaged and take action to address any adverse impact. In Spring 2005, the Scottish Executive Health Department requested that all NHS boards undertake Equality and Diversity Impact Assessments (EQIA). EQIA is a step-by-step process to enable NHS boards to develop policies and strategies that meet the demands of equality and diversity legislation.
The EQIA tool will help boards meet their duty to carry out gender impact assessment as long as the gender dimension has been clearly considered. This section discusses GIA but is just as relevant to broader EQIA tools which include a gender dimension.

Since the GED is focused on outcomes, gender impact assessing relevant policies, practices and developments will enable outcomes to be delivered.

GIA is not just about developing a scheme every three years. It is a continuous practice to embed gender equality into everything a health board undertakes. It is key to the everyday business of a health board.

**What do you need to do?**

**What do I have to do?** Ask questions about a policy, such as:

- Does the policy promote gender equality?
- Does the policy reinforce gender stereotypes?
- Is there evidence to suggest that boys, girls, women and men including transsexual people, have different needs, experiences, concerns or priorities in relation to a policy area?
- Could the policy unintentionally disadvantage people of one gender or the other, or transgender people?
- Is it appropriate to include stakeholders, staff and service users in a GIA consultation?

**Begin Gender Impact Assessing current priorities now: Cancer, Mental Health, CHD.**

**Why Gender Impact Assessment?**

- Many health boards have incorporated GIA into their existing EQIA practice. They already recognise that it is a useful tool to help them to identify unexpected negative impacts on men and women, including transsexual people.
- It helps to avoid unintentional discriminatory practices, and to build fairness into new developments from the start.
- It can help in identifying areas for positive action to promote gender equality.
- The outcomes from GIA’s can be useful learning to support continuous improvement across the organisation and to build into self assessment processes.

**Effective Gender Impact Assessment is key to effective mainstreaming of equality**

1. Identify all aims of the policy
2. Consider the evidence
3. Assess the likely impact
4. Consider the options
5. Consult on the policy
6. Decide whether to adopt a policy or not
7. Make monitoring arrangements
8. Learning from Results

**Some useful points to take into consideration when undertaking GIA:**

- How is gender equality monitored?
- Who monitors the quality of the GIA work?
- Set out a vision for the difference a GIA will make, for example, helping to reshape services for women and men to achieve a national health target
- GIA will cover all practices and policies and not just new policies; you may need to prioritise which policies you assess first, based on the principles of proportion and relevance to gender equality

**Remember the key points**

- Evidence and data collection: break down information by gender
- Raise awareness of the Gender Equality Duty, ensure that staff understand ‘gender’
- Gender Impact Assess policies, legislation and services continuously
- Keep the needs of transsexual people in mind
Section 5
Other things to think about to promote Gender Equality:

5.1 Employment
The NHS in Scotland is the largest health sector employer with approximately 153,000 staff. Some information about NHS staff in Scotland:

- Women make up 78% of staff in the NHS
- Largest proportion of which are nursing and midwifery staff - approx 43%
- Midwifery and nursing staff that are women - approx 90%
- Female nurses and midwives employed on a part time basis-50%.

The large percentage of women working in the NHS in Scotland has implications for the career progression of nurses and midwives, as well as of managerial succession planning for the NHS.

Example: Within the nursing profession, maternity and/or career breaks often result in career regression. If nurses do not maintain their clinical knowledge and practice, they regularly go back to a lower grade or at worst, lose their registration status.

Although women make up nearly 78% of the NHS Scotland workforce, the evidence relating to rates of pay, employment conditions, pensions and occupational segregation show a high level of gender based inequality. The typical woman's experience of employment is different to that of men's due to the demands of trying to balance employment and domestic care responsibilities.

The gender composition of the medical profession shows rising numbers of female medical graduates and more than 50% are women, who are increasingly making up a substantial part of the medical workforce in the NHS. There is, however, gender separation of the medical workforce with women preferring general practice as opposed to acute specialities and other senior positions. This is partially due to general practice offering more flexible work practices, providing more of a balance between work and family life.

Within the NHS in Scotland, there is a gender imbalance within a sector dominated by women, but with low levels of representation at senior level.

For many women, their experience is of low pay, low skill jobs and a marked pay gap. Work life balance policies may have enabled many women to combine employment and work at home, but it has reinforced the notion that this is a women’s responsibility.

Employment measures are often interpreted to be about assisting women with achieving a work life balance and less attention is given to the changing role of men in the workforce.

5.2 Equal Pay

5.3 Agenda for Change

5.4 Publishing an Equal Pay Policy Statement

5.5 Training

5.6 Procurement

5.7 Transsexual People - Gender Reassignment

5.8 Enforcement

“Within the NHS in Scotland there is a gender imbalance within a sector dominated by women, but with low levels of representation at senior level.”

Pictured Right:
Kathleen Robertson, Antenatal Clinic Sister, NHS Fife
Existing assumptions about what men and women do and the resulting expectations this creates, may lead to unfair and unequal treatment. To counter balance this, the NHS could encourage more men to adopt work life balance policies.

Of employees who work in the Health and Social Work sector in Scotland (2006), 77% are women, however women only make up 19% of Chief Executives in the Health Service.

A member of staff is dedicated to supporting employees on these issues and is determined to promote childcare responsibilities to male colleagues. Everything has to be evidence based and clear data on improved recruitment and retention of employees, improved staff morale and improved service delivery to patients and their relatives. Since April 2003, there have been 21 applications for paternity leave and the Work life Balance Manager supports fathers in addressing custody and guardianship matters. “Unless we get parity of childcare for men, we’ll never get equality for women” the organisation says.

Some ways of improving the service you provide could be:
• Look at how jobs are advertised, are all posts advertised out with the health board?
• Are all jobs open to suitably qualified people, regardless of their gender or the hours they work?
• The areas of pay and merit based promotion are still issues, though the public sector has made the most accommodation here, has your health board?
• Reduce any long hours culture that exists
• Flexible working policies open to all, not just for staff with care responsibilities

5.2 Equal Pay
It has now been over 30 years since the Equal Pay Act came into force and there is still inequality between women’s and men’s pay.

While the pay gap has narrowed in Scotland, it still remains at 11.2% overall for full time equivalents. The pay gap for part time work (female hourly part time pay compared to male hourly full time pay) is 38.5%.

Around 2 in 5 women (42%) and 1 in 10 (11%) men work part time. For men working part time, the pay gap is similar to that of women – 38% compared with male full time hourly earnings.

Three causes have been identified which need to be acted upon in order to close the public sector gender pay gap:
• Occupational Segregation
• Discrimination
• Impact of caring responsibilities

Taking action on closing the gender pay gap as an employer will help to make the most of the potential of all staff and also help to close the productivity gap within a health board.

Taking action on gender equality will enable the board to attract and retain staff and to develop a more productive and motivated workforce that is better able to deliver high quality public services.

Example: An NHS organisation has increased the number of men working part-time from 2 to 61. The organisation looked at the interests of different groups, such as new fathers, flexible workers, non–resident dads (including custody and guardianship issues).

Example: A member of staff employed by a health board in Scotland went on maternity leave. During the initial period of her maternity leave she was awarded a pay rise. On querying why the rise was not included in her monthly salary she was told by a member of her HR team that she was not entitled to it until after her maternity leave was finished. This clearly breaches the Equal Pay Act by penalising the staff member for being pregnant.

What a health board could look at:
• Offering flexible working hours choices such as flexitime, job sharing or term-time working for both women and men.
• Offering flexibility in terms of working location can mean allowing people to work from home, other offices or centres or wherever suits the worker if appropriate.
• Offering flexibility in work tasks could mean removing any traditions in task allocation; introduce portfolio working for example, where people have a collection of tasks or projects to work on.
• Positive action, supporting women to consider senior roles through training and mentoring.
• Making efforts to increase the number of female porters or male nurses it employs.
5.3 Agenda for Change
Agenda for Change is a new pay and reform package that aims to ensure that people who work in the NHS are paid on the basis of equal pay for work of equal value. It applies to all directly employed NHS staff, except the most senior managers and those covered by the Doctors’ and Dentists’ Pay Review Body. The Agenda for Change pay review that is currently taking place within the NHS in Scotland will be impact assessed at national level.

5.4 Publishing an Equal Pay Policy Statement
Under the specific duties, all listed bodies need to consider including an equal pay objective in their gender equality scheme. This means that each organisation will need to undertake a process of determining whether their policies and practices are contributing to the causes of the gender pay gap. This should be done in consultation with employees and others, including trade unions. Organisations which choose not to include an equal pay objective within their scheme will need to justify their reason for this.

In addition, by 28th September 2007, health boards with 150 or more full time equivalent staff will be required to publish a statement outlining their policy on equal pay between men and women. They will need to report on this statement within three years.

For more information on equal pay, see the Gender Duty Scottish Code of Practice, the Code of Practice on equal pay and our guidance on meeting the gender duty on employment. www.eoc.org.uk/fairforallgender

5.5 Training
Methods for monitoring training outcomes could be put in place in order to assess the training impact on staff, to ensure the quality of training is satisfactory and that women and men have equal access to training opportunities.

Multi media training and learning (such as e-learning) should be used to support trainer led gender education, and not as the sole method. In order to mainstream gender equality fully, gender equality training should be mandatory. Training will only deliver best value if all staff working across all aspects of a health board are aware of the need for change and are given the opportunity to implement that change.

It may be worthwhile to mix groups of staff when organising face to face training sessions. For example, board members, medical secretaries, cleaners and other staff to attend the same training sessions, allowing staff to see that responsibility for gender equality is across an organisation and not just directed at certain staff.

It may be useful to find out what particular staff needs there are firstly, ensuring the best type of training is provided. A list of methods to train and raise gender awareness could be:

- training programmes - face to face gender equality training
- e-training to support and follow up on face to face training
- staff briefings, series of lunchtime events on different aspects of gender equality
- “Train the Trainers” sessions, to cascade gender equality learning
- induction for new staff on gender issues
- building goals and targets relevant to the duty into staff personal development plans across the organisation.
- recognising progress in achieving gender equality when rewarding individual and team performance.
- staff newsletter – regular items
- staff and health board intranet system
- staff surveys
- invite staff to share their gender experiences and those of their families with board staff/workers in a facilitated workshop environment
- use the same forum to explore ways in which community engagement could be enhanced for health staff, contractors and others
- consider appointing a member of staff in GP surgeries, clinics and health centres to over see the integration and mainstreaming of gender equality into day to day working practice

NHS organisations that treat staff fairly:

- Are more productive
- Are more innovative
- Have a positive corporate image

- Reduce absenteeism and sick rates
- Retain skilled staff more easily

Explanation of Terms:

**Good Practice** - examples of organisations who are already taking gender into account when planning services or in employment of policies.

- NHS organisations that treat staff fairly:
  - Are more productive
  - Are more innovative
  - Have a positive corporate image
  - Reduce absenteeism and sick rates
  - Retain skilled staff more easily
5.6 Procurement
The requirements of the Gender Equality Duty will apply to the procurement of all goods and services supplied to NHS Scotland Health Boards as well as to GP’s, consultants and dentists in their commissioning roles. As providers, they will be required to consider gender equality if it is written into their contract with a health board. Other independent contractors, including treatment centres, will be covered by the duty to the extent that they are exercising a public function. All suppliers of services to the NHS in Scotland must have an Equal Opportunities Policy that they adhere to. Procurement is an activity that health boards should seek to develop baseline data for and monitor later progress for gender equality.

For more information on the area of procurement, please refer to guidance at www.eoc.org.uk/fairforallgender

5.7 Transsexual People - Gender Reassignment
The Gender Equality Duty requires health boards to pay ‘due regard’ to the need to eliminate discrimination and harassment towards transsexual staff. Although the gender duty does not explicitly require the promotion of equality of opportunity between transsexual and non-transsexual people, those working within NHS Scotland should aim to do this as a matter of good practice.

The term transsexual is usually used to describe a person who intends to undergo, is undergoing or has in the past undergone gender reassignment (which may or may not involve hormone therapy or surgery), and it is this individual who receives protection under the law.

Transsexual patients should be treated with respect and a health board has a moral responsibility to ensure that they do not suffer discriminatory behavior also. To ensure that transsexual staff, patients and carers’ are treated appropriately, a health board might consider specific training for staff on transsexual issues.

For more information on this area of legislation, please refer to our guidance on ‘The Gender Equality Duty and Transsexualism in Employment’ www.eoc.org.uk/fairforallgender

Explanation of Terms:
Procurement - buying or purchasing of services. The process where a health board enters into a contract with an external company or person to carry out works, provide goods or services. This could be from a private company, another public organisation, or a voluntary sector organisation.

Transsexual - is a person who intends to, is undergoing or has undergone gender reassignment to change sex. It means that a person identifies with the sex other than that on their birth certificate or often feels they were born in the wrong body.

Gender Reassignment - a process taken under medical supervision, of reassigning a person’s gender by changing physical, social or other characteristics.

Gender Dysphoria - is when someone’s sense of who they are in relation to being boys/men or girls/women is different to that of the gender they were assigned at birth.
Other things to think about

5.8 Enforcement
The Gender Equality Duty will be enforced firstly by the Equal Opportunities Commission (EOC) and from October 2007 by the Commission for Equality and Human Rights (CEHR). The CEHR will have the power to undertake formal assessments and to issue compliance notices in connection with a breach of the general duty. It will also be empowered to serve compliance notices on public bodies failing to meet the specific duties.

Monitoring and Reviewing
The Scottish Health Council (SHC) has a central role in assessing NHS Scotland’s public involvement and equal opportunities duties, which includes gender equality. With a remit to monitor, promote and quality-assure the Patient Focus Public Involvement activities undertaken by health boards and to hold the NHS to account for its performance on involving the public, the SHC assessment will ask Boards to identify how they have considered gender equality in meeting their Performance Management targets (HEAT).

The Diversity Task Force (DTF) acts as an internal assurance mechanism, ensuring NHS Scotland has the policies and procedures in place to deliver year on year improvement in meeting their equalities requirements. In partnership with Fair for All – Gender, the DTF will undertake quality assurance of GED schemes to identify good practice as well as areas where NHS Scotland needs to improve.

Audit Scotland will also have a role to play, as will various patient and voluntary organisations in their monitoring of individual health boards.

For detailed information on enforcement issues, see the Scottish Code of Practice at www.eoc.org.uk/fairforallgender

The extent to which compliance with the duty has been undertaken will be assessed by the EOC on the following criteria:

- Information
- Consultation
- Transparency
- Proportionality
- Effectiveness

Explanation of Terms:
Commission for Equality and Human Rights (CEHR) - this is the new unified organisation that will bring together the 3 current equality commissions, the Equal Opportunities Commission, the Disability Rights Commission and the Commission for Race Equality. It will also focus on human rights and the three other areas of discrimination: age, religion and belief, sexual orientation.

Enforceable by law - a law that has been passed by parliament that must be obeyed, for example, the Gender Equality Duty. It means that failure to comply with the duty's requirements could result in prosecution.

Key points to remember:
- Evidence and data collection: break down information by gender
- Raise awareness of the Gender Equality Duty, ensure that staff understand 'gender'
- Gender Impact Assess policies, legislation and services continuously
- Keep the needs of transsexual people in mind
Section 6
Additional Information

6.1 Useful tips to support success
Here are some key requirements for success in achieving a health service that embraces gender equality:

- Ongoing health board top-level commitment with appropriate organisational resources to help achieve gender equality.
- Board level leadership and accountability, senior level support and accountability.
- Developing a shared understanding of gender issues and a shared vision of what gender equality could look like for a health board, this could be linked to organisational objectives.
- Specialist staff to steer the process and develop gender awareness and analysis skills.
- Developing good systems of disaggregating new and existing data by gender.
- Involve staff, patients, carers, unions, voluntary sector and stakeholder organisations in the gender development process, including consultation and gender impact assessment.
- Involving staff in the development and implementation of the GED in order to provide improved health outcomes for gender sensitive services and interventions.
- Building gender equality into standards and objectives and into routine organisational procedures such as policy and budget approval, department targets, job descriptions, objectives and appraisals.
- Mainstreaming gender: take steps to ensure that the different needs between women and men are understood and acknowledged in all areas of work, from the planning of services, recruitment and management of staff to education and training, delivery of care and audit and evaluation. Mainstreaming applies to all levels of staff.

6.2 Some practical tips on mainstreaming gender across a health board

“...The Fair For All - Gender and Equal Opportunities Commission partnership demonstrates our commitment to working together to tackle gender health inequalities and to promote the benefits of diversity across Scottish society.”

Pictured Right:
Alexander Keir, Dental Nurse, NHS Lothian
6.2 Some practical tips on mainstreaming gender across a health board

- Embed gender equalities issues into performance management and appraisal systems, ensure all staff know the benefits of gender equality and how it affects their work.
- When there is organisational change, make sure gender is taken into account. Build it into all policy development and change structures so that it is considered a matter of course.
- Where does the Equality and Diversity Team sit within your health board? If it answers directly to the Chief Executive then there will be more chance of success with GED implementation.
- Use formal and informal networks and key members of staff to spread gender equality.
- It is hard to keep up momentum once the initial work has been done. Getting gender equality into mainstream service design is the most likely way to bring long-term benefit.
- Consider having gender equality ‘champions’ throughout the health board.
- It is important to bring the community into the organisation to give them a voice. They can help to monitor progress and in setting priorities.

“Health is a state of complete physical, mental and social well-being and more merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living. It is a positive concept emphasising social and personal resources as well as physical capabilities”.

6.3 References

9. EOC Wales/Welsh Consumer Council (2006) Gender Equality in Public Services: Care for Older People
10. EOC Wales/Welsh Consumer Council (2005) Gender and Bus Travel in Wales
11. EOC Scotland/Shared Intelligence (2005) Gender Public Sector Duty Pilot Project
17. EOC briefing / Peter Baker (2005) Improving the health of men & women The sex war in health is over
6.4 Legislation
1. The Equality Act 2006
2. The Gender Reassignment Act 2004
3. The Race Relations (Amendment) Bill 2000
4. The Scotland Act 1998
5. The Human Rights Act 1998
7. The Race Relations Act 1976
8. The Sex Discrimination Act 1975

6.5 Glossary - some useful terms

**Code of Practice** - The legally binding interpretation of the Gender Equality Duty. It will assist with what is needed under the law, to fulfil the obligations that the NHS in Scotland has and will be available on the EOC website.

**Equal Value** - When work is different but considered to be of equal worth in terms of demands, such as decision-making, skills and effort.

**Gender Identity** - A person’s sense of identity defined in relation to the categories of male and female. It is important to note that not everybody identifies only with one gender or the other. Some may identify as both male and female, while others may identify as male in one setting and female in another.

**Multiple Identity** - Coming from more than one defined community, for example being black and gay, or lesbian and an older person.

**Positive Action** - This is encouraging people from an under represented group to apply for jobs, training or promotion. In terms of gender equality, this could mean placing an advert in a magazine read specifically by men of a certain age, or women from a specific background to encourage them to apply for a job or jobs in certain sectors. However, all candidates would be subject to the same short listing procedures. This is lawful under the Sex Discrimination Act. Positive discrimination is unlawful in the UK. This would mean that an employer would only short list people from the under-represented group.

**Transparency** - When an organisation has made information on its decision making process, priorities and actions widely available to the public. This could include employers who list the criteria that they use in recruitment.

Further glossary terms available at www.eoc.org.uk/fairforallgender

6.6 Contacts

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6.5 Acknowledgements

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7. Mark Ward, National Co-ordinator, Mens Health Forum Scotland
8. Laura Turney, Gender Lead, Gender Mainstreaming Team, Scottish Executive Equalities Unit
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