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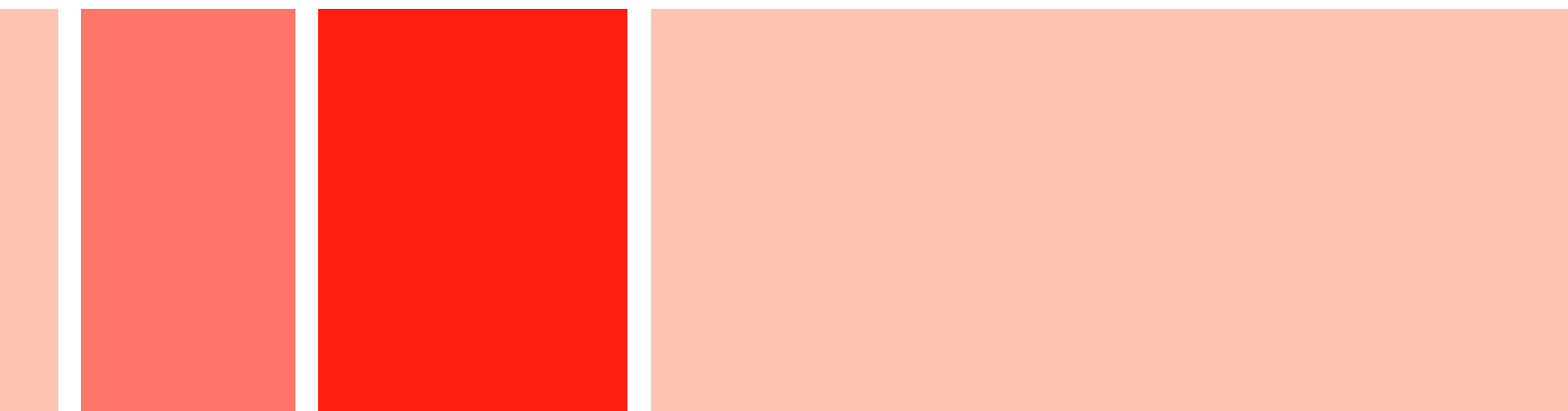
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Review of Evidence of Inequalities in Access to Health Services in Wales and the UK: Gender, Gender Reassignment, and Sexual Identity



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ESRC PhD Internship Programme

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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Acronyms

| | |
|--------|---|
| BME | Black and minority ethnic |
| Bpas | British Pregnancy Advisory Service |
| CEMACE | Centre for Maternal and Child Enquiries |
| CEMACH | The Confidential Enquiry into Maternal and Child Health |
| EHRC | Equality and Human Rights Commission |
| GP | General Practitioner |
| LGB | Lesbian, Gay and Bisexual |
| LHB | Local Health Board |
| T | Transsexual |

Executive Summary¹

Background

This report seeks to review and synthesise the body of evidence on inequalities and inequities in access to health services that are associated with characteristics of gender, sexual identity and gender reassignment. It is envisaged as the first part of a full review of inequalities of access to health services that will form a foundation for the development of interventions and the sharing of good practice.

This review is based only on published evidence for inequalities in Wales and the UK and does not review current practice.

Primary Care Services

There is more research that relates to inequalities of access to primary care services compared to other areas. In addition, the evidence is mainly based on larger samples of the population, with the notable exception of data for Lesbian, Gay, Bisexual and Trans people. Though we can be less confident in the reliability of this data for these latter groups, we have significantly greater knowledge about the experiences of LGB and Trans people than has been included in previous reviews.

Although consultation rates differ for women and men in the UK, with women being more likely than men to access their GP or practice nurse, evidence suggests that there are only minor differences in their preferences in how to access or book GP surgery services. Men are only slightly less likely than women to state that they have a preferred GP, prefer same-day appointments or that their surgery's opening times are convenient for them. Women and men are as likely to say that they would like additional opening hours, in particular after 6:30pm and at the weekend. Men continue to be less likely than women to use NHS Direct services despite agreeing that they are convenient. Evidence for gender differences in help-seeking is conflicting and inconclusive.

Relying on public transport may pose a barrier to accessing health services as it is less convenient than private transport, particularly for disabled people or people travelling with children. There is some evidence to suggest that particular women may feel unsafe.

It is difficult to collect robust statistical data for Trans people in Wales and the rest of the UK, though there is data available thanks to a larger survey

¹ The points presented here reflect conclusions shown in the literature. This does not exclude the possibility that similar issues affect further groups of people not yet been demonstrated through research, for example, some of the issues affecting LGB people with regards to assumptions about their care needs, or fear of prejudice, may also affect Trans people.

conducted recently and further data relating to their experiences of health services (**see Gender Reassignment**). Trans people may face barriers to accessing 'safe-spaces' such as community group meetings due to working hours and lack of non-gendered facilities. Sixty five per cent of Trans people report experiencing 'negative interactions' within general health services.

Lesbian, Gay or Bisexual people have less confidence in their GPs than straight people and report poorer experiences of consultations. Only a quarter of LGB people felt they had received advice that was relevant to their sexual identity. Some feel that they have had no opportunity to disclose their sexual identity to a health professional or would fear doing so. There is strong support for the development of 'safe-spaces' for LGB and Trans people in which to receive health advice. The most vulnerable people in these groups would prefer to consult a specialist GP.

Referral and Records

There are indications that the process of changing an individual's biological sex and name on their medical record is inconsistent for people undergoing gender reassignment. This can cause great distress to individuals and the repercussions of this can 'out' them, for example through wrongly or dual addressed letters.

When consulting LGB people, health professionals can sometimes make inappropriate assumptions about their patient's health needs based on their sexual identity.

There is also only a small amount of research on whether men and women, who present with the same symptoms, are treated or referred differently because of their sex. Evidence in this area remains contradictory and inconclusive.

Intersections

The quality of evidence for 'intersectional' disadvantage is varying.² Statistics from the GP Patient Survey 2011-2012 give us reliable information about usage for BME groups. Smaller pieces of evidence that inform us about other minority groups are less robust but can be used to highlight relevant concerns.

Ethnicity: Looking at the GP Patient Survey for 2011-2012, people from Black or ethnic minority backgrounds (BME) are more likely than white people to have never seen their GP or practice nurse. BME men are more likely than

² Disadvantage may be 'intersectional' when an individual's adverse experience is associated with more than one characteristic. It may be that disadvantage arises as a result of a particular combination of characteristics or that disadvantage that is associated with each of the characteristics is compounded.

any other group to report that usually only one GP is available at their surgery. BME men are more likely than white men to say that they have accessed out-of-hours services in the last 6 months. Other evidence suggests that the sex of the GP or nurse may represent a barrier to access for Gypsy or Traveller people and language barriers among some BME groups may impede understanding of health advice.

Age: Older LGB people are more likely to say that they will need to rely on care services in later life, but some express fears of prejudice from carers and that disclosure of their sexual identity may adversely affect their care. There is limited evidence that adolescent girls report lower self-esteem than boys.

Disability: LGB disabled people also report concerns about care staff prejudice and maltreatment. Women and younger disabled people are more likely to report barriers to accessing healthcare, but the reasons for this are unclear.

Other marginalised or vulnerable groups such as homeless people, those fleeing from domestic abuse, or lone parents may have reduced access to health services due to lack of transport, the cost of reaching services, or difficulty finding alternative childcare.

Pregnancy and Maternity

Evidence in this area comes from small-scale studies that give us insights into issues for further research.

Ethnicity: Women from BME backgrounds are more likely to book late for antenatal care and language barriers among some groups may impede understanding of health advice. Women's preferences for interpreters can be complex: some experience difficulties accessing professional interpreters or experience discomfort with interpreters they do not know, preferring friends and family to interpret. Yet, for others this can compromise their ability to communicate sensitive information or emotions in an open manner.

There is some evidence that health professionals can make assumptions about patient preferences or health needs based on ethnicity and that these can be inappropriate. Refugees and asylum seekers appear to be particularly vulnerable and face multiple barriers to access, including: lack of interpreters, lack of knowledge among health professionals about Female Genital Mutilation, mixed-sex services, difficulties registering with a GP, lack of understanding of UK healthcare procedures and organisational structure, and accessing low-income benefits.

Sexual Identity and Trans

Same-sex parents or co-parents³ may be reluctant to disclose their family status to health professionals, and report mixed experiences of whether they feel included by maternity professionals. They may also experience difficulties accessing relevant information and support.

During the time available for this research, no studies on experiences of UK services of Trans parents were found. Further work is needed to identify whether this represents a genuine research gap, or simply insufficient time to identify in this review.

Age: Local evidence suggests that some younger parents feel stigmatised by health services because of their age. Young fathers can feel uncomfortable attending antenatal classes and marginalised during check-ups. Some young men also report that they find it difficult to attend appointments, because they cannot secure time off from work/education. Evidence for inequality regarding young women's access to abortion services is unclear, but there has been an indication that the NHS is less likely to carry out abortions after 13 weeks than at private clinics. This has the potential to cause inequality in access to abortion services, particularly for those who rely on public transport.

Disability: Disabled people may experience lack of accessible equipment or facilities for postnatal care in hospitals.

Sexual Health

Much of the information in this area comes from local studies. Lack of ability to generalise for the whole population may be considered a concern regarding data for larger populations such as women and men; however, for minority or 'hidden' populations data can be difficult to obtain.

For young men, it has been suggested that opening hours of GUM clinics and reliance on public transport may pose a barrier to accessing sexual health services, along with peer pressure and concerns about confidentiality.

Fifteen per cent of Lesbian or Bisexual women have never been offered a smear test and there is a perception among LGB people that there is little visible information about LGB sexual health. LGB people report that health professionals sometimes make inappropriate assumptions about their sexual health needs and that sexual health risks for LGB people are not fully understood by all health professionals. Bisexual people are least likely of all to agree that health information caters for all groups. Trans people are most likely to disagree that health information is appropriate to their identity or sexual identity.

Some BME women may find it more difficult than women of white background to talk with friends and family about sexual health, pregnancy and abortion,

³ The term 'co-parenting' describes a context where the parents are not in a marriage, cohabitation or romantic relationship with one another.

and may also perceive that health services do not appreciate cultural differences.

Cancer Treatment

Some large surveys offer us robust evidence of inequalities of experience of cancer treatment and screening services. However, it is important to remember that research that asks about attitudes and perceptions often tell us about social and cultural *norms*. Though interviews and self-reporting surveys are an often necessary and convenient method of collecting data, we should be wary of inferring a direct relationship between perceptions and behaviour.

Women are more likely than men to have access to a Clinical Nurse Specialist (CNS). Having access to a CNS is associated with increased satisfaction of cancer treatment. Yet, men are generally more positive than women about their experience of cancer treatment: especially regarding staff attitudes, privacy, provision of sufficient information, and being treated with dignity and respect.

The association between level of knowledge about colorectal cancer screening and having negative attitudes is inconclusive: whilst men are slightly more fatalistic in attitude towards bowel cancer than women, they are more likely to report that they 'never feel frightened' at health appointments. Women express greater levels of disgust and embarrassment about the bowel cancer screening procedure.

Some evidence suggests that men's partners may be influential in them taking action on health issues.

Exercise and Weight

There are few sources of evidence for inequalities in access to exercise and weight-management services. The data on these areas cannot be considered robust but only an indication of the issues.

LGB and Trans people express a fear of prejudice that may discourage them from exercising in public spaces.

Women are more frequently recorded as obese by their GPs but also are more likely to consult for problems with eating. The relationships between norms of 'masculinity' and exercise/food are complex and differ significantly between various masculine ideals.

Alcohol and Smoking

There are inequalities between men and women, not only in the rates of referral for substance misuse, but also in mode of referral. There is very little other robust evidence in this area and some of the conclusions from the data are conflicting: the relationship between alcohol tolerance and sex is unclear and there is a lack of robust evidence for gendered attitudes towards and usage of alcohol and smoking.

There is some evidence that prior to the regulations on smoking in public places, Lesbian or Bisexual women were less likely to want to give up smoking than Gay or Bisexual men or people identifying as an 'other' gender. It was not possible in the time available for this research to identify comparable studies conducted after the introduction of these measures.

Gender Reassignment

We are not able to estimate the number of people who identify as 'Trans', or the number of people who may wish to undergo gender reassignment but who have not yet begun the process, and so data relating to this population cannot tell us the prevalence of particular problems in relation to the wider population. However, the evidence that does exist is detailed and a good indication of the issues that Transsexual people might face.

Some people experience difficulties in getting GPs to refer them for gender reassignment services and some GPs are not fully informed about gender reassignment processes or refuse treatment. There are gaps in provision of certain services in Wales. There is strong support for more local services and GPs specialising in Trans health needs. Satisfaction with Gender Identity Clinics is extremely varied and a high number of Trans people report having experienced negative interactions in this setting. Some Trans people report withholding information or lying at Gender Identity Clinics due to perceived irrelevance of questions or fear that treatment will be delayed or withheld.

Criteria for qualifying for gender reassignment may not be consistent among local health authorities. A minority of Trans people feel adversely affected as a result of health staff prejudice. Up to 59% of people undergoing gender reassignment are not entirely happy with the support they received from surgery or nursing staff. This figure may be higher for public health services.⁴

It is generally not possible to move between Gender Identity Clinics if you move away from the area: this may prove a barrier for people relying on public transport or who have limited funds.⁵

Prison

⁴ A new standard Gender Dysphoria care pathway has recently been developed in Wales that is likely to address some of the problems raised.

⁵ *Ibid.*

Evidence for inequalities in access to health service whilst in prison is available from few sources: these consist of studies and policies commissioned or produced by various government departments.

Prisoners who have experienced gender-based violence may need special health care provision and pregnant women who arrive in prison may have had unequal access to services previous to admission and subsequently have different health needs whilst an inmate.

Some details of provisions that are available to prisoners undergoing gender reassignment remain ambiguous. There is a lack of evidence on the experiences or safety of prisoners undergoing gender reassignment and a need to monitor the implementation of guidance.

Mental Health

The small amount of data on the subject of usage of mental health services is more robust than the majority of the research that discusses attitudes towards mental health. However, as outlined above, caution needs to be exercised in making any connection between attitudes expressed by participants in research and patient behaviour.

Men are more likely than women to be formally referred to NHS mental health services or to be admitted to independent hospitals, whereas women have higher rates of informal admission. Men may be more likely than women to find themselves in situations that put them at risk of mental illness. From attitudinal studies, some men express concern at the availability of information about mental health and urgent help. Some report difficulties discussing their mental health with a GP and would prefer to consult a specialist GP (though these data are not compared with those for women). Men express slightly less tolerant attitudes towards people with mental health issues, but are more likely to believe that people can completely recover.

Women with mental health issues may not feel comfortable in mixed-sex services.

Rates of detention in medium and high security wards are higher for BME people and Black African and Black Caribbean men are more likely to be in receipt of mental health services compared to white men. There are concerns among some BME groups over the cultural sensitivity of mental health services.

LGB and Trans people who have mental health difficulties are more likely to report that they have felt uncomfortable using mainstream services and a majority report experiences of negative interactions within this setting. Almost a third of Trans people who have used mental health services report feeling that their gender identity was not seen as valid but as a symptom of mental ill-health. Thirty eight per cent of Trans people who have been inpatients have

experienced problems such as harassment, misgendering or uncertainty as to where they will be placed within single-sex facilities.

Pharmacies

Only a handful of studies have looked at the issue of pharmacy use and more data is needed in this area for policy development: it seems that only a small proportion of men visit pharmacies for general health advice. Contrary to some hypotheses about self-treatment among men, men may be slightly less likely than women to buy over-the-counter medicines. Pharmacies are often used for medical advice when GPs' time is deemed to be 'too valuable' to spend on minor health issues, and when pharmacists are believed to be qualified to diagnose illness.

Further services and intersections

This section includes evidence of inequalities in access to services that have not yet been included, or that are associated with two or more protected characteristics including gender, gender reassignment or sexual identity. Much of the data for further intersectional disadvantage and services is based on small-scale investigations. This evidence should be regarded as a window into the issues that people may face when accessing health services and a sensitising tool in the development of interventions.

There is some evidence that assumptions may be made about an individual's ability to care for a relative or partner based on their sexual identity. Older LGB and Trans people may fear discrimination and abuse from care providers. Bisexual people may have health needs that are not addressed by mainstream, Lesbian or Gay-specific services.

For some, lack of disabled access and long waiting times may be a barrier to accessing mental health services and women with learning disabilities may have reduced access to support during the menopause.

People who are divorced or widowed are more likely to experience mental health difficulties.

The Law

There is little evidence on this topic, but we may be confident in that some legal difficulties remain for people who undergo gender reassignment: transsexual people who are married may need to divorce and then obtain a civil partnership in order to obtain their Gender Recognition Certificate. There are indications in research that this process can be distressing.

Although the methods used to obtain evidence of concerns expressed by LGB people are not always robust, it echoes worries about lack of understanding and/or prejudice towards sexual minority people in other areas of health service. A small number of LGB people have expressed concern that health professionals may not be able to identify their next of kin in an emergency.

Respect and Dignity

As with other areas of evidence in this review, the methods used to gather data from minority groups are not always as robust as would be preferred for the development of policy or interventions. Attitude surveys also present challenges to interpretation, as outlined previously. However, the experiences reported do raise important issues of inequity that should not be ignored.

According to the only study in this area, one in seven Trans people report feeling treated adversely by health professionals and there are reports that some Trans people are placed in hospital wards that are inappropriate for their sex. Similarly, Intersex people are not always included in appropriate screening programmes.

In some cases, health professionals insist on procedures that are not relevant to LGB people. A minority of LGB people in Wales report negative experiences of health care and a minority of LGB people would not register their same-sex partner as next-of-kin for fear that their care would be adversely affected.

Health professionals can make inappropriate assumptions about the fertility or pain management preferences and needs of BME women.

In the only study that could be located on this issue, NHS-provided abortion services receive more negative feedback on how supportive services are for young women compared with specialist providers such as Marie Stopes or British Pregnancy Advisory Service (bpas).

Recommendations – Next steps

1. Complete Review of Protected Characteristics

In the endeavour to reduce inequality, it is important to make recommendations based on this review *and* a review of the remaining protected characteristics and issues that have not been discussed in this report. Many issues, for example communication with patients, will be cross-cutting.

2. Review Interventions and Develop Case Studies to Share Good Practice

It is possible that some of the operational-level suggestions made here are already being implemented by some practitioners or Local Health Boards (LHBs) within Wales. Examples of good practice need to be identified and more systematically shared across Wales, for example, by making case studies available.

Background

This report seeks to review and synthesise the body of evidence on inequalities and inequities in access to health services that are associated with characteristics of gender, sexual identity and gender reassignment. It is envisaged as the first part of a full review of inequalities of access to health services that will form a foundation for the development of interventions and the sharing of good practice.

This review is based only on published evidence for inequalities in Wales and the UK and does not review current practice.

This project arose from a desire to have an up-to-date research base to inform the Welsh Government's Strategic Equality Objectives. These objectives form part of the Welsh Government's actions to meet the duty under the Equality Act 2010 to advance equality, eliminate discrimination and foster good relations in Wales. Included in the report are data from academic literature and reports by government, local authorities and third-sector organisations. Where possible evidence is specific to Wales but much of the evidence is UK-wide. By compiling the available evidence in this way, we point to gaps in our knowledge and ask questions for further research.

Strategic Equality Objective 6, *Public Services*, and the research that supported its writing, highlights some striking inequalities in health outcomes in Wales that are associated with an individual's sex. The research draws attention to unequal uptake of health services in Wales and possible inequities in access to particular services.⁶ There is further UK-wide evidence that men and women experience some health services differently. A sample of these inequalities will be presented in more detail in the methodology section that follows in order to frame the report.

Alongside evidence relating to inequalities amongst women, men, people with different sexual identities and people undergoing gender reassignment, this report also includes evidence for inequalities for other people who identify as Trans but who do not desire or intend to undergo gender reassignment. Although data pertaining to these populations are limited, this report aims to integrate available evidence throughout.

The issue of gender and the terms with which we talk about it is a contested terrain. The section **Gender, Gender Reassignment and Sexual identity** includes a more in-depth framing of the language and conceptual framework used in this report.

⁶ In this report, a distinction is made between the terms 'inequality' and 'inequity': the former describes a disparity in outcomes, for example, women are more likely than men to access primary health services through their GP, whereas 'inequity' implies an injustice or cause that could in theory be altered, such as the hypothesis that opening times of GP surgeries may limit men's access to these services as they often coincide with men's average working patterns.

Methodology and Situating the Research

Methodology

Search Strategy

The scope of this report was initially defined by identifying a need for a more detailed evidence base to inform the development of the Welsh Government's Strategic Equality Objectives. These were focussed more in accordance with the project's length: see **Fig. 1**. It is envisaged that further stages of research will be commissioned in order to review the remaining protected groups.

The evidence was obtained through searching academic journals using the online databases Ovid, Scopus and Web of Knowledge. This search strategy used the terms 'health', 'access', 'inequ*', '*gender',⁷ 'help-seeking', 'uptake', and 'stereotype', to locate studies from Wales and the rest of the United Kingdom. There are a large number of studies conducted abroad, in particular from the USA, Canada and Australia, which have not been included in this report, but which may yield information applicable to people in Wales. Data was also gathered from NHS Evidence online, key governmental reports on health inequalities, Equality and Human Rights Commission (EHRC) reports, searching the wider web and through following references from documents to further articles and reports.

Where possible, evidence is specific to Wales. Wales-specific data are limited and so, where not otherwise stated, data relates to the whole of the UK. Most quantitative data is sourced from existing analyses found within academic papers, governmental or third-sector reports. Evidence that was published before 1990 was generally not included.

This review endeavours to be as thorough as possible and pulls together a large number of studies. It synthesises evidence from studies that use a variety of research methods. Due to the difficulty of collecting robust data from certain populations, and to the range of research methods employed, quality of evidence is not consistent across sources and this review cannot be considered fully systematic.

Smaller, qualitative studies have been included alongside statistical evidence as, although these cannot be generalised, they provide more detailed insights into individuals' experience of particular services. This type of knowledge is not generally captured in the quantitative studies found. Concerns about reliability of evidence, such as sample size, research method or geographical location, are highlighted throughout the report.

⁷ An asterisk* denotes a truncation of a term. This allows the user to search for terms sharing the same root e.g. 'inequ*' searches for both 'inequality' and 'inequity', '*gender' searches for both 'gender' and 'transgender'.

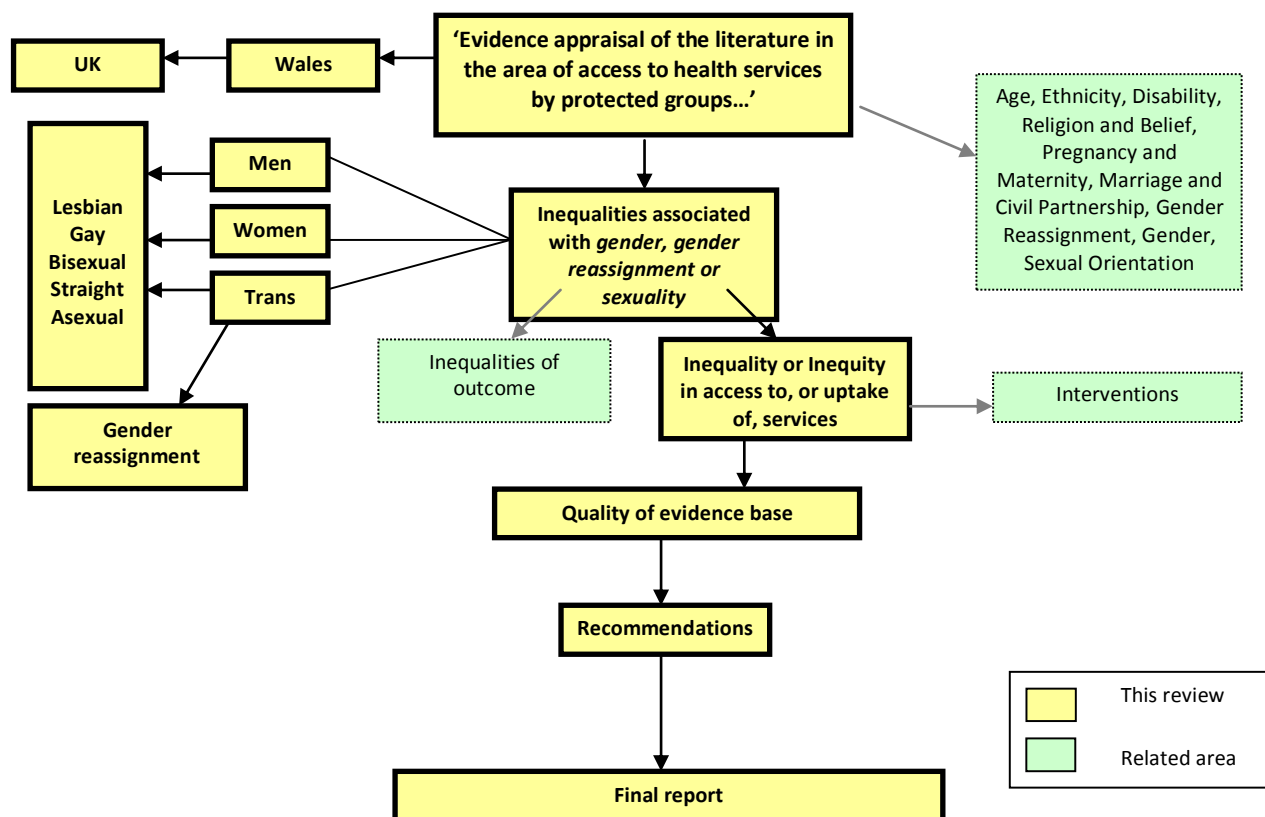


Fig. 1 Map of the literature and project scope

Situating the research

Gender, Gender Reassignment and Sexual Identity

There are ongoing debates over the concepts of ‘sex’ and ‘gender’ that challenge both what we mean by them and how they shape our lives. It is therefore important to acknowledge and engage with these debates in the framing of this research.

Although in common usage the terms ‘sex’ and ‘gender’ are frequently conflated, in official documents a distinction tends to be made between ‘sex’, as referring to the particular biological features by which we categorise the human population, and ‘gender’, as socially constructed behaviours, attitudes and values. In this report, the term ‘gender’ is not necessarily considered to refer to traits that individuals ‘have’ but rather their *behaviours*. When referring to and citing from other studies, these terms may have been used by authors in alternative ways. In particular, ‘gender’ is often employed as an adjective of ‘sex’ when it is possible that the latter term could imply sexual activity.

In recent years, academic theory has questioned the distinction between a biologically determined ‘sex’ and socially constructed ‘gender’ along with ‘identity’ as being a stable and coherent concept. Of particular importance to this review, it has been argued that there is great variety amongst individuals that we might class as ‘women’ and ‘men’: sometimes individuals do not fall neatly into the male-female binaries with which most countries categorise

members of their population. It is imperative that these debates, this heterogeneity, and these often marginalised individuals are not hidden in research on gender. Yet, it is equally important to recognise that the male-female binary plays a significant role in the social organization of our society and that there are striking inequalities when looking at the data for health in Wales through this lens.

Research that attempts to deal with these issues needs to be sensitive as to how it uses terms and in the claims that it makes. This report presents evidence for gendered inequalities in health on the basis that definitions of gender are historically-specific, local and ever-changing, as are the inequalities with which they are associated. The objective of designing health provision that takes into account current gender inequalities is not to claim that these are stable and is to recognise the requirement of continuous reassessment.

Individuals who express a desire to undergo gender reassignment (often referred to as Transsexuals, though there is considerable variation in how members of this group identify themselves) are protected under the Equality Act 2010 (the Act). This review focuses on evidence for inequalities faced by these individuals, but also considers barriers that may be experienced by other individuals who do not wish to undergo gender reassignment but who are not cis-gender (or 'cis'),⁸ such as Transgender, Gender Ambiguous, Agender, Bigender, Genderqueer, Transvestite, Intersex people and those who do not want to define their gender. As these identities are very rarely disentangled in research, in this report member of this group will be referred to as having Trans identities.⁹

Sexual identity¹⁰ is protected under the Act. It is included as part of this first report as there are important intersections with the characteristic of gender with regards to the assumptions that we make about individuals' lives and health needs. In existing evidence, Lesbian, Gay, Bisexual and Trans identifying respondents are commonly grouped together. This data must be treated with caution as although people with these identities may face similar issues of discrimination, some of their health needs are likely to be different.

⁸ The term 'cis' is used to refer to people for whom assigned sex at birth and gender are seen socially as being congruent

⁹ Conflicting estimates have been made of the Trans population and it appears that there are no publicly available statistical data with which a firm estimate of the Trans population can be made. GIRES report that 2,487 people had been awarded a Gender Recognition Certificate (GRC) by the end of 2009. This indicator cannot represent the number of Trans or other gender-variant people who do not undergo gender reassignment or who have not applied for a GRC. Further data is available at: <http://gires.org.uk/grp.php> Other statistics suggest that in 2008 7,500 people required life-long hormone therapy after transition MITCHELL, M. & HOWARTH, C. 2009. Trans Research Review. *Equality and Human Rights Report Series*. NatCen for the Equality and Human rights Commission.

¹⁰ 'Sexual orientation' is the term used in the Act to refer to this protected characteristic, however, the term 'sexuality identity' is preferred in this report as 'Queer' identities contest that sexual desire is necessarily 'oriented' in a binary sex model.

Inequalities associated with the characteristics of gender, sexual identity and gender reassignment cannot easily be separated out from their interactions with other protected characteristics (age, disability, religion and belief, pregnancy and maternity, marriage and civil partnership, race and ethnicity), along with other factors such as education and socioeconomic status. Whilst recognising the limitations of doing so, the scope of this report has necessarily been focussed on gender and sexual identity but includes key information about the remaining protected characteristics where relevant. This report recommends the conduct of a second review to analyse fully the evidence for inequality amongst members of the remaining groups and to reassess the conclusions drawn in this review.

Health Inequalities – Outcomes

In order to situate the evidence provided in this report, we briefly highlight a sample of the gendered health outcomes in Wales.¹¹

Socioeconomic status has a far-reaching impact on health inequalities and the compounding effect that this has over the life course is described in detail by the *Marmot Review (2010)*. Characteristics other than this also have a role to play in causing inequality and in the recent Equality Consultation Questionnaire, conducted by the Welsh Government; gender emerges as one with particularly complex associations.

Although 'health' was perceived as being sixth most associated with inequalities due to 'gender' (13%), when cross-tabulated with the sex of the respondent 15% of female respondents selected 'health' as a concern for gender inequality compared with only 5% of respondents identifying as male: the greatest disparity in responses from women and men behind 'employment' (Welsh Government, 2010). The 'headlines' in health outcomes seem to confirm that some differences in health outcomes are associated with gender in Wales:

- Life expectancy at birth was 4.3 years longer for women than men in Wales in 2009 (Welsh Government, 2011a).
- Overall, women are more likely than men to report being treated for multiple illnesses (Welsh Government, 2011b).
- In 2010, male circulatory mortality for those under 65 years of age in Wales was calculated at an age-standardised rate of 55 per 100,000 population compared to 21 for women (Welsh Government, 2011a).
- In 2008, although the rate of cancer mortality was comparable for women and men, more men died from non-gender specific diseases than women (Department of Health, 2008).
- Men are more likely than women to be overweight in Wales, though rates of obesity are comparable (Welsh Government, 2011b).
- In Wales, a higher percentage of women than men report being treated for a mental illness (Welsh Government, 2011b).
- The rate of mental health disorders is higher in women than men aged 45-85 but in the young and very old age groups there is a higher prevalence in men (Department of Health, 2008).
- With the exception of gonorrhoea, the incidence of sexually transmitted infection in 2008 was rising faster in women than in men. Though the prevalence of HIV is more common in men than women, this is increasing more rapidly among those who have sex with people of the opposite gender than among men who only have sex with men (Department of Health, 2008).

¹¹ The statistics on health collected through the Welsh Health Survey rely on answers given in a self-completed questionnaire and therefore reflect people's *understanding* of their health as opposed to being the results of clinical assessments.

- Suicide rates are consistently higher among men than women (Department of Health, 2008).

These are just a sample of the gendered inequalities that have been observed. Though the causes for these inequalities are likely to be complex, they call in the first instance for an inquiry into the extent to which inequality and inequity in *access to services* have a role to play in producing these outcomes.

This report also engages with inequalities in access to health services associated with sexual identity and Transgender characteristics:¹²

- According to international research, LGB people are at significantly higher risk than heterosexual people of suicidal behaviour, mental health conditions, substance misuse, and substance dependence (King et al, 2003).
- There are differences in health outcomes among the LGB identities: Lesbian/Gay women and Gay men are more likely to describe their emotional and mental wellbeing as 'good' or 'very good' in the last year than Bisexual and Queer¹³ respondents (65% and 64% compared to 57% and 48%). Bisexual and Queer respondents are also more likely to have experienced mental health difficulties in all categories except stress (Browne, 2007).
- Trans people report significantly poorer emotional and mental wellbeing in the last 12 months than those who are not Trans (Browne, 2007).
- Trans people are far more likely to have considered suicide in the last five years (56%) than non-Trans respondents who have had mental health difficulties in the past five years (28%) (Browne, 2007).

¹² See also ADDIS, S., DAVIES, M., GREENE, G., MACBRIDE-STEWART, S. & SHEPHERD, M. 2009 The health, social care and housing needs of lesbian, gay, bisexual and transgender older people: A review of the literature. *Health & social care in the community*, 17, 647-658

¹³ The term Queer refers to an identity in which individuals do not describe themselves as straight, gay, lesbian or bisexual. In some contexts beyond this report it can be used as an umbrella terms for all sexual or gender minorities.

Access

When exploring inequalities of access to health services, the concept of 'access' can be interpreted in a number of ways. The following aspects are included in this report on inequalities and inequities:

- a) **Accessibility:** whether or not health services are within practicable reach of their users accounting for impact of protected characteristics.
- b) **Help-seeking behaviour:** whether users with particular characteristics attempt to access health services and the reasons for which they might not do so.
- c) **Experience of Services (respect and dignity):** whether health services are perceived to provide care that sensitively accommodates needs associated with protected characteristics. This could also have an impact on help-seeking behaviour.
- d) **Quality of encounter (referral and records):** whether appropriate and equitable referrals are made to other services and whether medical record-keeping is equitable.

There may be further interpretations of 'access' that are not included in the scope of this report that are important when considering other protected characteristics. For example, it could be considered that the *effectiveness* of particular health services could have an impact on access to them in terms of the likelihood that individuals will seek them out based on their reputation. However, due to the limited time available, the evaluation of service effectiveness is beyond the scope of this review.

Health-affecting behaviours such as exercise, smoking, diet and alcohol consumption also have an effect on the uptake and demand on public health services, and these may also be patterned by social characteristics such as gender, sexual identity or gender reassignment. Though this report looks at some aspects of these behaviours in relation to usage of services, it does not develop them in full.

The following review is organised primarily by *type of service* and secondarily by *protected characteristic*. Intersections between them are discussed where relevant.

Evidence for Inequalities and Inequities in Access to Services

Primary Care Services – Summary of Key findings

- Women are more likely than men to access their GP or practice nurse
- There are minor differences in how men and women prefer to book appointments at their GP practice
- Women are slightly more likely than men to have a preferred GP, to prefer same-day appointments, and to secure them
- Women are slightly more likely to report that opening times are convenient for them
- Women and men are as likely to agree that further opening times after 6:30pm and at the weekend would be beneficial
- Relying on public transport may pose a barrier to accessing services in terms of convenience and safety, particularly for those with children or disabled people
- Marginalised groups of women may face difficulties attending pre-arranged appointments
- Men give positive feedback about NHS Direct but are less likely to use it than women
- Evidence is conflicting on the impact of ‘masculinity’ norms on men’s help-seeking
- Working hours and lack of non-gendered facilities may pose a barrier to access to Trans ‘safe-spaces’ such as community groups
- 65% of Trans people report experiencing ‘negative interactions’ within general health services
- LGB people have less confidence in their GPs than Straight people and are more likely to say that their GPs are ‘poor’ or ‘very poor’ at giving them enough time, listening to them or treating them with care and concern
- Only a quarter of LGB people feel they receive advice that is relevant to their sexual identity
- Some LGB people feel they have no opportunity to disclose their sexual identity or fear doing so
- There is strong support among LGB and Trans people for the development of ‘safe-spaces’ for health advice and some of the most vulnerable would prefer to see a specialist GP

There is greater evidence that relates to inequalities of access to primary services than for many other services. The evidence is also on the whole more robust as studies are based on larger samples, with the exception of data for Lesbian, Gay, Bisexual and Trans people. Though we can be less confident in the reliability of data for these populations, we know significantly

more about the experiences of LGB and Trans people than in previous reviews.¹⁴

General Practitioners (GPs) and other Primary Care Services

The *Welsh Health Survey (2010)*, shows that whilst for both men and women the percentage that report talking to a GP or seeing a practice nurse in the past two weeks increases with age, this trend is particularly pronounced for men. In younger adults (up to 54 years), women were more likely than men to have talked to a GP or practice nurse in the last two weeks. The report suggests that consultations by women in the younger age groups that are associated with family planning or pregnancy could account for some of this difference.

GP Patient Survey 2011-2012 results

An initial analysis of the GP Patient Survey 2011-2012 by the author of this report reveals that 60% of women report that they had been to see or had spoken to their GP in the past 3 months compared with 48% of men. Eighteen per cent of men had not been to see or had spoken to their GP for 12 months compared with 9% of women. Men were more likely than women to say that they had never seen or spoken to a GP from their GP surgery, but the percentages of people in this category were very small (2% compared with 1%).

Women were more likely to report that they had seen or spoken to a nurse in the last 6 months than men (58% compared with 45%), and men were more likely to say that they had never seen or spoken to a nurse at their GP surgery (12% compared to 4%). This difference may be explained in part by women's use of nurses for contraceptive advice or prescription, but there is no data to confirm this.

Consulting disparities between women and men are supported by indicators in other research, for instance, women are less likely to be *unaware* of an HIV status than men (Porter et al, 1993).

There was little reported difference between men and women in the ease of getting through to someone at the GP surgery on the phone and that the receptionists were helpful. Women were only slightly more likely than men to say that they felt overheard in the reception area and that they were not happy about this (27% compared with 22%).

¹⁴ It is possible to argue that thanks to the smaller size of the Trans population that there is potential to gather *more robust* data than that for the general population as it may be possible to sample a greater proportion of the population, however, it is important to continue to exercise caution in interpreting these statistics as different methods may be required to access hard-to-reach populations.

There were few reported differences in how women and men normally book appointments to see a GP or nurse¹⁵, with only a slightly higher number of women booking an appointment by telephone (92% of women compared to 87% of men), and that it was their *preferred* method to book appointments in this way (83% compared to 79% of men).

Women were more likely to say that they had a preferred GP with 61% responding 'yes' compared to 52% of men, but men were more likely to say that they were able to see their preferred GP 'always or almost always' (45% compared to 40% of women). However, men and women reported about the same ability to secure an appointment to see or speak to someone.

Last time they had booked an appointment, women were both slightly more likely to prefer an appointment on the same day (43% compared to 39%) and to secure one (38% compared to 34%). These very slight differences may reflect disparities in ability to attend on the same day, or may relate to the nature of the appointment, for example, women were more likely than men to report that they had wanted to see a nurse (20% compared with 17%). Perhaps surprisingly, only a slightly greater proportion of women found their appointment 'very convenient' (50% compared with 47%).

Men reported slightly shorter waiting times at the GP surgery than women with 11% saying that they saw their GP in less than 5 minutes compared with 9% of women. Twenty six per cent of women saying that they waited more than 15 minutes compared with 22% of men. It is likely that other factors, not captured by this study, affect these results, such as the relative times of day at which men and women had appointments and nature of appointment (with GP or nurse).

Ratings on whether the GP gave them enough time, that the GP listened to them, explanations of tests and treatments, GP involving them in decisions about their care, treating them with care and concern and confidence and trust in GPs yielded very similar results for women and men. Women were slightly more likely to rate nurses as being either 'very good' or 'good' on each of these aspects than men. However, men were more likely to report in each case that these questions did not apply to them instead of giving a rating.

Women were more likely to agree that their GP surgery was currently open at times that were convenient for them (80% compared to 76%), but men were more likely to select 'don't know' when asked this question (8% compared to 5%). Of those who said that their surgeries were not open at convenient

¹⁵ Options were, 'in person', 'by phone', 'by fax machine', 'online' and 'doesn't apply'. Respondents could select more than one response. There are a very small number of studies investigating the use of the internet for health advice: see GALLAGHER, S. & DOHERTY, D. 2009 Searching for Health information online: characteristics of online health seekers. *Journal of Evidence-Based Medicine*, 2, 99-106., and GRAY, N. J., KLEIN, J. D., NOYCE, P. R., SESSELBERG, T. S. & CANTRILL, J. A. 2005. Health information-seeking behaviour in adolescence: the place of the internet. *Social Science & Medicine*, 60.

times, women and men largely agreed that additional opening times would be most beneficial to them after 6:30pm and on weekends.

A slightly higher proportion of women reported that they knew how to contact an out-of-hours GP service: 61% compared with 55% of men, though few people across the sexes (13%) had tried to call one in the past 6 months.

Women

Women are more likely to report practical problems in access, citing lack of transport or caring responsibilities (Doyal et al, 2003). Although not focussed on access to health services, evidence from research in Scotland suggests that women have reduced access to cars and are less likely to have a driving license and therefore rely more heavily on public transport. It is suggested that as a result of this women face additional personal safety risks and difficulties such as being 'encumbered' with children or shopping. The report also suggests that potential cost and complexity of journeys may disadvantage women with low-incomes. Women living in rural areas have reduced access to transport, as do older and disabled women (though respondents indicate that low-floor busses help with this) (Reid-Howie Associates, 2000).

For marginalised groups of women, there is evidence of different preferences for type of health service: Pearce et al. (2002) in a study of 21 young women who have been or were currently involved in sex work highlighted their preferences for accessing particular kinds of health services such as drop-in sessions, and their difficulties in attending appointments.

Men

It has been hypothesised that one reason why the uptake of primary care services is lower amongst men is that the opening hours are inconvenient for those working full-time, and that a greater proportion of men work full-time than women. Yet, it has also been shown that men are also less likely to use the telephone advice line NHS Direct than women (21% compared to 30%) (Knowles et al, 2006, Lerner, 2009).

Men's motivations to use NHS Direct have been examined by Goode et al. (2004). The mixed-method study found that when men used the service they were most often calling for their partners, themselves or a child but that they were often encouraged to do so by their female partners. The authors emphasise that the men who used the service gave positive feedback on it and suggest that its unobtrusiveness into the working day was valued.¹⁶

¹⁶ Non-participant and participant observation, 'Conversation Analysis' of 120 taped calls, interviews with 33 male and female NHS Direct staff (22 nurse advisers, 1 nurse Team Leader, 2 nurse trainers, 5 call handlers, and 3 Health Information staff), and interviews with 60 users of NHS Direct.

Qualitative research has begun to explore how dominant forms of masculinity might have an impact on how men interact with primary health services. In Jeffries and Grogan's (2012) small-scale study of seven young men (aged 22 to 33), accounts of reasons for visiting GPs and experiences of them reveal a complex interplay between types of strength regarded as being masculine and the vulnerability or disempowerment in experiences of seeking help from a health professional.¹⁷ It is not possible to generalise from the results of this study, but investigations of this type may be important in trying to design interventions to promote uptake of services among men.

Yet, Coles et al (2010) warn that particular interventions may reinforce dominant masculinities through portraying healthcare as a service that was predominantly feminine and that it is simply accommodating men. These authors emphasise the dangers of legitimising men's disengagement with health concerns through trying to engage with dominant male stereotypes in health marketing or outreach campaigns. Coles et al's focus groups with 82 men of a socially deprived area of England show a negative reaction to male stereotypes. The authors suggest that health campaigns could exploit this by challenging stereotypes.

We should be cautious in assuming causal relationships between gendered identities and health-related behaviours: although it is widely perceived that norms of masculinity and femininity have an impact on the differences between men and women in reporting illness, the assumption being that women are more likely than men to report illness, in particular mental illness and 'minor' mental health conditions. This opinion is frequently expressed in reports.¹⁸ Despite local, qualitative evidence for this, some studies show that there is *not* strong evidence to support this assumption. Galdas et al.'s (2010) review of the literature on gender differences in help-seeking emphasises a highly complex and contradictory range of conclusions reached by a number of studies conducted both in the UK and the US. The range of methodologies and measures employed in these studies makes them extremely difficult to compare.

Whilst there is some evidence that men are less likely to seek health advice than women, there is also a large amount of evidence refuting gender differences in symptom recognition, reporting and help-seeking. Figures can also be skewed by the increased contact that women have with health services during pregnancy, for contraceptive advice and for childcare (though the absence of men from these visits may in itself be significant). These reasons for seeking advice may also impact on studies that measure the number of 'healthy' women and men who consult.

¹⁷ The men were interviewed by an older male interviewer, a factor which is not discussed in the study. There may also be significant variation between men of different ages, sexualities, professions and cultural backgrounds, a weakness of this study to which the authors indicate.

¹⁸ See for example, DOYAL, L., PAYNE, S. & CAMERON, A. 2003. Promoting gender equality in health. *Interpreting*, 4, 3EQ.

Galdas et al. (2005) call for more research that accounts for the differences in help-seeking behaviour *between* men and for more research on men alone including qualitative work. The reason for this, the authors argue is that the psychological, social and cultural processes behind help-seeking behaviours can only be captured through qualitative research and in-depth studies with men. There are examples of this that have been published since Galdas. et al's (2010) review: some show that men draw on the concept of masculinity to describe their attitudes towards their health, but importantly studies also challenge notions that there is any one type of 'masculinity' in attitudes towards health (Hale et al, 2010, Farrimond, 2012, Sloan et al, 2010, Witty et al, 2011, Maclean et al, 2010). Though likely to achieve greater depth, studies that focus on men only are not able to highlight differences in the way men and women account for their help-seeking behaviour, something that is acknowledged by Galdas and co-authors in a later study (Galdas et al, 2010).

Emslie et al. (2001) find, through qualitative interviews, that we talk in gendered ways about cardiac disease with discussions of the issue focussed on groups of men as both the most likely to experience the disease and other groups of men as least likely. Women were discussed as experiencing longer-term heart conditions to men. We see from this study that it is essential to bear in mind that in *talking* about our actions, we express ourselves within the frames of meaning that are common in our society, such as the norms of masculinities and femininities. These expressions cannot be taken to have a direct relationship to behaviour; investigations into the *accounts* that people provide for their behaviour cannot necessarily be interpreted as *explanations* for them and we must be circumspect in presenting them as so.

Evidence for the 'over-reporting' of particular health-problems by women is another theme in the literature to which Galdas et al. (2010) draw attention. We must also be cautious when interpreting these data, and not yet discount the possibility that symptoms and illness may be *experienced* in gendered ways.

Trans

There is some detailed qualitative evidence relating to the experiences of Trans people using UK health services.

This evidence predominantly reports on experience of health services once in receipt of care and other issues that are discussed in sections below, such as problems with records and referral and being treated with respect and dignity. Some evidence suggests that for Transsexuals primary care services such as GPs can act as a barrier to receiving further advice on gender reassignment; this issue is discussed in section ***Gender Reassignment***.

For Trans people there can be access issues to a range of services. Some of these are raised in the North West Trans Needs Assessment Report: the availability of a non-gendered toilet makes a service more welcoming to Trans people and avoids discrimination, a changing room should be provided for

those who cannot attend appointments dressed as their identifying gender and who wish to change before participating. Some Trans respondents also raise the issue of working hours as a barrier to accessing some services and 'safe spaces' such as support or community group meetings (Trans Resource and Empowerment Centre, 2010).

In the *Trans Mental Health Survey 2012* 65% of Trans people who had accessed general health services had experienced negative interactions (558 responses) (McNeil et al, 2012). Though not comparable with data for the rest of the UK or for Wales, the proportion of Trans people who were dissatisfied with GP services in Scotland appears to be slightly higher than for Straight women and men (see **Sexual Identity** below): 46% of respondents who had used an NHS GP as Trans patients rated the quality of the service they received as 'Very Good' or 'Extremely Good' while 14% rated the service quality as 'Very Poor' or 'Extremely Poor'.

Sexual Identity

The charity Inside-Out underline the difficulties in collecting more robust data from the LGB community in Wales as there are few networks between people in rural areas and that for all people sexual identity can be a very personal issue, which some individuals choose not to disclose when responding to surveys. Nevertheless, there is some UK-wide evidence available.

A perceived lack of regard for sensitivity to sexual identity from GPs is supported by qualitative evidence from Robertson (1998) that was gathered as part of a larger qualitative study into Gay men's health needs. Robertson's sample is not representative of Gay men in the UK, over-representing well-educated men of high socio-economic status and those who engage with the 'Gay community'.¹⁹

When asked if they felt confidence and trust toward their GP, 6.1% of GB men answered 'No, not at all' compared with 3.7% of their Straight counterparts. For LG women this difference was a little greater at 6.8% compared with 4.1%. Fifteen per cent of GB men rated their overall experience of GP surgeries as 'poor' or 'very poor' compared with 11.2% of Straight men. Just over 14% of LB women answered this way compared with 10.3% of Straight women (Department of Health, 2012).

LGB people can experience difficulties in receiving health care and advice that is appropriate to their sexual identity. In research by the charity Stonewall, only a quarter of Gay or Bisexual men report that health professionals had given them information relevant to their sexual identity (Stonewall Cymru, 2012). It is important to note that from these results it is difficult to disentangle those respondents who had *not sought* advice relating

¹⁹The author emphasises that the experiences and voices of older Gay men, men coming to terms with their sexual identity and married Gay men may not be heard in this study and that the boundaries and characteristics of the 'Gay community' are highly contested.

to their sexual identity. The results of the small-scale, community-led study of LGB equality issues in Wales by Inside-Out, indicate how the question asked by Stonewall may have been interpreted by respondents: in this study only 10% of LGB questionnaire respondents report that they had received *inappropriate* sexual health advice (Cook et al, 2007).

At the same time, some people feel they have had no opportunity to disclose their sexual identity to health professionals, 15% report no opportunity for Gay or Bisexual men to 'come out' to their GP (Stonewall Cymru, 2012), or are reluctant to do so for fear of adverse treatment as a result of prejudice. A YouGov survey of LGB people in Britain commissioned by Stonewall received 1,658 LGB responses: one in fourteen Lesbian and Gay people expected to be treated worse than their heterosexual counterparts for a routine or emergency procedure. Eight per cent had the same expectations about GPs. Lesbian/Gay women are twice as likely as Gay men to expect to be treated worse (Hunt and Dick, 2008).

In this same survey, there were regional differences across the UK: Lesbian and Gay people in Wales were found far more likely to expect unequal treatment in an emergency and during routine procedures than those in the South West (14% compared to 2% for emergency hospital, 16% to 2% for routine treatment). 12% of respondents from Wales expected that they would be treated worse by their GP than a heterosexual counterpart (Hunt and Dick, 2008). Some caution is needed in interpreting these results however, as the sample breakdown across regions is not provided and the Welsh sample is likely to be very small.

In a study conducted with the LGB and Trans population of Brighton and Hove (Browne, 2007) opinions were divided over whether specific GPs for this community would be preferred. Respondents, who are disabled, isolated, or who had mental health difficulties were more likely to want a specialist GP service. There was strong overall support for 'LGBT Health and Wellbeing centres' with 90.5% of respondents in favour. Focus groups suggested that these could include 'safe-spaces' for exercise alongside social areas. It was highlighted that a centre of this nature would need to contribute to rather than replace the improvement of 'friendly' mainstream services, due to a concern expressed by some that LGB and Trans people's access to health services could become 'ghettoized' (Browne, 2007).

Referral and Records - Key findings

- Evidence is inconclusive as to whether symptoms presented by men and women are assessed differently because of the patient's sex
- Some LGB people report that assumptions are sometimes made about their health needs, on the basis of their sexual identity
- Practice is inconsistent on changing gender/sex status and name on medical records for people undergoing gender reassignment

Referral

Gender

It has been suggested in some reports that once in receipt of care, individuals may be treated differently according to their gender (Doyal et al, 2003). In recent research, the issue of heart disease is discussed in terms of the possibility that men and women present doctors with different symptoms and are referred differently (Department of Health, 2008). In a study of historical medical notes from April 1996 to March 1997, Bowling et al. (2001) found that older patients and women are less likely to undergo exercise testing and cardiac catheterisation, and subsequently revascularisation procedures, despite similarity with men in diagnostic attributes.

However, the evidence remains contradictory on this subject with some studies refuting that there is gender *inequity*: for instance, one study shows that although there are sometimes differences in care given to women and men, lack of difference in health outcome suggests that patients are given the care that is required (Raine et al, 2002).

In a study by Williams et al (2004), conducted with general hospitals and specialist centres in Wales, some of the gender differences in the treatment and testing of patients after myocardial infarction (heart attack) were far smaller when results were adjusted for the higher age at which women usually present themselves to health services. The authors conclude that more research is needed into whether the reduced likelihood that both older men and women will receive testing and treatments following heart attack can be medically justified.

On the subject of referral for hip replacement, Juni et al. (2010) found that women were less likely than men to be on the waiting list for 'total hip replacement'. Women with hip pain were found to be as likely as men to be prescribed medication, but less likely to be referred to specialist care by their GP. The authors argue that these gender disparities could not be entirely explained by differences in help-seeking, willingness to undergo, or fitness for, surgery, thereby suggesting inequity of referral (Juni et al, 2010).

Ross et al.(1999) find some gender differences in the frequency with which GPs in Glasgow refer patients who present with mental health issues, with a higher rate of referral for male patients than for female patients with the same symptoms. There are several suggested causes for this difference, none of which could be verified by the authors' study: GPs perceived that women would be more likely to independently consult again and/or awareness that men are more at risk of suicide. Further work could explore these possibilities and their implications.

Sexual Identity

Respondents to the Welsh Government 2010 Equality Consultation Questionnaire report that assumptions are often made about an individual's sexual identity and that this can have an impact on their perceived medical needs and inappropriate or lack of referral to services (Welsh Government 2010).

Records

Trans

The issue of medical record-keeping arises predominantly with regards to people who are undergoing gender reassignment. Insufficiently detailed record-keeping can also result in inappropriate assessment of an individual's medical needs, particularly for Trans or intersex people. For example, Fish (2007) reports instances of intersex women being asked to participate in inappropriate treatment such as smear tests or being asked questions regarding menstruation. Individuals may not be included in appropriate cancer screening programmes, such as breast or prostate.

Complexities arising from the need to categorise and record an individual's gender reach beyond medical records to difficulties in collecting data from people who do not identify with the terms 'male' or 'female'. There are plural terms in which people describe their gender and some people choose not to define their gender as unified or stable. Similarly, people who have undergone gender reassignment may not identify with a 'Trans' identity but rather as 'woman' and 'man'. Collecting data via surveys can therefore be problematic as it is likely that some people will not respond to the categories offered, or will feel marginalised by them, and thus are not fully represented in evidence. It is essential that the complexity of gender identification is considered when collecting data and producing research for public policy.²⁰

²⁰ See key debates in HINES, S. 2006. What's the difference? Bringing particularity to queer studies of transgender. *Journal of Gender Studies*, 15, 49-66.

Intersections - Key findings

- BME people are more likely than white people to have never seen their GP or practice nurse
- BME men are most likely to report that usually only one GP is available at their surgery
- White male respondents are less likely than BME men to have accessed out-of-hours services in the last 6 months
- Limited evidence suggests that the sex of the GP/nurse may be a barrier to access for Gypsy or Traveller people
- Low levels of literacy or language barriers in particular groups can impede understanding of health advice
- Older LGB people may be more likely to rely on health care services in later life but express fears that their sexual identity may affect their care
- Women and younger disabled people are more likely to report barriers to access
- LGB disabled people can be concerned about disclosing their sexual identity
- People who are homeless or fleeing domestic abuse may be disadvantaged by the cost of reaching health services
- Limited evidence suggests that adolescent girls report lower self-esteem than boys
- Lone parents may face barriers through having reduced access to private transport and struggle to find alternative childcare

The quality of evidence for intersectional disadvantage is varying. Statistics from the GP Patient Survey 2011-2012 give us reliable information about usage for BME groups, but smaller pieces of evidence that inform us about other minority groups is less robust and can be used only to highlight relevant concerns.

Key intersections

A full appraisal of inequalities in access amongst individuals that share characteristics other than gender is beyond the scope of the current review. However, there are some key ways in which inequality is associated with more than one characteristic, including gender, sexual identity or gender reassignment. The majority of the intersections that emerged in the evidence are highlighted in this section with additions throughout the remainder of this report.

Ethnicity

In response to the GP Patient Survey 2011-2012, there were some differences reported between women and men from BME²¹ and white ethnic backgrounds. Both BME and white women were more likely to say that they had been to see or had spoken to their GP in the last 3 months. Of those who had not seen or spoken to their GP in over 12 months, BME people were less prevalent (14% BME men compared to 18.2% white men, and for women 7% BME compared with 9.3% white). Though the numbers were low, BME people were more likely than white to say that they had never been to see or had never spoken to their GP: 3.1% compared to 1.7% for men and 1.4% compared to 0.7% for women.

This pattern is echoed in responses to whether they had seen or spoken to a nurse. However, whereas BME and white women report in similar rates that they have seen a nurse in the last 3 months, this percentage is slightly lower for BME men than white men (28.7% compared to 30.5%).

Although they echoed a general positivity in the helpfulness of receptionists in GP surgeries among white respondents, BME men and women were slightly less likely to say that they had been 'very helpful' rather than 'fairly helpful'. This difference was slightly higher between BME and white women than men, but this percentage is mostly accounted for in the greater proportion of BME men responding that they didn't know.

A very slightly higher proportion of BME men prefer to book appointments at the GP surgery in person than other respondents (32% compared to 30% of white men and 31% of women). With regards to preference for a particular GP, more BME than white respondents answered that there was usually only one GP available at their surgery.

Although overall both a higher proportion of women than men answered that they were aware of how to access out-of-hours GP services, the percentage of white male respondents who reported that they had tried to access these in the last 6 months on behalf of themselves was lower than that of BME men (4.6% compared to 7%).

There are some additional pieces of evidence regarding inequalities in access to health services for those sharing characteristics at the intersection of gender and minority ethnicity: in 2008, the Department of Health reported that compared with white British women, Indian women report poor health but also low attendance at appointments (Doyal et al, 2003). In a study of women's access to transport in Scotland, it was suggested that BME women from particular cultural or religion backgrounds may have reduced access to public transport due to a lack of women-only services (Read-Howie Associates, 2000).

There is limited research into attitudes towards and usage of health services among Gypsy and Traveller communities in the UK. Though small in scale,

²¹ Includes Gypsy and Traveller and mixed/multiple ethnicity DEPARTMENT OF HEALTH 2011-2012. GP Patient Survey.

with 29 respondents, a recent study of people sharing this characteristic and living in South Wales was conducted and offers us a glimpse into some issues of access (Duggan, 2012). The author emphasises the difficulties facing research with this community, stating that the questionnaire was designed to be short in order to encourage participation and that women from the community were able to collect data that would otherwise have been unavailable to the male researcher. Further research in this area is needed to establish the extent to which the access issues identified are related to gender.

Sexual Identity, Age, Disability

There is limited evidence on the health needs of the Lesbian, Gay or Bisexual (LGB) population in Wales, and even less for older LGB people. There is UK-wide evidence that suggests that in later life, more LGB people report that they would need to rely on their GP or health services than the heterosexual respondents (18% compared with 10%). They also express concerns over disability or in-home care in relation to understanding of their sexual identity by health professionals (Guasp, 2007, Hunt and Dick, 2008). Only 49% expressing that they could be open about their sexual identity without fear of prejudice from their local health services, with Bisexual men least likely to agree or strongly agree that they could be open (43%) followed by Bisexual women (48%), Lesbians (52%) and Gay men (72%) (Ellison and Gunstone, 2009).

Like non-disabled LGB people, disabled LGB people can feel mistreated as a result of disclosing their sexual identity to health professionals: in a qualitative study by Molloy et al. (2003), participants reported feeling judged, roughly handled and feeling pressured to use contraceptives even when the patient did not need them. Others reported feeling mistreated because of a combination of sex (female), age and disability.²²

In a study by Williams et al. (2008) just over half of the sample of 46 disabled people reported that they had *not* experienced barriers to accessing health services (from a given list). Women were slightly more likely to report that they had experienced barriers than men (54% to 43%) as were younger disabled people. The more common reported barriers were 'difficulties with transport', 'distance to premises', 'need someone to accompany me on all journeys', and 'need to be accompanied at appointment', but we cannot compare responses from men and women from these results.

In Dye et al.'s (2001) national study, 19% of the deaf people who had consulted in the previous two weeks had an interpreter present. Men were twice as likely as women to use an interpreter. These results are difficult to elucidate clearly as it is not clear whether differences are due to preference or availability of an interpreter, or indeed how 'interpreter' has been defined: if

²² This is a fairly extensive qualitative study that draws on a large sample of people with a range of disabilities, ethnic backgrounds and locations in England.

defined as a professional interpreter, availability of friends/family to interpret may be a factor.

Homelessness

In a survey of access to transport in Scotland, one participant highlighted that women who are temporarily homeless are significantly disadvantaged by the cost of public transport when wishing to utilise health services. Similarly, for women fleeing domestic abuse, whose partners may restrict their access to money, cars or learning to drive (Read-Howie Associates, 2000).

Age

There is some evidence of gendered health reporting in adolescents, with girls reporting lower self-esteem and higher levels of negative self-efficacy than boys. Girls also report greater unhappiness and more frequent past worries (Bergman and Scott, 2001). There is very little evidence on this topic, and it is difficult to assess from this example whether gender inequalities are due to differences in reporting or health status.

Marriage and Civil Partnership

A literature review of inequalities in access to health services in Northern Ireland cites evidence that lone parents are often counted as a socially excluded group. As members of this group, lone mothers and fathers may have reduced access to health services as a result of lack of access to private transport and subsequent reliance on public transport (DHSSPS, 2004).

In Jayaweera and Garcia's (2000) literature review of mainly qualitative studies, they find evidence that women can even forgo health appointments due to cost and inconvenience of travel or childcare, citing difficulties experienced by lone mothers in coordinating bus and appointment times and finding flexible childcare that could meet the demands of waiting times in hospital departments. There is a lack of evidence that explores possible differences between the barriers to health services faced by lone mothers and lone fathers.

Pregnancy and Maternity – Key findings

- BME women are more likely to book late for antenatal care
- Language barriers among some BME groups may impede understanding of health advice
- Some women experience difficulties accessing professional interpreters or experience discomfort with interpreters they do not know
- It is reported that health professionals sometimes make assumptions about preference or care needs based on ethnicity
- Refugees and asylum seekers face multiple barriers to health services including lack of interpreters, mixed-sex services, difficulties registering with a GP, lack of understanding of UK healthcare procedures and accessing low-income benefits and a lack of knowledge among health professionals of Female Genital Mutilation issues
- Some groups of women do not feel comfortable in antenatal classes
- Some younger parents fear stigmatisation by health services
- Evidence for inequality in access to abortion services is unclear, but there is some evidence that the NHS is less likely than private clinics to carry out abortions after 13 weeks
- Some young fathers do not feel comfortable attending antenatal classes and feel marginalised during check-ups
- Some (young) men report that they find it difficult to attend appointments as they cannot secure time off from work/education
- Disabled people may experience lack of accessible equipment or facilities for postnatal care
- Same-sex parents or co-parents may be reluctant to disclose their family status to health professionals, and same-sex co-parents report mixed experiences of whether they feel included by maternity professionals
- Same-sex parents may experience difficulties accessing relevant information and support

Evidence in this area is limited and more robust evidence is recommended for the development of policy. However, the small-scale studies that exist give us some insights into possible issues to explore further.

Pregnancy and Maternity - Intersections

Although inequality in access to maternity services could be said to have an impact primarily on women, it is important to consider inequalities between women who share other characteristics and also for fathers. The Confidential Enquiry into Maternal and Child Health (CEMACH) (now, the Centre for Maternal and Child Enquiries (CEMACE)) report *Why Mothers Die 2000-2002* (Lewis and Drife, 2004) found that some characteristics that women share are associated with higher risk of maternal death:

- Mothers from socially disadvantaged background were up to 20 times more likely to die than their counterparts from more advantaged groups with the death rate of those living in the most deprived areas of England being 45% higher than the least deprived
- Lone parent mothers were more likely to die than those in stable relationships
- BME mothers were on average three times more likely to die than white mothers, with the rate of death among Black African women, newly-arrived refugees and asylum seekers up to seven times higher.
- 20% of the women who died during maternity from 'direct' or 'indirect' causes had booked maternity care after 22 weeks gestation or had missed over four routine antenatal appointments
- 35% of mothers who died were obese, a figure that is 50% higher than the representation in the general population
- 14% of the maternal deaths were women who had declared themselves victims of domestic violence and 8% had problems of substance abuse (Lewis and Drife, 2004)

The King's Fund (2008) advises us to treat this issue with caution as routine data are not collected for all mothers in the UK. These figures do, however, highlight inequalities among characteristics that require further investigation.

There is one source of evidence that suggests that there may be inequalities between women in terms of informed decision-making. In a study of twelve maternity units in Wales that had not bought into MIDRIS *Informed Choice* leaflets, O'Cathain et al. (2002) found that overall a large minority of women did not feel that they had exercised informed choice during their pregnancy and post-natal care. These results varied by decision point (such as Ultrasound screening and screening for Downs syndrome), maternity unit, and other individual characteristics, such as education. It is important to bear in mind, as the authors themselves emphasise, that this study measured *perception* of informed choice rather than level of knowledge and understanding among participants.

Ethnicity

The results of Rowe and Garcia's (2003) systematic review of antenatal care usage show that in good quality evidence of inequalities associated with ethnicity, all four studies that they had identified demonstrated that Asian women were more likely to book late for antenatal care than white British women. This review also showed that 'three of the five studies looking at antenatal attendance and social class found that women from manual classes were more likely to book late for antenatal care and/or make fewer antenatal visits than other women.' The review does not investigate the extent to which social class and ethnicity may work together in these results, suggesting this as an avenue for further research.

The Race Equality Foundation's (REF) briefing paper on addressing inequalities in maternity services in the UK summarises much of the literature

on BME women's access to and experiences of maternity services up to 2008 (Bharj and Salway, 2008). The key findings with regards to access are that both qualitative and quantitative studies find lower satisfaction with service among BME women than among white women (Redshaw et al. 2007). BME women are more likely to attend their first antenatal check-up after the recommended twelve weeks' gestation, and are less likely to attend regular antenatal care. They subsequently have fewer antenatal check-ups. Although they are less likely to have discussed breastfeeding with a midwife, BME women are much more likely to breastfeed exclusively after birth (Redshaw et al. 2007).

It must be noted that there may be significant variation among and within ethnic groups, an example can be found in Woollett and Dosanjh-Matwala's (1990) study of Asian women who expressed strong support for antenatal care with a low number of them missing appointments. Though this study is now dated, it sensitises us to the dangers of glossing over variations among BME groups both in the collection and interpretation of research.

In terms of experiences of service, the REF (2008) briefing paper points out that there is a lack of evidence on the differences between women of various BME groups and relating to other characteristics such as level of education, socioeconomic status and migration status. The main concerns that arise in current research are a lack of accessible information, inadequate interpreting services, cultural insensitivity and lack of continuity of care and support. It hypothesises that services may also be poorly adapted to the mobile lifestyle of Gypsy and Traveller women.

Bowes and Domokos' (2003) large-scale study of Pakistani and white women suggests that women of some BME groups and of lower socio-economic backgrounds can express a lack of knowledge about childbirth, whilst middle class, white women are much more likely to express confidence in their knowledge and a sense of choice over their care.

A small, scoping study by Davies and Bath (2002) suggests that women from some cultures (Somali in this case) may prefer to receive and find it easier to engage with information about health matters orally rather than in written form due to cultural traditions or levels of illiteracy. The 13 Somali women in this study, from a Northern city in the UK, valued information obtained from health visitors and sometimes used them as a route to access to GPs. Both the expert status and informality of the information source was valued, alongside any linguistic help.

A small-scale study with Bengali women by Almond and Lathlean (2011) highlights concerns of inequity in post-natal depression services, finding that the nurses expressed concern that although a policy and commitment to equitable treatment was in place, that the patients were not sure if nurses properly understood their problems or if they were willing to account for the cultural requirements of their patients.

Studies with Somali women have reported that for those who required an interpreter friends and family were often asked to help. Some women raised concerns with using friends and family as interpreters due to sensitivity or confidentiality of some health information alongside the undue time burdens that it was felt to place on others (Davies and Bath, 2001, Bulman and McCourt, 2002). In a study conducted in 1989, it was found that long waiting times could also deter women from asking friends and family to accompany them as interpreters (Woollett and Dosanth-Matwala, 1990). Though dated, this study highlights the importance of providing professional interpreters. In addition, in another study, though friends and families are not seen as ideal interpreters, concerns have been raised regarding the quality of some professional interpreters in their ability to understand either the patients themselves or medical terminology (Davies and Bath, 2001). It is unclear from this study how many people may be affected by English-language barriers to health services with today's provision for interpreters.

Again on the issue of communication, Almond and Lathlean (2011) raise concerns over the quality of the professional translation service provided, with respondents preferring to use relatives informally. This, however, was felt to have a potential impact on the freedom with which the women could express their concerns and feelings. Equity in information provision was being addressed at the sites of study as, at the time, some leaflets were only available in English. Asylum seeking and refugee women who wish to improve their English may also experience difficulties in accessing language classes (Dumper, 2002).

Bulmer and McCourt's (2002) study, report problems with the management of births to women who have undergone Female Genital Mutilation (FGM), of which midwives and doctors did not have sufficient knowledge to manage birth. The authors note that since publication, a policy of antenatal gynaecological referral and the offer of repair for FGM had been introduced, but the evidence of the experience of current practice is not clear.

In a further qualitative study by the Maternity Alliance (Ali et al. 2004), Muslim women from a range of ethnic backgrounds echo the findings in the studies described above with regards to inadequacy of communication, inappropriate assumptions about FGM or lack of knowledge about it, and lack of support from nurses. Further issues were also raised: low awareness of antenatal classes, mixed-sex antenatal classes, poor involvement of Muslim parents in choices of their maternal treatment and care and the lack of privacy and female staff.

There is evidence from the Maternity Alliance's qualitative study of 33 women originating from a range of countries, that pregnant women with refugee or asylum seeker status have experienced difficulties in: registering with a GP (though, reports suggest that they may be given priority over others), accessing information about which maternity services to use at what time, accessing information about benefits for low-income mothers such as for transport costs, and accessing interpreters for antenatal classes (McLeish and The Maternity Alliance, 2002).

These women may also experience difficulties in securing childcare as they are not eligible for tax credits and may not have older family members to rely upon (Kofman et al. 2009).

In a 2002 study (McLeish and The Maternity Alliance, 2002), there appeared to be great variation in the experiences of refugee and asylum seeking women regarding maternity care: around half of the women in this study reported positive experiences of midwife and hospital care, but around half reported negative experiences of prejudice, poor treatment and feelings of loneliness. Of those women who reported negative experiences, a recurring theme was fear that they would be mistreated if they asked too many questions or asked for help:

‘Feeling entirely powerless themselves, they believed their safest course was to assume the worst about how professionals might misuse their power, and to be as compliant as possible’.

This study is small-scale and notes a selection bias towards women who could speak English, and was conducted 10 years ago, but does bring to attention the potentially extreme variation in quality of maternal services and emotional impact of this care. This study also highlights that for some women antenatal appointments or a need to look after their baby clashed with meal times and that arrangements for catching up on this meal were unclear. Practice of dispersing refugees is not always considered in relation to the specific emotional and practical needs of pregnant women and new mothers (McLeish and The Maternity Alliance, 2002).

A larger scale survey on access to maternity information, representative of women in the UK, was conducted in 1998 and raised issues that reoccur in the more recent qualitative work: women who had not attended antenatal classes, and who did not say that this was because they had already had a baby previously, reported that they did not feel comfortable, did not feel they would fit in or would prefer to speak to someone individually. This group included a majority of first time mothers, women under 20 years of age, BME women and women from lower socio-economic backgrounds (Singh and Newburn, 2000a).

Many of the concerns outlined above, surrounding ethnic minority groups, asylum seekers and refugees, and pregnant women for whom English is not their first language, are echoed in the 2003 House of Commons Health Committee’s report on access to maternity services²³. Homeless women, disabled women and women with severe mental health problems, women from the Traveller community and women under threat of domestic abuse are also highlighted as at-risk categories. Evidence in this report was gathered through testimony given by representatives of a number of maternity services,

²³ Language is also cited as a key issue in maternity care a further study of refugee experiences of healthcare DUMPER, H. 2002. *Is it safe here? Refugee women’s experiences in the UK.* London: Refugee Action.

NHS trusts and charities and so the quality of the evidence cannot be properly evaluated.

Age

In their systematic review of qualitative studies on teenage mothers' experiences in the UK, McDermott et al. (2004) collate evidence from a number of studies that show that young mothers are sometimes reluctant to use health services or other maternal support services for fear of stigmatisation by health professionals. This finding is echoed in Higginbottom et al.'s (2006) interviews with 45 young mothers, some of whom felt neglected or poorly treated by maternity staff in hospitals. This study was conducted with young mothers with BME heritage, but interviewees perceived that poor experiences of maternity care were linked to their age rather than ethnicity (Higginbottom et al. 2006). Some sociological literature suggests a connection to a tradition of health policy that frames teenage pregnancy as a 'problem to be solved' rather than as a 'process to be understood' (Aarvold and Buswell, 1999).

Some positive experiences were also reported, particularly in relation to services that focus specifically on young mothers such as Sure Start, though the cost of public transport was considered by some to be a barrier to such services (McDermott et al. 2004).

In terms of access to abortion services among under-18s, Lee et al. (2004) find that, when disadvantage has been accounted for, there is an association between the presence of non-NHS provided services, such as Marie Stopes or bpas clinics that perform abortions, and a higher proportion of abortions to incidence of pregnancy than in areas where there are no specialist services or where there are only referral clinics that do not perform abortions.²⁴ The authors warn that these results are likely to be affected by the placing of specialist centres in areas where there is *already* a higher proportion of abortions to pregnancy in order to meet need. They recommend more thorough investigation into the relationship between the availability and visibility of independent abortion provision and the proportion of uptake.

The availability of abortion after the first trimester of pregnancy may also affect young women disproportionately as they are more likely to present later than older women.²⁵ From qualitative interview data, it was reported that in most of the sites examined, abortions were not carried out by the NHS after 13-16 weeks' gestation: comments indicated that there was a 'division of labour' between NHS providers and bpas with the latter providing terminations after this point. The authors argue that this could result in women having to travel further for procedures (Lee et al. 2004).

²⁴ The authors note that these areas also tend to have greater family planning provision and higher proportions of female GPs.

²⁵ Department of Health (2003) Abortion Statistics, England and Wales, 2002. London: HMSO c.f. LEE, E., CLEMENTS, S., INGHAM, R. & STONE, N. 2004. A matter of choice? Explaining national variation in teenage abortion and motherhood. Joseph Rowntree Foundation.

Men

Though women could be said to be primarily affected by access to pregnancy and maternity services, it is also important to consider access for their partners. No evidence from female partners of pregnant women was found in this review, but there is some evidence from men.

Singh and Newburn (2000b), in a study of the partners of women using maternity services, found that the most common reasons for men not attending antenatal classes were: because their partner was not attending, or that they felt they knew enough from having a child previously, alongside not being able to get time off work (a significant factor for a third of the men surveyed). This was of special significance for first-time fathers. Men aged 15-19 gave additional reasons for not attending, such as embarrassment, not feeling comfortable in groups, and not believing that they would fit in with the other people who attended.

In a qualitative study with young couples, Ross et al. (2012) found that it was more common for young men to report negative experiences of health services than their female partners: they often felt excluded or marginalised during check-ups during the pregnancy or intimidated in antenatal classes which few other men attended.²⁶ Some young men thought that this was normal since their partner was carrying the baby, but some expressed wishes to be more involved with the pregnancy.

Of those couples that did not attend antenatal classes, reasons given include: preference for independent learning, issues with timing in terms of work or training, perceptions that staff would hold a negative view of them as young parents and scepticism of the benefit of classes (Ross et al. 2012).

Women who attended women-only classes or classes designed for young parents reported very positive experiences of not only information related to pregnancy and birth but also caring for the baby after birth. However, young men who had been excluded from some of these classes felt they had missed out on valuable information and a chance to be involved with the pregnancy (Ross et al. 2012).

Though young men and women reported generally positive experiences of care whilst in hospital, both reported that they would have liked more information and demonstrations of basic child care (though it is not clear from this study to what extent their status as young parents had an impact on this). Young fathers also expressed concern that they did not know how to support partners who felt depressed. This study was relatively small-scale and the sample composed of couples from a white ethnic background and was drawn from predominantly planned pregnancies, which the young couples

²⁶ Half of the couples in this study attended antenatal classes together, of those women who attended on their own the reason given was that the classes did not accept men.

welcomed. It also has a strong bias towards couples who were still together 18 months after the child was born (Ross et al. 2012).

Feelings of marginalisation by health staff, but also by partners' family members participation in visits to maternity services are echoed in a study of 23 young black or mixed heritage fathers and their partners (Pollock et al. 2005).

There was no substantial evidence relating to non-heterosexual parents or how this might interact with other characteristics such as age, disability or ethnicity.

Sexual Identity and Trans

The Human Fertilisation and Embryology Act 2008 has replaced reference to a need for a father for the welfare of a child to the need for 'supportive parenting'. This change supports the right for same-sex couples to receive fertility treatment. There are a large number of articles relating to experiences of maternity services by same-sex parents, but many of these studies were conducted in countries other than the UK.

Of the evidence that relates to countries within the UK, there is evidence that some LGB people feel that their family structures are not recognised, or are seen as 'unstable' by mainstream health services (PACE, 2001). One study in England found that less than half of LGB respondents who has considered using Assisted Reproductive Technology to conceive a child felt able to ask a health professional for advice (Mitchell et al. 2009).

In terms of experience of maternity services, a small study carried out by Wilton and Kaufman (2001), found that, although some of the respondents reported positive experiences of maternity services, many lesbian women were anxious about disclosing their sexual identity to midwives and to their GP. 'Booking in' forms and antenatal education were identified as being particular areas of concern, with half of the study's respondents expressing that classes were very heterosexually-oriented. Yet, the study also found that some people experienced a too studiedly 'neutral' response discomfoting as if the information were not recognised at all or was perceived as embarrassment. Not disclosing sexual identity was seen as a source of potential barriers to help for lesbian couples. Among the 50% of respondents who reported feeling that their needs were met, were examples of good practice where lesbian couples were made explicitly welcome.

A further small qualitative study of lesbian women's experiences of maternity care also yielded both positive and negative experiences (Lee et al. 2010). In a qualitative study of 10 lesbian co-mothers, Cherguit et al. (2012) found that although lesbian co-mothers had generally positive experiences of maternity services, they still had some doubts about their acceptance.

Of the respondents to one study, 45 lesbian mothers had positive experiences of maternity services during labour, compared with 13 who did not. Non-recognition of the other parent was a factor cited by those who had negative experiences. However, a far lower proportion of women reported negative experiences of postnatal care (Wilton and Kaufman, 2001). Goddard (2009) found that the needs of the non-pregnant lesbian partner of a couple may be ignored by some maternity services with some people expressing that they would feel more comfortable in classes dedicated to lesbian parents.

Goddard (2009) also finds that assumptions can be commonly made about a pregnant woman's sexual identity by maternity and post-natal services, and that forms can ask for a mother and father's name only, excluding the recognition of a same-sex parent. Responses to the offer or discussion of contraceptive needs with lesbian mothers can also motivate negative responses: some people felt that the raising of this issue demonstrated ignorance of the couple's specific needs. Yet, this information might be relevant to some people. Some questions asked by midwives on other topics, such as those regarding a child's biological father, or a mother's sexual history, were seen as irrelevant and intrusive. In other cases, women were not asked questions that may have yielded useful information, such as whether there was a co-parent, about a partner's needs, about confidentiality, or whether a woman had support from home (Wilton and Kaufman, 2001).

Some LGB parents may not receive the same level of support from their families of origin as heterosexual parents. The Lesbian and Gay Family Therapy Service may offer much needed support to LGB parents (Mitchell et al. 2009).

Writing on behalf of Stonewall, Hunt and Minsky (2006) argue that LGB families are still erroneously assumed to have a negative impact on the upbringing of children, which may make it difficult for same-sex couples to be open with health professionals about their family status. There is a small amount of evidence that LGB people may be reluctant to put themselves forward as potential foster or adoptive parents for fear of discrimination (Burkitt, 2007). There may also be less visible information available for LGB people about donor options, fostering, and adoption (Women's Resource Centre, 2009).

During the time available for this research, no studies on Trans parents experiences of UK services were found. Further work is needed to identify whether this represents a genuine research gap.

Other Services

Sexual Health – Key findings

- Opening hours for GUM clinics and reliance on public transport may prevent young men from accessing sexual health services
- Peer pressure and concerns about confidentiality may also discourage young men from accessing sexual health services
- There is little visible information about LGB sexual health
- Bisexual people are least likely to agree that health information caters for all groups
- LGB people report that health professionals sometimes make inappropriate assumptions about their sexual health needs
- Sexual health risks for LGB people are not fully understood by all relevant health professionals
- Trans people are likely to disagree that health information is appropriate to their identity or sexual identity
- Some disabled women are not fully informed about contraception
- Some BME women may find it more difficult than others to talk with friends and family about sexual health, pregnancy and abortion, yet may perceive that health services do not appreciate cultural differences

Much of the information in this area is less robust, however robust data for more minority groups can be more difficult to obtain and so the information available is presented here.

Sexual health services

Men

In a small scoping study of Chlamydia screening uptake among male university students, Fowlie et al (2010) found that 12% of their survey sample reported being screened annually, 51% said that they were screened less than once a year and 16% had never been screened. Though no comparator evidence with female students was gathered by this project, it explored some possible barriers to screening that is supported by the qualitative evidence that was gathered: 61% stated that the operating hours of GUM clinics were insufficient. Thirty seven per cent answered that the main reason for non-screening is peer perception and pressure. Lack of available information was perceived as an issue by 35% while 17% stated that the waiting times were a barrier (Fowlie et al, 2010).

In a report by the Department of Health, it is suggested that both men and women are more likely to take up screening services if they use their GP (Department of Health, 2008).

In a study of young men's first use of sexual health services in the UK,²⁷ Forrest (2007) finds that around 18-20% of interviewees either mentioned centre location, opening hours, or transport as potential barriers to their use of services (70% of respondents relied on public transport to visit the centres). Some young men reported that there were no public transport services that were convenient to where they lived and therefore access to the centre involved a long and complex journey by public transport or required access to a car. For others the journey, access to transport and opening hours all caused problems. An additional consideration was that absence from school, college or work was not conspicuous.

In terms of their concerns about visiting sexual health clinics, a large proportion of young men who participated in a study had concerns about confidentiality (67%), which overlapped with the desire not to be seen by peers or family members at the clinic. Some expressed confusion over why they were required to give personal information such as names and address on arrival (Forrest, 2007).

Sexual Identity

In a systematic review of the literature on cervical screening amongst Lesbian or Bisexual women, Fish (2009) highlights the characterising features of LB women's uptake of and access to these services as follows:

- Participation rates in cervical screening increase with age among LB women
- Time intervals between screenings appear to be greater than for heterosexual women and LB women were up to 10 times less likely to have had a test in the past three years
- LB who have never had sex with men were less likely to seek screening than those with a history of sex with partners of the opposite-gender
- Rates of women who have never been screened range from 12% - 17% in UK studies
- Cervical screening is not always considered necessary for LB women by health professionals
- LB women believe themselves to be low risk
- LB women may have had more adverse experiences of healthcare than heterosexual women
- There may be a reluctance to come out to health professionals among some LB women

²⁷ 33 interviews and 215 questionnaires with young men from various locations in the UK within proximity of a Brook centre. The sample is predominantly white, the majority between 16-19 years old and in full-time education. Though non-users of health services are represented in the survey portion of this study, their answers did not differ significantly from those of young men who did use clinics. Non-users are not represented in the qualitative research, but this captures some of young men's apprehensions of and problems with accessing services.

- Heterosexual assumptions pose a barrier to healthcare²⁸

Fish refers to 14 studies, two of which are conducted with women using health services in the UK. Her findings are supported by other evidence from the UK (CRUK 2008, Bailey et al. 2000, Diamant 2000a, Diamant 200b, DTI, 2004, Evans et al. 1997, Fish 2006, Fish 2007, Fish & Anthony 2005, Fish and Wilkinson, 2000a, Fish and Wilkinson 2000b, Hunt and Fish, 2008, Mantle, 1998, Marrazzo et al. 2001, NCEI 2008b, ONS, 2008, Peto et al. 2004, SHADY, 1996, Skinner et al. 1996)

In 2007 Stonewall conducted a study with over 6,000 LB women. Their results suggest that assumptions are often made by health professionals that all patients are 'heteronormative' in terms of the relationship between their sex, sexual identity and sexual health needs: sometimes Lesbian women are seen as a 'low-risk' category for sexually transmitted infections, both by themselves and by health professionals. LB women may not fully engage with appropriate sexual health services, with 15% of Lesbian or Bisexual women over the age of 25 reporting that they have never had a smear test. It is not clear how this figure compares with heterosexual women.

A small amount of qualitative evidence suggests that this may be related to ambiguity and lack of information on medical needs. In a small-scale study, Formby (2011) highlights the invisibility of Lesbian or Bisexual women's sexual health needs in NHS policy priorities, leaflets available at health centres and in school sexual education programmes. She suggests that this could lead to a lack of awareness that LB women are at risk of particular sexually transmitted infections and a sense of being marginalised by health services. Among this small number of women it was perceived that health professionals lacked understanding about lesbian sex and the risk of contracting STIs and so delayed or avoided sexual health check-ups (Formby, 2011).

Browne and Lim (2008) found that when asked, some LGBT respondents gave reasons for not believing that they needed a sexual health check-up. These included being in 'monogamous' and/or 'committed' sexual relationships and that they were not worried about the risks associated with their sexual practices or relationships. Identities of partners can also influence perceptions of sexual health needs, with some respondents saying that because of who their partners are they do not need sexual health check-ups, including a large proportion of Lesbian respondents and those who do not have sex with men.

These results may point to a lack of knowledge regarding lesbian sexual health and women who have sex with women. Yet, the report is careful to emphasise that, 'it cannot be assumed that Lesbians *in general* are more likely not to seek sexual health check-ups because of a lack of knowledge regarding the risks of infection or sexual health check up services. Rather,

²⁸ FISH, J. 2009. Cervical screening in lesbian and bisexual women: a review of the worldwide literature using systematic methods.

there may be a need for more and better communicated information targeted at specific groups of Lesbians regarding why and when they might need sexual health check-ups, what they would involve and how to access them' (Browne and Lim, 2008). This study suggests that there are also other factors to consider, such as discrimination and embarrassment.

A small amount of qualitative evidence from the Brighton and Hove area of England, suggests that there may be differences in from *whom* LGB people are likely to seek sexual health advice: Lesbian respondents were much more likely (57%) than Gay men (9%), Bisexual respondents (21%) and those who identify as queer or as an 'other' sexual identity (22%) to have last had a sexual health check-up at their GP. Gay men were most likely to have last had a sexual health check-up at a sexual health clinic. Bisexual respondents were most likely to have had their last sexual health check-up at a sexual health clinic outside Brighton and Hove (21%), with the Terrence Higgins Trust, at an LGBT venue, or elsewhere (10%) (Browne, 2007).

Among the small number of respondents who had been involved with some sort of sex work (in exchange for payment, drugs, alcohol or somewhere to stay), over half had their last check-up at Claude Nicol clinic. It is not clear from these results whether people had disclosed their sexual identity at these appointments (Browne, 2007).

In terms of information on sexual health, Gay men in Brighton & Hove were much more likely to 'agree' or 'strongly agree' that available information was relevant to their sexual practices (75%) than Lesbians (25%), Bisexual respondents (39%) and those who identify as queer or an 'other' sexual identity (45%). Bisexual respondents were most likely to 'disagree' or 'strongly disagree' that information on sexual health in the area is diverse and caters for all groups. Qualitative evidence from the Bisexual participants in this study raise concerns that although there were some Lesbian and Gay-specific clinics available it was unclear whether these would have information relevant to Bisexual people (Browne, 2007).

On the issue of sexual health risks, one particular respondent highlighted that it is not only Lesbians who compose the population of women who have sex with women but also Bisexual women: Bisexual women might engage in a wider variety of sexual practices than allowed for in sexual health literature that is currently targeted at either Straight women or Lesbians, and might therefore have different requirements for information regarding sexual health risks and precautions. This argument is also important in informing advice for Bisexual men (Browne, 2007).

In another study, with Gay or Bisexual men, Stonewall reports that 26% of Gay or Bisexual men report that they have never been offered an HIV test (Stonewall Cymru, 2012). Though it is important that access to such tests are equitable, it is important to ensure that Gay or Bisexual men are not offered these tests as a result of prejudice.

Trans

The *Count me in too* study of LGB and Trans people in Brighton & Hove found that Trans respondents were much more likely (44%) than other respondents (15%) to 'disagree' or 'strongly disagree' that '*information on sexual health available in Brighton and Hove is appropriate to my gender identity or sexuality*' (Browne, 2007).

As discussed above, insufficiently detailed medical record-keeping can result in Trans, Intersex, or people who have undergone gender reassignment being sent inappropriate invitations for screening or not being included on relevant screening programmes. **See *Records***

Ethnicity

In a study based in Birmingham, focus groups conducted with a small number of Somali women raised issues of reluctance among young Muslim women to consult on sexual health issues and an inability to talk to their families about sexual health, pregnancy and abortion. Though a desire was expressed for confidential services such as Brook, some women felt dissuaded from attending because of perceived cultural differences between themselves and the service (Rabiee and Smith, 2007).

Cancer Treatment – Key findings

- Women are more likely than men to have access to a Clinical Nurse Specialist, who are associated with increased satisfaction with cancer treatment
- However, men are generally more positive than women about their experience of cancer treatment, in particular, about staff attitudes, privacy, being given information, and being treated with dignity and respect
- The association between level of knowledge about colorectal cancer screening and negative attitudes is unclear
- Men have a slightly more fatalistic attitude towards bowel cancer than women, but are more likely to report that they 'never feel frightened' at health appointments
- Men's partners may be influential in them taking action on health issues
- Women express greater levels of disgust and embarrassment about the bowel cancer screening procedure

Some large surveys offer us robust evidence of inequalities of *experience* of cancer treatment and screening services. Yet it is important to remember that data related to attitudes and perceptions tell us how people talk about

particular issues within a particular context and we should be cautious of inferring any direct relationships between perception and behaviour.

Cancer treatment services

Women and Men

It appears that men and women have more or less positive experiences of different aspects of cancer treatment. It is unclear from evidence whether gender inequalities in this instance are caused by differences in reporting or experience.

In a study measuring knowledge of and attitudes towards colorectal cancer, McCaffery et al. (2003) find evidence that although level of knowledge increased with age for both men and women, women demonstrate significantly better knowledge of the disease than men overall. However, women's attitudes were also slightly more negative along with those of the youngest age group. In general, low knowledge was associated with more negative attitudes and with intention to participate in colorectal cancer screening.

In a Men's Health Forum study related to the NHS Bowel Cancer Screening Programme, men were shown to be slightly more fatalistic than women in their attitudes towards finding out about illness, but for both men and women this category represented a minority (Wilkins, 2011).²⁹ Yet, in the same study, they were more likely to report that they 'never felt frightened' when they have an appointment about their health (68% men compared with 52% of women). It is important to remember that this type of self-reported study may tell us about the norms of masculine and feminine attitudes towards health rather than actual experiences of individuals of healthcare.

Coles et al (2010) found that themes that emerged in discussion groups included the important role of a man's partner in encouraging him to take action on a health problem. Men perceive that more screening programmes are available to women than men and that women have a greater awareness of them. Aside from fear and fatalistic attitudes, barriers were also perceived in that if one is fit and outwardly healthy there is no need to 'look for problems'. Disgust and embarrassment over the bowel cancer screening procedure were a problem for some men, but less so than for women (Coles et al. 2010).³⁰

²⁹ Among other questions, men were more likely to agree with the statement 'I would rather not know if something was seriously wrong with me' (22% of men and 14% of women). Sample of 522 men and 122 women but is not representative as selected from electoral register only. There is also a bias in the sample toward those who had agreed to participate in screening.

³⁰ 10 discussion groups conducted in the West Midlands (screening programme established) and South West areas (screening programme not yet established) and 12 telephone

Men are generally more positive than women about their experience of cancer treatment. Men are more positive than women about staff and about staff working well together. The same was true for privacy, being treated with dignity and respect, and being given enough information. Men are also more positive about discharge and post-discharge services and a greater proportion of men reported that they had received written information on different types of cancer and on free prescriptions (Quality Health, 2010)

On the other hand, women are more likely to report that they had seen their GP only once or twice before being referred to hospital, or had been seen within 4 weeks of this referral. They were more likely to claim that their health stayed the same during this waiting time and women were more likely to say they had been given information on side-effects of treatment and to be given the name of their Clinical Nurse Specialist (CNS) (87% compared to 81% of men). Women also reported in greater numbers that their hospital operation appointment had *not* been changed and that doctors did *not* talk about them as if they were not there (Quality Health, 2010).

The discrepancies in access to a CNS are significant as those with a CNS are more likely to report positive responses in being given information. There is uneven coverage of CNS across different tumour groups, and the research suggests that women's higher level of access to them may be accounted for by the greater number of CNS allocated to breast cancer wards (Quality Health, 2010).³¹

In a review of qualitative evidence about patients' experiences of presenting symptoms of cancer to doctors, Smith et al (2005) find some gender differences in how women and men perceive their own and each other's help-seeking behaviour. The authors suggest that there may also be differences in how men and women 'sanction', or legitimise, seeking help for symptoms (such as symptoms interfering with work). These suggestions are not drawn out in the research and require further investigation.

In the second phase of research, it will be important to investigate evidence surrounding the cut-off age for invitation to particular cancer screening programmes in relation to the evidence for incidence of cancer at these ages.

Exercise and Weight – Key findings

- Fear of prejudice may discourage LGB and Trans people from exercising in public spaces
- Women are more frequently recorded as obese but also are more likely to *consult* for problems with eating

interviews were conducted with men who may not have been picked on through the on-street marketing, such as disabled men.

³¹ Findings are largely echoed in 2011-2012. QUALITY HEALTH ON BEHALF OF THE DEPARTMENT OF HEALTH 2010. National Cancer Patient Experience Survey Programme 2010 National Survey Report. Department of Health.

- The relationship between norms of ‘masculinity’ and exercise or food are complex and differs according to various types of masculine ideal

There are sparse sources of evidence for inequalities of access to exercise and weight management services. The data on this issue cannot be considered robust and only an indication of problems.

Exercise and weight management

Trans and Sexual Identity

Although there is some evidence of concern that exercise facilities may be less accessible to LGB or Trans people, Browne and Lim (2008) reveal that among the reasons reported for not partaking in exercise, those related to identity or body image ranked below ‘lack of time’ and ‘cost’. However, among Trans respondents only, 43% indicated that a lack of Trans-friendly spaces represented a barrier to them being more physically active (Browne and Lim, 2008).

Women

Women are more frequently recorded as being obese by GPs, but rates of consultation with women are also higher (for hyper-eating and issues relating to comfort eating, self-esteem, and attitudes towards exercise) (Department of Health, 2008). The reasons given for this are speculative, but include an inequality of exposure to and participation in sports at younger ages (Department of Health, 2008).

Where people are referred to an exercise programme by their GP, it has been shown that men are more likely to complete the course (Department of Health, 2008). It is necessary to be circumspect in interpreting these data as women may be more likely to self-treat through private weight-loss groups (Department of Health, 2008).

Men

There is limited evidence that men conceptualise diet in ways that are not healthy according to government advice: Gough and Conner (2006) conduct interviews with 24 men to find that they express ‘cynicism about government health messages and a rejection of healthy food on grounds of poor taste and inability to satisfy’. It is important to be cautious about qualitative evidence of this kind as, although it may or may not reflect male eating behaviours or men’s attitude towards food, the sample size is very small and these data primarily tells us how men *talk* about food with others. However, in a later

study, Gough (2007) finds that these attitudes are reflected in the national British newspapers wherein there is a:

'[...] persistent adherence to hegemonic masculinities predicated on health-defeating diets, special occasion cooking of hearty meals, and a general distancing from the feminised realm of dieting. At the same time, men are constructed as naïve and vulnerable when it comes to diet and health, while women are viewed as experts' (Gough, 2007)

Though this evidence suggests reiteration of an unhealthy culture surrounding men and food, it is unclear how this affects men's help-seeking about weight and dietary issues. The authors of this study emphasise the need to recognise diversity among men: there are variations in the dietary customs of different cultures and some men take pleasure in cooking and eating. Elsewhere negative health behaviours to do with food, alcohol, and smoking have been associated with hegemonic constructions of masculinity, but Robertson (2006) emphasises that alongside this there are also discourses of a desirable healthy weight and fitness among men. The author is careful to point out in other research however, that *participation in sport* cannot always be directly linked to health-goals (Robertson, 2003).

Alcohol and Smoking – Key findings

- There are inequalities between men and women not only in the rates of referral for substance misuse, but also in *mode* of referral
- The relationship between alcohol tolerance and sex is unclear
- Robust studies of gendered attitudes towards and usage of alcohol and smoking are lacking
- Prior to the smoking ban, Lesbians and Bisexual women were found to be less likely to want to give up smoking than Gay or Bisexual men or people identifying as an 'other' gender

There is very little robust evidence in this area and some of the conclusions drawn from the data are conflicting.

Alcohol and smoking

Women and Men

According to StatsWales, more men are referred for alcohol and substance misuse than women at 25,933 referrals for men in 2010-2011 compared to 11,697 for women. It is not clear from these figures to what extent the difference in these figures is due to different rates of incidence or to issues of access and opportunity to diagnose.

There are marked differences between women and men in mode of referral for substance misuse: though the rates of referral for women are lower in all cases (apart from by maternity services), the gap is far wider for rates of referral via the courts, drug intervention programme, probation service, youth offending team, prison and Job centre than for educational establishment, support agencies, self-referral and GP.³²

In 2008, the Department of Health's report on *Gender and Access to Health Services* suggested that although biological effects of gender on alcohol tolerance have been explored for some time in the medical literature, there is evidence that perceptions of the impact of gender varies between cultures. The report also argues that treatment for alcohol addiction or smoking cessation programmes are often gender-blind (Department of Health, 2008).

Perceptions of alcohol-related behaviour may also be gendered, though robust evidence for this is lacking. A small-scale study of university students found evidence of gendered perceptions of alcohol consumption, even those students who expressed the most egalitarian views of gender equality expressed disapproval of women's drinking (De Visser and Smith, 2007). Yet, from the illustrative quotes given, there is an indication that this may be based on the *type* of alcohol consumed rather than number of units. Dempster (2011) found that although it was perceived that male and female students drank about the *same amount*, there was a clear association between heavier alcohol consumption and perceptions of masculinity.

Trans and Sexual Identity

Browne and Lim (2008) found that female smokers are less likely (64%) than male smokers (73%) or smokers who identify as of no gender or an 'other' gender (100%) to want help to stop smoking.³³

Gender Reassignment – Key findings

³² <http://www.statswales.wales.gov.uk/TableViewer/tableView.aspx> accessed 28-09-12

³³ The categories 'woman' and 'man' in this study include those who identified both as Trans and women so as not to assume that an individual who was Trans would necessarily have to identify as *Transwoman* or *Transman*. For further details see LIM, J. & BROWNE, K. 2009. Senses of gender. *Sociological Research Online*, 14, 6.

- We are not able to estimate the number of people who identify as 'Trans' or the number of people who may wish to undergo gender reassignment but that have not begun the process
- Some people experience difficulties in getting GPs to refer them for gender reassignment services
- A minority of Trans people feel adversely affected as a result of health staff prejudice and more have experienced negative interactions at Gender Identity Clinics
- Some GPs are not fully informed about gender reassignment processes and there are gaps in provision of particular essential services in Wales
- Criteria for qualifying for gender reassignment may not be consistent among local health authorities
- There is strong support for more local services and GPs specialising in Trans health needs
- It is generally not possible to move between Gender Identity Clinics if you move away, this may prove a barrier for people relying on public transport or who have limited funds
- Up to 59% of people undergoing gender reassignment are not entirely happy with the support they received from surgery or nursing staff. This figure may be higher for public health services
- Some Trans people report withholding information or lying at Gender Identity Clinics due to perceived irrelevance of questions or for fear that treatment will be delayed or withheld.

It is difficult to gather data from a robust sample due to the relatively invisible status of people undergoing gender reassignment, and so evidence may not be able to tell us the *prevalence* of particular problems. Nevertheless, available evidence does provide us with detailed information and a good indication of the issues that Transsexual people might face.

A new standard Gender Dysphoria care pathway has recently been developed in Wales that may address some of the problems raised with gender reassignment.

Gender reassignment

Those Trans individuals who choose to undergo gender reassignment in Wales are protected by the Equality Act 2010. Although it may be possible to retrieve figures of how many Gender Recognition Certificates have been issued, this only tells us how many people have completed their transition and little about how many people are currently in the process of transition or are considering gender reassignment. It is also extremely difficult to estimate the number of people with Trans identities who have not expressed a wish to undergo gender reassignment, although they may experience prejudice or inappropriate assumptions from health services **See Records and Respect and dignity.**

Some Trans people, who wish to undergo gender reassignment procedures, report barriers from primary care services in accessing further help or advice: in evidence gathered for England only, 21% of respondents report that their GP did not want to help with requests for gender reassignment and 6% of respondents report that their GP refused to help. Barriers from primary care services are also reported in access to other health services: 17% of Trans³⁴ respondents report being refused (non-Trans related) healthcare treatment by a doctor or a nurse because they did not approve of gender reassignment. Twenty nine per cent assert that in general being Trans adversely affects the way they were treated by healthcare professionals (Whittle et al, 2007).

Combs (2010) describes a lack of understanding about gender reassignment among GPs along with other Trans-related healthcare issues such as screening services: **See Records**. There may be access issues regarding the assignation of low priority for funding of gender reassignment treatment by some PCTs in England, though it is not clear as to how this is managed by Local Health Boards in Wales. It has been highlighted that there are gaps in provision in Wales of locally delivered services for those who have been identified as having Gender Dysphoria, such as endocrinology units or speech therapy, along with more highly specialised surgical procedures being currently commissioned from English centres. Welsh services are in particular need of improvement with regards to follow-up assessment and postoperative care (Phillips, 2012).

Combs' study also gives evidence that there are different criteria for gender reassignment surgeries across PCTs in England. Laird and Aston (2003) argue that male-to-female (MtF) and female-to-male (FtM) Trans people experience different inequalities in access to services, for example MtF people reported having to pay for electrolysis whilst FtM people reported barriers to accessing chest surgery.

In the *Trans Mental Health Survey 2012* respondents indicate variations in both demand and potentially supply (indicated by 'would like') for different surgical options. The differences in the proportion of respondents who have not had but would like some kinds of surgery are noticeably higher for some than for others, such as removal of breasts (double mastectomy) (McNeil et al, 2012).

Elsewhere, Hines (2007) has argued that the gender reassignment process operates as a 'one size fits all' service, regulated by medical practitioners and psychiatrists, in which individuals are obliged to conform to the medical discourse of 'being in the wrong body' when giving their life histories in order to qualify for treatment.

People who cannot afford private sector health services rely on their GP to refer them to appropriate gender identity services and to secure them an appointment. Browne and Lim (2008) reported negative feedback on the

³⁴ The identity 'Transsexual' may be preferred here, but 'Trans' is used in the original research

services received from a particular identity clinic in terms of unsympathetic treatment and presentation of Trans identity as an 'illness' or 'disorder'. When Trans respondents were asked what could have been done to improve their transition, over 65% said that a specialist local service was needed with 51% asking for a specialist GP.

Hines (2007) also suggests that there is a 'care gap' in the lack of counselling support for Trans people during the gender reassignment process, drawing on a small amount of qualitative evidence to suggest that, where possible, friends and family currently fill this gap. We should be cautious in considering whether this type of support should be made an obligatory part of the gender reassignment process, as Hines' study reports very mixed views on how important support groups are (Hines, 2007).

People undergoing gender reassignment may also encounter barriers to care if they relocate during their transition. This may disproportionately affect younger people. Combs (2010) states that:

'In general, once a trans person is established with a gender identity clinic, contact with another gender identity clinic is not accepted. This is a particular issue which affects younger trans people who have moved away from home to attend university because they have limited funds to pay for their travel back home for appointments with the gender identity clinic they are registered with'

In terms of experience of the gender reassignment process, in their mixed-method study of individuals' experiences of gender reassignment (or 'realignment' in this article) surgery, Khoosal et al. (2011) found that out of 104 MtF transitioning respondents, 59% were not entirely satisfied with the support they received from surgery and nursing staff, 24% did not feel supported at all, and 35% answered 'neutral'. The authors note that respondents tended to have felt more supported when they had used private sector health services. To improve patient experience, they recommend the making of 'access to specialist services less complicated within the NHS, making education and information more relevant and available to both users and their carers, and changing the perceived role of the psychiatric component of the process away from that of being a 'gatekeeper to services' (Khoosal et al, 2011).

This issue is echoed in a recent survey of Trans people.³⁵ The report highlights extremely variable reviews of treatment at Gender Identity Clinics (GICs) with 62% of people reporting having experienced negative interactions in this setting, 27% reporting that they have withheld information or lied to a Gender Identity Clinician, mainly for fear that treatment would be delayed or stopped or because questions were not felt to be relevant to their diagnosis. Thirty three per cent of respondents felt concerned about their mental wellbeing but unable to discuss their concerns at the GIC (McNeil et al, 2012).

³⁵ This is one of the larger surveys of Trans people conducted in the UK with data based on 889 responses

Khoosal et al. (2011) emphasise that in general, the younger the age at which the individual undergoes surgery the more satisfactory the outcome: this may have implications when considering the accessibility of gender-related advice or education during the life course. More robust research may be needed on this issue before firm recommendations can be made.

Prison – Key findings

- Prisoners who have experienced gender-based violence may need special health care provision
- Pregnant women who arrive in prison may have had unequal access to services previously and different health needs whilst an inmate
- Some details of provisions that are available to prisoners undergoing gender reassignment remain ambiguous
- There is little evidence on the experiences or safety of prisoners undergoing gender reassignment

Evidence for inequalities in access to health service whilst in prison is available from few sources, but these consist of studies and policies commissioned or produced by various government departments.

Health services in prison

There is limited evidence available of gendered inequalities in access to health services in prison. However, there is some evidence from local government that access to coordinated services in prisons may be limited. The Local Government Improvement and Development website calls for gender-sensitive provision, in particular for those who have experienced gender-based violence.³⁶

Women

Investigating the experiences of women prisoners, the Corston Report finds ambiguity in who is responsible for provision of health services to inmates (Corston and Britain, 2007). The report gives detailed evidence of health problems facing women in prisons, but does not highlight gender inequalities or inequities by giving comparator evidence for male prisoners. The report raises some important points: Corston notes that many of the women who arrived in custody pregnant did not have full access to maternity healthcare beforehand, such as being registered with a midwife. Though not suggested by the report, this could mean that certain women may need additional support or advice.

³⁶ Local Government Improvement and Development website: Offender and ex-offender health <http://sitetest.idea.gov.uk/idk/core/page.do?pageId=17340394> accessed 5-10-12

Gender reassignment

There are also issues surrounding access to gender reassignment in prison, an issue on which the Ministry of Justice has issued guidelines. Although these guidelines are detailed, there are still a few points that remain ambiguous. Individuals retain their right to continue gender reassignment treatment that is commenced before reception into prison and, if the prisoner applies for it, this should be continued unless the doctor working in the prison has reasonable clinical grounds for not allowing this. Transsexual prisoners have the right to items that assist with the presentation of their acquired gender such as own clothes, prostheses and essential make-up.³⁷ However, no publicly available data was found on prisoner experience of whether this process is adequate or on their treatment by other inmates, though the guidelines highlight that the assignment of prison wing (men or women) can be problematic for both the safety of the individual and other prisoners.

Mental Health – Key findings

- Men are more likely than women to be formally referred to NHS mental health services or to be admitted to independent hospitals
- Men may be more likely to find themselves in situations that put them at risk of mental illness
- Men are concerned with the availability of information about mental health and urgent help
- Some men express difficulties discussing their mental health with a GP and would prefer to consult a specialist GP
- Men express slightly less tolerant attitudes towards people with mental health issues, but are more likely to say that they can recover completely
- Women with mental health issues may not feel comfortable in mixed-sex services
- LGB and Trans people who have mental health difficulties are more likely to report that they have felt uncomfortable using mainstream services

The small amount of data that relates to the usage of mental health services are more robust than the majority of the research that discusses attitudes towards mental health. As outlined above, caution needs to be exercised in making any connection between attitudes expressed by participants in research and patient behaviour.

Mental health services

³⁷ MINISTRY OF JUSTICE NATIONAL OFFENDER MANAGEMENT SERVICE 2011. The care and management of transsexual prisoners. Unclassified ed.: Ministry of Justice.

Men

Official statistics for 2011-12 show that the total number of admissions for men to NHS mental health facilities is lower than that for women (5,093 compared with 5,470). However, the number of formal admissions (those detained under a section of the Mental Health Act 1983 and other legislation) is higher for men (699 compared with 579), with informal admissions lower for men (4,394 compared with 4,891). Looking at independent hospitals, the total number of mental health admissions is higher for men than for women (121 compared with 89).

Citing White (2006), the Race Equality Foundation argues that men often find themselves in conditions and situations that are considered to be risk factors for mental illness, such as exclusion from school, social deprivation linked to unemployment, involvement in crime and drug cultures, and prison. This may also be said of the armed services: speaking as part of a Men's Health Forum report, the mental health support charity for military veterans Combat Stress asserts that: 'On average it takes about fourteen years for an ex-serviceman, suffering attributable or aggravated psychological injury, to access help via our service' (Letford in Wilkins and Kemple, 2011).

Men's Health Forum asserts that compared to women, men have reduced access to emotional support from close family and friends, and are less likely to seek help for problems such as with their mental health that may be perceived as affecting predominantly women. This seems to be a logical inference, but there is currently no strong evidence available to support this assumption (Wilkins, 2010).

Though small-scale, qualitative data gathered through focus groups with 36 men conducted by Men's Health Forum indicates a desire for more or clearer information about what help is available to those with mental health concerns. Particular concerns were raised about information being up-to-date, available for parents of those with concerns about their mental health, information about routes to *urgent* mental health help, and the availability of information in languages other than English (Bengali was mentioned in particular), about how diagnoses of mental health conditions are made, codes of conduct, and patient rights. A few participants also raised concerns over the perceived short length of GP appointments and the limiting effect of this on being able to fully disclose their concerns about their mental health and/or emotions. On this subject, there was also a desire for a system whereby patients can identify GPs with a particular specialism in mental health (Wilkins and Kemple, 2011).

In terms of experience of GP consultations and treatment, a couple of participants of the same study report that, when conveying their mental health concerns, they have been interpreted as being aggressive towards health practitioners. On the other side, a couple of BME participants reported aggressive handling of them on the part of health staff. Concern over GP confidentiality with other members of an individual's family was also raised (Wilkins and Kemple, 2011).

Carrick Mind service users identified the lack of specialist services in rural areas as a barrier to access, particularly for those under mental stress. This report presents several comments expressing concern over the use of the adjective 'mental' in naming or advertising services as this has negative connotations. These findings cannot yet be considered robust or illustrative of wider experience, but do indicate areas about which more knowledge is needed (Wilkins and Kemple, 2011).

Men's Health Forum hypothesises that older men may be more at risk for distress:

'Some degree of loss is a common experience for many people in later life. Loss of employment, role and status may be accompanied by a decline in material wealth resulting from reduced income. Older men also face the increased likelihood of relatives and friends dying.'

Through consultation with their partner organisations,³⁸ the Forum suggests that older men may encounter barriers in access to mental health services as take-up of IAPT (*Improving Access to Psychological Therapies* programme) remains low despite their acceptance of referrals for people over the age of 65 since 2008. There may also be barriers to particular therapeutic activities such as volunteering due to physical access or particular activities not being promoted to older men. The report also highlights the importance of considering possible adverse effects of older men-specific services or treatments as this could create or maintain barriers to services usually provided to younger men that may be beneficial (Wilkins and Kemple, 2011).

Commenting on this research, Men's Health Forum ask if men from rural communities have a lack of access to specialist services, arguing that they may be required to travel long distances to seek help, there may be a lack of appropriate public transport and that information services are less likely to provide advice in preferred format or language. These issues may not, of course, be limited to *men's* access to health services only.

Though no specific evidence could be provided by the report, it is highlighted that men's experience of sexual abuse is relatively invisible in health promotion literature and that 'No specific NHS service exists to meet the specific mental health needs of men and boys in relation to sexual trauma' (Wilkins and Temple, 2011).

Although, based on current research, we cannot make claims for a direct link between attitudes towards mental health and the help-seeking behaviours of men; there is nevertheless evidence of differences between men and women

³⁸ MIND, The National Mental Health Development Unit, and members of the Men's Health Forum Expert Advisory Panel. Possibly due to the report's primary function of exploring initiatives aimed at improving mental health services for men, the robustness of the data presented in this report is not made clear within the document: though references are provided for some statistical data, references for many other statements are not given and could not be located.

on this issue. The Health and Social Care Information Centre (2011) found that men are less likely than women to display more tolerant attitudes towards people with mental health issues.

Men and women in this survey also reported differences in attitudes towards treatment of mental illness and causes of mental illness: 81% of women believed that the best therapy for many people with mental illness is to be part of a normal community compared to 77% of male respondents, 18% of women thought that as soon as a person shows signs of mental disturbance he/she should be hospitalised compared with 23% of men, 27% of men thought that existing services for those with mental illness were sufficient compared to 21% of women, and 18% of men thought that one of the main causes of mental illness is a lack of self-discipline and will-power compared with 13% of women. However, men were more likely than women to agree that people with severe mental health problems can fully recover (61% of men compared to 56% of women) (Health and Social Care Information Centre, 2011).

Women

There is some evidence from campaigns and small-scale surveys among service-users that women being treated for mental health disorders experience distress and do not feel safe in mixed-sex wards (Knowles et al, 2005), it has been suggested this may be more acute if they have previously experienced gender-based violence (Department of Health, 2008).

Ethnicity

According to a briefing by the Race Equality Foundation, the 2006 census of inpatient services in England and Wales found that for African and Caribbean people, rates of detention under the Mental Health Act 1983 were between 19-38% higher than average (Commission for Healthcare Audit and Inspection, 2007). Furthermore, they were more likely to be detained in medium and high secure wards, and there were higher rates of control and restraint (Keating, 2007).

Rabiee and Smith (2007) found that in general African and Caribbean users had negative perceptions of mainstream mental health services and that for some women mixed-wards and lack of female staff posed a problem. The service user survey, as part of the *Count Me In* survey of BME people in Britain, found that Black service users felt disadvantaged in inpatient services, reported higher levels of dissatisfaction with care. The report hypothesises that men from ethnic minority backgrounds who perceive mental health services as treating them inequitably may be discouraged from seeking help, though, robust evidence for this is lacking (Browne, 2007).

There is a concern surrounding rates of suicides by women from South Asian communities and awareness of and access to health services may be limited for some women experiencing domestic violence (Knowles et al, 2005).

Allmark et al (2010) state that a higher proportion of Black African and Black Caribbean men are in receipt of mental health services than white men. However, it is not clear whether this is due to a higher rate of incidence, higher rate of consultation, or differences in diagnosis and referral. It has also been found that a higher proportion of women than men in refugee and asylum seeker communities are likely to report poor health and depression (Gammell et al, 1993).

Sexual Identity and Trans

According to Browne and Lim (2008), those LGB or Trans people who report having experienced significant emotional distress, depression, anxiety, stress, fears and phobias, problem eating/eating distress, panic attacks or self harm are more likely to report that they have felt uncomfortable using or feel excluded by mainstream services than other LGB or Trans people.

This study also identified the top five health priorities for LGB and Trans people in this area as being mental health (45%), sexual health (39%), drug use (37%), alcohol use (34%) and LGBT friendliness of the health service (24%). Help to stop smoking and access to counselling and support groups ranked close behind (Browne and Lim, 2008).

King and McKeown (2003) report that gay men and lesbian women were more likely than heterosexual people to have consulted a mental health professional in the past, regardless of their current mental health. However up to a third of gay men, a quarter of bisexual men and over 40% of lesbian women reported negative or mixed reactions from mental health professionals upon disclosure of their sexual identity. Bisexual women were less likely than lesbian women to report a positive experience. One in five LG men and women and a third of bisexual men reported that a health professional had inferred a causal link between their sexual identity and mental health issue. The study emphasises that it may be difficult for health professionals to find a balance between over-emphasising or ignoring a patient's sexual identity.

In a study by Hubbard and Rossington (1995), it was raised that in older age, LGB people may have concerns over dementia care. In terms of personal care, there may be a fear of how a disclosure of their sexual identity might affect their care, and in terms of care for partners there was a concern that they may not be recognised as next-of-kin. Research discussed in ***Other Services and Intersections*** suggests that this has not significantly improved since this research was conducted.

In a recent survey of mental health issues that affect Trans people in the UK, 63% of respondents who had accessed mental health services reported having experienced negative interactions. Twenty eight per cent of

respondents to this survey also felt that their gender identity was seen as a symptom of mental ill-health, with 17% reporting that they were told this explicitly but that they disagreed. Thirty eight per cent of Trans people who have been inpatients have experienced problems such as harassment, misgendering or uncertainty as to where they will be placed within single-sex facilities (McNeil et al, 2012). Concerns over appropriateness of treatment by mental health services are also raised in research with Trans people in Scotland (Morton, 2008).

Religion

Testimonies given by representatives of public services and charities provide The Safra Project with evidence that some Muslim LGB women experience difficulty in accessing mental health information and services. It is suggested that some women's movement may be restricted by their families and that this may impede access to health services. Concerns were also raised about cultural sensitivity among counsellors and other health professionals on the subject of Islamic culture or sexual identity and Islam.³⁹ Though these statements highlight issues that may be important in sensitising health professionals, the testimonial nature of this data makes it difficult to assess its robustness as evidence.

When considering access to mental health services in relation to experience of treatment, it is important to bear in mind that there may be other significant ways in which people differ that do not fall within the protected categories. In a qualitative study of how people who identify as men and women express issues surrounding mental health, although the authors found that there were gendered differences, in that on the whole women preferred 'listening' therapies and men 'talking' ones, they also found that women and men both expressed difficulties in describing the feelings of depression, and a significant diversity among women and among men with respondents variously valuing a close personal relationship with health professionals or perceiving that this personal relationship was a barrier to communication (Emslie et al, 2007).

Pharmacies – Key findings

- Only a small proportion of men visit pharmacies for general health advice
- Men may be slightly less likely than women to use over-the-counter medicines

³⁹ SAFRA COORDINATORS. 2003. The Safra Project: Identifying the difficulties experienced by Muslim lesbian, bisexual and transgender women in accessing social and legal services. SAFRA.

- Pharmacies are often used for medical advice when GPs' time is deemed to be 'too valuable' to spend on minor health issues and that pharmacists are qualified to diagnose illness.

Only a handful of studies have looked at the issue of pharmacy use with a focus on equality of access or usage by gender, sexual identity or gender reassignment. More data is needed in this area for policy development.

Pharmacies

In a nationwide survey with a sample of 470 men, it was found that 58% of men had visited the pharmacist in the past three months (Developing Patient Partnerships, 2004). Of those who had, 'prescription collection' was the most common purpose of the visit (58%). Only 3% reported that the purpose of the visit was 'general health'. 'General health advice' ranked behind 'toiletries' at 8% (Granville 2007).

Previous research has highlighted men in full-time employment and young men (aged 16-24) as groups with particularly low rates of use. This study also raises the point that decisions influencing pharmacy use can often be linked to what is considered 'inappropriate use' of a GP. Pharmacy use was found to be closely associated with a notion that a GP's time was more valuable than a pharmacist's; too valuable to 'waste' on minor health issues (Granville 2007). The study contains detailed information from qualitative data about reasons for pharmacy use, but there is a significant skew in the sample towards women and it is not disaggregated by gender.

According to more recent research by the Men's Health Forum, nearly nine out of ten people use 'over-the-counter' medicines to treat common health problems, but men are slightly less likely than women to do so (83% of men have used them in the last year compared to 91% of women) (Men's Health Forum, 2007). It is unclear as to the robustness of this evidence, but it appears to contradict assumptions that men are more likely to self-medicate than women. This is supported in some part by evidence from the *Welsh Health Survey*: around 2 in 5 adults reported buying medicines in the past four weeks, more common amongst women than men.⁴⁰

⁴⁰ WELSH GOVERNMENT 2011b. Welsh Health Survey 2010. Cardiff: Welsh Government.

Other services and intersections – Key findings

- Assumptions may be made about an individual's ability to care for a relative or partner based on their sexual identity
- Older LGB and Trans people may fear discrimination from care providers
- People who are divorced or widowed are more likely to experience mental health difficulties
- Women with learning disabilities may have reduced access to support during the menopause
- Bisexual people may have health needs that are not addressed by mainstream, Lesbian or Gay-specific services

This section includes evidence of inequalities in access to services that have not yet been discussed, or that are associated with two or more protected characteristics including gender, gender reassignment or sexual identity. Much of this data for other intersectional disadvantage and services is based on small-scale investigations. This evidence should be regarded as a window into the issues that people face when accessing health services and a sensitising tool in the development of interventions.

Access to other care services

Willis et al (2011) in a small-scale study of LGB and Trans carers highlight some of the assumptions that can be made about individuals' suitability to care for family members or partners based on their sexual identity. They give examples of instances in which it has been assumed that a Gay male relative is suitable to care for his mother as he poses less 'risk' to female members of his family, and another instance in which a Gay man was assumed to be necessarily in a long-term relationship with his partner and therefore should be able to care for his partner in his home.

Age

In a study by the Commission for Social Care Inspection (2008), 7% of care homes and 8% of domiciliary care providers reported carrying out assessments of LGB needs in care planning: two-thirds of LGB people said that they did not necessarily want to be supported by LGB staff as long as staff attitudes were positive about their sexual identity.

Some findings suggest that older users of mental health services are less likely to disclose their sexual identity to health professionals than younger ones (Warner et al, 2004), apart from in Brighton and Hove where the evidence is that older LGB people are more likely than younger generations to disclose (Ward et al, 2010). This difference could reflect a mixed picture of

results, a change in the 6 years during which these studies were conducted, or cultural specificity of the Brighton and Hove population.

In a study with 49 LGB people in London on their experiences of mental health services over the past 5 years, it is reported that:

'Amongst those participants who had wanted to access statutory services but couldn't or decided against it, the most commonly cited reason was difficulty with disabled access. This was followed by long waiting times, concern about being given unwanted treatment and concern about being told they had a disorder.'

Lack of visibility of LGB-friendliness in publicity for services was also cited as a barrier (Wintrip, 2009).

Marriage and Civil partnership

People who are divorced or widowed have a higher incidence of mental health disorders. Women have a higher rate overall (Allmark et al, 2010).

Disability

There is little evidence in this area. One study by McCarthy (2002) identifies a lack of availability of a service for women with learning disabilities undergoing the menopause. This study, though suffering a low response rate from participants, suggests that less than half of GP surgeries offered a specialist menopause service for women with learning disabilities. It also found that less than half of GPs contacted had treated a woman with learning disabilities and many of these had seen only one or two women. This suggests that there is a low level of demand for a specialist service. The study does not rule out the possibility for women with learning disabilities to attend mainstream services.

Sexual Identity

Although a small-scale study, the reliability of Jones' (2006) study of bisexual people and health services is reinforced by a wide reviewing panel of bisexual people and researchers of bisexuality. In the case studies, it is clear that bisexual identity can also complicate access to services because mainstream services, including counselling, may not give appropriate advice and at the same time bisexual people may not feel they 'qualify' for or are welcomed by Lesbian and Gay services (Jones, 2006).

The Law – Key findings

- Transsexual people who are married may need to divorce and then obtain a civil partnership to remain legally partnered
- LGB people express concern that health professionals may not be able to identify their next of kin in an emergency

There is little evidence on this topic, but we may be confident in that there are legal difficulties for people who undergo gender reassignment. Although the evidence on concerns expressed by LGB people may not be robust, it is a problem that echoes concerns about lack of understanding and/or prejudice towards sexual minority people in other areas.

Legal implications

Marriage law may disproportionately affect people who have undergone gender reassignment: for Transsexual people who are married, it is currently necessary for them to obtain a divorce and then a civil partnership if they wish to remain officially recognised partners.⁴¹

Among LGB people there is a lack of confidence in health professionals to be able or willing to identify the appropriate emergency contact or next of kin. This concern varies within the LGB grouping: according to Guasp (2011), one in seven (14%) Lesbian or Bisexual women report having been excluded from a consultation or decision-making process with regards to their partner's health or care needs, as have 8% of Gay or Bisexual men compared to 6% of heterosexual people. Moreover, more than two in five (43%) Lesbian, Gay or Bisexual people say they are not confident that medical professionals would consult the right person to make decisions about their care if they were unable to make their wishes known themselves. This proportion increases slightly to 50% for Lesbian, Gay or Bisexual people who do not have partners. While 38% of Straight people feel the same, there is no similar increase for single Straight people.

A particular concern was raised in this study about treatment of LGB people by faith-based care services (Guasp, 2011).

⁴¹ WELSH GOVERNMENT 2010. Equality Consultation Questionnaire Analysis.

Respect and Dignity – Key findings

- One in seven Trans people report feeling treated adversely by health professionals
- Some Trans people are placed in hospital wards that are inappropriate for their sex
- Intersex people are not always included in appropriate screening programmes
- A minority of LGB people in Wales report negative experiences of health care
- A minority of LGB people would not register their same-sex partner as next-of-kin for fear that their care would be adversely affected
- In some cases, health professionals insist on procedures that are not relevant to LGB people
- Inappropriate assumptions can be made by health professionals about the fertility or pain management preferences and needs of BME women
- NHS-provided abortion services receive more negative feedback on supportiveness from young women than specialist providers such as Marie Stopes or bpas

Experience of services: Respect and Dignity

Trans

Some Trans people report being victims of discrimination by health services with one in seven Trans people reporting that they have felt treated adversely by health professionals (Equality and Human Rights Commission, 2010).

There is also some evidence of inappropriate assumptions about gender and health needs. Some Trans people report that they have been placed in the wrong hospital wards (Whittle et al, 2007, Laird and Aston, 2003, Fish, 2007). Fish (2007) reports instances of intersex⁴² women in receipt of inappropriate treatment such as smear tests or being asked questions regarding menstruation. Trans and Intersex people are not always included in appropriate cancer screening programmes which can cause distress or embarrassment (Fish, 2007).

Sexual Identity

A minority of LGB people in Wales report negative experiences of health services: in their small-scale study of LB experiences in North and Mid Wales, Cook et al (2007) found that 15% reported having had a negative experience

⁴² An intersex identity can refer to people who possess both female and male biological features

whilst accessing health care and 3% had complained to the practice manager or Local Health Board though there is no comparison provided for percentages in the wider population.

Although 81% said they would register their same-sex partner as next of kin, those who said that they would not gave reasons that included fear of discrimination, feeling that their sexual identity would not be kept private, and fear that their treatment would be affected (Cook et al, 2007).

The *How Fair is Britain?* report suggests that LGB and Trans (along with Gypsy and Traveller populations) may feel misunderstood by health services (Equality and Human Rights Commission, 2010). In studies by Stonewall, Lesbian or Bisexual women in the UK report the making of assumptions about their sexual identity by health professionals and the asking of inappropriate questions (Hunt and Fish, 2008). Respondents also give examples of insistence on inappropriate procedures such as a pregnancy test for women who do not have sex with men (Hunt and Fish, 2008).

Though inaccurate assumptions about sexual identity cause distress or embarrassment, LB women also feel treated adversely in instances of disclosure of sexual identity: 77.5% of LB women reported that they had received inappropriate comments after a disclosure of sexual identity has been made, 75.6% of LB women report that their sexual identity was ignored after they had disclosed it and 93.5% of those who have not disclosed their sexual identity to health professionals report that they had no opportunity to do so (Hunt and Fish, 2008).

Only 13% of LB women report that they felt their partner was made welcome by health professionals and 26.3% of Gay or Bisexual men (Stonewall Cymru 2012) and one in two Lesbian or Bisexual women report having a negative experience of health care during the last year (Hunt and Fish, 2008, Stonewall Cymru, 2012).

Among older people, one in six Lesbian or Bisexual women and one in nine Gay or Bisexual men express having experienced discrimination when using GP services. One in eleven LGB people respond that they felt this discrimination to be related to their sexual identity (Guasp, 2011).

There is also some evidence that GPs and Practice Nurses might be hesitant to fully explore sexual health issues with non-heterosexual patients or with patients from some minority ethnic backgrounds. It is likely that this difficulty will affect the quality of the encounter between health professional and patient but research needs to explore this inference further (Gott et al, 2004).

Ethnicity

When using maternity services, some ethnic minority women can experience prejudicial attitudes and treatment with regards to their fertility. In a qualitative study by Davies and Bath (2001) with 13 Somali women, one particular woman describes how she was not encouraged to make decisions regarding

the care of her baby in comparison to other white, or 'Caucasian', women in the same ward. The sample of this study is small and so care must be taken in interpreting these results.

Bulman and McCourt (2002), in relation to Somali women, found that despite language barriers and evidence that women did not necessarily understand the side-effects of pain management techniques, assumptions were made by health professionals as to the women's expected pain management preferences. In this paper, language capabilities are emphasised as being crucial to providing equitable quality of care. It is also reported that some women had extremely negative experiences of post-natal care in hospital, including the 'seeming disinterest' of the ward nurses. This study does not provide any comparison or perceived comparison with women of other ethnic backgrounds on the same ward (Bulman and McCourt, 2002).

Kai et al.(2007) reveal uncertainty and cautiousness amongst health professionals in dealing with patients from minority ethnic backgrounds: participants, 'emphasised their perceived ignorance about cultural difference and were anxious about being culturally inappropriate, causing affront, or appearing discriminatory or racist'. We must be careful with such evidence on attitudes to note that wishes not to be perceived as racist or to cause offence were expressed as part of an interview with researchers and may not be taken to indicate *behaviour* of health professionals towards patients of minority ethnic background. Equally, we must not underestimate the desire among many health professionals to avoid discrimination or offence.

Age

For young women seeking abortions, there is evidence that a significant proportion experience treatments as being more negative because of their age. Lee et al. (2004) find, in qualitative data, that noticeably more negative accounts of abortion services (supportiveness, helpfulness, and post-abortion care) were given among their young respondents who had accessed NHS-provided consultations and procedures than those who had used specialist providers such as Marie Stopes or bpas. Just under one third of under-18s who had decided to continue with their pregnancy used negative terms at some point when describing their experience of abortion services, in relation to treatment of their status as *young* mothers (Lee et al, 2004).

Unanswered questions

Although the collection of robust data for particular inequalities is difficult, there are nevertheless some striking gaps in our knowledge and areas where evidence is weak. It is important to strengthen our knowledge of these areas in order that interventions may be more effective and to reduce the likelihood of unforeseen adverse effects.

Sexual Identity

With a few notable exceptions, such as in some work by Stonewall, much of the available evidence on sexual identity refers to the combined group 'LGB' or 'LGBT'. Although data are sometimes collected separately for Lesbian, Gay or Bisexual people, these identities are often combined to produce a larger sample. Though more robust in some senses, needs specific to each of these identities are lost.

Specifically, the needs of bisexual people can often be overlooked (Ward et al, 2010). Part of the reason for this is perhaps that the identity 'bisexual' can be understood in a number of ways (feelings, identity, behaviour) and is therefore not always identified with or selected by respondents in surveys.⁴³ As highlighted by the case studies in Jones (2009), bisexuality can make access to appropriate services more complex, particularly in counselling (feelings, identity, or behaviour) or sexual health services (predominantly behaviour). In some cases, bisexual people may not feel they 'qualify' for Lesbian and Gay services (Jones, 2009).⁴⁴ In any data collection, we need to make the particular meaning of bisexuality that we wish to capture more explicit to understand better the needs from a particular service.

Gender Reassignment

There is some evidence that Trans people may not access some health-related facilities such as exercise classes or public swimming pools for fear that they will be refused service or because these facilities do not properly accommodate them (Whittle et al, 2007).⁴⁵ We need to know more about what can be done to improve both facilities and attitudes in not only mainstream

⁴³ See a detailed argument in BARKER, M., RICHARDS, C., JONES, R., BOWES-CATTON, H., PLOWMAN, T. with YOCKNEY, J., & MORGAN, M. 2012. The Bisexuality Report: Bisexual inclusion in LGBT equality and diversity. Centre for Citizenship, Identities and Governance and Faculty of Health and Social Care

⁴⁴ See JONES, R. L. 2009. Troubles with Bisexuality in Health and Social Care. *In*: JONES, R. L. & JONES, R. (eds.) *LGBT Issues: Looking beyond Categories*. Edinburgh: Dunedin Academic.

⁴⁵ Whittle et al (2007) indicate that current research is conflicting on the differences between bullying of natal females with 'tomboy' characteristics and natal males with 'effeminate' characteristics.

services or Gender Identity Clinics but also other public services that have an impact on health.

Important to further research is an engagement with Trans people and third sector organisations to explore appropriate uses of terminology and methods for collecting data.

Gender

There is a gap in our knowledge of interactions between patient and health professionals. Some evidence shows us that there may be gender differences in referral or patients presenting with symptoms but these are so far inconclusive. By investigating the quality and nature of the encounter between health professionals and people with particular characteristics, we may find out more about variations in how symptoms are described or interpreted by both parties. This can be particularly important in exploring 'practitioner delay' in referring patients.⁴⁶ We need to be wary in interpreting the differences between women and men's consulting patterns, as frequency does not necessarily indicate effectiveness (Department of Health, 2008).

Domestic or other gender-based violence, an issue not discussed in this report, may have significant impact on access of victims to services through restriction of movement, funds, or transport. Like access to pregnancy and maternity services, access to help for victims of gender-based or domestic violence may be disproportionately difficult for people with particular characteristics, for example being older or disabled. A review of domestic abuse that outlines some of the key concerns and debates was conducted by the Welsh Government in 2008 (Communities and Cultures Committee, 2008) and a report on *The Right to be Safe* strategy was issued in 2011 (Welsh Assembly Government, 2011).

There was little available evidence on men's access to testicular or prostate screening. This issue may also affect some Transwomen.

A further consideration is that the pattern of work is changing for both women and men. We need to bear in mind as we collect data that this issue may have an impact on people's access to services such as maternity leave or ante/post-natal care and that this impact may be different for men and women.

There is an important message arising from current evidence on the relationship between dominant forms of identity, such as masculinity or femininity, and inequality of access to health services. Although claiming that dominant masculinities and femininities have no impact at all on help-seeking behaviours or attitudes towards health would be naive, a *causal* relationship

⁴⁶ Not only on the basis of a characteristic, but also for example for particular types of cancer, DEPARTMENT OF HEALTH 2008. The gender and access to health services study: final report. London: Department of Health.

between these factors has not been established. Thus, the evidence-based design of interventions on these grounds is problematic. Alongside this, it is important to be critical of any given intervention that makes use of dominant norms in order to target an audience, and to question whether this may simultaneously reinforce them and further marginalise Trans identities. We need to engage with the target groups, along with academic theory, in order to co-construct effective campaigns and promotions.

Further Considerations

Further Characteristics

It is often remarked that it is difficult to find robust data for some of the minority groups included in this report, for example Trans or LGB people. However, it is important to bear in mind that although numbers of respondents tend to be lower than for other groups within the population, surveys and other research have the potential to reach and represent a far greater proportion of the whole population.

There are some groups of people who tend to 'fall through the net' when we look at evidence through the lens of the nine protected characteristics as outlined by the Equality Act 2010. Although we can, as has been done in this report, include these groups into the umbrella categories, these sometimes sit uncomfortably and could easily be overlooked.

Transsexuals, Genderqueer, Gender Ambiguous, Intersex people and other Gender Non-conforming people who have no desire to undergo gender reassignment have been included in the category of 'gender' here but in much of the current literature this includes only people who identify as men or women. Information about the needs of people with these identities is difficult to find as surveys often do not accommodate them.

Details of gender inequities among asylum seekers and refugees have been included here under 'ethnicity', but it is important to note that the inequities that they face may not be a consequence of their ethnic origin but rather their legal status in the UK, lack of knowledge about UK organisations or difficulties communicating in English.

Homeless people and prisoners are also groups that have been discussed in this report, and face inequalities in access to health services that are particular to their groups. These groups have no clear protection under the umbrella terms of the protected groups of the Equality Act 2012 but have rights under human rights legislation.

The difficulties that lone mothers or fathers might face in accessing health services due to lack of finances, transport or childcare are also difficult to place under a protected characteristic being neither an issue of 'Marriage and Civil Partnership' or 'Gender', nor 'Pregnancy and Maternity'.

Further Services and Interventions

Some non-mainstream public services, such as exercise facilities, have been discussed in this report, but we might equally consider people's access to public 'green space' to be important for health and to be disproportionately available to different groups.

It has previously been recommended in some other reports that an increase in the number of health professionals who share particular characteristics of their patients may improve access and experience (Hunt et al, 2007). Whilst we might foresee some positive effects of this such as making patients feel more comfortable, additional language skills or cultural understanding, we also need to question the assumptions that this might entail. For example, if a health professional speaks a minority language, will their workload be disproportionate as they are called upon to interpret for patients? By hiring more people from a particular group, for example women, do we make assumptions about the degree to which women's needs, preferences and experiences are the same? We need to engage with the experiences of current health professionals and with academic debates on this issue in order to better evaluate this idea.

Finally, we need to be aware that issues of inequality can induce 'equity fatigue' in people and can be felt to be over-demanding. We should endeavour to give specific guidance for practice that is based on the best quality evidence possible and that will simultaneously improve access for people from as many groups as possible. Alongside this, we need to develop a better system for sharing evidence on inequality and on the design of results of trial interventions.

Recommendations Arising from this Review – Next Steps

1. Complete Review of Protected Characteristics

This report reviews evidence for inequality of access to health services for three of the protected groups under the Equality Act 2010. One of the main recommendations that arose from conducting this review is that the development of policy needs to be based on a review of the evidence of inequality in access for *all nine protected characteristics*. By conducting a full review, we will be more confident in pointing to issues of inequality that cut-across many characteristics, for example issues of communication.

The remaining protected characteristics are:

- Ethnicity
- Age
- Disability
- Marriage and Civil Partnership
- Religion and Belief
- Pregnancy and Maternity

There is likely to be large bodies of evidence available for the first three of the listed groups and smaller ones for the latter three, though it has been noted that there is a dearth of up-to-date evidence for BME groups in Wales.⁴⁷

Some of the evidence for these groups has been presented as part of this report, particularly with regards to Pregnancy and Maternity, but there is more evidence on intersectional issues, which needs to be evaluated. In particular, it was not possible to identify evidence for Trans parents' experiences of maternity services. Further research is needed to determine whether this represents a genuine gap in the evidence.

Due to time constraints, one area of research that is not included explicitly in this review is domestic or gender-based violence. It is suggested that evidence for this area is looked at in terms of intersections with other characteristics in the way that maternity services are discussed in this report.

Also not included in this report is evidence for unequal access to dental services, as this is often categorised in research separately from health

⁴⁷ SALTUS, R. & KAUR-MANN, K. 2005. Black and Minority Ethnic Mental Health Service Users in Wales: A snapshot of their views, *Mental Health Nursing*, 25, 5: 4-7.c.f. WINKLER, V. 2009. Equality issues in Wales: A Research Review. In: FOUNDATION, T. B. (ed.) *Equality and Human Rights Commission Research Report Series*. Manchester: Equality and Human rights Commission.

services, evidence for inequalities in access among those affected by the Trans status of a family member or partner, and the issue of substance abuse.

The process of review might follow a similar structure to that outlined in the methodology of this report and many of the references included in this report can be used as a starting point to locate evidence.

2. Review Interventions and Develop Case Studies to Share Good Practice

There is also a need for further research into interventions that have been implemented by various services to reduce inequality of access by various groups, and on good practice across Wales. There are good examples of health practice in Wales but these are not currently shared in a systematic way. Case studies of good practice should be made available on an accessible platform for practitioners to read, evaluate and reflect on their own work.

From a first glance, much of the evidence for interventions is likely to come from locally developed and implemented programmes that do not necessarily have a baseline from which to make robust measurements. Though in these cases it will be difficult to measure their effectiveness with any reliability, it is likely that they make up the bulk of the available evidence and it is therefore important that insight gained from them is not excluded. There may also be educational devices, such as the NHS North West LGBT Timeline⁴⁸ that could be conceptualised as an intervention but whose 'effectiveness' would be difficult to measure.

Evidence for good practice will need to be gathered through engagement with the network of people working for the various equality groups around Wales, and with practitioners, such as nurses and doctors, who have developed their own local means of dealing with inequity.

⁴⁸ http://www.help.northwest.nhs.uk/lgbt_timeline/timeline.html accessed 10/10/12

Limitations of this report

Although this review endeavours to be as representative of current evidence as possible, it has some limitations. Due to the limited length of the project it was not possible to undertake a fully *systematic* review. In particular, it is likely that there is further research on inequalities that is unpublished, such as doctoral theses or small-scale surveys undertaken by individual trusts or services. It was also necessary to exclude some pieces of evidence that were of low quality or that are referred to in reviews and reports by others and for which the original document could not be located. Evidence published before 1990 was generally excluded, but this does not rule out the potential ongoing relevance of some insights of earlier work. As noted in the methodology, international studies are also likely to yield relevant information on specific issues.

The recommendations made here are based on a review of evidence conducted for the characteristics of gender, sexual identity and gender reassignment only. They are therefore provisional and it is envisaged that they will be re-evaluated in light of a review of evidence for inequalities associated with the remaining protected characteristics along with any updates made to this review.

Consultation Workshop

In the latter stages of this review, a consultation was held with a number of stakeholders from organisations that engage with issues of inequality. Among those organisations who gave feedback on the report were: NLIAM, Diverse Cymru, Mencap Cymru, NHS, TransForum, Age Cymru, and Welsh Refugee Council.

Some of the feedback received suggested alterations to terminology or to the content of the report.

These were considered and the report amended. Suggestions were also received regarding the next stages of the project:

- It is important that any investigation into practice in the Welsh health services engages with the network of people doing equalities work in order to identify practitioners who have developed their own solutions to problems of inequity.
- There are key pieces of strategy and legislation for the remaining characteristics that need to be mentioned, such as the Mental Capacity Act. Key pieces of research were also suggested.
- The Welsh language is not discussed in this report, and though it is not a protected characteristic under the Equality Act 2010, it is likely that it will intersect with many of the issues raised. Further phases of research will need to make the Welsh language visible and to liaise with the Welsh Language Board.
- Patient pathways exist to help with some of the issues raised in this report, but they are not always used. It was also suggested that they can be used as a tool for learning.
- It could be productive for existing initiatives, such as 1000 Lives Plus (1000 o Fywydau a Mwy) to re-examine their strategies from the point of view of inequalities associated with protected characteristics.

It was noted that although promotions, campaigns and operational-level improvements have an important place, change is also needed at a strategic level. Further phases of this project should reflect on and engage with this need. It was agreed that similar workshops should be held at the beginning and end of the next project phases.

Finally, it was noted that great advances have been made in some areas. It was suggested that it would be beneficial for those working with equality issues to have a reflection on the progress that has been made so far in reducing inequalities in access to health services in Wales.

In addition, the following comments were noted, although they have not been investigated further as they hadn't been identified in the review of published literature:

- The dispensing of hormones and other gender specific drugs has the potential to breach confidentiality, which can 'out' Trans people to other staff and customers
- People undergoing gender reassignment may be required to give up smoking and reduce alcohol intake in order to be safely prescribed hormones. This can be a stressful time and individuals may need support.
- Weight problems may be of additional significance for some Trans people who face a BMI restriction to accessing gender reassignment surgery
- Trans people may feel that they don't qualify for LGB services, despite also identifying as Lesbian, gay or Bisexual

Concluding Remarks

This report provides an updated starting point for the development of interventions to reduce inequalities in access to health services among people who share various characteristics of gender and sexual identity or who are undergoing gender reassignment.

Although this report is addressed primarily to three of the nine protected characteristics, in order to cover and appraise the evidence available it also touches on some of the issues facing people of the remaining groups through the inclusion of intersectional inequalities. Intersections of protected characteristics can compound inequality or inequity. The majority of current research only focuses on pairs of characteristics, such as a combination of sexual identity and disability, and it is important to be sensitive to more plural combinations in future research.

The evidence is stronger in some areas than others, but overall the data that gives us the most detailed insight into the barriers to access that people face are small-scale and cannot conventionally be considered as reliable or 'robust'. This perhaps is a symptom not only of the relative short history of research into inequality, but also frameworks of funding that often only allow research on these issues to be done in small pockets and in short time-scales.

This sort of evidence is not easily generalised and so its reliability for developing national interventions could be seen as limited. Yet, these studies are valuable in that they provide us with a rich picture of problems arising *within local contexts* and are likely to give rise to interventions that will improve problems on a local level most effectively. The tension between intervening at the local and the national levels is a continuous one for those in public health policy and should have significant bearing on the type of research that it commissions.

From conversations with others working with evidence of inequalities, it is apparent that whilst the placing of emphasis on the need for further research is important, reviews of this type are also essential in ensuring that research is not unnecessarily repeated and that research does not become burdensome on those whose lives it seeks to improve.

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