

SECTION 7

**GENDER,
EQUALITY & HUMAN RIGHTS:**

**ACCESS TO HEALTH AND SOCIAL
SERVICES IN
NORTHERN IRELAND**

**Literature Review-
Equality & Human
Rights: Access to Health
and Social Services in
Northern Ireland**

Gender, Equality and Human Rights: Access to Health and Social Services in Northern Ireland

The DHSSPS and associated bodies have a statutory duty under Section 75 of the Northern Ireland Act 1998 to have due regard to the need to promote equality of opportunity between men and women. In addition to this, statutory health and social care bodies have a further obligation, under the Human Rights Act 1998, to ensure that the human rights of men and women are not unjustifiably interfered with by health, social care and public safety laws, policies, practices or procedures.

This section provides a brief review of recent literature on equality and human rights issues relevant to gender and access to health and social services. Part A relates to men and equity of access to health and social services. Issues explored include, the impact of men's attitudes on access to health and social services; men and mental health; the service needs of vulnerable groups of men; and, addressing the needs of fathers. Part B explores women's access to health and social services. Issues examined include the impact of deprivation and socio-economic status on service accessibility; women and maternity provision; fertility services and reproductive health; domestic violence; mental health; and, addressing the needs of women in rural areas. Finally, Part C examines literature relating to transgendered people and barriers in accessing appropriate health and social care.

It is important to stress that this section by no means provides an exhaustive list of all relevant issues relating to gender and equity of access to health and social services. Several other issues relating to gender and equity of access have been, or will be, addressed in other sections given that gender interacts with many of the other section 75 categories.

PART A: MEN

Men & Equity of Access to Health and Social Services

It is only in relatively recent years that men have been identified as a target population for the strategic planning of health care (McEvoy & Richardson, 2004:55). McEvoy & Richardson (2004:55) argue that there remains a fundamental lack of understanding and clarity about what is meant by "men's health" in

Ireland, which in part has been a result of very sparse and fragmented research into men's health in general. Parish (2001:1) maintains that the lack of definition and understanding of men's health is in itself a *"major barrier to the provision of services and the training of health and other professionals"*.

The disparities in health outcomes between men and women are well documented. Courtenay (2000) maintains that in constructing, displaying and maintaining their male identity, men are more likely to engage in risk behaviours which can be a serious hazard to their health and a major cause of men's higher mortality rates (McEvoy & Richardson, 2004:34).

The 2001 Northern Ireland Health and Social Wellbeing Survey appears to confirm the notion that men are indeed more likely to engage in risk behaviours. For example, although the survey findings highlight that generally there are similar rates of smoking between men and women, men are more likely than women to be heavy smokers with 48% of men consuming twenty or more cigarettes per day in comparison to 33% of women. In terms of alcohol consumption men are twice as likely as women to drink above the sensible weekly limit⁶² with 25% of male drinkers exceeding the sensible weekly limit in comparison to 14% of women.

In addition to this, a 2002/03 drugs prevalence survey of households in both the Republic of Ireland and Northern Ireland reveals that illegal drug use is nearly twice as prevalent amongst men than women (DHSSPS & NACD, 2003:3).

Thom (2003:6) suggests that there is clear evidence of gender differences in relation to risk taking and help-seeking behaviour and maintains that male roles and social identities may themselves be "risk factors" for higher rates of morbidity and mortality amongst men. Thom (2003:6) therefore stresses that male roles and social identities must receive greater attention in shaping preventative health care approaches.

On a more positive note, findings from the 2000 Northern Ireland Men's Life and Times Survey (Biddulph, 2001) indicate that many

⁶² The 2001 Northern Ireland Health and Social Wellbeing Survey defines the sensible weekly limit of alcohol intake as 21 units for males and 14 units for females.

men in Northern Ireland are indeed concerned about their health and access to appropriate health care services. The survey, for example, illustrates that:

- 84% of men supported the idea that clinics and doctors' surgeries should provide a special clinic just for men where they could get check-ups, advice and health information;
- 65% of men supported the provision of telephone helplines run by men, for men who require support and advice through difficult times; and,
- 74% of men believed that there is a need for special counselling services for men who need longer term help.

Men's Attitudes to Health and Social Care

Whilst there is a wide range of information regarding men's health outcomes and risk behaviours, there is very little existing research on the experiences of men in relation to accessing health and social services. What research does exist appears to suggest that men tend to be reluctant users of health services, particularly preventative health care (Men's Health Forum, 2002:2).

McEvoy & Richardson (2004:50) highlight that in comparison to women, men tend to have limited contact with physicians and other health services. The UK Men's Health Forum (2002:2) provide a number of suggestions as to why men tend to under-utilise primary care services in particular including:

- **difficulty of access** – a man's GP may be based some distance from his workplace and appointments are often only available during normal working hours.
- **cultural norms** – many men believe that they should "tough out" illnesses for as long as possible rather than admit to "weakness". It is not unusual for men to feel that they are "wasting the doctor's time".
- **false perceptions** – primary care services are often viewed by men as a service primarily for women and children.

- **lack of confidence** – many men lack the confidence to discuss their concerns with health care professionals;
- **racism and homophobia** – can be barriers to accessing services for gay men and men from black and minority ethnic groups.

An ICM survey of 470 men in GB carried out on behalf of Developing Patient Partnerships (DPP) found that almost half of the men questioned (48%) turned to their wife or partner for health advice. One in ten men (10%) stated that a lack of confidence stops them from seeking advice from their pharmacists. Over a third (39%) believed that a private consulting area would encourage them to use their pharmacies more often. Other key findings from the report highlighted that 55% of 18-24 year old men, 44% of 35-44 year old men and 30% of men between 35-44 still go to their mother with health worries, and almost a quarter of men (22%) admit their partners usually go to the pharmacy for them.

A survey conducted by MORI (on behalf of the Prostrate Research Campaign UK) of 1,361 adults aged 40 and over highlighted that there was widespread ignorance amongst men about the prostrate and prostrate cancer. The survey also revealed that 77% of men would discuss a serious health issue with women before seeing a doctor (Men's Health Forum Press Release, April 2004).

Research conducted by Arber & Davidson et al highlights that many older men tend to risk their health because they view a visit to the doctor as a sign of weakness. The research also suggests that many older men tend to prefer postponing making an appointment with their doctor until they are very sick (cited in Economic and Social Research Council Press Release, March 2003).

Arber & Davidson et al further propose that policy makers should recognise that older men tend to be very reluctant to access certain services, such as day centres, because such services tend to be geared towards the needs of older women. They also suggest that the needs of the growing number of older divorced men should be recognised because they tend to be less involved in formal organisations and have less contact with family, friends and neighbours.

Provided below are a number of recommendations emerging from the literature which are aimed at improving men's access to health and social care. These should be taken into careful consideration by the DHSSPS and its relevant bodies in order to develop a greater culture of inclusiveness for men and boys in health and social services provision.

Recommendations: Men's Health (McEvoy & Richardson, 2004)

- **That policy makers and health care practitioners must improve their understanding of male gender roles and seek to develop and deliver services that are aimed at men.**
- **That there is a major gap in existing research in Ireland with regard to the relationship between gender roles and the role of masculinity in constructing men's attitudes and behaviour towards health care. More research must be taken forward in this area.**
- **Differences in data collection protocols and procedures with regard to men's health should be addressed (including differences in data collection between north and south) in order that north-south data can be combined and compared in a more meaningful way.**
- **There is a need to develop a national policy for men's health relevant to men both north and south. In relation to this, it is vital that men are involved in the process of policy and practice development.**
- **Since men and women engage differently in health and social services, training should be provided for health and social care staff on men's health issues. More training is also needed to identify men's health needs at a local level.**
- **There is an urgent need for more health promotion initiatives which are specifically targeted at men. The Men's Health Forum in Ireland recommends targeting and promoting one particular men's health issue annually for the next five years (2004-2009) (for example, in mental**

health, prostate cancer, suicide and self-harm)

- Men's health advocates must be encouraged at a local level to act as men's health "champions".
- There is an urgent need for a review of resources allocated to men's health (in terms of funding, training and so on).

Recommendations: Men's Health (Men's Health Forum, 2004)

- There is a need for more clinical and non-clinical research in male-specific health concerns (for example, prostate cancer).
- Every health policy document should be committed to gender mainstreaming and should cover men's health as a specific issue. Gender and men's health must become as obvious a subject for inclusion as the health of minority ethnic communities or the health of other socially disadvantaged groups.
- Targets should be set for the achievement of men's health goals, potential example areas should include male suicide, cardiovascular disease, traffic accidents, obesity and smoking and alcohol consumption.
- The health care concerns of men (notably prostate health and sexual and reproductive health) must be given the same priority as the concerns that are of proportionate relevance to the whole population.
- Greater priority must be afforded at all levels to the support of family units (not just traditional families) since stable relationships are known to be protective of men and boys mental and physical health.
- Health care services, particularly primary care services, should be provided in a way which is convenient and accessible for men (opening hours outside working hours, male interest magazines in waiting areas, information

displays aimed at men etc).

- Existing evidence suggests that men are more likely to use services which are quick and convenient. Therefore, more primary care services should be provided in non-traditional settings (such as workplaces, sporting venues, pubs, social clubs etc).
- Local pharmacies are reported to be under-utilised by men, ways should be explored to make pharmacies and their valuable services more attractive to men.
- Men's access to confidential and anonymous sources of health advice (such as helplines, websites) should be encouraged as these often act as a "stepping stone" to the use of primary care services.
- Health care professionals must seek to avoid stereotypical notions that discourage and disadvantage men from access services. For example, notions that "men are better able to cope with pain" or that "men should be brave in the face of distressing news about their health".
- Health care providers at a local level must encourage and support men to become involved in consultative processes in order to seek views regarding what services men actually want.
- Men should be enabled and encouraged to become involved as fathers through ante-natal classes and parenting classes. There may be scope for a national campaign to encourage fathers rather than mothers to take their children (particularly boys) to routine health care appointments.
- In order to support health promotion initiatives targeted at men, specialist training and the construction of a sound evidence base of what works should be developed. Training in men's health must become part of the core curriculum for health professionals of all kinds.

Men & Mental Health

Much concern has been expressed about the increasing incidence of suicide in Northern Ireland, particularly amongst young males. The DHSSPS *Equality and Inequalities in Health and Social Care Statistical Overview* (2004:70-72) for example, reveals that the majority of suicides between 1983 – 2001 were by males (76%), with the suicide rate highest for males in the 25-34 age band (19%) and the 16-24 age band (18%). Suicide risk factors included depression, alcohol dependence, combined alcohol and drugs misuse, unemployment, relationship break-up, social isolation, being unmarried and living alone (DHSSPS, 2003a:26).

The mental health charity MIND suggest that men tend to be more vulnerable to mental health problems and suicide than ever before due to a combination of factors such as:

- the fact that many men are brought up not to talk about their problems or feelings or to admit that they may be depressed;
- the reluctance of many men to consult with their GP for mental and emotional problems; and,
- unemployment and the adverse impact of the continued decline of certain industries (such as manufacturing) upon men and their mental health.

White (2001:12) provides a number of suggestions for improving the mental health of men and for improving men's access to health and social services in general including:

- working with schools to develop within boys an emotional literacy to enable them to recognise and articulate their worries;
- working towards de-stigmatising depression within society to allow men to come forward and seek help;
- recognising that men, in comparison to women, tend to lack social networks (such as men who are widowed, divorced, separated).
- establishing early morning, evening and weekend opening hours of health centres;

- a greater use of male receptionists;
- a greater linking of health services to sport;
- avoidance by health care staff of viewing a male patient as a “quick patient”; and,
- raising the skills of young men in order that they are confident enough to make their own medical appointments.

Statutory health and social care commissioners and providers should begin to explore ways in which such recommendations could be taken forward in order to improve the mental health of men and boys.

Identifying “Vulnerable” Groups of Men

It is important to recognise that men are a diverse group whose experiences in terms of accessing health and social services can vary considerably according to age, marital status, ethnicity, disability, sexual orientation, socio-economic status, geographic location and so on. Research and literature which explores the complex interaction between gender and these factors are, however, examined further in other sections of this report.

Briefly examined below and overleaf are but a few examples of “vulnerable” groups of men who have been identified by the literature as experiencing particular gaps in health and social service provision in Northern Ireland.

Men as Victims of Domestic Violence

A study by Brogden & Saranjit (2004), commissioned by the Office of the First Minister and Deputy First Minister (OFMDFM), recounts the experiences of male victims of domestic violence in Northern Ireland.

The report reveals that men can experience a range of abuse inflicted upon them by their partners including, physical violence, emotional abuse, finance abuse, sleep deprivation, sexual assault and destruction of property. The report highlights that men experiencing domestic violence often felt that emotional abuse had

by far the longest lasting consequences for them (Brogden & Saranjit, 2004:26).

Whilst the study highlights that there are many examples of positive support given to men by health and social care staff, many of the respondents felt that social services, in particular, were reluctant to acknowledge or provide support for male victims and tended to be more supportive of the female partner (Brogden & Saranjit, 2004:62). Respondents also described mixed responses by GPs when approached for support and advice. A number of men in the study stated that their GPs took a sympathetic and proactive approach to the problem whilst others highlighted that their GPs lacked understanding.

Brogden & Saranjit (2004:5) argue that very little is known about male victims of domestic abuse in Northern Ireland. They further suggest that traditional concepts of masculinity appear to be the primary reason for the failure of men to report incidents to statutory agencies (including health and social services). The report highlights that there is a vacuum in the current support structures for men who are victims of domestic abuse and it makes a number of recommendations for action by the DHSSPS and other relevant bodies. A number of these recommendations are highlighted overleaf for consideration.

Recommendations: Men as Victims of Domestic Abuse (Brogden & Saranjit, 2004)

- **That services dealing with the *physical* injuries of male domestic violence victims must be more sensitive in order to appreciate that such victims may also need referrals for *mental and emotional* effects.**
- **There must be a commitment to raise awareness in the statutory sectors of male victimisations through the education and training of staff.**
- **That a helpline be established to act as both a counselling service and as a referral agency with regard to those males who wish to have support.**

- **That public information programmes on male victims of domestic violence should be developed. This should include the provision of information and referral leaflets in GP surgeries etc.**
- **That training packs should be developed for social workers within the context of existing training programmes to recognise and deal with male victimisation.**

Men and Bereavement

There appears to be a lack of support for men experiencing bereavement in Northern Ireland. A study by McCreight (2004), for example, highlights that the impact of pregnancy loss on male partners has been largely overlooked in research. McCreight (2004: 326) suggests that, “the perception that men have only a supportive role in pregnancy loss is unjustified, as it ignores the actual life-world experiences of the men, and the meanings they attach to their loss, in what may be a very personal emotional tragedy for them where they have limited support available.” The study acknowledges that there is a need for hospital staff and indeed the wider community to recognise the male partner’s grief in pregnancy loss.

It is therefore clear that a greater focus is needed to identify gaps in service provision in regards to men and bereavement care.

Men as Survivors of Sexual Abuse and Rape

The experiences of men as survivors of sexual abuse and rape remains largely hidden in Northern Ireland. Survivors NI, a Northern Ireland based group which provides a telephone helpline for male survivors of rape and sexual abuse states that the, “issue of disclosure for men is a tremendous trauma exasperated by the perception in society that men must be strong and be able to deal with any situation. Men feel they can deal with this issue themselves and are concerned that disclosure means questioning their position as men by society. The reality is that men live with

the same effects as females when dealing with this issue and society has made it more difficult for disclosure by men”.⁶³

A report by the Northern Ireland based InterAgency Group on Sexual Abuse⁶⁴ acknowledges the emergence and expansion of services in recent years for adult survivors of sexual abuse in Northern Ireland. However, the report suggests that, services continue to remain “piecemeal” rather than on a planned basis, that there continues to be a lack of co-ordination between different agencies and that there is a variability in the quality of services offered to adult survivors.

There is clearly a gap in service provision which requires a greater focus by health and social care providers in co-operation with the community and voluntary sectors. A number of recommendations, made by the InterAgency report, which are aimed at addressing these gaps are outlined below for consideration.

**Recommendations: Men as Survivors of Sexual Abuse and Rape
(InterAgency Group on Sexual Abuse, The Heather Report)**

- **Development of clearer and easier routes to enable adult survivors to access appropriate services.**
- **Ensure that immediate help is provided for survivors in the period between disclosure and the commencement of therapy.**
- **That the provision of services are located in places that are accessible for people.**
- **Access should be as such that it is easy for clients to return for therapy as major life events can precipitate the need for additional therapy.**
- **That training is provided (at different levels) for all staff in the voluntary and statutory sectors who are likely to**

⁶³ Information extracted from NI Survivors website
<http://survivorsni.tripod.com/survivorsnorthernireland/id19.html>

⁶⁴ The InterAgency Group on Sexual Abuse is a group of statutory and voluntary sector agencies who provide services and care for adult survivors of sexual abuse within the WHSSB area.

encounter adult survivors.

- **That residential care is made available on a short stay/respite basis in a therapeutic setting with emphasis on support, counselling and group work.**
- **That strategies are developed to dispel the myths about sexual abuse, that a booklet should be developed on the availability of services and how to access them. The development of a proactive strategy targeted at excluded groups.**

Addressing the Needs of Fathers

Research suggests that men often feel unprepared for fatherhood particularly during pregnancy and the postnatal period. A briefing paper prepared by Fathers Direct⁶⁵, for example, note that:

- men often feel excluded from important decisions about the birth and care of their child;
- men often “take a back seat” during their partners pregnancy and tend hide feelings of isolation, fear, and detachment;
- there is very little information and support particularly targeted at fathers and there are few men’s networks and courses in fathering skills; and,
- antenatal classes are often inaccessible to men as they usually occur during working hours.

The Father’s Direct paper does acknowledge that there are pockets of innovative practice across the UK such as initiatives which make antenatal classes accessible after working hours and also maternity wards which permit fathers to sleep over after the birth of their child. Sure Start schemes and initiatives by the Health Promotion Agency and by various community groups have done much to address the needs of fathers in Northern Ireland.

⁶⁵ a national information centre on fatherhood

However, Father's Direct suggest that the provision of services for fathers varies widely from one part of the country to another and draws attention to the fact that there is no standard pattern or national guidance for fathers' involvement in pregnancy and postnatal care across NHS hospitals and clinics.

It is clear that supportive and caring fathers are vital for both children and mothers. Father's Direct make a number of suggestions to improve the inclusion of fathers in the birth and care of their children. Many of these suggestions have undoubtedly already be adopted by many of the hospitals and health centres throughout Northern Ireland. However, they are worthy of consideration by those who do not have such procedures in place.

Recommendations: Support for Fathers (Fathers Direct)

- **Midwives and all those involved in maternity services should encourage prospective and new fathers to be actively involved in the decision-making process regarding their baby.**
- **Managers may need to identify any barriers to engaging fathers in antenatal and postnatal care and seek to resolve them.**
- **Consideration should be given to men-only discussion groups in antenatal sessions. Consideration could also be given to using male facilitators in such sessions.**
- **Fathers should be provided with appropriate practical and emotional support during and after pregnancy to prevent, as far as possible, their partners from developing postnatal depression.**
- **Fathers should be encouraged to understand that they can have an important role as advocates on behalf of their partner or baby.**

PART B: WOMEN

Women & Equity of Access to Health and Social Services

“*Other Borders*”, a cross-border health strategy for women in the North West of Ireland, identifies five key factors which determine women’s mental health and emotional well-being (Derry Well Woman, 2003)⁶⁶. These factors include socio-economic status; educational attainment; lifestyle; environment; and, social capital and community background.

These issues are briefly examined overleaf. It should be recognised that the complex interaction of all of these factors can adversely impact on how women access health and social services.

Key Determinants of Women’s Mental Health:

- **Socio-Economic Factors:** low income and poor housing conditions cause stress and feelings of powerlessness. Getting beyond the “poverty trap” is problematic as a lack of affordable childcare and appropriate public transport often restrict women’s access to employment opportunities. Poor transport to health facilities is a significant issue, particularly for women living in rural areas.
- **Educational Factors:** negative school experiences, often lack of confidence, low self esteem and low educational attainment. Access to adult education is restricted due the availability of public transport and the lack of affordable childcare.
- **Lifestyle Factors:** long term dependency on prescription drugs (for depressive and sleeping disorders) often leads to anxiety. Lack of available counselling and other holistic therapies exacerbate this problem. Inadequate access to other health services, such as access to breast cancer screening for the over 65s and access to female doctors, are identified as additional causes of stress.

⁶⁶ The strategy emerged from a consultation exercise with almost 2,000 people in the Western Health and Social Services Board area (Northern Ireland) and the North Western Health Board (Republic of Ireland).

- **Environmental Factors:** various environmental factors believed to adversely impact upon women's mental health (for example, fear of attack due to inadequate street lighting).
- **Social Capital and Community Factors:** Anti-social behaviour (such as crime and racism) also identified as factors leading to stress and anxiety. Social networks (such as family, neighbours, colleagues) are found to be important for emotional well-being. However, women who lack social networks are subject to depression related to social isolation. This again tends to be exacerbated by lack of affordable transport and childcare.

The cross-border strategy makes a number of recommendations for addressing the five determinants of women's health and emotional well-being. These recommendations are outlined below and should be taken into consideration by the commissioners and providers of statutory health and social services.

Recommendations: Women's Health (Other Borders, Women's Health Care Strategy, 2003)

- **Monitor and review prescribing practices in relation to long term repeat prescriptions for women.**
- **Improve the availability of counselling services and other holistic therapies.**
- **Ensure that the health and social care system responds to the core concerns of women's health needs. Key concerns include poor access to woman doctors, a lack of breast cancer screening for older women, and a greater recognition of reproductive and mental health problems.**
- **Improve staff attitudes in health care settings.**
- **Help develop and promote social networks for women in both urban and rural areas and enable women to influence policy and decision-making. Develop health forums to ensure that women's perceptions of health needs can influence policy, practice and service provision.**

The cross-border strategy further recognises the existence of diversity amongst women and highlights that certain sub-groups of women have different needs in terms of accessing health and social services. The strategy has identified the health and social care needs of five target groups of women for whom it suggests there are gaps in service provision.

The main health and social care issues (and recommendations) emerging from the strategy in relation to these five groups (that is, older women, women in poverty, lone parents, traveller women and black and minority ethnic women) are briefly summarised below. Again it is imperative that, in terms of facilitating equity of access, that the strategy's recommendations are taken into consideration in the design and delivery of statutory health and social services.

Sub-Groups: Key Health and Social Care Access Issues

Older Women: key issues for older women include, the long term unreviewed use of prescription drugs and a lack of openness amongst some health care professionals to discuss the issue; perceived bias in the health care system in relation to certain treatments for older women (for example, age limits for screening services); ageism and other negative health care staff attitudes; barriers to accessing healthcare including transport problems (particularly in rural areas); and, marginalisation from decision making and planning processes.

Women in Poverty: key issues for women living in poverty include, a lack of help for eating disorders and smoking cessation; the long term unreviewed use of prescription drugs; domestic violence as a “taboo” subject; and, lack of access to exercise due to costs (for example, costs of gym membership, leisure centres and other such activities).

Lone Parents: key issues for lone parents include, dependence on prescription drugs for depression; lack of awareness and availability of counselling and mental health services (particularly in rural areas); negative attitudes from some health and social care staff (such as GP staff, staff in A&E Departments); difficulties in

accessing appropriate transport to healthcare facilities; and, a perceived bias towards lone parents in accessing post-natal care.

Traveller Women: key issues for traveller women include, a lack of home visits from GPs; issues such as alcohol misuse and domestic violence not openly discussed; and, powerlessness in influencing policy and decision-making.

Black and Minority Ethnic Women: key issues include, communication and language barriers; lack of health and social care information available in languages other than English; hidden domestic violence; and, marginalisation due to racism and poor English skills.

**Recommendations: Addressing the Needs of Specific Groups of Women
(Other Borders, Women's Health Care Strategy, 2003)**

Older Women

- Prescription drugs should be reviewed on a case-to-case basis initiated by both doctors and patients. This should include community education on prescription drugs and the provision of counselling services as a complement or alternative to prescription drugs for mental health problems.
- Improvements in the provision of health services for older women including doctors with expertise in this area, well woman clinics, contraceptive and screening services.
- Review of barriers to accessing health care (such as lack of available childcare and transport).
- Promotion of meaningful participation of older women's representatives in planning and decision-making.

Women in Poverty

- Conduct a review of the barriers to healthy eating and exercise for women on low incomes.
- Improve support and services for women with eating disorders.
- Create more places on smoking cessation schemes.
- Develop more counselling services as a complement or an alternative to prescription drugs for mental and emotional

health problems.

- **Work in co-operation with other statutory agencies and the voluntary sector to increase public discussions of domestic violence.**

Lone Parents

- **see recommendation on prescription drugs and counselling services above.**
- **see recommendation on reviewing barriers to healthy eating and exercise.**
- **Increase awareness of post-natal depression amongst GPs.**

Travellers

- **Conduct a review of GP home visits to Traveller sites.**
- **In association with other statutory and voluntary agencies, promote the discussion of domestic violence in Traveller communities.**

Black and Minority Ethnic Women

- **See recommendation on prescription drugs and counselling services above.**
- **Provision of adequate interpreting services for black and minority ethnic women, particularly female interpreters for female service users.**
- **Improve the availability of information on health and social services in other languages.**
- **Conduct outreach work with minority ethnic women on mental health issues.**

Women and Maternity Provision

During 2002-03 the House of Commons Health Committee explored the issue of inequities in access to maternity services for a range of disadvantaged women including, women from black and minority ethnic groups; refugees and asylum seekers; women for whom English is not their first language; women living in poverty; women who are homeless; traveller women; women living under the threat of domestic violence; women with severe mental health problems; and, women with severe disabilities.

The report revealed that, “...some of the most disadvantaged and vulnerable women, who have the greatest need of care and support through pregnancy and the early stages of motherhood, are less likely to receive the same quality of care as other women. In some cases they do not gain access to services at all”.

Whilst the report focused upon the English experience its findings highlighted a range of access barriers which *may* also be applicable to women in disadvantaged groups in Northern Ireland.

Outlined below are some of the specific barriers to accessing maternity services experienced by this range of women. The report’s recommendations for improving access to services are also noted and should be taken into consideration in developing more equitable access to maternity services in Northern Ireland.

Access Barriers to Maternity Services:

- **Black and Minority Ethnic Women:** are more likely than white women to contact maternity services later in pregnancy and more likely to miss routine appointments. The Royal College of Midwifery (RCM) have identified institutional racism, a shortage of women from minority ethnic groups becoming midwives, and, complacency in areas with small black and minority ethnic populations as the main barriers to service access.
- **Refugees and Asylum Seekers:** pregnant asylum seekers may be particularly vulnerable as they are less likely to speak English or have family or friends for support. Cultural and religious differences in relation to maternity care exist. Many women are also unaware of when and where to access services and particular difficulties can be experienced by women accessing maternity services in detention centres.
- **Those who do not speak English as their first language:** experience restrictions in accessing appropriate care due to lack of advocacy and interpretation services. Inappropriate use of relatives as translators often make it difficult for women to maintain a confidential relationship with health professionals.
- **Women Living in Poverty:** attendance at antenatal appointments can be costly and difficult for women living in

poverty where affordable and convenient transport is unavailable. Financial implications exist for women on low incomes who have to travel long distances to be with their babies in special care units.

- **Women who are Homeless:** particular problems faced by women living in temporary accommodation in terms of registering with a GP, this is particularly significant as the GP plays a vital role as a gatekeeper to other maternity services.
- **Traveller Women:** the transient lifestyle of many Traveller women presents difficulties in accessing antenatal and postnatal care. Often staff lack access to comprehensive medical records for Traveller women as they move to and from different locations. Traveller women can also experience negative attitudes from some health and social care staff which can make them reluctant to access the services.
- **Women and Domestic Violence:** women experiencing domestic violence are often reluctant to come forward for maternity care services. They may have, for example, partners who prevent them from attending appointments, or their situation can often prevent them from participating fully in discussions on maternity care.
- **Women with Severe Mental Health Problems:** lack of specialist practitioners available to childbearing women with mental illnesses and a lack of co-ordination between mental health services and maternity services is problematic.
- **Women with Severe Disabilities:** women with learning difficulties are particularly encouraged not to become mothers and can face negative attitudes from health and social care staff if they chose to do so. Problems for disabled women include a lack of intercom systems in maternity units (for women with hearing impairments) and a lack of height variable cribs to enable women with disabilities to reach their babies themselves.

Recommendations: Inequities in Access to Maternity Services (House of Commons Health Committee Report, 2003)

- **Action should be taken to recruit midwives from black and minority ethnic communities. This could include the identification of ‘champions’ from black and minority ethnic communities to inspire younger people in these communities to pursue careers in maternity services.**
- **Given the high incidence of domestic violence in pregnancy, relying on relatives to interpret for women who are not proficient in the English language can be dangerous. All maternity services should ensure that the use of relatives as interpreters does not deny women the opportunity that maternity care provides to report domestic violence or to discuss other issues such as mental health.**
- **Maternity services and staff running antenatal classes and undertaking postnatal visits should have access to advocacy and interpreting services.**
- **An assessment of the difficulties experienced by low income families who have to spend long periods visiting their babies in special baby units should be conducted. Steps should be taken to ensure that sufficient financial support is provided to meet travel and other costs.**
- **All maternity services should have access to support services to which they can refer women experiencing domestic violence.**
- **Steps must be taken to ensure that maternity and mental health services work together to support women during pregnancy and the postnatal period. Lead practitioners should be appointed to ensure that care for women with mental health problems is properly co-ordinated.**
- **Maternity units and services must be made accessible to all groups of people with disabilities (by providing height variable cots, for example).**

The recently published statistical overview of equalities and inequalities in health in Northern Ireland (DHSSPS, 2004:221) highlights that whilst 60% of females aged 15-44 live within 15 minutes of a maternity hospital, over 12,000 women live more than 40 minutes away from the nearest hospital. Access to maternity services for women in rural areas of Northern Ireland is an issue which has and will continue to be widely debated.

Women, Fertility Services and Reproductive Health

Fertility Services

The Government continues to be committed to making available publicly-funded fertility services⁶⁷. Since 2001 a wider range of treatments including in-vitro fertilisation have been made available on a limited basis in Northern Ireland. However, resources are limited and this undoubtedly has implications for equity of access to fertility services.

The DHSSPS (2003:33) fertility services consultation paper *“From People to Parents”* notes, any eligibility criteria applied for fertility services is likely to give rise to criticism particularly in relation to age restrictions, restrictions based on marital status and restrictions on those who already have dependent children.

Reproductive Health

The *“Other Irish Journey”* published by Marie Stopes International in 2001, outlines the findings of a survey of Northern Irish women attending abortion clinics in GB in 2000/01⁶⁸. The report reveals the nature of the barriers faced by women from Northern Ireland in accessing abortion services.

The report highlights, for example,

- that 95% of women would have preferred to access abortions in Northern Ireland;

⁶⁷ although the issue of fertility services has been placed under the category of women in this section, it must be acknowledged that that access to fertility services is an issue of importance to both men and women.

⁶⁸ 155 questionnaires completed by NI abortion-seekers in a six month period from October 2000 to March 2001. In addition to this, 30 qualitative interviews were also conducted.

- that there was widespread mistrust of GPs with some women feeling that they qualified for an abortion in Northern Ireland but found that their GP was confused about their rights under law; and,
- that almost half (44%) of women had to borrow money to finance their abortion.

The report also suggests that day care abortion services may create barriers to women on low incomes and women in rural areas from accessing such services. For example, women on low income find it financially difficult to meet the high costs charged for day return flights and women from rural areas find it difficult to access late-night public transport on their return home.

Recommendations: Women and Abortion (Marie Stopes International, 2001)

- **extension of the British 1967 Abortion Act to Northern Ireland as a prelude to the introduction of more progressive legislation.**
- **funding of NI abortions at British clinics as an interim step.**
- **GP training pre and post registration on abortion law in GB and NI.**
- **training for support staff, especially those in GP surgeries, on the need for confidentiality.**
- **school nurses to receive training on guidelines on the full range of choices available in an unplanned pregnancy, and to imparting these to students in an impartial way.**

Recent news reports suggest that there may be inequities access to emergency contraception across Northern Ireland. A BBC News article (*"Morning After Pill 'Scandal'*, 20 July 2004), for example, reported that 13 of Northern Ireland's 15 Accident and Emergency Departments refused to prescribe the morning after pill to those who requested it. The article also reports that some GPs

are refusing to prescribe emergency contraception on ethical, moral or religious grounds.

It is clear that access to such services has important and often conflicting human rights implications, for both service users and for the health and social care professionals administering the services.

Women and Domestic Violence

In 2003, the Northern Ireland Women's Aid Federation published the results of a short study⁶⁹ examining women's perceptions of the attitudes of health professionals to domestic violence and their effectiveness and competency in dealing with women experiencing domestic violence. The report highlights that until recently there has been very little research carried out on domestic violence and its health implications in Northern Ireland (NI Women's Aid Federation, 2003:6).

GPs are often the first access point for women seeking help whilst in an abusive relationship, and the manner in which the GP or other health care professionals responds can make an immense difference to the life of the women and their children (NI Women's Aid Federation, 2003:11).

However, the British Medical Association (1998) have identified a number of reasons why doctors find it problematic identifying women experiencing domestic violence including, the doctor's fear of exploring the issue; a lack of knowledge about domestic violence and of organisations which could help; lack of time and resource constraints; lack of training; doctor's feelings of powerlessness; and, the patient's unresponsiveness to questions and denial of abuse. These factors, in addition to the beliefs held by many women themselves (for example, fear the doctor would take their children away, fear that the doctor would tell their partners), are barriers to women accessing appropriate services.

The Women's Aid report suggests that many GPs do not appear to be making referrals to Women's Aid and other appropriate agencies as a matter of routine practice. It recommends that GPs and other health and social care professionals receive appropriate

⁶⁹ a survey of 63 women resident in refuges in Northern Ireland.

training and information on the referral agencies which are available (Women's Aid Federation, 2003:22). Other recommendations outlined in the report which are aimed at reducing barriers in access to services are outlined below.

Recommendations: Women and Domestic Violence (NI Women's Aid Federation, 2003)

- **There are large variations in the quality of health professionals' responses to domestic violence. Health professionals of all disciplines must be made aware of the huge public health problems which result from domestic violence.**
- **Health care professionals must receive adequate training in order that they may be able to refer women to other appropriate agencies which can help. Training should be part of the undergraduate curriculum and on continuous professional development programmes.**
- **The DHSSPS must carry out an audit of domestic violence services and health care professionals. This should include an assessment of what training is available, the extent of interagency work and staff attitudes and responses to domestic violence.**
- **All health care agencies and facilities including A&E Departments, GP surgeries should develop and implement policies and guidelines on domestic violence.**
- **There should be continued commitment from health professionals to participate in inter-agency fora and domestic violence initiatives.**

Women and Mental Health

A consultation document published by the Department of Health in 2002 entitled "*Women's Mental Health: Into the Mainstream*", highlights that poverty, low social status, social isolation and the experiences of child sexual abuse, domestic violence and sexual

violence are all issues which tend to be more common amongst women than men. The document also notes that the complex interplay of all these factors can have a major adverse impact upon women's mental health.

The consultation document identifies particular sub-groups of women who are vulnerable to mental ill health (Department of Health, 2002:16-20) and for whom there are existing gaps in service provision. These vulnerable groups include women who are mothers and or/carers; older women; black and minority ethnic women; lesbian and bisexual women; transgender women; women involved in prostitution; women offenders; women with learning disabilities; and, women with substance misuse problems.

It is important to recognise that as part of women's "multiple identities" they may fall within several of these categories and that this can create complex and multiple barriers to accessing appropriate mental health services. Poverty and social disadvantage are common features amongst these different groups of women and have a profound and detrimental impact upon their mental health.

Mental Health and Vulnerable Groups of Women (Department of Health, 2002):

- **Women who are mothers and/or carers:** the interaction of socio-economic factors, in conjunction with being at home with children, puts low income women at greater risk of mental ill health. Lone mothers are particularly susceptible to mental ill health because they are at greater risk of socio-economic disadvantage and more likely to experience social isolation.

Caring for dependent adults or disabled children can also have a significant impact upon mental health. Carers providing substantial amounts of care face financial hardships, often finding it difficult to combine their caring role with paid employment.

- **Older Women:** poverty and social isolation tends to be more common in older women than men as women are less likely to have personal or occupational pensions as they get older. Women also live longer and are more likely to experience bereavement in old age, with their partners dying earlier than

they do. An increased life expectancy also means that older women are more likely to experience institutional care which is often associated with loss of independence. Depression is common amongst older women who have physically disabling conditions and this can often go undetected as the aging process is blamed on changes in mood or social functioning.

- **Black and Minority Ethnic Women:** the interrelationship between gender, culture and ethnicity is under-researched in terms of its impact on mental health and emotional well-being. Racism, language barriers, and social isolation alongside factors such as poor housing and poverty can have a detrimental effect upon the mental health of black and minority ethnic women.
- **Lesbian and Bisexual Women:** women who do not define themselves as heterosexual often have added stressors in their lives given the degree of stigma prevalent in society. Studies suggest that the non-heterosexual community have a higher prevalence of anxiety, depression and substance misuse.
- **Transsexual Women:** Transsexual women and men experience stigma and discrimination which may contribute to poorer mental health.
- **Women Involved in Prostitution:** often experience high levels of violence both as children and adults. Drug and alcohol misuse, homelessness and discrimination can impact upon the mental health.
- **Women Offenders:** women in prison tend to experience high levels of mental ill health and this can often co-exist with substance misuse.
- **Women with Learning Disabilities:** in many cases mental ill health of people with learning difficulties often remains undetected due to a lack of understanding on the part of carers in addition to potential communicative disabilities. Risk factors known to contribute to the development of mental illness such as stigma, low self-esteem, abuse, low levels of social support, poor coping skills and chronic ill health can occur more frequently in people with learning disabilities.

- **Women who misuse drugs and/or alcohol:** there are gender differences in alcohol and substance misuse. The consultation paper argues that women misusing substances (particularly alcohol) are more likely to experience greater social stigma.

“Women’s Mental Health: Into the Mainstream” maintains that understanding the nature and causes of mental ill health in these diverse groups of women is essential in developing services that are responsive to the needs of different women. Whilst this consultation is aimed at women’s mental health services in England and Wales important lessons can be drawn for mental health services in Northern Ireland such as:

- developing a women’s health strategy as part of a wider commitment to addressing inequalities in the delivery of mental health services;
- providing equity in service access to all and recognising that gender differences in women and men need to receive equal focus in researching, planning, commissioning and delivering services;
- placing importance on exploring different models of care which specifically address women’s mental health needs (for example, single sex inpatient care, women-only counselling sessions); and,
- ensuring that clinical governance arrangements formally include gender and other dimensions of inequality. That is, developing quality and monitoring standards which take gender into account. This should involve the inclusion of gender and other inequality dimensions in staff training programmes and developing a culture of evidence-based practice in regards to gender.

Recommendations: Women and Mental Health

- **That the DHSSPS and its associated bodies take note of the Department of Health consultation paper *“Women’s Mental Health: Into the Mainstream”* in developing mental health services for women.**

Women in Rural Areas

There generally appears to be a lack of available research on the inequities experienced by women in rural areas in relation to accessing health and social services. There are notably, however, a number of practical difficulties in researching the lives of women in rural areas. These include regional variations on the definition of what is rural and the fact that rural women are not a homogeneous group (that is, they have varied lifestyles, incomes, needs and family situations) (Shortall, 2003:5).

Shortall (2003:5) suggests that whilst rural and urban women face many of the same issues, there are certain aspects of rural life which impact specifically upon rural women. Childcare provision, for example, is particularly problematic for women in rural areas given the population density and travel implications.

Young Women in Rural Areas

A recent report commissioned by the YWCA⁷⁰ (2002), *“Beyond the Bus Shelter”* examines the experiences of young women in rural areas. Whilst this study concentrates upon young rural women in England and Wales, it is likely that many of these experiences are also relevant to the lives young rural women in Northern Ireland.

In regards to barriers in accessing health and social services, the report reveals that the lack of anonymity in rural areas often means that personal issues such as sexual health, contraceptive needs, illicit drug misuse, alcohol misuse, self-harm and domestic violence are not openly discussed. The study suggests that young women in rural areas are often deterred from seeking professional advice in relation to these issues because they fear that their family and friends will find out.

Literature on the barriers to accessing services encountered by rural women in Northern Ireland is extremely limited and is clearly an area which requires much greater attention. The YWCA report makes a number of recommendations aimed at improving access to health and social services for young women in rural areas.

⁷⁰ YWCA (Young Women’s Christian Association) is a leading charity working with young women experiencing disadvantage in England and Wales.

Recommendations: Young Women in Rural Areas (YWCA, 2002)

- **More use of outreach facilities and telephone helplines in rural areas, as young women in rural areas often cannot access facilities due to their location and lack of transport, and also because they often lack confidence in using services.**
- **Enhance GP practices in rural areas. Many young rural women are not seeking advice from their local doctor for sensitive healthcare issues because they fear a lack of anonymity in close-knit rural communities. Well-women clinics, outreach work and training for GPs is recommended.**
- **There is a need for more holistic services, particularly for young women with children, where information and guidance on a range of issues can be accessed under one roof.**

PART C: TRANSGENDER

Transgendered People & Equity of Access to Health and Social Services

The Scottish Inclusion Project publication *“Towards a healthier LGBT Scotland”* define transgender as,

“..an inclusive, umbrella term used to describe the diversity of gender identity and gender expression. The term can be used to describe all people who do not conform to the common ideas of gender roles, including transsexuals.” (2003:8).

It is crucial to recognise that despite common misconceptions, transgender people are not a homogeneous group. The concept of transgender incorporates a wide range spectrum of identities including transsexual, biological intersex and transvestism. Transgender people’s experiences of and access to health and social services can also be compounded by a range of other social

determinants such as age, socio-economic status, ethnicity, geographical location and so on.

Literature on transgender people and inequities in access to health and social services is extremely limited, particularly in Northern Ireland. The scarcity of research on transgender issues is perhaps attributable to a number of factors including the sensitive nature of conducting such research and the fact that it is only relatively recently that the needs of transgender people has been given recognition and placed on the policy agenda.

The Scottish Inclusion Project (2003:34) argues that the health needs and service experience of the transgendered population has remained one of the most neglected areas of research in relation to lesbian, gay, bisexual and transgender (LGBT) health. The paper "*Towards a healthier LGBT Scotland*" (Scottish Inclusion Project, 2003) has identified a number of common issues that the transgender population share with the wider lesbian, gay and bisexual (LGB) population in regards to health and social care.

These included:

- the prejudiced attitudes of some healthcare providers;
- poor communication and negative attitudes of some health care staff often led to an inability to disclose sexuality or gender;
- that health care providers had limited knowledge of LGBT health care issues, and that staff received only minimal training in such issues; and,
- that LGBT people often delay attendance or are reluctant to attend screening programmes because of the issues outlined above.

Additionally, further significant barriers to accessing health and social care which specifically relate to transgender community have been identified (Scottish Inclusion Project, 2003). These include:

- the haphazard availability of treatment and services specifically for transgendered people across Scotland;

- little knowledge by health and social care staff of what services are available for transgendered people locally;
- a lack of co-ordination of services which often leads to frequent inappropriate referrals and can cause delays in diagnosis and treatment;
- little knowledge of transsexual and transgender issues amongst many GPs;
- transgender often confused with sexual orientation by health and social care staff;
- mental health is a serious concern but there is no targeted provision for transgendered people in Scotland; and,
- people often have to travel long distances to be seen by appropriate staff.

A Public Health Institute of Scotland (PHIS) report entitled "*Transsexualism and Gender Dysphoria in Scotland*" (2001) suggested that a number of factors relating to health care professionals could lead to significant barriers for transsexual people in terms of accessing appropriate services. Such problems include:

- professional isolation and widespread ignorance amongst professionals of gender identity problems;
- widely polarised views of transsexualism and gender dysphoria amongst professionals ranging from strong moral disapproval to considerable empathy; and,
- that routes to referral are often not clear amongst professionals.

There is a scarcity of research on the experiences of transgendered people in Northern Ireland. As a result, their health and social care needs and the difficulties they experience in terms of accessing health and social care are largely overlooked. Whilst the research and literature cited above relates to transgendered people in Scotland many of the potential barriers to accessing appropriate health and social services may also be applicable to the experiences of transgendered people in Northern Ireland.

Outlined below are a number of recommendations identified by both PHIS and the Inclusion Project in relation to transgender and health and social services in Scotland. It may be possible that a number of these recommendations could be adapted to suit the Northern Ireland context including the establishment of a Managed Clinical Network (or some similar structure) and a health and social care needs assessment for transgender people (if these are not already in place).

**Recommendations: Transgender
(Public Health Institute of Scotland, 2001)**

- **Transsexualism and gender dysphoria remains an under-researched area. It is imperative that an integrated programme of audit and research be established.**
- **Transsexual people, particularly those seeking gender reassignment, are likely to come in contact with a wide range of health and social care professionals (such as GPs, psychiatrists, psychologists, speech therapists, endocrinologists, surgeons). As contact with services tends to be on a long term basis, services should be local and community-based where possible.**
- **Taking into account the haphazard access to health services, a Managed Clinical Network on Gender Dysphoria should be established.**

**Recommendations: Transgender
(Scottish Inclusion Project)**

- **The abolition of mixed sex wards is becoming an increasingly important issue. Transgendered people must be taken into consideration in relation to future planning and provision.**

Gender, Human Rights & Equity of Access to Health and Social Services

In a speech on "*Protecting the Human Rights of Males in Northern Ireland*" in 2001, Professor Brice Dickson of the Northern Ireland Human Rights Commission, draws attention to the fact that many major international documents on human rights focus on the rights of women and children but that there is no existing document which focuses upon the rights of men. Dickson (2001) maintains that men also can be members of vulnerable groups and therefore highlights that it is crucial that policy, law and practice on human rights is developed in such a way that it ensures protection for men also.

With regard to human rights and health, Dickson (2001) argues that the health care system disadvantages men by not according them the same degree of screening for certain conditions as it does for women. He provides a comparison of the screening and treatment policies of conditions such as prostate cancer with those for breast and ovarian cancer as an illustration of this point. Dickson also suggests that in the case of abortion, the rights of men are extremely restricted in that the father has no legal right to prevent the abortion from being carried out.

Research in the area of men's health and human rights, particularly in terms of accessing services, is extremely limited and is clearly an area which requires greater attention.

Literature exploring the linkages between women's health and human rights is more widely available, particularly in relation to the issues of sexual health and reproductive rights. Much of this research, however, tends to focus upon the violation of women's rights on an international rather than a local level. Organisations such as Amnesty International and Human Rights Watch have widely documented violations of the human rights of women on a global scale, including issues such as violence against women, female genital mutilation and the illegal trafficking of women.

Many of these issues have important implications for health and social services and may become even more significant to Northern Ireland as it evolves into an increasingly multi-cultural society. Again, however, there is clearly a need for more locally based

research in regards to the issue of women, health and human rights.

References

Biddulph, S. (2001) *“Men in the Mirror”*, Northern Ireland Life and Times Survey, Research Update, No 7.

BBC News. “Morning-after pill ‘scandal’”, 20 July 2004.

British Medical Association (1998). *Domestic Violence: A Health Care Issue?* Summary available to download at <http://www.bma.org.uk/ap.nsf/Content/domesticviolence1998>

Brogden, M. & Saranjit, S. (2004) *Abuse of Adult Males in Intimate Partner Relationships in Northern Ireland*. Belfast: OFMDFM.

Derry Well Woman (2003) *Other Borders: Women’s Mental Health and Emotional Well-Being*.

Developing Patient Partnerships. “*Mum’s the Word for Men Seeking Advice on Medical Matters.*” Developing Patient Partnerships E-News, 29 April 2004.

Department of Health (2002) *Women’s Mental Health: Into the Mainstream. Strategic Development of Mental Health Care for Women*. London: Department of Health Publications.

DHSSPS (2003a) *Promoting Mental Health: Strategy and Action Plan, 2003-2008*. Belfast: DHSSPS.

DHSSPS (2003b) *From People to Parents: A Consultation Document on the Future of Fertility Services in Northern Ireland*. Belfast: DHSSPS.

DHSSPS & NACD. (2003) *Drug Use in Ireland and Northern Ireland: First Results from the 2002/03 Drug Prevalence Survey. Bulletin No. 1*.

DHSSPS. (2004) *Equality and Inequality in Health and Social Care in Northern Ireland: A Statistical Overview*. Belfast: DHSSPS

Dickson, B. (2001) *Protecting the Rights of Males in Northern Ireland*. Speech to Men and Human Rights Seminar. 5 October 2001, Belfast. (available to download at www.nihrc.org)

Fathers Direct. *How to Build New Dads. From Here to Paternity: supporting mothers by supporting fathers.* (available to download at <http://www.fathersdirect.com/files/pdf/ff2htmgd.pdf>)

“How Loneliness and Health Risks of Older Men Go Unseen in a World Geared to Older Women”. *Economic and Social Research Council (ESRC) Press Release*, 24 March 2003)

House of Commons Health Committee. (2003) *Inequalities in Access to Maternity Services.* Eighth Report of Session 2002-02. (available to download at www.parliament.the-stationary-office.co.uk/pa/cm200203/cmselect/cmhealth/696/696.pdf)

InterAgency Group on Sexual Abuse. *The Heather Report.* (available to download at www.sexualabuseiag.co.uk/heather.htm)

Men's Health Forum UK. (2004) *Getting it Sorted: A Policy Programme for Men's Health.* London: Men's Health Forum.

Men's Health Forum UK. (2004) “*Still Lazy After All These Years*”. Men's Health Forum Press Release. 26 April 2004.

MIND. *Men's Mental Health Information Sheet.* (available to download at www.mind.org.uk/Information/Factsheets/Men)

McCreight, B.S. (2004) “*A grief ignored: narratives of pregnancy loss from a male perspective.*” *Sociology of Health and Illness*, Apr '04, Issue 3, Vol 26, p326.

McEvoy, R. & Richardson, N. (2004) *Men's Health in Ireland.* Belfast: Men's Health Forum in Ireland.

NHS Scotland & Stonewall Scotland. (2003) *Towards a Healthier LGBT Scotland.* Glasgow: Inclusion Project.

Northern Ireland Statistics and Research Agency. (2002) *The Northern Ireland Health and Social Wellbeing Survey 2001. Bulletin No. 6.* Belfast: NISRA.

Northern Ireland Women's Aid Federation. (2003) *Domestic Violence and Health Professionals: A Short Study on Women's Experiences.* Belfast: Northern Ireland Women's Aid Federation.

Parish, R. (2001) *“Tackling Men’s Health Inequalities: What Can the Government Do?”* in a Report of a one day multi-disciplinary conference, Royal College of Physicians, December 2001.

Public Health Institute of Scotland (2001) *Transsexualism and Gender Dysphoria in Scotland*. Glasgow: Public Health Institute of Scotland.

Rossiter, A. & Sexton. M. (2001) *The Other Irish Journey : a survey update of Northern Irish women attending British abortion clinics, 2000/01*. London: Marie Stopes International.

Shortall, S. (2003) *Women in Rural Areas: A Policy Discussion Document*. Cookstown: The Rural Community Network NI.

Thom, B. (2003) *Risk Taking Behaviour in Men: Substance Use and Gender*. London: NHS Health Development Agency.

White, D. (2001) *Report of the Scoping Study on Men’s Health*. London: Men’s Health Forum.

YWCA (2002) *Beyond the Bus Shelter: Young Women’s Choices and Challenges in Rural Areas*. Oxford: YWCA.

Useful Web-Links*

Women

- **Northern Ireland Women's Aid Federation** - lead voluntary organisation challenging domestic violence in Northern Ireland. We strive to create a safe and supportive society for women, children and young people affected by domestic violence.
www.niwaf.org
- **Women's Aid** - national charity working to end domestic violence against women and children.
www.womensaid.org.uk
- **Youth Action** – gender equality unit.
www.youthaction.org

Men

- **The Men's Project** – a local initiative within the Parents Advice Centre. Its aim is to increase awareness of the issues facing local men and boys and to promote their social inclusion.
www.mensproject.org
- **Men's Health Forum** - UK voluntary organisation working to improve the health of men of all ages.
www.menshealthforum.org.uk
- **Men to Men** - local group looking to challenge society's and men's own view of the role of men. Involved in areas such as men's human rights, men as recipients of domestic violence etc.
www.mentomen.org
- **Youth Action (NI) Young Men's Project** – includes publication on young men's health, working with young men and young men and violence.
www.youthaction.org

Transgender

- **Press for Change** - political lobbying and educational organisation, which campaigns to achieve equal civil rights and liberties for all transsexual and transgendered people in the United Kingdom.
www.pfc.org.uk

Sexual and Reproductive Health

- **The Gender Trust** – support and information centre for gender identity issues.
www.gendertrust.org.uk
- **Brook** – national voluntary sector provider of free and confidential sexual health advice and services for young people under 25. Includes a policy and research section.
www.brook.org.uk
- **Family Planning Association** - charity working to improve the sexual health and reproductive rights of all people throughout the UK.
www.fpa.org.uk
- **Marie Stopes International** – provides sexual and reproductive health information and services world wide.
www.mariestopes.org.uk
- **National Aids Trust** - HIV and AIDS policy development and campaigning organisation.
www.nat.org.uk
- **Terrence Higgins Trust** - HIV & AIDS charity in the UK.
www.tht.org.uk

* Please note that this is NOT a definitive list of relevant websites.