INVISIBLE

HEALTH, SEX, AND GENDER INEQUALITIES: INSIGHTS FROM SCOTLAND'S THIRD SECTOR

SARAH LATTO, MAY 2026

vhs
voluntary health scotland

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FOREWORD

Since joining Voluntary Health Scotland (VHS) in May 2025, I have spent a significant amount of time speaking to our members and wider partners to better understand the health landscape in Scotland. However, you don't have to be working in Scotland's health landscape to have an awareness of gender-related health inequalities. For most of us, they are an ever-present, but often hidden, reality of our lives.

As a cisgender woman I have often felt invisible when navigating Scotland's health system. I have first-hand experience of my pain being minimised and my symptoms being dismissed by clinicians. I have undergone several medical procedures where the failure to offer pain relief or anaesthesia left me in significant physical and mental distress.

Often our experiences of health are defined by wider societal norms. Both my mum and my mother-in law provided unpaid care for their mothers after a diagnosis of Alzheimer's, an extraordinarily cruel disease that affects more women than men.

Several of the men in my life have grappled with mental ill health, often battling the stigma associated with asking for help. I have attended two heartbreaking funerals for young men who died by suicide when they didn't get the support they needed in time.

Whilst writing this research, my dad was diagnosed with prostate cancer. 1 in 8 men will receive this diagnosis in their lifetime. Thankfully it was caught early when he proactively approached his GP for a blood test – not always the case in the absence of a national screening programme.

This research has been personally cathartic, but it has also provided a fascinating insight into the vital role of third sector organisations in addressing health inequalities in Scotland. It felt like each of the research participants I spoke to was providing another piece of a big jigsaw puzzle.

I hope that this report helps to make the invisible visible, and promotes greater understanding of the relationship between health, sex and gender. I further hope that it helps to influence those with the power to change policy or practice to look again at every part of the health system through a gender inequalities lens.

Sarah Latto
Policy and Public Affairs Lead

GLOSSARY

There are no easily identified shared definitions of key terms related to sex and gender in Scotland. As such, we have adopted definitions from the World Health Organisation and Equality Network, a Scottish LGBTI Rights organisation.[1] These are summarised below.

CISGENDER

A person who identifies with the sex they were assigned at birth. Cisgender is the word for anyone who is not transgender. (Equality Network LGBTI+ Glossary)

GENDER

The characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours and roles associated with being a woman, man, girl, or boy, as well as relationships with each other. (World Health Organisation, Gender and Health)

GENDER IDENTITY OR LIVED GENDER

Our internal sense of who we are, and how we see ourselves in regards to being a man, a woman, or somewhere in between/beyond these identities. (Equality Network LGBTI+ Glossary)

NON-BINARY

Identifying as either having a gender which is in-between or beyond the two categories 'man' and 'woman', as fluctuating between 'man' and 'woman', or as having no gender, either permanently or some of the time. (Equality Network LGBTI+ Glossary)

SEX/BIOLOGICAL SEX

The different biological and physiological characteristics of females, males and intersex persons, such as chromosomes, hormones and reproductive organs. (World Health Organisation, Gender and Health)

TRANSGENDER/TRANS

Equivalent inclusive umbrella terms for anyone whose gender identity or gender expression does not fully correspond with the sex they were assigned at birth.(Equality Network LGBTI+ Glossary)

[1] At some points in the report we adopt terms that differ from the glossary to accurately reflect source material that we are referencing, but this will be explicit or within quotation marks.

INTRODUCTION

Scotland's 2023 Gender Equality Index scored access to health services and social care in Scotland at 99 out of 100 for gender equality. This effectively means that, according to a range of data sources, gender equality in Scotland's health system has *almost* been achieved. Whilst this score does not reflect certain health datasets that are specific 'to women only'[2], it is still astonishing.

This research was named (IN)VISIBLE to challenge the assumption that sex and gender-related health inequalities are easily identifiable and well understood. Many of the impacts of sex and gender on health are complex and opaque, leaving many people feeling invisible in Scotland's health system. This research does not profess to offer a holistic view of the sex and gender-related health inequalities that exist in Scotland. Instead, it offers a snapshot of the insights provided by some of our members in Scotland's Third Sector, and a platform to build that evidence base further.

VHS chose to explore the relationship between sex, gender and health because it was a common theme in discussions with our members. The findings detailed in this report were largely gathered between October 2025 to March 2026. All VHS members and wider stakeholders were invited to participate through an anonymous survey, two facilitated workshops, and a series of one-to-one discussions. Over fifty people from a wide range of organisations contributed to the research, and these inputs are the basis for our research findings and recommendations.[3]

This report reflects the complex relationship between sex, gender and health for *all* adults[4].

Whilst there is clear evidence of systemic misogyny in our healthcare system, women have a higher life expectancy in Scotland than men. For the period 2022-2024, life expectancy at birth in Scotland was 81.06 years for females and 77.12 years for males. Transgender and non-binary people also experience significant challenges accessing healthcare that differ from those experienced by people who are cisgender.

In writing this report, we are mindful of the polarising nature of the narrative around sex and gender that has emerged in recent years. The Supreme Court ruling in 2025 that 'sex' in the Equality Act 2010 refers exclusively to biological sex, not gender identity or lived gender, has far-reaching implications that we do not intend to debate in this report. However, it is clear from the evidence shared by our members that both sex and gender have a considerable impact on an individual's health experiences and outcomes.

We attempt to explore these differences, and resulting inequalities, objectively and sensitively in this report through five interrelated themes. These are physiological differences, health infrastructure, health workforce, societal norms, and intersectional barriers. We further offer six recommendations for addressing sex and gender-related health inequalities in Scotland.

[2] The sub-domains within the 'women specific health domain' are: termination of pregnancy, IVF waiting times, contraception, and maternal health.

[3] Further details about the methodology for this research can be found in Appendix 2.

[4] The exclusion of children and young people from this research reflects the fact that the evidence provided by our members largely focused on adult experiences. It should not be interpreted as a suggestion that children and young people do not experience health inequalities related to sex or gender.

1. POLICY AND LEGAL CONTEXT

The policy context regarding sex, gender and health in Scotland is complex. This chapter provides a summary of some of the more pertinent legislation and policy developments from recent years. However, it should not be viewed as a holistic reflection of all legislation and policy that relates to sex, gender and health.

UK LEGISLATIVE CONTEXT

The most important piece of legislation defining rights and protections according to sex and gender in the UK is the Equality Act 2010. The Equality Act protects people from unfair treatment based on nine protected characteristics. These are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Discrimination or harassment related to any of these characteristics is prohibited in a wide range of settings, including employment, education, the provision of goods and services, housing, and the delivery of public services.

Underpinning the Equality Act is the Public Sector Equality Duty (PSED). This sets out general duties that require all public authorities in the UK to consider how their policies and decisions affect people protected under the Act. In Scotland, additional specific duties detail a range of requirements for Scottish 'listed authorities' on reporting and monitoring on equalities compliance.

In the Equality Act 2010, sex as a protected characteristic is defined as:

'(a) a reference to a person who has a particular protected characteristic is a reference to a man or to a woman;

'(b) a reference to persons who share a protected characteristic is a reference to persons of the same sex.'

In April 2025, a UK Supreme Court ruling found that the definitions of 'sex', 'man' and 'woman' in the Equality Act relate to 'biological sex'. Whilst 'sex' in the Equality Act does not therefore apply to lived gender, transgender people are somewhat protected from discrimination under the Equality Act given that gender reassignment is also a protected characteristic. The Gender Recognition Act 2004 also states that legal recognition of a person's acquired gender changes their sex 'for all purposes' to correspond with that gender.

Before the ruling, many public bodies such as NHS Scotland operated under the understanding that having a gender recognition certificate (GRC) legally changed one's sex for the purposes of the Equality Act. Scottish Trans believe that the ruling *'removes legal gender recognition from trans women and trans men who have gender recognition certificates (GRCs), for the purposes of equality law'* and *'has created significant uncertainty about how all trans people, whether they have a GRC or not, should be treated in a huge range of services and spaces'.*

SCOTTISH HEALTH POLICY LANDSCAPE

Whilst not explicitly related to sex and gender, the Scottish Government's Population Health Framework, published in June 2025, acknowledges the need for services to be person-led. It recognises the importance of the 'Building Blocks of Health' – the social, economic, and environmental factors that are the primary drivers of health and health inequalities. The Framework commits to the development of a Healthcare Inequalities Action Plan which will ensure better collection and analysis of healthcare inequalities data by key variables, including gender.

The Population Health Framework builds on the Scottish Government's commitment to 'Realistic Medicine' which advocates for a personalised approach to care. This approach requires the creation of open and trusting relationships between people and their healthcare professionals to help people to make informed choices about their treatment. Key to this is *'moving away from the 'doctor knows best' culture to ensure a more equal partnership with people'.*

More explicit gender-related health policy also exists, including the Scottish Government's Women's Health Plan which was first published in 2021. The first iteration detailed a range of actions to improve women's health inequalities. The initial priorities of this plan were to:

- ensure women who need it have access to specialist menopause services for advice and support on the diagnosis and management of menopause
- improve access for women to appropriate support, speedy diagnosis and best treatment for endometriosis
- improve access to information for girls and women on menstrual health and management options
- improve access to abortion and contraception services
- ensure rapid and easily accessible postnatal contraception
- reduce inequalities in health outcomes for women's general health, including work on cardiac disease

In January 2026, Phase Two of the Women's Health Plan was published, and identified a further four priority programmes:

- Transform gynaecology services
- Eliminate cervical cancer
- Better understanding and support of women's brain health
- Innovation to support women and girls

At a Cross Party Group on Health Inequalities meeting in January 2026, the Women's Health Champion, Professor Anna Glasier OBE, stated that the aim of the Women's Health Plan is *'a Scotland where health outcomes are equitable across the population so that all women and girls enjoy the best possible health throughout their lives.'* She spoke further about the extensive consultation undertaken with a range of organisations, including several that have provided evidence for this research, that underpinned the plan.

The Scottish Government has produced a Gender Identity Healthcare Protocol for Scotland, informing local health boards on how gender identity healthcare should be accessed and provided. It details the non-surgical and surgical interventions available via NHS Scotland to support adult gender identity healthcare.

Finally, the Scottish Government has expressed a commitment to further relevant policy and legislative developments, which are now subject to the result of the May 2026 election. This includes the proposed Human Rights Bill which would embed international human rights directly into Scot's Law. It also includes the Government's ongoing development of a Gender Equality Strategy in Scotland.

2. PHYSIOLOGICAL DIFFERENCES

Given that this chapter relates exclusively to physiological differences, we adopt the terms 'assigned male' and 'assigned female' when referring to physiological differences according to biological sex, unless otherwise stated or where other terms are adopted by referenced sources. All future chapters relate largely to gender rather than sex, and we revert to 'men' and 'women' to reflect this unless otherwise stated.

The extent to which physiological differences resulting from sex or gender impact on health is not always fully understood by those working in the health system. Indeed, physiological differences between assigned males and assigned females are not always binary and often change over time.[5] In addition, the physiology of many trans and non-binary people often changes considerably as a result of gender affirming healthcare.

There are a number of health experiences that are largely determined by biological sex. Certain cancers originate in organs that are only found in one biological sex – prostate, testicular, ovarian and cervical to name a few.[6] Only assigned females can physically experience menstruation, pregnancy, childbirth, miscarriage, and menopause. Indeed, there are certain health conditions that relate exclusively to assigned females as a result of their menstrual cycle such as polycystic ovary syndrome, adenomyosis or endometriosis.

Prostate cancer is one such condition that is determined by biological sex. Currently, one in eight assigned males will get prostate cancer in their lifetime. In November 2025, the UK National Screening Committee recommended against a universal screening programme for prostate cancer, and instead recommended screening for assigned males with a genetic pre-disposition through the BRCA gene variant.[7] Prostate Cancer UK have called this decision 'deeply disappointing', as a missed opportunity to leverage the available data within the NHS to provide sufficient evidence for screening assigned males at highest risk, namely those who are Black and those with a family history of the disease.

Another example of health inequalities that are largely determined by biological sex can be found in the understanding and treatment of endometriosis. According to a recent Endometriosis UK report, it currently takes over 9 years to receive a diagnosis of endometriosis. A report providing lived experience insight into Endometriosis, published by the Scottish Government in 2023, reported that as many as 1 in 10 assigned females have the condition. Many of the participants of this Government research reported that healthcare professionals dismissed or misdiagnosed symptoms and suggested that heavy or painful periods were 'normal'. One respondent in the Scottish Government report stated that:

'It felt like when the GP had their mind set on a diagnosis, like gastric issues, there was no way of convincing them otherwise. More openness to consider other things would have been a better alternative.'

[5] It is important to note that biological sex is not always binary with the presence of people who are intersex. It is estimated that 1.7% of the population is born with intersex traits.

[6] Gender transition treatments can change an individual's eligibility for certain screening programmes beyond their biological sex. This is explored further later in this chapter.

[7] This is because the main blood test used to detect prostate cancer, the PSA test, is not accurate enough to detect prostate cancer that needs treatment. It can falsely identify men who do not have prostate cancer, or it can also miss some cancers. This means that many men might have to undergo unnecessary and often unpleasant tests and/or unnecessary treatment.

In our survey[8] to inform this research, one respondent stated:

> **'As a manager I have a number of staff with endometriosis who sometimes come into work looking really unwell. But endometriosis is not well understood and does not have the profile of something like diabetes in terms of recognition and public understanding. I would love to have some training about supporting staff with endometriosis.'**

The Health and Social Care Alliance (The ALLIANCE) and Engender reported in 2023 about the experiences of pregnancy and maternity services in Scotland during the Covid-19 pandemic. They found that assigned females experienced an array of challenges during this time including inconsistencies in the application of guidelines, isolation during key appointments and birth, and a lack of post-natal and antenatal support. This resulted in considerable emotional trauma, poor mental health outcomes, and feelings of isolation. One respondent in the ALLIANCE and Engender research, stated that:

'It feels like the world has moved on, while myself and other mums are still dealing with the emotional trauma of separation during what should have been the happiest times of our lives. It has stopped us trying for another baby.'

Whilst many health conditions or experiences can be defined by biological sex, there are many conditions where the impacts of sex-related physiological differences are less well known.

The Neurological Alliance of Scotland shared that assigned females are significantly more likely to experience certain neurological conditions than assigned males, including Multiple Sclerosis (MS), Myalgic Encephalomyelitis (ME), Functional Neurological Disorder (FND), migraine, and dementia. They also shared that certain neurological conditions are experienced differently between assigned males and assigned females, often leading to delayed diagnosis or misdiagnosis for assigned females specifically.

It is often unclear why assigned females are more likely to experience certain neurological conditions. In their groundbreaking Decode ME research with the University of Edinburgh, Action for ME have identified that approximately 80-84% of people with ME are assigned females. It also found that assigned females with ME tend to have more symptoms and greater symptom severity. Whilst the reasons for this are unclear, the discovery of eight genetic markers for ME through this study potentially paves the way for future research.

A further difference in health outcomes can be found in how assigned males and assigned females react to medications or treatments. This can be a major contributor to health inequalities, particularly when many treatments are not tested on assigned females as extensively as they are on assigned males, or trials don't record the sex or gender of subjects at all.

One participant of our research shared that much clinical testing is biased towards assigned males before it even reaches human testing. Many trials are conducted primarily on male mice, or the biological sex of the mice is not reported. This is an issue given that an academic study published in 2017 found that *'a large proportion of mammalian traits...are influenced by sex' and that this 'has implications for interpreting disease phenotypes in animal models and humans.'*

A 2025 article in the British Medical Journal reported that *'women comprise fewer than half of the participants in clinical trials'* and that this has *'created gaps in knowledge about women's health, as well as how sex and gender affect health outcomes for everyone'*. It further states that:

'The consequences of gaps in knowledge about sex and gender include misdiagnosis (for example, in cardiovascular disease, attention deficit-hyperactivity disorder, and multiple sclerosis), drug misdosing (for example, in the absence of sex specific treatment guidelines, unnecessarily high doses of drugs for heart failure cause increased adverse effects in women), and inappropriate treatments (for example, under-prescription of drugs for pain conditions for women).'

[8] Details of the survey can be found in Appendix 3.

Reflecting this, a representative from the Neurological Alliance of Scotland stated that:

> **'With many medicines, women are seen as 'little men' where dosage is based on the 'typical' 70kg man. This means that treatments for neurological conditions, which only exist for a few conditions, like MS, Parkinson's and epilepsy – are not necessarily designed with women in mind.'**

Similarly, a representative from Chest Heart and Stroke Scotland reflected on the fact that assigned females who have had a heart attack are less likely to be prescribed drugs that would prevent a recurrent episode. They stated that:

'Women are underrepresented in clinical trials and experience cardiac events differently from men. This, along with unconscious bias, is expected to be driving this decision making. But it is an area where more study is required to get the full scope of the challenges.'

Reflecting this, the aforementioned BMJ article suggests the need for innovative clinical trial designs which offer better representation of gender by simplifying eligibility criteria. It further suggests a more decentralised approach to clinical trials that 'meet patients where they are', as well as wider involvement of people with lived experience in the development of clinical trials.

Physiological differences in sex also have implications for the effects of recreational substance misuse. In 2025 the Scottish Recovery Consortium published Women in Recovery, a rapid review of evidence which found that:

'Physiologically women respond differently to substances than men, the evidence indicates drugs cause greater damage to their heart and vascular system and are more likely to die from an overdose compared to men.'

The review also found sex-specific medical problems arising from drug dependence, including increased infertility, risk of miscarriage, and premature delivery. These findings have considerable implications for how substance use/misuse is addressed in public health messaging and in how it is approached by alcohol and drug recovery services.

Finally, it is important to emphasise that the physiology of transgender and non-binary people can change significantly during their transition, creating new biological realities that need to be reflected in our health system. Following hormone therapy, for example, many transgender women will require breast screening. A representative from Scottish Trans highlighted the lack of clinical research in this space, and mentioned 2021/22 funding from Scotland's Chief Scientist Office for research into the long-term health outcomes for those accessing gender identity healthcare. Because of these, often poorly understood, physiological changes, it is often too simplistic to treat trans people according to their sex assigned at birth and more person-centred approaches are required.

It is clear from the evidence provided by our members that the physiological differences between individuals according to sex and gender have a considerable impact on health outcomes and experiences. Whilst some of these differences are expected, many are significantly less visible or understood. Despite these fundamental differences, much medical research does not adequately reflect sex and gender identity, leading to considerable gaps in knowledge and treatment pathways.

3. HEALTH INFRASTRUCTURE

This chapter explores the impact of Scotland's health infrastructure, by which we mean the environment, spaces, buildings, systems and services which exist to promote good health or facilitate access to treatment or support. This includes NHS systems and buildings, but also the many other places, spaces and systems which support or facilitate access to health-related activity. It is clear from speaking to our members that Scotland's health infrastructure has a tangible role in reinforcing health inequalities related to sex and gender.

Firstly, the NHS infrastructure presents considerable challenges, particularly when we consider the complexity of gender. One reason for this is that NHS systems and services tend to operate according to binary gender categories which can be particularly exclusionary for people who are transgender or non-binary. Every NHS Scotland patient has a unique 10-digit Community Health Index or CHI number. The CHI number identifies your gender, with the ninth digit being even for females and odd for males. This number is used to ensure that patients are correctly identified and indicates eligibility for many screening programmes. Trans and non-binary individuals can request that their CHI number changes when they transition, however for those who requested a change to their CHI number prior to 14th June 2015 this will have implications for the invitations they receive for screenings that are associated with biological sex.

A representative from LGBT Health and Wellbeing reinforced this point, and highlighted a NHS Scotland Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people from 2022 which found that:

> **'Trans men and women were not always being invited to attend screening appropriate to their anatomy, and the perception was that the onus was on the patient to remember to specifically ask for it. Trans men and women recognised the importance of having screening tests, but were concerned they would not remember to ask for them, and also had anxiety about having tests/ procedures which were discordant to their gender identity.'**

Further to this, a representative from Scottish Trans stated that the NHS digital infrastructure, which operates on a binary male/female system, is a significant barrier to the provision of person-centred health care in a range of ways. In the development of a policy for trans people to donate blood, for example, the IT infrastructure was a major barrier because donor sex could not be recorded accurately for medical purposes whilst respecting gender identity. This is reinforced in a 2023 Association for Blood Donor Professionals case study, which stated that *'this [scenario] highlights how deeply ingrained binary gender systems are in our infrastructure, potentially impeding progress across various sectors'.*

The complexity of gender in Scotland is better reflected in how the third sector records gender. Indeed, in our survey of members to inform this research, none of the respondents use binary categories based on biological sex to record gender identity. Instead, 71% provided multiple choice inclusive gender options, and 21% invite people to 'self-describe'.

The physical health infrastructure also presents barriers to people who are trans or non-binary. A representative from Breast Cancer Now raised that breast screening services, particularly waiting rooms, tend to be perceived as 'women only spaces'. Whilst this will be a barrier for many trans and non-binary people, it could be a barrier for men who are diagnosed with breast cancer. The representative added that:

'a lot of people who might be experiencing gender dysphoria, they're not going to want to be perceived in that space...and they're going to just think I'm not going to go.'

Another challenge presented by the physical infrastructure of the health system is that hospital wards are organised according to binary sex categories. One respondent to our research from Scottish Trans shared anecdotal evidence of several transgender people choosing not to be admitted to hospital because they would be placed on a ward that does not align with their gender.

There is a lack of Gender Identity Clinics (GICs) in Scotland, and a lack of capacity within GICs to offer appointments in a timely manner, meaning that many people in the trans community face long waits to access support for their transition. The Sandyford GIC in Glasgow is a well-publicised example of this. It is the only clinic for young people under the age of 18 in Scotland and, according to the Scottish Trans website, current waiting times for a first appointment are four years for young people and over five years for adults. However, over 4000 people were reported to be on the waiting list for a first appointment at the Sandyford Clinic in 2025, and a representative from Scottish Trans shared that a person joining the waiting list now would wait at least 80 years for a first appointment. All other GICs in Scotland have waiting times of around two years.

The implications for the trans community as a result of these waiting times are stark. The 2022 Health Needs Assessment found that 15% of individuals referred to the GIC had bought cross-sex hormones online, and many accessed private treatment at great financial cost. One respondent to the Health Needs Assessment stated:

> **'I'm still on the waiting list for the (GIC). I've still not got a date for my initial appointment and I've waited 22 months, so I'm temporarily seeing a private specialist... That is having a huge financial impact, and that's been one of my biggest worries. I had some savings and they've been depleted to zero. I think I can continue to have the private treatment until the end of the year, but if I haven't transferred to the NHS by then I'll have to sell my flat.'**

It also found that many trans people experience suicidal ideation, although this tended to subside after transition. Nearly half (49%) of 'trans-masculine men' and 39% of 'trans-feminine women' reported that they had attempted suicide.

Barriers presented by a lack of dedicated capacity and resource in the NHS are also regularly experienced by cisgender women. In the Age Scotland 2025 Big Survey of Older Adults, 60% of respondents felt that there was not enough information or support available to help with symptoms of the menopause. In addition, a representative from The ALLIANCE highlighted findings in the Independent Forensic Mental Health Review that there is not currently a forensic mental health facility for women in Scotland. The report found that:

'The lack of high secure provision for women within Scotland was universally seen as unacceptable.'

And that:

'The Review heard from clinical teams and relatives of women who had spent years being moved from service to service to try to access the care and treatment they needed.'

This review took place between 2019 and 2021. The Scottish Government announced in early 2025 that they will develop a high-secure provision for women in the State Hospital.

Another example of NHS infrastructure gaps relates to women who experience miscarriage or baby loss. This includes a historic lack of dedicated private spaces, separate from wider maternity services, in many hospitals for those who have experienced a loss. Several of our members have worked closely with the Scottish Government to improve experiences, including The Miscarriage Association and Held in Our Hearts who contributed to the Framework for Miscarriage Care in Scotland which was published in September 2025. The Framework states that:

'Women/couples who wish to avoid walking through areas where there are other pregnant women should be given the choice of using a different exit, or if that is not possible, they should, if they wish, be compassionately accompanied through the shared area rather than being left to walk alone.'

Held in Our Hearts have additionally worked closely with NHS Lothian to provide essential supplies in family rooms, including hand-knitted clothes and moses baskets. They also fundraised to provide a cold cot at St John's Hospital and a cuddle cot at the Royal Infirmary Edinburgh. These allow bereaved families to grieve with their infant for longer.

It is important to also explore potential gender-related barriers presented by the wider societal infrastructure which impacts on health. It was noted in the Population Health Framework, published in June 2025, that as much as 80% of what affects health happens outside the health and care system. The Population Health Framework also focused heavily on the need to shift to a prevention-centred health system.

Some examples of gender-specific barriers presented in the wider health infrastructure relate specifically to accessing physical activity. The 2024 Scottish Health Survey found that women were less likely than men to meet the recommended levels of physical activity – 58% compared with 66% of men.

Walking Scotland, in their 2025 Walking and Wheeling Survey, found that 39% of women would be more likely to walk or wheel more often if they felt safer when walking after dark, compared with 24% of men. Similarly, 28% of women said that they would be more likely to walk/wheel if there was better lighting along pavements and paths in their local area, compared with 20% of men. In a similar vein, the 2022 LGBT Health Needs Assessment found that only 5% of trans women currently go to the gym but 39% would like to.

There are also clear links between gendered health outcomes and socio-economic status, with people living in Scotland's most deprived communities and those on low incomes significantly more likely to experience poor health. Life expectancy in the most deprived areas of Scotland was 10.5 years lower for females and 13.2 years lower for males than in the least deprived areas in 2022-2024.

The Scottish Health Equity Research Unit (SHERU) published their 2025 Inequality Landscape Report in September 2025. This showed that health and income are inextricably linked. The report states that:

'Limited income makes it harder for people to adopt healthy behaviours and creates stress for households struggling to make ends meet. There are obvious negative outcomes from this: people may struggle to afford essentials like food or heating. Perhaps less obviously, the gap between those with low incomes and those with middle or higher incomes can also lead to social isolation – a factor that negatively impacts health.'

Data from Carers Scotland suggests that 28% of unpaid carers live in poverty – as many as 100,000 people. Given that 73% of carers are women of working age, this will heighten their inability to access health care. National figures for breast screening in 2020-2023 published by Public Health Scotland show that women from more deprived areas were significantly less likely to attend for breast screening, with only 64.2% going for screening compared with 82.8% of women living in the least deprived areas.

A representative from Breast Cancer Now highlighted 'train the trainer' pilots that they are undertaking to improve breast screening uptake amongst underrepresented groups, with a whole section exploring potential barriers. They further spoke about the key role of Community Link Workers in addressing barriers in community environments.

Similarly, economic inequality is a key driver of violence against women and girls (VAWG). A 2025 parliamentary briefing published by Engender exploring primary prevention of VAWG shared that 'the root cause of VAWG is gender inequality', and that women who are financially insecure are more likely to experience VAWG. For example, women with no recourse to public funds, meaning that they cannot claim most state benefits, tax credits or housing assistance in the UK, are three times more likely to experience VAWG.

Whilst women are vulnerable to the impacts of poverty on their health, the 2025 SHERU Inequality Landscape Report also found that one of the most vulnerable groups when it comes to the impacts of poverty are young men. They add that this represents a policy 'blind spot'. Young men from deprived communities often face exclusion from education, employment, housing and mental health.

The report further found that young and middle-aged men, particularly those from deprived areas, are more likely to not attend hospital appointments, and more likely to have 'deaths of despair' – suicide, drug or alcohol-related deaths. This is reflected in the rate of probable suicide mortality in Scotland, which showed that the rate for males was 2.9 times the rate for females in 2024.

Families Outside shared that the criminal justice system is a further driver of income-related health inequality. Indeed, they report that the impacts of imprisonment have a disproportionately detrimental impact on women. A representative from Families Outside shared that:

> **'Women experience significant harms across the justice system, as victims, perpetrators of crime, and as those impacted by a family member's imprisonment. These harms are often distinct from those experienced by men and intersect with poverty and existing trauma.'**

They also shared that women who encounter the justice system are more likely to be the sole carer for a child, and only 5% of children remain in the family home when a mother goes to prison leading to considerable trauma.

A 2022 Families Outside report further found that the costs of supporting a family member in prison fall disproportionately on women, negatively impacting their health and wellbeing. Indeed, 96% were living in absolute poverty, and supporting a family member in prison incurs considerable costs including travel for visitation.

The housing infrastructure in Scotland also has a considerable impact on gender-related health outcomes, although this is not well understood. Homelessness data from the Scottish Public Health Observatory shows that 58% of main applicants in households assessed as homeless or threatened with homelessness in 2023/24 were men, and 68% were single households, primarily single men. In addition, 2024 homeless death statistics found that 78% of homeless deaths were male. These figures would suggest that homelessness primarily affects men, but the reality is quite different.

An Engender publication on this theme found that the way homelessness is measured in Scotland means that the extent and nature of women's homelessness is not well understood. The report further shares that women are more likely to experience housing affordability problems, but that their housing instability is often 'hidden'. These findings have implications for gender-related health inequalities given that housing has been identified as a key determinant of health in both research and policy, including in the Population Health Framework.

Whilst the examples above do not represent a holistic view of the infrastructure-related causes of gender health inequality, they are indicative of a wider challenge, particularly for women and transgender or non-binary people. They demonstrate the presence of systemic and structural barriers in the NHS which perpetuate gender inequality, often the result of resource or capacity challenges. They also point to barriers in the wider Scottish landscape which have an indirect impact on the health of people according to their gender.

4. HEALTH WORKFORCE

During our research we uncovered evidence of significant gender bias and misogyny in the wider health workforce. In our survey to support this research, 'lack of staff understanding of unique needs' was the most commonly reported barrier people face when accessing services, with 'discrimination or stigma' a close second.

This is particularly prevalent in the treatment of women and trans or non-binary people, although we have also found evidence of bias in how men are treated for particular conditions. It is important to note that the experiences referenced in this chapter are likely reflective of a minority of frontline healthcare workers, but the presence of bias is clearly prevalent enough to impact perceptions and experiences of health services.

Evidence of misogyny, or prejudice against women, in Scotland's health system is extensive. We heard numerous examples from VHS members of women reporting being misdiagnosed, excluded, or dismissed by medical professionals. One respondent referred to this as 'institutional gaslighting'.

The Young Women's Movement gathered considerable evidence on this theme for their Status of Young Women in Scotland 2024-25 report. This shared that many young women feel that they are not taken seriously, that their health concerns are dismissed, and that their symptoms are minimised. One respondent stated that:

'As a young woman in Scotland I feel some services do not take me seriously when I approach them... I feel I am brushed off quite often when I contact doctors about my mental health. I personally believe I need a further diagnosis but have struggled to gain this from a GP.'

This is further reflected in a response to our survey to support this research, where one respondent stated that:

'We hear of women not able to receive support for their perimenopause symptoms, their difficulties accessing interventions like HRT, challenges finding suitably trained health professionals, being dismissed by professionals, and their symptoms not viewed holistically.'

A representative from Chest Heart and Stroke Scotland further reported that:

'Women living with several of CHSS's conditions find they are less likely to receive the treatment they need in both acute care as well as secondary and/or tertiary prevention. It may be that they can access services, but do not receive the same treatment as men.'

They shared evidence that women who have an intracerebral haemorrhage are less likely than men to receive care in line with stroke standards, and that stroke survivors who are women are less likely to be prescribed medication aimed at reducing the risk of future strokes.

Women are also less likely than men to be prescribed treatment to prevent future heart disease. In response to this, CHSS have developed a training module for health professionals looking specifically at women's heart health and in its first year this module was accessed over 10,000 times. They have also developed their own Women's Health Action Plan to support the actions and recommendations identified in the Scottish Government's Women's Health Plan, including prioritising training for health professionals and improving public awareness, and a refreshed CHSS Women's Health Action Plan will be published later this year.

A similar picture can be seen with women accessing end of life care. A representative from Marie Curie shared that women often have to report greater symptom distress to be taken seriously for pain management at the end of life. This is reinforced by a 2022 academic scoping review exploring gender disparities in end-of-life care, which found that women are *'routinely under-treated for pain'* despite being more likely than men to ask for pain relief.

The presence of bias within the health workforce is not just limited to the experiences of women. A representative from CAPS Advocacy cited an unpublished collective advocacy project which found that men who present with eating disorders *'either were dismissed or didn't get taken seriously by GPs or other healthcare professionals'.*

There is also evidence of bias experienced by people who are trans or non-binary when they seek medical support. One participant in our research said that accessing support with gender transition *'comes down to the lottery of do you have a sympathetic GP or not'.*

The Scottish Trans and Non-Binary Experiences Report found that 61% of trans and non-binary people avoid services due to fear of harassment and fear of being misunderstood. Similarly, a scoping review co-produced by LGBT Health and Wellbeing and the Glasgow Centre for Population Health found that:

> **'the predominant hetero- and cis-normative culture within healthcare settings...can create discriminatory, homophobic and transphobic patient interactions... These themes lead to LGBT+ users of healthcare services in the UK, and beyond, not accessing or delaying vital care when it is needed, and a lower uptake of generic public health messaging, screening initiatives, and vaccination efforts.'**

The evidence collated regarding the prevalence of bias and misogyny in the health workforce in Scotland is indicative of the need for people to have choice and continuity in who treats them. Indeed, several participants in our research discussed the importance of relationship-building and trust in the delivery of health care.

This aligns with the principle of Realistic Medicine, whereby all decisions about a person's care should be made jointly between the individual and their healthcare team. However, our members shared that this is not always enacted in practice, particularly when accessing GP services. One respondent shared that:

> **'It's not so much that I need an appointment this week, it's far more important to me that I see my chosen doctor and I'm sure that's many people's experience because none of us walks in with just a single health condition. We walk in with a health condition plus an entire medical history.'**

This is also reflected in research completed by The ALLIANCE and Engender about access to pregnancy and maternity services during the Covid-19 pandemic. Many respondents interacted with multiple midwives, and this had an impact on their ability to develop trusting relationships.

The 2025 Realistic Medicine survey of health professionals provides an insight into why one of the central tenets of Realistic Medicine – person-centred care – can be difficult to implement in practice. Insufficient time was the most commonly selected barrier for GPs (63%), Pharmacist / Pharmacy Technicians (63%), Resident Doctors (59%) and Consultants (53%). One respondent stated that:

'In the current working environment and constant crisis mode, it's hard to see how staff can be enabled to practise Realistic Medicine really and truly.'

When clinicians are experiencing increasing pressures on their time, this hampers their ability to build meaningful relationships with patients and could explain why so many people report experiencing care based on gender-related bias.

This could be partially mitigated by more widespread access to a Community Link Worker. According to the VHS Essential Connections Report published in Nov 2023, approximately 80% of GP practices in Scotland currently have access to a Community Link Worker.

The MOU for the 2018 General Medical Services contract describes a Community Link Worker as:

'a generalist practitioner based in or aligned to a GP practice or Cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality.'

People need time and continuity of care to feel seen and heard. An increasingly high proportion of GP consultations include discussions around non-clinical issues which may have a significant impact on an individual's health and require non-medical interventions to be resolved. Community Link Workers are usually part of the Multi-Disciplinary Team in Primary Care, and therefore have the potential to provide person-centred insights to wider clinicians.

Roisin Hurst, Project Manager for the Scottish Community Link Worker Network comments:

'Community Link Workers are a fantastic resource within primary care. Unlike with short 10 minute GP appointments, Community Link Workers can spend several weeks really getting to know someone and understanding their issues. They take a person-centred approach to supporting patients with non-medical issues and help them to engage with services in their local area. They really are the essential connectors in their local communities.'

Whilst the evidence above represents a series of snapshots regarding apparent gender-related bias in the provision of healthcare, it does point to a wider issue that is pervasive enough to impact perceptions of care. Of course, not all clinicians will operate based on gender stereotypes. However, it clearly occurs frequently enough to create a perception of bias and misogyny that undermines trust in the health system for many.

5. SOCIETAL NORMS AND STIGMA

Many of the stereotypes explored in the previous chapter have roots in wider societal norms relating to gender. Indeed, many of these norms are pervasive and often internalised, leading to considerable impacts on health outcomes for people of all genders.

A social norm that is particularly damaging from a health perspective is that women tend to assume more responsibility for parental and/or unpaid caring roles. This is reinforced in data which shows that the majority of unpaid carers are women. The 2023-24 Carers Census shows that almost three quarters – 73%- of unpaid carers are women. Similarly, a representative from Family Fund, which supports families of seriously ill and disabled children, reported that 95% of respondents to their 2025 Cost of Caring Survey were women.

This may be a result of internalised assumptions about who should provide care, but it can also be traced to systemic reinforcement of gender norms. A representative from Carers Scotland shared evidence from the State of Caring Report survey for 2025 that fewer female respondents were asked if they were willing to provide unpaid care than male respondents – 13% compared with 20% – when an individual was discharged from hospital. This suggests that women are more likely to be presumed as willing carers than men, however this data is skewed by the fact that the survey was overwhelmingly completed by women.

The representative from Carers Scotland reflected on this trend, and shared that:

> **'There's a systemic bias against women and I think that comes from the societal expectation that women provide care, that women are automatically nurturing, that women are automatically able to not feel uncomfortable about things like providing personal care. And I think that all of these different messages play into how the health service potentially interacts differently with male carers compared to female carers.'**

This imbalance in the make-up of unpaid carers in Scotland has particular implications for health inequalities because unpaid carers are less able to seek or access health services or wellbeing-related activity. In the Carers Scotland State of Caring 2025 report, approximately one third of unpaid carers reported that they had bad or very bad physical health and/or mental health. Many unpaid carers reported ignoring their own health needs because of the demands of caring, and of these health needs being exacerbated by their caring role. One unpaid carer reported having *'no time to work on my own health and the duties of caring have worsened my health significantly'.*

The representative from Carers Scotland further reflected that the trend for women to have children later in life has led to 'sandwich caring' whereby people – often women – have caring responsibilities for both children and older relatives. This further compounds the impacts of caring on the ability for women to prioritise their own health, including the socio-economic impacts explored in Chapter 3.

Another reflection of the impact of societal gender norms on health outcomes can be seen in access to end-of-life care. A representative from Marie Curie highlighted that men tend to be referred for end-of-life care later because they are more likely to have been cared for at home by a partner or spouse. This can be somewhat explained by varying life expectancies between men and women given that men are more likely to die earlier.

However, the representative from Marie Curie reflected that women are also likely to present earlier for end-of-life care *'for reasons of not wanting to feel like a burden [on loved ones]'*. Indeed, a literature review completed in 2022 found that traditional gender norms and expectations do have a significant impact on end-of-life choices. It identifies studies that suggest women are *'worried more about being*

a burden' and that health care providers *'delegate more work to female care givers'*. It also found evidence that women experience an *'expectation to provide care so [their] husband can have a good death'.*

The Scottish Partnership for Palliative Care shared an article exploring the 'neglect' of gender in palliative care research. It found that societal concepts of 'duty' can have considerable impacts on gender roles in an end-of-life context. It states that:

'There is evidence that doing 'what a wife is supposed to do' can carry significant responsibilities within a heteronormative end-of-life context for some women. It is not just expected that a wife will provide care but will provide a certain type of care which will realise a husband's vision for a 'good death'.'

Social norms also have a detrimental impact on the health outcomes of men. In particular, there is considerable evidence that men are less likely to seek medical help, particularly for mental health issues. In 2022, See Me partnered with the Mental Health Foundation, Glasgow Caledonian University and The Lines Between on the Scottish Mental Illness Stigma Study. This found that men may be less likely to receive a diagnosis of mental illness due to *'gender stereotypes which deny them access to vocabularies of distress'*. It further adds that this *'may be linked to the finding that women are more likely than men to seek help and access Primary Care support.'*

The impact of gender norms restricting access to certain health services for men is further reflected through the Scottish Community Link Worker Network. There is anecdotal evidence that men are significantly less likely to be referred to a Community Link Worker than women. This could be caused by clinician bias or by men not accepting this type of support. One Community Link Worker stated that:

'Those men that we are referred, for some reason they just will not take up the service. There's still this stigma with men and mental health issues. It's like 'no, no, I don't need support.'

This reluctance to access support is reflected in figures from Held in our Hearts, a baby loss charity. They found that uptake of their services was significantly lower for men. For example, only 6% of peer support sessions were for dads only, and 19% of counselling sessions were for dads only. One dad in his testimonial said that:

'I try to be supportive but how do you support your wife through this, where do you start. I'm not the priority here.'

In March 2026, the Patient Charter for Miscarriage Care in Scotland was published. This is a groundbreaking and important document that has been developed in partnership with several third sector organisations, including two VHS members. However, whilst the Charter states that it is *'for both women and their partners'*, the wording of the Charter is almost entirely focused on women. It repeatedly uses the word 'you' to refer only to the woman, with phrases like *'if you get pregnant again'* or *'if you are spotting or bleeding'*. Using language that centres the woman in a Charter that details sources of support that are purportedly for both parents following a miscarriage could perpetuate the norm that miscarriage support is only for women.

Reflecting on this, representatives from Baby Loss Retreat emphasised the importance of language in overcoming the perception that baby loss support is primarily for women. They also spoke about the importance of tailoring support, recognising that men might require a different approach to women. They are exploring a male-only section on their app, which is currently in development, as well as offering flexible support for men led by a male employee.

The internalisation of societal norms is recognised by the Scottish Men's Shed Association which promotes men's health and wellbeing though a network of over 200 Men's Sheds. Given the hesitancy of many men in accessing support for their mental wellbeing, the Scottish Men's Shed Association manifesto speaks of a 'health by stealth' model, whereby men receive wellbeing benefits in an indirect way by participating in activities which interest them. Similarly, their 2026 'Silent No More' Campaign is advocating for a men's Health Plan to address this *'silent health crisis'.*

There is also a persistent barrier for trans and non-binary people related to wider societal norms and stereotypes. The 2024 scoping review exploring the social determinants of LGBT+ health and wellbeing found that:

> **'it is evident that transgender people appear to endure the worst forms of societal, political, institutional and interpersonal discrimination, exclusion and microaggression.'**

It further found that:

'trans people are further stigmatised, sensationalised, misunderstood, and mischaracterised within the media, political discourses and across all facets of public life'

The constant exposure to such narratives has a 'profound' impact on the mental and physical health and wellbeing of trans and non-binary people. In fact, one study found that *'the psychologically and cognitively corrosive impacts of life-course exposure to discrimination and microaggressions'* is linked to higher rates of common forms of dementia in older LGBT+ communities.

This level of societal and institutional discrimination of trans and non-binary people has a considerable impact on their likelihood to seek help for their health. As reflected in Chapter 4, evidence from Scottish Trans suggests that 61% of trans and non-binary people avoid services due to fear of harassment or of being misunderstood.

In 2024, the University of Glasgow completed a realist review of literature to better understand the causes of 'missingness', or the repeated non-attendance of health appointments in primary care specifically. The report identified that a significant factor in a patient's decision to engage is whether they feel that the service is *'for me'*. It further states that:

'The internalisation and anticipation of stigma or hostility is thus a central part of missingness, resulting in reactive avoidance to prevent relational threat or the threat to identity, even in circumstances of urgent need.'

The report also identified the presence of practical or time-related barriers to attending appointments. It states that *'multiple urgent and competing priorities might result in reduced prioritisation of health or appointment attendance relative to other needs'* and specifically references that *'caring responsibilities take precedence'*. It further found that primary care in the UK is a 'gatekeeper-led' system with complicated appointment systems which do not always offer timely appointments or patient choice. This could result in situations where *'patients may not be able to reconcile attendance with competing demands or with the rhythms and patterns of their lives.'*

It can therefore be concluded that gender-related societal norms and stereotypes play a considerable role in health experiences and access to health care. Women are often less able to prioritise their own health because they tend to assume caring responsibilities, whilst men and trans/non-binary people are more likely to avoid seeking healthcare due to internalised stigma and widespread societal prejudice. This often manifests in 'missingness' from the health system.

6. INTERSECTIONAL BARRIERS

It is clear from the evidence provided by our members that sex and gender contribute to significant health inequalities in Scotland. However, when gender inequalities intersect with other protected characteristics, the potential harm to health is often compounded or magnified. This chapter will explore intersectional health inequalities where gender combines with other forms of identity leading to more detrimental health experiences.

One protected characteristic that seems to heighten gender-related inequalities is age. Specifically, older women seem to be at increased risk of gender-related bias, and this can present as health 'rationing' for some. In an unpublished Age Scotland report to support Phase Two of the Women's Health Plan, many focus group participants reported that the quality of health care for older women is average or poor. This was because health concerns were dismissed, sometimes in a patronising way, by health professionals as 'wear and tear'. Age Scotland refer to this as a form of ageism. One focus group participant stated that:

> **'There's an assumption that because you are older and you're a woman that, you know, there is going to be bits of you that are worn out and you've just got to face it.'**

The report also found that stigma around mental health makes it more difficult for older women to ask for support, and that a greater focus is needed on health challenges post-menopause, including bone density and mental health.

A representative from Age Scotland also spoke about perceived ageism amongst older women regarding breast screening age limits. Currently, breast cancer screening is not routinely offered over the age of 70. On the NHS Inform website, it states that this is because *'there is not clear evidence that the benefits of screening people in this age-group outweigh the potential risks of harm'*, however the risk of breast cancer increases with age. This Cancer Research UK report states that:

> **'Older women have poorer knowledge that breast cancer risk increases with age, and this may be due to women incorrectly assuming they are no longer at risk of developing the disease after routine NHS breast screening invitations have ended.'**

One participant of our research further highlighted the potential impact of breast screening age limits for trans and non-binary people in particular. This is particularly prevalent for trans women and non-binary people assigned male at birth who are taking hormonal treatments. According to Breast Cancer UK, they may have an elevated risk of breast cancer compared to cis men but the long-term effects of hormone treatment are not well understood. Indeed, the intersectional barriers experienced by trans and non-binary people are a considerable evidence blind spot and urgently require additional research.

Continuing on the theme of age, it has been previously explored in Chapter 3 that working-age men are more likely to have 'deaths of despair'. Researchers from Glasgow Caledonian University have sought to better understand why younger men do not engage with Men's Sheds, and have created factsheets detailing interventions that will help to attract younger men.

Women with disabilities are likely to have negative health outcomes or experiences due to a combination of misogyny and ableism. This is particularly prevalent for women with learning disabilities accessing gynaecological or reproductive care. Engender partnered with the Scottish Learning Disabilities Observatory in 2018 to publish the 'Our Bodies, Our Rights' report. This found that support for disabled women was often impacted by ableist stigma.

It spoke about *'infantilising'* treatment where *'doctors and other practitioners have made assumptions about [disabled women's] fertility, capacity and desire to parent.'* It further stated that:

'Disabled women report frequently facing pressure to terminate their pregnancies, from doctors, guardians, social service workers, parents and carers. Much of this pressure stems from misconceptions about their roles in society, their abilities and even the inheritability of certain impairments or conditions.'

Similar themes can be found in the experiences of migrant women, particularly women of colour, navigating maternity services in Scotland. The latest Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK) report for 2023 found that still birth and neonatal mortality rates in the UK remain significantly higher for ethnic minority groups. The reasons behind these statistics were referred to by MBRRACE-UK as a 'constellation of biases' where women faced multiple inter-related challenges.

In their 2024 'Birth Outcomes and Experiences Report', Amma Birth Companions found that practice issues or discrimination affected 37% of 76 recorded cases. Issues included lack of attention, delayed pain relief, inadequate consent, communication challenges, disregard for preferences, and insensitive or disrespectful behaviour. One Birth Companion who contributed to the report stated:

'[Client] said she didn't have a good experience with the doctor. He was very irritable and asked why she was there. She said he wasn't speaking very nicely and seemed annoyed. He said he could do a procedure during the C-section to stop her having any more children. When [client] said she didn't want this, he said they will have to organise contraception as she shouldn't have any more children.'

When we spoke with representatives from Amma Birth Companions to inform this research they shared further examples of systemic bias around maternity care in Scotland. For example, decisions about inducing labour are often informed by baby size charts that are based on white babies. They also spoke about the challenges gaining *informed* consent from migrant birthing mothers on issues like pain relief and contraception due to language or cultural barriers. However, they shared that the publication of the Birth Outcomes and Experiences report has had a considerable impact on service provision in Glasgow, and Amma Birth Companions have worked proactively with NHS Greater Glasgow and Clyde to address the issues raised.

Continuing the theme of migrant women, a representative from LGBT Health and Wellbeing shared that LGBT women seeking asylum experience significant health and wellbeing inequalities. This includes high rates of mental ill health, suicidal ideation and self-harm. They spoke about medical misogyny *'intersecting with racism and queer phobia'* and common stereotypes regarding asylum seekers, creating the conditions for inadequate health experiences. LGBT Health and Wellbeing have a specific 'New Scots' Project providing emotional, practical and legal support to LGBTQ+ asylum-seeking people.

Our members have also shared evidence of the poor health outcomes experienced by men as a result of ethnicity. A clear example of this can be found in research projects undertaken by Feniks, in partnership with both NHS Scotland and See Me in 2018 and 2020, which found that suicide rates for Polish men were almost twice as high as the rate for Scots. It further found that this relates to internalised gender stereotypes preventing Polish men from seeking help, coupled with heightened loneliness and isolation.

In addition, we heard anecdotal evidence from a Community Link Worker that men from the Gypsy/Traveller community can be less likely to access Primary Care. She stated that:

> **'I covered a settled travelling community when I was a community link worker and actually for me the real barrier was within primary care and some of the challenges that they had getting registered, filling out forms. So their preference was always to wait until a limb was hanging off and turn up at A&E, so they would be known to A&E departments and never seen by a general practitioner... It's definitely a gender issue because the GP would actually go in [to the Traveller site], so it wasn't that the GP wasn't accessible, but that the males just wouldn't engage.'**

A combination of practical challenges such as difficulties navigating GP registration processes and gender-related norms around helpseeking behaviour may contribute to lower engagement with general practice. As a result, some individuals were reported to delay accessing care until their health needs became more acute, at which point they were more likely to present at Accident and Emergency services.

While primary care services and outreach were available, male residents were less likely to engage with these routes of access. This may contribute to patterns of service use that rely more heavily on urgent and emergency care rather than planned or preventative support.

This is further reinforced in 2022 research from England and Wales exploring Gypsy/Traveller lived experiences of health, which found that participants reported accessing healthcare only when very unwell, and that delayed health seeking is particularly described among men. It further found that lack of access to female health practitioners undermines the seeking of healthcare for women in the community too.

Some intersectional barriers are less well understood, despite us having clear evidence of their presence. For example, the 2022 LGBT+ Health Needs Assessment found that bisexual women have disproportionately high levels of negative health outcomes. They are more likely to report depression, self-harm, disordered eating and being in abusive relationships. The reasons behind these findings are unclear, but the difference is significant enough to indicate considerable health impacts.

This reflects a wider issue about the availability of evidence on intersectional health inequalities. During this research, we heard of several examples of VHS members undertaking or prompting research on intersectional health issues because the national data could not be adequately disaggregated. A representative from The ALLIANCE stated that:

> **'Not only do we have data gaps, but where we have data, particularly when you're talking about disaggregated data, it is not statistically significant enough for us to base anything on it. That's also coupled with a too easy dismissal of the qualitative evidence.'**

They further added that:

'I think that the third sector particularly has done a very good job of trying to fill some of those data gaps in relation to the research that it has done, whether as providers of services or as advocacy, lobbying and policy making organisations.'

This reflects an important point about intersectional health inequalities more broadly. It is clear from evidence provided by our members that intersectional inequalities, where gender is a considerable factor, are significant in Scotland. However, national statistical data is insufficient for understanding the true impact of these inequalities. If we do not fully understand how different forms of identity, bias, or discrimination intersect and compound health inequalities, identifying solutions becomes more challenging. The third sector clearly has a vital role in promoting greater understanding of intersectional health inequalities in Scotland, and in improving health experiences.

7. RECOMMENDATIONS

This research has uncovered significant sex and gender-related health inequalities in Scotland. Whilst progress has been made to understand and address these, much more still needs to be done.

We have identified six recommendations that the Scottish Government, NHS Scotland, and the wider health system in Scotland should take forward to address the inequalities detailed in this report.

1. ENSURE THAT HEALTH POLICY REFLECTS THE TOTALITY OF SEX AND GENDER-RELATED HEALTH INEQUALITIES.

The successful implementation of Realistic Medicine principles in Scotland's health system, specifically person-centred care, requires policy that reflects the social determinants of health, including sex and gender.

All health policy must adopt a sex and gender lens, and there is a key role of Equality Impact Assessments in surfacing sex and gender-related health inequalities. However, there is also a need for targeted health policy that is evidence led, asset-based, and informed by voices of lived-experience to address deep-rooted systemic inequalities.

The Women's Health Plan is a welcome and necessary development which fulfils a significant role in responding to known inequalities in women's health. However, future iterations of the plan should reflect some of the root causes of misogyny in the health system, including greater recognition of intersectional barriers that many women experience.

It is also important to recognise that sex and gender inequality in the health system is not limited to women. Targeted policy is required to address the considerable inequalities experienced by trans and non-binary people in accessing health care that is free from stigma and discrimination.

It is vital that the specific inequalities experienced by men are afforded dedicated policy interventions. Men require targeted support with their mental health, particularly younger men experiencing socio-economic exclusion.

2. ENSURE THAT HEALTH RESEARCH AND DATA REFLECT THE IMPACT OF SEX AND GENDER ON HEALTH EXPERIENCES AND OUTCOMES, INCLUDING HOW SEX AND GENDER INTERSECT WITH OTHER PROTECTED CHARACTERISTICS.

It is evident that considerable knowledge gaps exist regarding the impact of sex and gender on health. Further steps are required to ensure that clinical trials seek to achieve sex and gender balance, and that the impact is recorded in the results. This includes better reflecting the impact of biological sex, particularly for women at different life stages, but also the impact of physiological changes resulting from gender affirming healthcare.

Action is also required to ensure that population level research and datasets reflect sex and gender-related health experiences, as well as how sex and gender intersect with other protected characteristics. Such data should also be transparent and accessible to ensure that all sectors, including the third sector, can use it for inclusive service design.

3. ENSURE THAT THE WIDER HEALTH WORKFORCE IS REQUIRED TO UNDERTAKE TAILORED TRAINING ON THE SPECIFIC IMPACT OF SEX AND GENDER ON HEALTH OUTCOMES AND EXPERIENCES, IN LINE WITH EFFORTS TO EMBED REALISTIC MEDICINE.

It is clear that there is a lack of consistent understanding within the health workforce regarding the impact of sex and gender on health outcomes, and the importance of sex and gender as key considerations in person-centred care. Mandatory training should be developed for the wider health workforce, at all levels and in all sectors, that addresses the cross-cutting themes identified in this report and raises awareness of the impact of social norms, stigma, and discrimination.

Further, tailored learning opportunities should be developed, in partnership with third sector organisations, that reflect the impact of sex and gender in specific health specialisms. The CHSS e-learning module on women's heart health is an example of how this could work in practice.

4. INVEST IN DEDICATED SYSTEMS, SERVICES AND SPACES THAT ADDRESS COMMON SEX AND GENDER-RELATED BARRIERS THAT CONTRIBUTE TO 'MISSINGNESS' IN HEALTHCARE.

Too many barriers to positive health experiences and outcomes originate in our health infrastructure – the systems, spaces, and services that underpin our health system.

Planned improvements in NHS digital infrastructure must better recognise the complexity of sex and gender identity. The binary nature of how sex/gender is recorded in digital systems is a considerable barrier to providing person-centred health services. In addition, the ongoing improvement of patient data tools, including the MyCare.scot app, must better facilitate patient data-sharing and support patient choice in accessing healthcare services.

Dedicated gender-specific services and spaces are required to ensure patient accessibility and safety, both in the public and third sectors. This includes dedicated trans health clinics, inclusive wards for inpatients that respect gender, inclusive screening services, and mental health and alcohol and drug recovery services that are tailored to sex/gender differences.

5. INVEST IN CAMPAIGNS TO RAISE PUBLIC AWARENESS OF THE IMPACT OF SEX AND GENDER ON HEALTH EXPERIENCES AND OUTCOMES.

Many of the issues explored in this research are not well understood by the population in Scotland. Increasing knowledge of this will empower people to make informed decisions about their health.

It is vital that efforts are made to increase public awareness of how health outcomes and experiences are impacted by sex and gender through dedicated public campaigns which also signpost to relevant sources of support, many of which can be found in the third sector.

It is also important to ensure that more generic public health campaigns are cognisant of the varying impacts of sex and gender, providing specific guidance on symptoms, impacts and treatments.

Finally, public campaigns that raise awareness of sex and gender-related rights and protections will ensure that people can self-advocate if they believe that their right to health has been compromised or that they have experienced discrimination.

6. RECOGNISE THE VITAL ROLE OF THE THIRD SECTOR IN UNDERSTANDING INTERSECTIONAL HEALTH INEQUALITIES, PROVIDING INCLUSIVE SERVICES AND AMPLIFYING VOICES OF LIVED EXPERIENCE.

Perhaps the most important lesson from this research is the vital role of the third sector in understanding and responding to sex and gender-related health inequalities. Third sector organisations provide inclusive and trusted services that reflect the complexity of the relationship between sex, gender and health.

They are also a rich source of data in understanding intersectional health inequalities and regularly provide a bridge between policy-makers and people with lived experience. This was evident in the range of third sector organisations that contributed to the development of Phase 2 of the Women's Health Plan.

With this in mind, it is vital that third sector organisations are meaningfully consulted in the formulation of all health policy, that their research and insight is given equal weight to other data sources, and that they receive dedicated sustainable funding for the provision of gender-inclusive services.

CONCLUSION AND NEXT STEPS

It has been a significant undertaking for the VHS team over the past seven months to complete this research project. We have spoken with over fifty representatives from within our membership, as well as other important stakeholders including academics and third sector experts in gender issues. Thank you to all of the people who gave their time so generously in support of this research. We extend a special thanks in particular to our Research Volunteer, Dr Syeda Afia Ali, who supported the design of our research methodology and collated much of the population level data that reinforced this research.

We are confident that this report offers a new and compelling narrative regarding the relationship between sex, gender and health in Scotland. The third sector is a vital source of both qualitative and quantitative evidence regarding health inequalities in Scotland, as well as offering an important link between policymakers and voices of lived experience.

Publication of this report is only the beginning. We plan to produce further resources based on these findings in the coming months. We further intend to lead on the dissemination of these findings, along with emerging Third Sector research or data on this theme, throughout Scotland's health system and beyond. We also hope to support the implementation of the recommendations by working with relevant decision-makers.

We encourage VHS members and stakeholders to share this report widely, and to get in touch with us if they have any ideas for collaboration. We also urge those in a position to influence relevant policy or practice to carefully consider the recommendations in this report and take proactive steps to make them a reality.

This report belongs to all of us. Let's work together and take action to address gender-related health inequalities. Let's make the invisible visible.

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APPENDIX 1: METHODOLOGY AND RESEARCH PARTICIPANTS

Twenty-seven organisations provided evidence through workshops and 1-1 conversations. Twelve provided evidence and insight by email. Twenty individuals also responded to our anonymous survey on the theme.

WORKSHOP 1: 20TH NOVEMBER 2025 – 10 PARTICIPANTS

Ellie Wagstaff,, Marie Curie

Ruth Jeffery, Public Health Scotland

Lucy Mulvagh, Health and Social Care Alliance (The ALLIANCE)

Beth Hailstones, Breast Cancer Now

Sarah Henning, Prostate Scotland

Jennifer Stewart, Health and Social Care Alliance (The ALLIANCE)

Kirsty Morrison, Chest Heart and Stroke Scotland

Danielle Coll, Perth Women's Aid

Hannah Loret, Dundee University

Rebecca Hoffman, LGBT Health and Wellbeing

WORKSHOP 2: 25TH NOVEMBER 2025 – 7 PARTICIPANTS

Leeanne Killen, CLW Manager, North Ayrshire

Leon Pepper, We Are With You

Jane Miller, Health and Social Care Alliance (The ALLIANCE)

Louise Rogers, Health and Social Care Alliance (The ALLIANCE)

Allie Cherry-Byrnes, Fast Forward

Dr Dagny Gasking, Independent Expert

Niamh Allen, Caps Advocacy

1-1 DISCUSSIONS:

- Mar Sanchez Fernandez – Young Women's Movement
- Florence Oulds, Ryan Butter and Erin Lux – Equality Network and Scottish Trans
- Lucy Hughes, Engender
- Beth Allen, Age Scotland
- Fiona Collie, Carers Scotland
- Amanda Purdie and Maree Aldam, Amma Birth Companions
- Joseph Woollcott, Prostate Cancer UK
- Salena Begley MBE, Family Fund
- Rachel Bell, British Heart Foundation/Non-Communicable Disease Alliance Scotland
- Liam Challenger, Marie Curie
- Vic Valentine, Scottish Trans
- Julie Cowie and Danielle Hutcheon, Glasgow Caledonian University
- Julie and Bryan Morrison, Baby Loss Retreat

SHARED WRITTEN EVIDENCE:

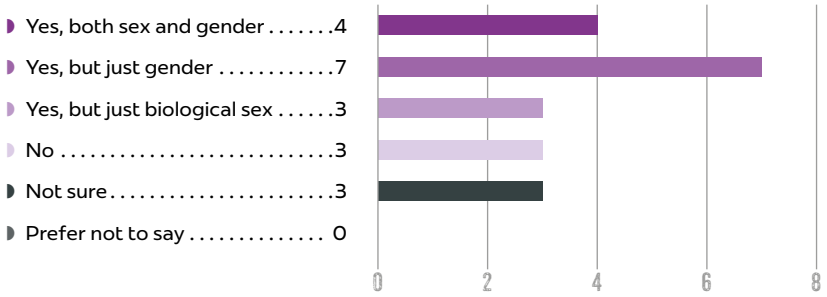
- Scottish Partnership for Palliative Care
- CHSS
- Family Fund
- Walking Scotland
- Families Outside
- Neurological Alliance of Scotland
- Carers Scotland
- Age Scotland
- Feniks
- Scottish Recovery Consortium
- Action for ME
- Scottish Trans

APPENDIX 2: SURVEY RESULTS

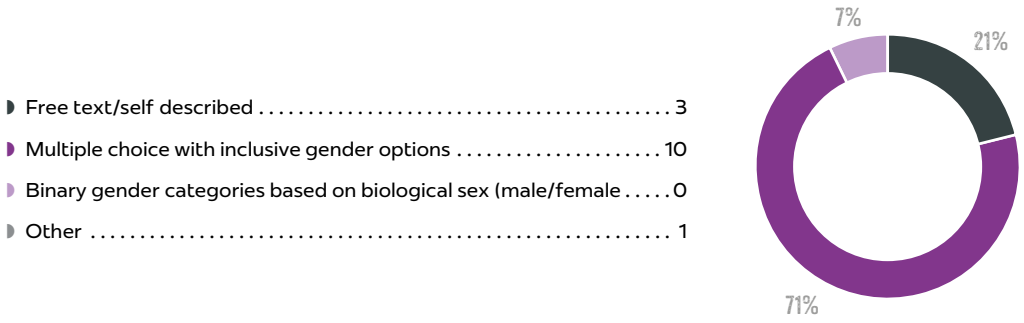
We invited all VHS members to complete a survey throughout November and December 2025 exploring the relationship between gender and health. This survey was developed with input from a range of third sector organisations that advocate for the rights of particular gender groups. The findings were referenced extensively throughout the research report.

Twenty individuals responded to the survey. The open-text responses are not able to be published due to identifying factors. However, full responses to the quantitative questions can be found below:

1. DOES YOUR ORGANISATION COLLECT DATA ON THE GENDER IDENTITY AND/OR SEX OF THE PEOPLE YOU WORK WITH OR SUPPORT?

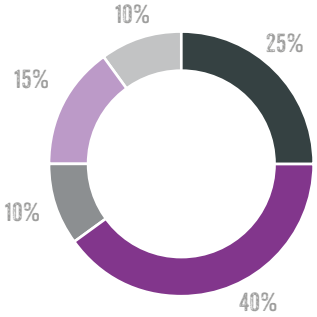


2. HOW IS GENDER IDENTITY OR SEX RECORDED?



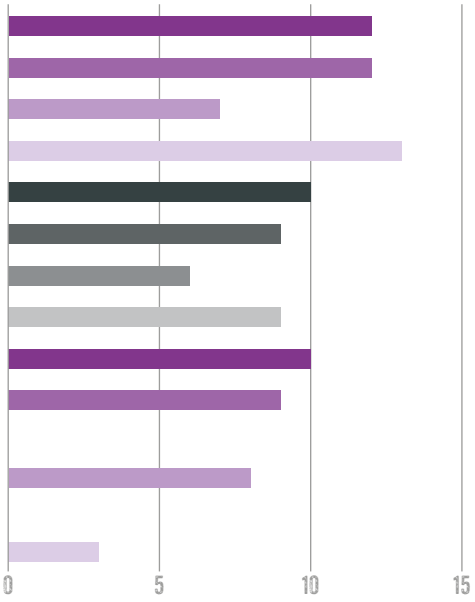
3. DOES YOUR ORGANISATION OFFER GENDER-SPECIFIC OR GENDER-INFORMED SERVICES?

- Yes..... 5
- No 8
- In development 2
- Not applicable 3
- Don't know 2



4. IN YOUR EXPERIENCE, WHAT GENDER-RELATED BARRIERS DO PEOPLE FACE WHEN ACCESSING HEALTH SERVICES? SELECT ALL THAT APPLY.

- Lack of inclusive services 12
- Discrimination or stigma.....12
- Inadequate data collection 7
- Lack of staff understanding of unique needs 13
- Lack of sufficient resource 10
- Fear of disclosure or privacy concerns..... 9
- Administrative barriers 6
- Lack of inclusive or safe places..... 9
- Fear that their pain/symptoms will be minimised ... 10
- Difficulty arranging appointments around work/or caring responsibilities 9
- Accessibility barriers related to wider characteristics, e.g. language..... 8
- Fear of disclosure or privacy concerns.....3



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ABOUT VOLUNTARY HEALTH SCOTLAND

We are a movement for health creation working to reduce health inequalities to enable the people of Scotland to live well. We believe that health is more than the absence of illness, and together with our members and partners we champion this belief. We collaborate to provide the national voice for third sector health organisations in Scotland.

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