

# The Forgotten Minority

Development worker Danny O'Neill attests that older people are a "forgotten minority" and highlights how the Dumfries and Galloway Elderly Forum are fighting back with a vengeance!

Mention equality and diversity and there's a fair chance that equal rights for women or minority groups springs to mind, and rightly so. There is, nonetheless, a large section of the population who are still actively campaigning for equal treatment, and have only recently been afforded any sort of limited protection in law.

Sadly, older people continue to face discrimination on a daily basis. This can take many forms to include not being able to access day-to-day services such as bank accounts and travel insurance or, more importantly, being denied some types of healthcare as a result of health programmes having an upper age limit.

Perhaps the reason that so little fuss is made about such blatant discrimination stems from the fact that older people are not the sort of fashionable group that grabs media headlines yet, paradoxically, is a group that we would all aspire to join one day.

Formed in 1988, Dumfries & Galloway Elderly Forum has grown from a small band of 15 or so friends, to one of the largest pensioner organisations in the country with over 3500 Members.

The ethos of the group has always been to give a voice to the voiceless, and, in addition to promoting the welfare of older people, the Forum has long recognised the benefits to be gained from working with diverse groups of people.

This has led to the Forum working closely with other groups in Dumfries & Galloway including the local Multicultural Association, Interfaith Group, Coalition of Disabled People and LGBT (Lesbian, Gay, Bisexual and Transgender) Scotland.

Forum Members have also recently worked with the Youth Issues Unit at Dumfries and Galloway Council to plan a conference that will investigate commonality between issues affecting younger and older people.



Representatives from the Forum attended the NPC (National Pensioners Convention) Pensioners' Parliament in Blackpool in 2006

In addition to these initiatives, the Forum continues to be represented on other bodies including the Diversity Development Consortium, and the soon to be re-launched Diversity Working Group. The Diversity Working Group was formed to promote diversity awareness and anti discriminatory practices across the region, this being a priority action identified in the Regional Community Plan.

Nationally, the Government is currently consulting on its Single Equalities Bill which includes provisions to outlaw discrimination on the basis of age. This new Bill aims to consolidate various pieces of legislation drawn up during the last three decades. However, many would argue that it simply doesn't go far enough.

In Scotland, the previous Scottish Executive recently identified age along with faith, sexual orientation, disability, race and gender as the 'six strands of diversity'. The Forum has also actively supported campaigns by Age Concern, and is currently promoting the 'Just Equal Treatment' campaign organised by Help the Aged.

The good news is that measures such as these are helping to change attitudes, albeit slowly. It can only be hoped that these initiatives will go towards helping the Westminster Government achieve its commitment of creating a culture of zero tolerance of unequal treatment. After all, you'll be old yourself someday.

For further information on Dumfries & Galloway Elderly Forum, visit [www.dgef.org.uk](http://www.dgef.org.uk)



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information, ideas and good  
practice on community  
development and health.**



## Healthy Scotland for all

Equality here, equality there, equality everywhere . . . Never has there been such a monumental and seismic time for equality, with the Equality and Human Rights Commission (EHRC) opening its door on 1st October 2007 and the harmonizing of Equality laws underway in the auspices of the Discrimination Law Review.

New powers, new resources and the ERHC 'State of the Nation' report could be pivotal in addressing institutionalised and social discrimination not just once in a life time but every three years. Thus CHEXPoint provides a timely and well thought out counterpoint to what is happening on the ground and in the communities. These include articles by;

- Elspeth Gracey, exploring 'Inclusive practice' and the 'hard to reach' tag. The very nature of the institutionalised 9-5 service delivery model is questioned.
- Pete Seaman gives a practical example of how to engage communities meaningfully in a field where tokenism is rife.
- Eleanor Logan discusses the all-important aspect of funding and how it needs to have built-in support and be multi-layered to support communities and individuals.
- Danny O'Neill provides an insight into the all-too-often 'Forgotten minority' that hopefully we all will enjoy i.e. being a member of the Older or Elderly community.

The language as ever will change, evolve; points of intersection, capability, equality of opportunity will be key battleground rallying calls. After all, bringing together the equality strands means everyone will have a stake in the outcome.

**Andrew Gardiner and Douglas Guest on behalf of the CHEX Editorial Board**

### Stop Press . . . Community Health Initiatives - Raise your Profile Now!

Against this positive background of work on equalities and diversity, CHEX reports that many Community Health Initiatives (CHIs) are facing reduced funding, reduction of services and possible closure. Many Community Health Projects and Healthy Living Centres are funded only until March 2008. CHEX is pressing this message at a national level. Regional networks such as 'Lothian Community Health Projects Forum' and 'West of Scotland Community Health Network' are lobbying at a regional and national level.

We would urge you to raise your profile NOW by:

- Gathering and presenting evidence of your effectiveness in accessible formats for distribution both locally and nationally. Provide local and national champions of your cause with this information. Keep them fully informed.
  - Contact your key funders – Community Health Partnership, Local Authority, Lottery Board, establish current position and seek support to negotiate beyond March 2008.
  - Mobilise local grass roots support through your management committee or board of directors and service users. There may be local celebrities who will rally to your cause.
  - Write to local Councillors and MSPs, highlighting evidence of your impact on health inequalities and stress the implications of loss of services.
  - Identify and seek support from local allies such as other community and voluntary organisations, supportive staff in public services. Agree collective action.
  - Identify and seek support from national Networks such as CHEX, Voluntary Health Scotland and Community Food and Health Scotland. Please keep us informed of your successes.
  - Compile articles about your impact on health for local and national newspapers.
- There are many actions you can undertake, but it is important to target your energies on specific activities. If you need support or advice with any of these activities, contact Elspeth Gracey at [Elspeth@scdc.org.uk](mailto:Elspeth@scdc.org.uk) and Paul Nelis at [Paul@scdc.org.uk](mailto:Paul@scdc.org.uk)

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## What does 'inclusive practice' actually mean?

*Elspeth Gracey, CHEX Practice Development Manager, explores the challenges in making 'inclusive practice' inclusive!*

The phrase 'inclusive practice', when applied to community health, has the potential to challenge undesirable health-damaging discrimination and exclusion and change people's lives, reversing health inequalities. This is done not by ignoring difference but by acknowledging the needs of individuals and working to ensure that barriers to participation are removed.

This means treating each person as an individual, with equal respect and an equal right to good health. This is easy to say but not always easy to do.



**Elspeth (standing) leads at a recent Roundtable Discussion event in Glasgow**

In the CHEX seminar in December 2005, 'Community Development Works for Equalities', people from a range of backgrounds and organisations spoke of a sense of fear and discomfort when considering issues of inclusive practice - fear of causing offence and the worry of "getting it wrong". Ultimately, people agreed that the way forward was to 'feel the fear and do it anyway'. That this should be the approach means we must accept that we will not always get it right. Honest mistakes, which are used for future improvement, provide a better approach than the biggest 'sin' of all which is to do nothing.

It is not enough to sit back and wait for people to come to us. We must be active in thinking about what it is we have to offer and how we can make our activities truly inclusive. This means taking action to identify the barriers to participation and then addressing them by doing things differently in the future.

We must all be prepared to be challenged and to challenge and this may be the source of our discomfort in connection with the topic of equalities. Only through this process will inclusive practice become integral to what we do and no longer be an 'add on' or an after-thought.

Part of the debate also revolves around whether or not work in communities experiencing multiple deprivation is equalities work. Well, given that we know there is a widening health gap associated with socio-economic deprivation, for me the answer is obvious.

The phrase 'hard to reach' begs the question "by whom?". It is worth considering that maybe people are not 'hard to reach' - maybe our organisations are simply not accessible enough, either geographically or by the nature of how they operate, (Monday – Friday 9-5), thus isolating ourselves from people who are right where they have always been if only we will go and look for them.

People are viewed as being 'a problem' but, in fact, what is at play is that people are experiencing problems and, unless we organise to support them and help to remove barriers to participation and remove discrimination, it is us who have the problem and continue to generate problems for others.

Those who have a physical disability are not disabled people. Our society is further disabling by creating unnecessary barriers which the individual is then left to overcome. Inclusive practice is about becoming part of the solution and not reinforcing the barriers. We need to be actively enabling.

Inclusive practice can result in conflict for those working in this way. An established group may perceive new ways of working, or adapting existing activities to ensure others can be included, as favouritism or special treatment and feel threatened by what is perceived to be an erosion of their existing situation. The original group may simply express discriminatory views which need to be challenged. Therefore, the ability to resolve conflict is an essential part of inclusive practice.

There is often the perception that equalities work is for specialist organisations or only for specially trained individuals within an organisation. While specialist training can help us to explore these issues and benefit our practice, and some organisations specialising in specific areas is perfectly legitimate, working in an inclusive way is not only the preserve of specially appointed individuals. It is a responsibility for all of us and each of us can make a difference. Indeed, it is only if it becomes something that each of us is prepared to act on that things will improve.

Those attending our seminar in 2005 were clear about the difference that being more inclusive would make.

They came up with an impressive list, of which here are just a few:

- ✗ Safer healthier communities
- ✗ People feeling better supported
- ✗ People feeling confident to engage with other groups
- ✗ Communities self sufficient
- ✗ Services more responsive
- ✗ Increased community cohesion and community spirit
- ✗ More 'whole' community events and services.

**Elspeth Gracey, CHEX Practice Development Manager (Elspeth@scdc.org.uk)**

In making grants we have had some dedicated programmes which have a particular equalities emphasis e.g. we ran the Ethnic Minority Grants Scheme and now run the Race Equality Integration & Community Support Fund. Because of this involvement, we also get a good percentage of minority ethnic led organisations accessing our other grant programmes e.g. Go4Volunteering. Our core programmes, which most people know us for, are designed to stimulate and support volunteering e.g. Unemployed Voluntary Action Fund and our new Volunteering Scotland Grant Scheme. With the latter, 70% of the volunteers involved in the grants must be from 'hard to reach' groups so we have teams of people actively volunteering who have experience of homelessness, living with addictions, mental health issues, physical disability, etc.

Making a grant award is the easy bit though (and, even though it may not feel like it, getting a grant can be the easy bit!). Making the work happen and delivering change is a lot more challenging and VAF prides itself on being an 'investment funder'. This means that we are actively involved in supporting people we fund through providing training, one to one support and opportunities to learn and network with other grant holders. We also work with those we fund to highlight the success stories, good practice and also the challenges we all face in making change happen.

With us being 25 years young, we have just been through a process of 'stock taking'. In doing this, we decided that we would like to build the skills of those we work with at the same time and involved a small team of grant holders as Community Researchers. They were then trained and supported to undertake a review of the impact of the grant making and also the impact of the investment support VAF provides. From this, we have just produced two research reports. But, more importantly, we learnt first hand of the value of peer led community research. The researchers also greatly valued the opportunity to develop their skills: "I have developed new skills and I am thinking about how I can use the methods we looked at for analysing the project I work for in a more concise way. I am thinking about using volunteers in our own project to get the views of the people who use our services and the benefits the service provides."

This is a short insight into our work and our approach to making the world a more equal place. In doing so, we take an approach which encourages active involvement in society, recognising that we all have an equal right to be involved and at times all that it required is a common sense and human approach to removing any barriers.

**Eleanor Logan, Voluntary Action Fund (eleanorl@voluntaryactionfund.org.uk)**



**Community researchers in action**

## The National Reference Forum Project

*Parveen Khan, National Resource Centre for Ethnic Minority Health Community Development Manager describes the Project's work in supporting community engagement with the National Reference Forum – A Forum set up for the eight national/special NHS Boards to engage with black and minority ethnic communities on their policies and services.*

The aim of the Project is to support the National Boards in meeting their obligations under their race equality schemes to consult, involve and engage with Black and Minority Ethnic (BME) communities on health strategies. Seven of the eight National Boards jointly funded the proposal for 3 years in June 2005.

The membership of the National Reference Forum (NRF) consists of Lay Advisors from the Black and Minority Ethnic communities including Gypsy Travellers. It comprises of Lay Advisors from across Scotland with an interest in activism and equalities. There are currently 16 individuals on the National Reference Forum. The profile of the NRF is 10 women and 6 men. One individual has a disability and one member is from a Gypsy Traveller background.

Meetings are on a quarterly basis and we are keen to use community development approaches to build capacity and support long term engagement of the Lay Advisors and the National Boards.

The benefit of adopting a community development approach to consulting, involving and engagement with community groups is for the Forum to become 'process driven' which helps build the capacity of communities to meaningfully take part in decision making and feel empowered to participate at all levels within community engagement structures. As Black and Minority Ethnic Communities comprise of groups from many cultures, we work to ensure our approaches are responsive to different needs and expound the principles of the Standards of Community Engagement, in particular "skill must be exercised in order to build communities, to ensure practice of equalities practice of equalities principles, share ownership of the agenda, and to enable all viewpoints to be reflected."

If you would like more information, contact Parveen Khan on [parveen.khan@health.scot.nhs.uk](mailto:parveen.khan@health.scot.nhs.uk)



## Community Engagement: seeking voices not normally heard

Dr Pete Seaman, Glasgow Centre for Population Health, describes the challenges in developing an effective community engagement strategy.

The good intentions that underlie community engagement are hard to fault. Within the Glasgow Centre for Population Health we recognise that solving an issue as longstanding and as intractable as Glasgow's health problems will require more than top-down policy solutions. As many people as possible need to be involved in addressing the causes of, and solution to, the city's health problems.

Just having the good intention to include a diversity of viewpoints does not mean you'll necessarily get them. This is particularly the case if you expect the engagement to be on the organisation's own terms and to their established patterns of working without recognising that organisational cultures do not interface particularly well with those found 'on the ground' in communities. This can be the biggest downfall of engagement strategies; for example, the assumption that holding a public meeting will make an organisation more accessible to anyone other than those who are comfortable with the idea of public meetings. 'Community' does not necessarily have a sign on it, it doesn't always meet in a community hall, it doesn't always refer to itself as a community group, it certainly doesn't wish to see itself given an acronym and slotted into a community engagement flow-chart!

In a recent exercise in community engagement, I attempted to explore the process by which we can better engage with communities through research. I did not want it to be another case of research being done to and not with the community, so we sought to recruit and train volunteers from the local community to be the researchers on their own projects, identifying their community health concerns from their privileged position of community members. Although the project did not have a stated aim to include specific equalities groups, I was interested in developing ways of making engagement as open to as many people as possible.

Ten volunteers were trained in participatory research methods, who then went out and engaged their communities in topics relating to health. In numerous ways, the resulting project was a success. Their findings were insightful and helped us in understanding health and well-being in relation to the resources and barriers that people experience in their daily lives. We also saw ten highly committed individuals benefit from training by increasing their confidence and skills. The success, however, was based on a big commitment from the volunteer researchers who had to give at least 4 full days of their time to the project. Sure, others were engaged less intensively; those who the volunteer researchers spoke to in the shopping centres, streets, hospitals and schools as they collected their data. Yet the barriers both in terms of reserves confidence and available time meant some could not take part despite the offers of childcare and full expenses being paid.

I learned that various forms of engagement will only be attractive to discrete segments of the community and that accessing voices not normally heard will involve designing engagement locally and tailored to the distinct circumstances of the group in question. It is perhaps clichéd to say 'one size does not fit all', but there needs to be recognition that different voices need different spaces and ways of working in order to be heard. What will always be true is that, unless ways of working put the needs of these groups first, it will be another case of superficial involvement and of ticking boxes.

Pete Seaman ([pete.seaman@glasgow.gov.uk](mailto:pete.seaman@glasgow.gov.uk))

## Funding a more equal world

Eleanor Logan, Voluntary Action Fund Chief Executive demonstrates how a funding programme can make a difference for everyone in communities.

The Voluntary Action Fund (many of you will remember us as UVAF) is 25 years young this year. VAF was formed in response to the need to build skills and capacity within individuals to enable them to be fully active in society. In taking this forward, VAF have consistently challenged inequality, as this inequality has been at the heart of why people aren't fully active or engaged. So, how do we take this laudable aim and make it work in practice? Well, we do this in the following ways:

- ✕ We stimulate action through funding small pieces of work
- ✕ We support those we fund in developing their skills and those they work with
- ✕ We involve our communities of interest in shaping our grant making and also researching it.

## From Local to National and Back Again

Lizanne Conway, Programme Manager for the Community and Voluntary sectors at Health Scotland highlights the underpinning of equalities work in community-led health and explains the role of the new Directorate for Equalities and Planning to be based at Health Scotland.

As reflected by Scotland's wide array of community-led health activity, our communities also exhibit great diversity across many dimensions, including gender, sexuality, age, social circumstance, ethnicity, culture, religion and geography. Migration and mobility further enhance this dynamic mix. These dimensions, when fully embraced and responded to, can have many positive influences but, when this does not happen, many challenges affecting the most marginalised communities can surface, particularly around health and access to health care.

Despite overall improvement in Scotland's health, some of Scotland's communities still have far less equal health outcomes than the national average due to a complex interplay of many factors. For example, recently published figures by the Faculty of Public Health [Ref 1] show that there can be big differences in life expectancy and infant mortality amongst black and minority ethnic communities living in the UK. Gay and bisexual men are also known to be seven times more likely to commit suicide compared with the general population, and the uptake for cervical screening is known to be 85% for women aged 20 to 64, but just 3% for women with learning difficulties living in family care. Similarly stark findings also exist for the unequal health outcomes of Scotland's homeless populations and for its children and older people living in poverty. The reality of health inequality is, therefore, not hard to evidence and, as a result, a wide range of equality legislation is now in force to ensure that all public bodies demonstrate an explicit commitment to equality and inclusiveness in everything they do. However, the challenge now for Scotland is about action - how can this legislative commitment to tackling inequality in all its forms be effectively implemented?

Learning the lessons from community-led health activity is a good place to start when considering effective action. Understanding diversity by reaching out to communities and tackling the underlying causes of such inequity rather than the symptoms are at the heart of a community development approach to health improvement. Scotland's community-led health networks have much to share about what works and what needs to happen nationally to progress change, and there has never been a better time than now for this experience to be shared with national agencies.

By April 2008, a new Directorate of Equalities and Planning will be based within NHS Health Scotland, which will continue and build on the work of the currently separate Fair for All equality strands such as the National Resource Centre for Ethnic Minority Health. This new directorate will aim to better facilitate our shared understanding and integration of the equality and diversity agenda into all NHS Scotland and its partners' activities designed to reduce inequalities in health. A consultation process is now underway. Community-led organisations can use this opportunity to share their experience and views to help shape this new development within Health Scotland. To find out more and for all background papers, please visit

<http://www.nhs.uk/about/planning-inequalities/index.aspx>

If you would like to discuss this issue in more detail and share your ideas, please contact me, Lizanne Conway, Programme Manager for the Community and Voluntary Sectors at [lizanne.conway@health.scot.nhs.uk](mailto:lizanne.conway@health.scot.nhs.uk) or call 0141 300 1051. Thank you.

[Ref 1: Ph.Com: The Newsletter of the Faculty of Public Health, June 2007. Accessible via website [www.fph.org.uk](http://www.fph.org.uk) (ISSN 1472-7501)]

## The Equalities Review: Fairness and Freedom: 'The Final Report of the Equalities Review' (published Feb. 2007)

This Final Report of the Equalities Review makes the case for equality in very positive terms. It shows evidence that, in spite of many advances, we still live in a society in which too many people's destinies are determined by who and what their parents were, and where they were born. It also warns that, though we do need to provide laws that will enable the removal of barriers to success, legislation will not by itself deliver a better, fairer, more equal society. The Report provides data, analysis, tools and policy that help individuals and institutions to tackle these challenges. The Report was commissioned by the previous Prime Minister and was written by an independent Equalities Review Panel, chaired by Trevor Phillips. The Report can be downloaded at

[http://www.theequalitiesreview.org.uk/upload/assets/www.theequalitiesreview.org.uk/equality\\_review.pdf](http://www.theequalitiesreview.org.uk/upload/assets/www.theequalitiesreview.org.uk/equality_review.pdf).

For information on alternative formats, contact 0870 1227 236.

## Creating an Expectation of Entitlement – Equality for all

*CHEX-POINT seldom provides a platform for individual analysis of policy implications but, with the implementation of the Gender Equality Duty in April 2007, this stimulating article from Niki Kandirikira, Director of Engender provides a provocative analysis of discrimination within market forces and points to optimistic changes ahead both for women and men.*

As women seeking equality in Scotland we are living in exciting times. The Gender Equality Duty [GED] that came into force in April 2007 is the most significant legislation to support women's equality since the Sex Discrimination Act, 1975. The duty takes the onus off the individual to prove that a public body treated them unfairly and places it firmly on the public body to be proactive and prove they were fair.

Meanwhile, the three commissions on gender, race and disability are merging into the Commission for Equality and Human Rights and we are being consulted on the development of a Single Equalities Act. We hope this will level all equality legislation upwards so that women, men and transgender people, black and minority ethnic people, disabled people, lesbian, gay and bisexual people, the young and the old and people living with mental ill health can expect equality and justice regardless of their religion or belief.

At Engender, we want to take opportunity from these developments to:

- ✗ use the GED to draw attention to women's continuing experience of inequality
- ✗ use the emergence of the CEHR to initiate deeper thinking about how and why institutional sexism persists
- ✗ use the consultation of the Single Equalities Act to initiate a gendered socio-economic analysis of equalities

**Women's lived experience:** We need to acknowledge women's inequality; women remain the primary unpaid carers of children, sick relatives and older people and pay a heavy price in reduced income, career progression and their pensions [The average woman retires on 53% of the pension of the average man]. Even when women work in care, they are undervalued - caring jobs are 'traditionally' done by women and are poorly paid. In short, women are more likely to be poor. So, one can't help but question why, as we move into the language of poverty, the word 'woman' disappears from the discourse? Why is women's poverty wrapped up in the language of lone parents, childhood poverty and impacts on the family?

Why does addressing women's poverty have to be described by its impact on others?

**Institutional sexism:** We need to acknowledge institutional sexism; girls out perform boys at school, secure proportionally more places at university and perform equally well in academia. Why then does a woman leaving the university with the same degree in the same subject earn 15% less within 4 years?

**Gendered inequalities:** The most obvious way to discuss gendered inequalities is to explore the lived experience of black women, older women, disabled gay men, older disabled lesbians etc. The possible list of intersections goes on and on, and the results would likely make very disturbing reading.

However, what may be more useful is to understand the commonality in the cause of the systemic discrimination of the different groups. Why do we, as a society, persistently discriminate against women, transgender people, black and minority ethnic people, disabled people, lesbian, gay and bisexual people, people with mental health problems, older people, young adults, children and subaltern men? After 24 years working in equalities, I am more and more convinced that the cause is our pursuit of wealth and the focus on the market economy as the measurement of our success.

Thankfully, things are changing. People are realising that economic success does not necessarily translate into life satisfaction or happiness. They are acknowledging costs of economic development, demonstrating concern about trade justice and environmental sustainability - but patriarchal hegemonic structures and systems organised around the market economy are so much a part of the way we think, organise and do things that we get caught up in defining success in £'s and perpetuating inequality.

The equality duties and CEHR are tools in the pursuit for social and economic justice and thus provide an opportunity to evidence Scotland's progress towards equality using both social and economic indicators.

What would happen if the measurement for Scotland's success was happy healthy people [life satisfaction] rather than GDP?

For further information, contact Niki Kandirikira on

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## LGBT Centre for Health & Wellbeing

*Judi Syson, Chair of the LGBT Centre for Health & Wellbeing, sets out the strengths of a Healthy Living Centre in working with lesbian, gay, bisexual and transgender (LGBT) people.*

Holistic model of health – that's what captured my imagination and got me involved in a healthy living centre project! Having come from a background where the application of science and medicine makes a difference to patients, it was really motivating to look at the concepts from a much broader perspective and realise there was so much more to healthy living. My day job is a leadership role in a large pharmaceutical company running clinical research so it's a very different environment.

The LGBT Centre for Health & Wellbeing is a unique Healthy Living Centre initiative, opened in 2003 and funded by the Big Lottery Fund and local NHS organisations to promote health and wellbeing among lesbian, gay, bisexual and transgender (LGBT) people. The project also aims to support mainstream health services to be more accessible to those community members living and working in Edinburgh, the Lothians and the Borders.

LGBT people can experience health inequalities through the impact of living with prejudice and discrimination or may find it hard to access the support they need because of fear of a homophobic or trans-phobic response from mainstream services. The project has provided training for local healthcare professionals to support their understanding of providing an inclusive service for LGBT people. The feedback received from HCPs attending this training has been excellent and reflects the high quality approach the staff team takes to the development and delivery of these sessions.

As well as providing more traditional health education resources and other information, the Centre has a staff team dedicated to community development, health promotion, training and consultancy and volunteer co-ordination. I first got involved when a friend let me know the centre was looking for new board members. The volunteering programme itself is now thriving, courses are over subscribed and the volunteer group are themselves a source of wellbeing for each other and visitors to the centre.

The Centre is a safe and central meeting point for LGBT people and also supports local community groups by providing space and support. There are currently thirty groups using the Centre as a base, ranging from a thriving community theatre group, creative writing, Primetime; a group for older gay men, T-time; a social support group for people who identify as transgender, to groups supporting people with the management of their alcohol use.

Sport and fitness activities are offered in partnership with local community based facilities and the Centre tries to work with mainstream service providers whenever possible. This year, the Centre has supported the first swimming group in Scotland specifically for transgender people. This partnership approach has benefits both ways, as staff and agencies often feel more confident about providing services for LGBT people after working with the Centre, or once staff have attended our training.

Volunteer and community member involvement is a central part of the ethos and working of the Centre and people are generally not shy about giving us feedback. Our recent Needs Assessment (available on-line at <http://shout.to/lgbthealth/>) has proved popular and is giving us much needed information with which to develop appropriate and relevant services in the future.

I really enjoy my work as Chair of the Board, it has broadened my knowledge of working in the charity funded environment and allowed me to use my experience as a business leader in staff management and strategy delivery in a new and exciting way. Being involved with a highly professional staff team and a Board representative of the sector agencies and community members is an excellent opportunity to learn about different ways of working. Seeing the project manage through difficulties and forward to the strength and success of the community impact today provides me with challenge and motivation in equal measure.

The challenge for the project and the centre remains to ensure that our services reach out to all members of the LGBT communities and that our work with the health care sector becomes an important part of the equality agenda as legislation and customer expectations develop in the future.

**JUDI SYSON & the Project Team**

For info, visit [www.lgbthealth.org.uk](http://www.lgbthealth.org.uk)



**LGBT staff at work on a Transgender Awareness session**