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Gender equalities work in health organizations in England

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Introduction

Gender mainstreaming based on top-down policy processes can mean that 'gender-rich policies …turn into gender-poor practice', reinforcing and perpetuating the inequalities mainstreaming policies seek to address (Van Eerdewijk, 2014: 345). Analysis of the 'failure' of gender mainstreaming in practice frequently stresses a disjuncture between the transformative ideals embedded in gender mainstreaming and what happens once gender equalities strategies are translated into practice (Hankivsky, 2005). Policy implementation is an important aspect of the policy process in relation to the success and failures of gender mainstreaming, but has less often been addressed from a feminist perspective (Callerstig, 2014).

This paper explores the idea that what we might call the 'policy implementation gap' (Exworthy et al., 2002) helps to explain the limited progress that has been made by gender equality strategies. The focus here is gender equality work in the health sector in England, drawing on findings from qualitative interviews with equalities leads in primary care commissioning organisations. Despite the widespread adoption of gender mainstreaming in health settings, gender inequalities in health persist. These are complex: life expectancy for men is lower than that of women in virtually every country in the world, although the size of the gap varies, and while women often report more ill health than men this varies both across the life course and between conditions. These patterns of difference reflect both biological factors and gender-linked influences, including social determinants of health as well as how, and how well, health systems address and meet the needs of women and men (Wilkins et al., 2008).

While strategies to address gender equality have become more common across a range of policy areas at intergovernmental, regional and national level, the

implementation of such policies continues to prove problematic (de Vries et al., 2015). The translation of gender equality strategies into practice can be side-lined for various reasons – how it is conceptualised, a lack of explicit discussion of what is meant by gender, a failure to explore underlying contradictions and tensions and organisational 'plaque' or resistance for example (Kvidal and Ljunggren, 2014). Although this study focuses on England, the issues identified are of wider relevance. In 2006 the UK introduced a new requirement for all public sector organisations to promote equality between women and men, and similar changes have been introduced in thirteen of the EU Member States (Fredman, 2009). In these countries earlier equalities legislation was reactive, meaning that responsibility for action lay with other actors, particularly individuals and trade unions. The addition of this proactive duty creates new challenges, but research with those responsible for implementing these new public sector duties, exploring their work and the problems they face, has been limited. This paper therefore aims to add to understandings of the role and significance of policy implementation in equalities work in the public sector.

Theoretical framework

Gender mainstreaming has been the subject of intense scrutiny as a number of writers have questioned what is meant by gender mainstreaming, and why it appears to have underachieved on its early promise (Van Eerdewijk and Davids, 2014). This debate highlights both pragmatic barriers such as a lack of gender disaggregated data, training and capacity (Theobald et al., 2005) together with political lack of will (Van Eerdewijk 2014).

One of the key questions is whether gender mainstreaming can be seen as transformative or compliant, and the extent to which the loss of mainstreaming's

transformative potential helps to explain limitations in practice (Lombardo and Meier, 2009). This is particularly associated with the ways in which the shift from agenda setting and policy formulation to implementation and practice leads to a reliance on depoliticised and bureaucratic approaches, and technocratic tools which encourage a focus on inputs rather than outcomes (Squires, 2010; Sainsbury and Bergqvist, 2009). Gender mainstreaming ideals are translated into simplistic and homogenous policy solutions (Van Eerdewijk, 2014), while distancing feminist networks involved in dialogue in earlier stages of policy development (Roggeband, 2013). Gender relations of power are also not explored within policy implementation (Erasmus and Gilson, 2008), and solutions do not address underlying structural causes of gender inequality (Van Eerdewijk, 2014). As a result of these collective and intertwined failures gender mainstreaming often achieves only symbolic results (Lee-Gosselin et al., 2013).

Our analysis of the roles and views of equalities leads in the health sector in England draws on ideas about the ways in which gender equalities strategies 'shift and bend' in the process of being implemented, and the role of policy actors in the 'doing and undoing of gender', including the discursive power of gender policy making (Callerstig 2014 p53). Policy implementation is often viewed as a discrete part of the policy process, something that is separate from policy formulation (Exworthy et al., 2002). The reality is more complex, and as policies move from national to local level those responsible for their implementation are engaged in their (re)formulation, interpretation and invention, opening up institutional space for resistance, challenge and contestation.

These actors play a key role in what happens to equalities policies in practice, while also shaping policy and gender discourse through their discussion, agenda setting,

the development of tools and interventions. A close-up study of such actors can add to our understanding of the success and limitations of gender equality strategies, particularly when gender is not embedded across the mainstream policy agenda but assigned to equalities leads, which can lead to it being seen as low priority (Hannan, 2011; Van Eerdewijk, 2014).

To date there is relatively little research looking at local level actors in the context of equalities policies. Studies of the implementation of early anti-discrimination laws in local authorities suggest these were accompanied by low resources, a lack of political will and leadership and that those carrying out this work largely occupied weak positions within institutions (Conley and Page, 2010). More recent research on the implementation of equalities policies in both the public and private sector suggests that the lack of progress reflects the focus on the technical aspects of the process combined with a failure to challenge stereotypes or unpack concepts, including the meaning of gender (Lee-Gosselin et al., 2013). In addition, equalities officers are often not gender experts, leading to a lack of 'deep knowledge' which is critical for the success of gender equality policies (Van Eerdewijk and Davids, 2014). Lee-Gosselin et al.'s (2013) case studies of the implementation of gender equality policies in private and public sector organisations in Canada and Morocco, for example, found a lack of internal involvement or acceptance of the legitimacy of the policies, and a failure to address the need for cultural change within the process. Research explicitly looking at the implementation of equalities policies in health settings has often focused on top-level policy making rather than local level implementation. In a study of national health policies in Australia which revealed a disappointing and largely gender-blind approach, Keleher (2013) suggested that the implementation of a Women's Health Policy at national and state level might,

perversely, have reduced the perceived need to mainstream gender in other areas of health policy. In Germany healthcare was one of the first sectors to adopt gender mainstreaming at national level, although results were disappointing, with fragmented approaches, a lack of systematic monitoring, and a failure of new policies to adhere to mainstreaming principles (Kuhlmann and Anmnandale, 2012). An emerging literature at local level also suggests weaknesses in the implementation of equalities policies. Ali et al. (2012) found that many of those holding responsibility for leading equalities work in the health sector in the UK following the 2006 Act lacked either generic management skills or specialist equalities knowledge, and that there was confusion about what the role entailed, together with lack of organisational support.

This study aims to add to understanding of how implementation can fail, by looking at those in public sector health organisations who are responsible for 'doing gender work'. Policy analysis has identified the importance of policy entrepreneurs, the actors (individual or organisational) engaged in getting a particular policy problem and/or solution onto the agenda (Kingdon, 1995; Exworthy et al., 2002). However, we also need to explore the role of those at local level, the 'street-level policy entrepreneurs' (SLPEs) who implement policy within the organisation (Arnold, 2013; Exworthy et al., 2002). While policy entrepreneurs develop broad policy initiatives, local 'agents of change' add detail, drawing on their own knowledge and expertise, and that of support networks, negotiating with others particularly those within the organisation who are resistant to such innovations, and securing both resources and acceptance or agreement of others (McGauran, 2009):

> "conventionally described as powerful only in certain delimited arenas and relatively helpless outside them…. street-level bureaucrats can use intellectual,

> social and political capital to adopt or develop policy innovations to improve implementation processes in which they are embedded, then seek to entrench those innovations in the practices of bureaucratic peers. These officials can be policy entrepreneurs." (Arnold, 2013: 321-322)

This paper aims to add to understandings of gender equalities policy 'evaporation' in practice, focusing on the actors charged with the implementation of gender equality policies in order to develop a framework which incorporates the part played by localised policy entrepreneurs. The equalities leads described here do not deal with the public directly, and their decisions, and opportunities to develop and subvert policy through implementation, lie in a different context. Instead, they are middle level bureaucrats who are one or more steps removed from day-to-day dealings with consumers of services. While they may or may not have supervisory and budget responsibilities, they have limited decision making power, and they are responsible for meeting specific targets and the demands of higher management, they play an important part in shaping policy in a direct way (Petchey et al., 2008).

Gender equality policy in the UK

A number of countries have introduced strategies to address gender inequalities in health, including the UK which in 2006 adopted a proactive approach requiring all public authorities to promote gender equality in their activities. This followed a 'window of opportunity' in 1997-2010, under the Labour government, which reflected the need to appeal to women voters, the significance of feminist activists within the party and in Parliament, and pressure on national governments from the EU and UN to adopt gender mainstreaming principles (Annesley et al., 2010). These factors enabled key actors to engender the policy agenda across various departments. Changes introduced during this period included the creation of a cabinet-ranking

Minister for Women, a Women's Unit, and equality targets in Public Service Agreements between Ministries and the Treasury (Annesley et al., 2010).

One of the main achievements was the 2006 Equality Act which created a public sector duty in relation to gender equality, together with other duties on race, disability and transgender. The duty required all public sector organisations to end discrimination against men or women, and to promote equality of opportunity. This moved beyond existing anti-discrimination legislation, requiring equality considerations including gender to be mainstreamed across all policies and decisions.

The subsequent 2010 Equality Act brought together provisions of earlier legislation, and extended the cover to nine 'protected characteristics': sex, age, disability, gender identity and gender reassignment, marriage or civil partnership (in employment only), pregnancy/maternity, race, religion and sexual orientation. The 2010 Act also introduced greater flexibility in how organisations publish their equalities work, and the idea of 'proportionality' in relation to equality objectives for organisations of different sizes.

The public sector duty applies to every level of the health sector, from the Department of Health downwards, and day-to-day responsibility for meeting the duty falls to NHS provider and commissioning organisations. The NHS has a long, if uneven, history of attention to gender equality, both in their role as employers, and through specific policies to meet the needs of women or men. For example the Women's Mental Health Strategy (DH, 2004) outlined gender sensitive approaches to services and adopted principles of gender mainstreaming in arguing that gender considerations needed to be integral to decision making and service provision, rather than an afterthought. Similarly, the 2002 National Suicide Prevention Strategy

identified young men as a key risk group which policy should address (DH, 2002). However, the NHS has also been criticised for pursuing gender blind policymaking, which disadvantages either men or women, and for failing to address differences in need and service use (Doyal et al., 2003; Wilkins et al., 2008)

Following the 2006 Act health organisations were required to demonstrate that they were meeting the public sector duty by publishing information about their equalities strategy. NHS Trusts and PCTs created Equality Schemes, with most adopting Single Equality Schemes to address all of the groups covered by the Act. In these organisations responsibility for writing and implementing Equality Schemes needed to be allocated. While some organisations already had equalities officers, or a member of staff with responsibility for equality as part of their remit, the 2006 Equalities Act legitimised and formalised the space within organisational culture for work that may or may not have already been in place.

Current equalities work in the NHS in England faces significant challenges due to the expansion of equalities in the 2010 Act and the reorganisation of health care in the 2012 Health and Social Care Act. This abolished Primary Care Trusts (PCTs) and transferred their responsibilities for commissioning local health services partly to newly formed Clinical Commissioning Groups (CCGs) and partly to national NHS bodies and Local Authorities, creating a fragmented structure. These shifts created a particularly complex environment for those engaged in equalities work in the health sector, but there is little evidence to date on how the sector has responded to the public sector duty. A review of PCTs shortly before the 2006 Act entered into force suggested that few of them were prepared in terms of their responsibilities under the legislation, or were used to considering gender routinely in decision making, and 13% were unaware of the new requirements (Men's Health Forum, 2006). A later

study commissioned by the Equalities and Human Rights Commission, the body which oversees the duty, reported weak performance in health organisations across all of the equalities, but particularly in relation to gender (EHRC, 2011).

Methods

The paper is based on a small scale exploratory study of equalities work in commissioning bodies in the NHS. The goal was to identify perceptions of those working as equalities leads within the health sector, in relation to the significance of their work and the barriers they encountered. Ethical approval for the study was granted by the ethics committee at the School for Policy Studies at the University of Bristol, which conforms to guidance of the Social Research Association (SRA). Ethical approval from NHS Research Ethics Committee was not needed in line with national guidelines on work of this nature.

A purposive sample of PCTs as at September 2012 was identified to ensure a mix of organisations serving different populations (e.g. rural/urban, inner-city, north/south). Fifteen PCTs (10 per cent of PCTs at the time) were selected and equalities leads were identified from website material and personal contact. Nine of the fifteen leads contacted agreed to participate in the study, the remaining six either could not be contacted (three); did not reply (one) or agreed to take part but proved unable to find the time to do so (two). Although initial sampling was based on PCTs, as a result of the period during which the interviews took place, some of those contacted and included in the study were employed in PCT clusters, NHS trusts or the new CCGs. Semi-structured interviews were conducted by phone in October and November 2012, and lasted on average 40 minutes, with informed consent obtained in all cases. The topic guide was drawn up following a literature review and included questions about implementation, the lead's role, responsibilities, experience and

training, and their perceptions of factors influencing or acting as barriers to their work. Interviews were recorded and transcribed in full, and analysed using NVivo to identify index themes and emerging analytical categories.

Of the nine equalities leads interviewed, three were male and six were female. Three of the leads worked for a PCT Cluster, consisting of a number of PCTs, three were based in a single PCT, two were in NHS Trusts and one was working for a CCG. They were based in a range of geographical regions in England and in a mixture of inner city, urban and rural settings. Respondents' job titles reflected their equalities work with some variations: five held the role of 'equality and diversity' lead or manager, one described their role as equalities engagement lead, one as equality, diversity and human rights coordinator. Two had job titles which were not directly 'equalities' based: the respondent in the CCG was a strategic development manager, while one of the leads based in an NHS Trust was a public health consultant, with a 'corporate' role in equality and diversity across the PCT.

Findings: Equalities leads and policy implementation

Equalities leads as agents of change

Equalities leads can be seen as policy entrepreneurs (Kingdon 1995) with roles as both implementers and in formulation of policy through their interpretation of broad objectives into organisational practice. Leads both 'do' gender equality work while aiming to disrupt gendering processes (De Vries et al. 2015), meaning that their role, their approach and experience are important in terms of practice, and what they tell us about the significance given to the work within organisations.

The level of equalities experience among the leads varied considerably. While two had held public sector equalities roles for a long time, for others this was their first responsibility for equalities work, including one who had previously been a marketing

manager for an NHS Trust and another who was an operational manager seconded to a human resources post.

Not all of the leads had been appointed through a formal process to recruit an equalities expert. One explained:

> "the senior management team were having an away day where we looked at what all the pieces of work we were leading were and what all the statutory duties of the CCG would be and then assigned main leads to each of those duties, and that's when I decided to be the equality and diversity lead.."
>
> (Female Strategic Development Manager)

For others, the job had been inherited or developed out of other responsibilities:

> "Because I used to manage the equality lead, the equality role came back to me when he left" (Female Public Health Consultant)
>
> "I was seconded to HR to undertake some specific project work, and that role …migrated into leading on E&D" (Female Equality and Diversity Lead)

Training available or required within a post is important in shaping equalities discourse and the implied value of equalities within organisations (Hankvisky 2013). For most leads training consisted of the NHS mandatory equalities training, although two had followed a short equalities programme run by the Institute of Leadership and Management and three had Masters qualifications in related fields. More specific learning was largely self-directed and voluntary: leads talked about being 'self-taught' and having to 'read up' on the issues which interested them or which they felt were important in their role. This lack of a requirement for a specific body of knowledge, combined with the way leads had been recruited, helps to construct a discourse in which equalities work is seen as non-specialist, requiring no particular expertise (Ali et al., 2012).

Resources

A common finding in studies of gender mainstreaming in health settings is the impact of under-resourcing. This includes the lack of gender disaggregated data, training and dedicated personnel (Theobald et al., 2005). These problems were reiterated by the equalities leads. While the data they wanted on gender were generally available, problems remained with out-of-date systems, the reliance on data collected by healthcare providers and a lack of resources to deal with the data that they had access to. Statistics were often only available at national level, rather than at a local level. There were mixed reports about the adequacy of data on the workforce, with three feeling it was inadequate, but on the whole, and in contrast with other studies, gender disaggregated information was seen as more readily available than data on other aspects of their work, particularly disability or ethnicity.

Capacity was seen as lacking in other ways however. Leads reported having insufficient time to meet the expectations of their role, too few staff in the equalities team and insufficient administrative support:

> "Also …this organisation is going through a bit of a bun fight at the moment, in terms of who's supposed to be providing me with admin support. Is it my old support from public health, or is it my new support from the Quality & Governance Directorate, or is it a mixture of both? It's a mixture of both, which often ends up that nobody does it" (Male Equality and Diversity Lead #2)

Organisational change

Public sector change and disruptions such as those following the 2012 Health and Social Care Act reorganisation increase uncertainty and risk averse behaviour, and add to policy implementation difficulties (Page 2011; Carey and Crammond 2015).

Staffing difficulties, in both equalities roles and wider administrative support, were seen as having been exacerbated by workforce turnover in the period around the 2012 Health and Social Care Act. This was a period of confusion and lack of clarity over the future, and leads felt they struggled to ensure that equality and diversity remained a high priority:

> "I think sometimes equality is something that's the first thing to go when restructure happens" (Female Equality and Diversity Manager #2)
>
> "work around equality requires a certain level of stability, stability of system, stability of workforce" (Female Equality and Diversity Manager #1)

The implementation of the equalities agenda can also be undermined by lack of leadership, particularly senior and middle tier management (Lee-Gosselin et al., 2013; Page, 2011):

> "you need to have leadership which understands the value of equality and diversity.. I've got examples of good leadership and bad leadership and how equality thrived under that good leadership and how it struggled under the weaker leadership" (Female Equality and Diversity Manager #1).

The importance of management support for the implementation of equalities policies meant that turnover among higher level staff during periods of uncertainty was especially problematic. However leads also saw the transition between organisations as an opportunity to embed equality work within the new CCGs, and a way of ensuring good practice from the start. A new equality tool introduced by the NHS was seen as improving uniformity between different sectors and offering the opportunity to improve engagement with service users, although leads were also concerned that the tool raised expectations which were unlikely to be met without additional resources.

The addition of new equalities

The 2010 Equalities Act created further demands, with the introduction of new equalities or 'protected characteristics', which have impacted on policy implementation (Mannell, 2014; Conley and Page, 2014). One particular effect is the introduction of a single equality duty across all of the characteristics to replace multiple duties, which might offer the opportunity to develop more integrated approaches. However, research suggests that equalities officers across a range of organisations are concerned that integrated approaches, without explicit attention to intersectional experiences, can dilute or obscure gender inequalities (Hankivsky, 2013; Conley and Page, 2010).

Single Equality Schemes aim to address public sector duty requirements collectively and have taken what might be described as an 'additive' approach to intersectionality (Squires, 2009), listing each of the different 'characteristics' separately. Policies adopted have not explored intersectionality as a framework or the implications of multiple subjectivities for health needs and outcomes (author publication). Instead equalities policies refer to the health needs of specific sub populations, mainly identified by two aspects of inequality, such as black women or young gay, lesbian and bisexual people for example. This lack of explicit discussion of how inequalities intersect leaves policies unable to do more than target very narrow needs, while adding to discursive representations of the problem as being at the level of the individual rather than structurally determined social determinants of health and power (Bacchi, 1999).

The tension of addressing all of the specific equalities identified by the legislation, and the reality of complex health experiences, was reflected in the way equality leads talked about the concept of gender:

> "I also think that gender in itself it's a lot more nuanced and subtle than that so you're going to, perhaps the focus in future's going to be not so much one of men and women but it's going to be on black women, or gay men" (Female Equality and Diversity Manager #1)
>
> "It's when you start drilling down into gender …. as more of a generic group … if you're wanting to talk about men and women and disability and ethnicity and sexuality as a group of people, that's when it becomes a difficult issue, so I think people assume that when you're talking about gender, its just men and women." (Male Equalities Diversity and Human Rights Coordinator)

While gender is a complex concept, what it means is often taken for granted in policy formulation, and the policy problem is represented in a limited and individualised fashion, as the need to offer women or men specific services for example (Callerstig, 2014; Bacchi, 1999).

In outlining the necessity for health interventions which recognise health differences between women and men, leads also identified specific sub-groups within women and men, such as Muslim women who might prefer female-only sessions and instructors. These recognitions of multiple inequalities were narrowly framed around established binary discourses in health, such as ethnicity and gender, rather than other inequalities less often discussed in policy literature, such as ethnicity and transgender, and rather than more complex multiple subjectivities.

In addition, lack of resources in the light of these extra responsibilities posed further problems:

> "we're not just looking at three, four, five or six protected characteristics, we're now looking at nine, it doesn't mean that the law's given us resource to

be able to do nine characteristics in the same way" (Male Equality and Diversity Lead #2)

The continuing relevance of gender?

A related problem is the perception, at the level of practice, that gender equality has been achieved in comparison with other inequalities (Conley and Page, 2010). Gender equality is framed as less relevant than other inequalities at this micro-level of policy implementation, even while gender mainstreaming and equality strategies are endorsed at national level. This way of viewing gender as having been 'done' reflects broader social discourses in which the introduction of gender equality legislation can lead those responsible for policy development and implementation to see the question as having been dealt with, in contrast to other inequalities (Eyben, 2010). It also reflects the problems which arise when gender equality goals are 'bent' or reinterpreted during policy implementation which proceeds without discussion over the concept of gender equality or the objectives (Callerstig, 2014; Lombardo and Meier, 2009)

Leads in this study expressed this concern that colleagues sometimes viewed gender as having been addressed by earlier policies:

"I think that there is a bit of perception that we're winning the war … gender can feel a bit like ah well, do you know what, we've had the 70s, we've had feminism, it's all fine, no-one's gonna make space for gender and challenging those assumptions I think is hard" (Female Strategic Development Manager)

The 2010 Equalities Act and the extension of the equalities which need to be addressed by health organisations had added to this belief that gender was now less of a priority:

> "the introduction of other protected characteristics is often seen that we have achieved gender equality because you compare it to areas like transgender in which… far less work has been done around things like sexual orientation compared to things like gender equality" (Female Equality and Diversity Manager #1)

'Tick box' discourse and resistance

Equalities work is often described as morphing from transformative policy goals into narrow technocratic methods during implementation (Eyben, 2010), reflecting the presentation of gender equality as a rational and simple problem, open to technical solutions, compared with the messier reality (Lombardo and Meier, 2009; Ali et al., 2012). Approaches such as gender impact assessment tools are appealing because they offer opportunities for measureable results, particularly if resources are constrained (Kuhlmann, 2009; Lee-Gosselin et al., 2013), but gender discourse becomes invisible and fragmented by the 'pretence' that it is being addressed (Mannell 2014). At the same time, implementation is limited by individual and organisational resistance, both active and passive (Lee-Gosselin et al., 2013), and is harder to overcome in organisations where the role of equality leads is marginalised by departmentalism and their status within the organisation, meaning they need the support of others within the hierarchy (Callerstig, 2014).

The leads highlighted these problems in their work:

> "it risks becoming this tick box exercise. It smacks a little bit of what an absolutely brilliant policy but just implemented in a really bad way." (Female Strategic Development Manager).

Similarly, the development of Single Equality Schemes was seen as a process which became the end objective in itself:

> "with the Single Equality Schemes there were too many actions on there. Initially it was supposed to be about accountability, there were named officers, but actually it was a bit of a rush at the end of the year, it was trying to get the box ticked rather than actually working through the year on a set agenda." (Female Equality and Diversity Manager #2)

However, strategies to reduce resistance are also possible (Lee-Gosselin et al., 2013), including the avoidance of equalities language, in order to sell equalities work to colleagues by:

> "So what we've done…, we don't talk about equality and diversity and human rights we talk about health inequalities, we talk about what is our primary function and how do we best get it."(Male Equalities Diversity and Human Rights Co-ordinator)
>
> "I think just the term, equality and diversity – I don't know why – turns people off. I just don't use the term, equality and diversity. "(Female Equality and Diversity Lead)

Discussion

A number of studies have shown that the transformative potential of gender mainstreaming "gets lost in the micro politics of practice" (Van Eerdewijk and Davids, 2014: 309), and the discussion here of the work and perceptions of equalities leads helps to flesh this out. Some of the reasons why equalities policies are limited in practice reflect more general implementation problems identified by Exworthy et al. (2002) – organisational and policy change and workloads for example. But data presented here highlight a number of problems for gender policies which add to our understanding of why gender mainstreaming often fails in practice.

The first is that implementation at local level can be accompanied by a marginalization of equalities issues, which are diverted to nominated individuals, rather than being part of the mainstream agenda (Sainsbury and Bergqvist, 2009). Leads often do not have deep gender knowledge, and their in-job training is voluntary, suggesting such knowledge is relatively unvalued by the organisation. Leads disguise their work as 'business as usual' in the face of resistance within the organisation to equalities objectives, have relatively little managerial power and low levels of resources, and while senior management support for their work is significant, this leaves them vulnerable to managerial change and disinterest.

The second theme relates to the shift at implementation stage from a transformative ideal to technocratic approach (Gideon, 2012), and the role of equalities specialists in this. Equalities leads rely on technocratic solutions such as impact assessments which turn equalities objectives into bureaucratic goals, recreating an organisational discourse in which equalities work is a tick-box exercise, and further distancing the work from the mainstream policy agenda and objectives (Kenney, 2003).

The third theme to emerge from this research highlights new problems within integrated approaches to equalities work, when gender can become obscured or marginalized. This problem is deepened by the way policy implementation uses taken for granted assumptions – about the meaning of gender or of intersectional experiences of discrimination – in the absence of ways within policy in which these concepts might be unpacked, explored and broadened out. Gender becomes a meaningless 'nonsensical metaphor' served by the technocratic implementation process (de Vries et al., 2015).

This study also identifies the importance of thinking about the extent to which equalities leads can or do act as street-level policy entrepreneurs and how this

affects the implementation of equalities policies from above. While the success or otherwise of policy is influenced by a number of factors, equality leads are critical in the day-to-day delivery of equalities policies. The work they do impacts, shapes and bends policy objectives, often through small, incidental and unnoticed shifts in policy as it develops at local level (Arnold 2015). The leads in this study varied in the extent to which they might be described as 'entrepreneurs' however. For example, equalities leads take decisions over which aspects of their work to prioritise, which can create or reinforce ideas about which aspects of inequality are more important, and which have already been addressed, but they also have to rely on the support of senior management to validate their work. The extent to which leads were explicitly recruited as experts and as individuals with a commitment to equality objectives – and might be in a position to act as SLPEs – varied between organisations, suggesting that the background of the lead is an important element in how equalities policies develop at local level not simply because of the need for 'deep knowledge' but also because this increases the potential for the policy entrepreneurship that aids implementation of policies which are not accepted across the organisation.

Conclusions: Barriers to gender equality work in practice

This paper has drawn on interviews with equalities leads in the health sector in England to explore their background, the barriers they face and their perceptions of implementing gender equalities policies developed at national level. While a small number of interviews can offer only tentative conclusions, it appears that the implementation of gender equality policies in the health sector is limited by resources, a lack of 'deep knowledge' and gender expertise. It is also affected by organisational change, which opens up opportunities to embed equalities work into emerging cultures but can also mean that equalities objectives lose out to other

needs and priorities, particularly in the context of pressures created by new demands. In addition, the translation of national level policies into local practice is often accompanied by a reliance on bureaucratic solutions and tools, which encounter resistance from within the organisation. This in turn helps to marginalise equality as something that is dealt with elsewhere, rather than being part of the mainstream agenda, while *gender* equality can start to be seen as less important than other equalities within an increasingly integrated approach.

A number of recommendations might follow from this, for practice, theory and research. In terms of practice, this study suggests the need for more explicit discussion of what is meant by gender and how gender interacts with other equalities objectives, clearer articulation across different scales of policy of the differences between goals of equalities policies and the ways in which they might be achieved and evaluated. The deep knowledge of equalities leads needs to be recognised and valued while their potential to act as SLPEs needs to be fostered more explicitly. In addition the limitations of short-term tools which leave organisational processes and discourse intact and the underlying problem unexplored have to be addressed (Lee-Gosselin et al., 2013). This entails a recognition of the messiness of both problems and solutions, and the role of policy in shaping discourse.

Implications for research include the need for in-depth studies of policy implementation in this area, focusing on the implementation gap and the role of street-level policy entrepreneurs from a gender perspective. This means looking at how national and top-down equalities policies are implemented across various organisations, and the role and potential of local 'agents of change' in complex public sector settings. Understanding the challenges faced by these local 'agents of change' and taking steps to recognise and support them is vital to understand the

'policy implementation gap' that exists between national policy and action at a local level.

References

Ali S, Burns C and Grant L. (2012) Equality and Diversity in the Health Service: An Evidence-Led Culture Change. *Journal of Psychological Issues in Organizational Culture* 3: 41-60.

Annesley C, Gains F and Rummery K. (2010) Engendering politics and policy: the legacy of New Labour. *Policy & Politics* 38: 389-406.

Arnold G. (2013) Street-level policy entrepreneurship. *Public Management Review* 17: 307-327.

Bacchi C. (1999) *Women, Policy and Politics: The construction of policy problems,* London: Sage.

Callerstig A-C. (2014) Making equality work: Ambiguities, conflicts and change agents in the implementation of equality policies in public sector organisations. *Linköping Studies in Arts and Science No 607.* Linköping University

Conley H and Page M. (2010) The gender equality duty in local government: The prospects for integration. *Industrial Law Journal* 39: 321-325.

Conley H and Page M. (2014) *Gender Equality in Public Services: Chasing the Dream*: Routledge.

de Vries JA, Bendl R and Pringle J. (2015) Champions of gender equality: Female and male executives as leaders of gender change. *Equality, Diversity and Inclusion: An International Journal* 34: 21-36.

DH. (2002) National Suicide Prevention Strategy for England. London: Department of Health.

DH. (2004) Women's Mental Health Strategy. London: Department of Health.

Doyal L, Payne S and Cameron A. (2003) Promoting Gender Equality in Health. Manchester: Equal Opportunities Commission.

EHRC. (2011) Performance of the Health Sector in meeting the Public Sector equality Duties. Trowbridge: A Focus Consultancy report for the Equalities and Human Rights Commisssion.

Erasmus E and Gilson L. (2008) How to start thinking about investigating power in the organizational settings of policy implementation. *Health Policy and Planning* 23: 361-368.

Exworthy M, Berney L and Powell M. (2002) 'How great expectations in Westminster may be dashed locally': the local implementation of national policy on health inequalities. *Policy & Politics* 30: 79-96.

Eyben R. (2010) Subversively accommodating: feminist bureaucrats and gender mainstreaming. *IDS Bulletin* 41: 54-61.

Fredman S. (2009) Making Equality Effective: The role of proactive measures Brussels: European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities Unit EMPL/G/2

Gideon J. (2012) Engendering the health agenda? reflections on the Chilean case, 2000-2010. *Social Politics* 19: 333-360.

Hankivsky O. (2005) Gender vs. diversity mainstreaming: A preliminary examination of the role and transformative potential of feminist theory. *Canadian Journal of Political Science-Revue Canadienne De Science Politique* 38: 977-1001.

Hankivsky O. (2013) Gender Mainstreaming: A Five-Country Examination. *Politics & Policy* 41: 629-655.

Hannan C. (2011) Gender mainstreaming: failings in implementation. *Kvinder Køn & Forskning* 1: 63-66.
Keleher H. (2013) Policy scorecard for gender mainstreaming: gender equity in health policy. *Australian and New Zealand Journal of Public Health* 37: 111-117.
Kenney SJ. (2003) Where is gender in agenda setting? *Women & Politics* 25: 179-207.
Kingdon J. (1995) *Agendas, alternatives, and public policies,* New York: Longman.
Kuhlmann E. (2009) From Women's Health to Gender Mainstreaming and Back Again Linking Feminist Agendas and New Governance in Healthcare. *Current Sociology* 57: 135-154.
Kuhlmann E and Anmnandale E. (2012) Mainstreaming gender into healthcare: a scoping exercise into policy transfer in England and Germany. *Current Sociology* 60: 551-568.
Kvidal T and Ljunggren E. (2014) Introducing gender in a policy programme: a multilevel analysis of an innovation policy programme. *Environment and Planning C: Government and Policy* 32: 39-53.
Lee-Gosselin H, Briere S and Ann H. (2013) Resistances to gender mainstreaming in organizations: toward a new approach. *Gender in Management: An International Journal* 28: 468-485.
Lombardo E and Meier P. (2009) Stretching, bending and inconsistency in policy frames on gender equality. In: Lombardo E, Meier P and Verloo M (eds) *The discursive politics of gender equality: stretching, beinding and policy making.* London: Routledge.
Mannell J. (2014) Conflicting policy narratives: Moving beyond culture in identifying barriers to gender policy in South Africa. *Critical Social Policy* 34: 454-474.
McGauran A. (2009) Gender mainstreaming and the public policy implementation process: round pegs in square holes? *Policy &; Politics* 37: 215-233.
Men's Health Forum. (2006) The Report of the Gender Equity Project: What the "Gender duty" provision of the Equality Act 2006 will mean for the health of men. London: Men's Health Forum, with Essex Primary Care Research Netowrk and Department of Health.
Page ML. (2011) Gender Mainstreaming — Hidden Leadership? *Gender, Work & Organization* 18: 318-336.
Petchey R, Williams J and Carter YH. (2008) From Street-level Bureaucrats to Street-level Policy Entrepreneurs? Central Policy and Local Action in Lottery-funded Community Cancer Care. *Social Policy & Administration* 42: 59-76.
Roggeband C. (2013) Gender mainstreaming in Dutch development cooperation: The dialectics of progress. *Journal of International Development* 26: 332-344.
Sainsbury D and Bergqvist C. (2009) The promise and pitfalls of gender mainstreaming. *International Feminist Journal of Politics* 11: 216-234.
Squires J. (2009) Intersecting inequalities: Britain's equality review. *International Feminist Journal of Politics* 11: 496-512.
Squires J. (2010) Beyond Multiple Inequalities: Transversal Intersectionality, Diversity Mainstreaming and Participative Democracy. *Kvinder Køn & Forskning* 23: 85-93.
Theobald S, Tolhurst R, Elsey H, et al. (2005) Engendering the bureaucracy? Challenges and opportunities for mainstreaming gender in Ministries of Health under sector-wide approaches (vol 20, pg 141, 2005). *Health Policy and Planning* 20: 265-265.
Van Eerdewijk A. (2014) The micropolitics of evaporation: Gender mainstreaming instruments in practice. . *Journal of International Development,* 26: 345-355.
Van Eerdewijk A and Davids T. (2014) Escaping the mythical beast: gender mainstreaming reconceptualised. *Journal of International Development* 25: 303-316.

Wilkins D, Payne S, Granville G, et al. (2008) The gender and access to health services study: final report. . London: Department of Health.