Department
of Health &
Social Care

WOMEN'S
HEALTH
Let's talk about it

Results of the written evidence submitted by organisations and experts to inform the Women's Health Strategy for England

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Contents

Note that this report represents the views of organisations and experts who responded to our call for evidence, and we recognise that in some cases there may be alternate views on specific issues. The inclusion of recommendations from organisations and experts does not mean they are endorsed or accepted by DHSC/government.

Executive summary

The Department for Health and Social Care (DHSC) launched a call for evidence in March 2021 to inform the first-ever government-led Women's Health Strategy for England.

This report focuses on the submissions we received from 436 organisations and individuals with expertise in women's health, including the charity sector (34%), academia (22%), industry (10%), clinicians (7%), professional bodies (7%), pressure groups (7%), NHS organisations (3%), parliamentary groups (2%), royal colleges (1%), local government (1%), think tanks (1%), and others (6%).

Many of the insights align with what women told us directly through our public survey (which received nearly 100,000 responses from individuals in England) and focus group study. In this report we briefly highlight commonalities, but mainly focus on the new and additional points raised. We would recommend reading all three reports alongside one another to get a complete picture of the evidence generated.

Menstrual health and gynaecological conditions

114 submissions talked about menstruation and/or gynaecological conditions.

Key points

The causes of period poverty and wider poverty are intrinsically linked. Some in financial hardship are having to rely on food banks to access period products for free, and/or overuse single-use period products, which can cause bacterial vaginosis, urinary tract infections, and toxic shock syndrome. Beyond meeting a physical need, period poverty can negatively impact women's mental wellbeing and sense of worth.

There is a lack of recognition both within and beyond the healthcare system that menstruation does not need to be heavy and painful for it to impact someone's quality of life, and their participation in education and the workforce. Most people who menstruate will experience premenstrual syndrome, the symptoms of which vary and can include mood swings, anxiety, tiredness, headaches, and in severe cases, depression and suicidality.

Sexual health and contraception

67 submissions talked about sexual health and/or contraception.

Key points

The barriers to accessing information, services and support will be greater for some groups of women due to systemic biases, cultural and/or religious beliefs. For example, there are reports that girls and women have been told that they should not try to get pregnant because they have a disability, or that their risk of contracting a sexually transmitted infection is minimal or non-existent if they only have sex with other women. There are also reports that some women are not able to access emergency contraception, or have been dissuaded from doing so, because of family or community ties to pharmacists, who hold specific religious beliefs about sex before marriage and pregnancy termination.

Other women will be impacted by geographical variations in the commissioning and funding of sexual and reproductive health services. It is estimated that almost half of councils have reduced the number of sites delivering contraceptive services since 2015. This can make it more difficult for women to access contraception for non-contraceptive purposes (e.g., to manage heavy menstrual bleeding) and to afford the cost of travelling further.

Fertility, pregnancy, pregnancy loss and maternal health

196 submissions talked about fertility, pregnancy, pregnancy loss, and/or maternal physical and mental health.

Key points

When it comes to getting pregnant, there is a lack of information on the impact of lifestyle choices and pre-existing health conditions on fertility, the efficacy and safety of ‘add-on’ treatments sold by fertility clinics, and options for fertility preservation. This is not helped by the inconsistent implementation of fertility treatment guidelines and varying funding levels across Clinical Commissioning Groups, meaning that where you live and whether you are in a heterosexual relationship can affect your level of access to IVF provision.

Reports of women not feeling heard during and after pregnancy are common. This includes being dismissed when raising concerns about reduced foetal movement, being denied pain relief when in labour, and not being given due care and attention when reporting physical and mental health issues (such as pelvic organ prolapse and postnatal depression). More also needs to be done to address ethnic and socio-economic disparities in maternal and neonatal outcomes, and to recognise that women's experiences of miscarriage, baby loss and bereavement will vary, and require personalised support.

The menopause

80 submissions talked about the menopause.

Key points

There are gaps in training provision and guidelines for healthcare professionals, which hinders effective menopause care. For example, menopause training is often not mandatory and relies on self-directed learning, and clinical guidelines tend to emphasise the risks associated with treatment options such as hormone replacement therapy, rather than evidence on potential benefits, and how to support women to make an informed choice.

Beyond the healthcare system, the menopause is still a taboo topic in many workplace settings, and there are variations in menopause support policies and awareness of the different symptoms women can experience beyond hot flushes (such as 'brain fog'). This can contribute to productivity and retention issues – issues which are set to increase, with more women aged 50 and above participating in employment.

Gynaecological and other cancers

55 submissions talked about gynaecological, breast, and/or other cancers.

Key points

Public information campaigns tend to be one-off rather than sustained initiatives. Women lack high-quality and up-to-date information on risk factors for female cancers across the life course, and how to spot the signs of different gynaecological cancers. However, raising awareness is not enough. Some may avoid seeking help, and others may not be listened to when they do. For example, women who have been sexually assaulted may fear being retraumatised during a smear test and some healthcare professionals may dismiss or misdiagnose cancer symptoms as other conditions such as endometriosis, irritable bowel syndrome, or mental ill health.

More broadly, there is a need to ensure women receive personalised care plans and holistic needs assessments, so that they have meaningful opportunities to ask questions, discuss options, and raise concerns such as the impact of cancer treatment on their fertility. It is also important that women living beyond cancer do not get left behind; for example, some women have not been able to proceed with breast reconstruction following a mastectomy due to the COVID-19 backlog in elective care.

Mental health

151 submissions talked about mental health and/or addiction and substance abuse.

Key points

It is essential to understand how mental ill health can stem from and interact with women's health conditions across the life course, and how mental health outcomes may vary between groups of women. For example: premenstrual dysphoric disorder can cause anxiety and suicidal thoughts; depression during and after pregnancy is common; middle-aged women may struggle to secure a diagnosis of bipolar disorder as their symptoms are attributed to hormone shifts and the menopause; and women from ethnic minority backgrounds, who identify as lesbian or bisexual, have a disability, and/or are from an inclusion health group may be at a higher risk of poor and long-term mental health issues.

It is also important to acknowledge that some women may struggle to access the services they need or may find that the support available is not appropriate when they do. For example: young women have been told that their eating disorder is 'just a phase' and that they need to lose more weight to be taken seriously; ethnic minority women are more likely to encounter mental health services through criminal justice pathways and through the Mental Health Act rather than primary care; and male-dominated substance abuse services may overlook differences in how women's bodies process drugs.

Healthy ageing and other conditions

113 submissions talked about healthy ageing and other conditions (including autism, autoimmune conditions, cardiovascular disease, chronic and long-term conditions, and neurodegenerative diseases).

Key points

Women in England tend to live longer than men, but they also spend a greater proportion of their lives in ill health and disability. Despite this, there is an inadequate focus on the health needs of older women and a reluctance to prioritise their concerns; for example, female incontinence and bone breakage due to osteoporosis are commonly accepted as unavoidable consequences of getting older.

There is also a lack of understanding and recognition of how women may experience the same conditions as men in different ways, and therefore present with different risk factors and symptoms. For example: the guidelines used to diagnose autism contain questions which are based on symptoms predominantly displayed by males, which contributes to women being diagnosed much later in life, and/or misdiagnosed with anxiety or other emotional disorders.

Violence against women and girls

77 submissions touched on violence against women and girls (including domestic, sexual, and ‘honour’-based abuse).

Key points

Violence against women and girls can take many different forms, and the impacts are wide ranging. For example, hymenoplasty is often carried out for cultural reasons among specific minority ethnic groups, and can result in complications such as bleeding, inflammation, infection, and scarring in the vagina, as well as psychological trauma and poor mental health outcomes. Despite there being no scientifically proven benefits, it is still a medical procedure that can be carried out by independent providers.

Barriers when trying to access healthcare support can be particularly severe for women who: have been subject to years of prolonged violence and abuse, are being abused by multiple perpetrators, are isolated within a particular community through language or culture, have mobility issues or special needs, or are reliant on their abuser for their care or money.

Recommendations moving forward

Organisations and experts put forward a wide range of recommendations to improve women’s health outcomes and service provision across the life course. Here, we highlight overarching themes and provide a few examples.

Increase public awareness of women's health topics and improve access to high-quality information in digital and non-digital formats

For example:

- update content on fertility and fertility treatments on the NHS website
- run sustained information campaigns in partnership with community and voluntary sector organisations to destigmatise topics such as baby loss, improve awareness of the range of symptoms associated with conditions such as the menopause, and encourage women to access healthcare services such as cervical screening
- equip teachers with better knowledge and resources to educate all children on the practical and emotional aspects of managing menstrual symptoms

Introduce and update legislation to better protect women and improve service quality

For example:

- legislate to ban virginity testing and hymenoplasty in England
- update the Human Fertilisation and Embryology Act 2008 to support the evaluation of technological and medical advances, support the sharing of routinely collected data across NHS services, quality improvement initiatives, and research studies, and enable the Human Fertilisation and Embryology Authority (HFEA) to have oversight of some currently unlicensed activity

Ensure national guidelines are fully and consistently implemented, and extended where necessary to address important gaps

For example:

- implement NICE guidelines across the NHS to improve endometriosis care, reduce diagnosis times and avoid multiple repeat GP, hospital and A&E visits
- support Clinical Commissioning Groups / Integrated Care Systems to follow NICE guidelines on IVF provision, and extend access to women who missed their chance to try for a baby during the pandemic
- implement the National Bereavement Care Pathway across all NHS trusts

- ensure schools and colleges refer to national guidelines on the safe teaching of mental health issues, including eating disorders and self-harm

Improve healthcare professionals’ education and continuous development to better listen to and support women

For example:

- roll-out standardised menopause training to all practising GPs and practice nurses, with an emphasis on identifying the root causes of symptoms and how these symptoms overlap with other conditions
- roll-out training across the healthcare system on conditions that present differently in women compared to men, with reference to new and emerging research
- ensure healthcare professionals have the necessary training to better support women who experienced (and may still be experiencing) trauma or abuse

Prioritise integrated, holistic, and user-centred care models to respond to the varying needs of women across the life course

For example:

- create more women’s health hubs
- appoint dedicated women’s health leads across Integrated Care Systems
- ensure women diagnosed with cancer are given a personalised care plan and holistic needs assessment
- co-design policies and services with women, and specialist, community and voluntary sector organisations

Increase funding to improve women’s health services and address disparities between men and women, and different groups of women

For example:

- reduce the cost of period products and build on the commitment made by the UK’s Period Poverty Taskforce to provide free period products in schools and colleges
- increase funding for sexual and reproductive health services

- increase investment in midwifery services, maternal mental health services, and the cancer workforce
- enable rehabilitation services to meet the needs of women, including more beds, short in-house programmes, and women only centres

For employers to improve their workplace provisions and policies to better support women in different situations

For example:

- increase provision of workplace policies and guidance to better support women going through the menopause
- sanction the use of sick leave rather than annual leave to help women manage the impacts of chronic conditions such as endometriosis
- implement pregnancy loss policies in all workplaces, including paid leave for employees who experience a miscarriage or stillbirth

Areas for future research

Organisations and experts also called for greater investment in research and data to plug evidence gaps, inform medical guidelines and treatments, and evaluate initiatives. Here, we highlight overarching suggestions and provide a few examples.

Expand and optimise data collections to monitor trends nationally, by sex, and by other characteristics

For example:

- make it the norm to disaggregate data by cancer type (rather than pooling all gynaecological cancers together given their varying diagnostic and treatment pathways) and by other characteristics such as ethnicity
- collect and link data to better understand and monitor the impacts of menstruation and gynaecological conditions on educational outcomes and attainment, and on workforce participation and sick absence rates
- collect longitudinal data on cancer in non-symptomatic women

Investigate the links between health conditions, and the impact of COVID-19 on women's health

For example:

- investigate the links between: polycystic ovary syndrome and metabolic syndrome; gynaecological conditions and mental health outcomes; and early menopause and Alzheimer's disease
- understand the impacts of COVID-19 and long-COVID on women's menstrual health and menopausal women, and any long-term impacts of receiving COVID-19 vaccines during pregnancy

Ensure women with different characteristics are represented in clinical trials and invest in community-based, participatory research

For example:

- conduct clinical research to better understand the genetic causes of cancers in ethnic minority women, especially those of South Asian origin
- identify why sexually transmitted infections, HIV, use of emergency contraceptives, and conditions such as fibroids are more prevalent in black women
- better reach and understand the needs of underrepresented, minority, and inclusion health groups by designing and conducting research in collaboration with specialist, community and voluntary sector organisations

Invest in research and evaluations to understand the efficacy and effectiveness of health treatments, service models and interventions

For example:

- evaluate the efficacy of practice models (such as Continuity of Care), and workplace adaptations and policies
- review data and evidence on the safety and efficacy of IVF add-on treatments
- monitor the wider benefits of hormone replacement therapy on osteoporosis and cardiovascular disease

- evaluate the ability of Femtech apps to help women understand their hormonal fluctuations and augment existing support, and the effectiveness of AI technologies to predict which pregnancies will develop life threatening foetal growth restriction

Introduction

In March 2021, the Secretary of State for Health and Social Care and the Minister of State for Patient Safety, Suicide Prevention and Mental Health launched a call for evidence seeking views on the first ever government-led Women's Health Strategy for England.

There were 3 parts to this call for evidence:

- a 'Women's Health – Let's talk about it' public survey, which was open to all individuals aged 16 and over in England
- an open invitation to organisations and individuals with expertise in women's health to submit written evidence
- a focus group study with women across England, undertaken by the University of York in collaboration with the King's Fund

This report focuses on the written evidence submitted by 436 organisations and individuals with expertise in women's health. It should be read alongside the results of our public survey (which nearly 100,000 women in England responded to) and the focus group study, to get a complete picture of the evidence generated.

A description of the types of organisations and experts who responded, and our approach to analysing their written evidence, is set out in the 'Methodology' section of this report.

The results are then discussed under the following headings:

- Menstrual health and gynaecological conditions
- Sexual health and contraception
- Fertility, pregnancy, pregnancy loss, and maternal health
- The menopause
- Gynaecological and other cancers
- Mental health
- Healthy ageing and other conditions
- Violence against women and girls

At the start of each section, we provide a recap of the key findings from our public survey and then set out the findings from organisations and experts.

A glossary of the health conditions and other key terms we refer to is available at the end of this report.

Methodology

In this section, we provide an overview of how organisations and experts could submit evidence to us, how we processed and analysed the data, and points to consider when interpreting the results.

Format

Organisations and individuals with expertise in women’s health were able to submit written evidence between 8 March and 13 June 2021.

Submissions were accepted in word and PDF format and could be uploaded to an online portal or emailed to DHSC’s Women’s Health Strategy Call for Evidence mailbox.

There were no set questions, but as a guide we expressed an interest in receiving data, research, and information on:

- women's voices – for example, evidence on women’s voices not being listened to in relation to specific conditions or types of interaction with healthcare professionals
- information and education on women’s health – for example, evidence on women’s and practitioners’ understanding of female-specific conditions
- women's health across the life course – for example, evidence on if or how current services do not meet women’s specific needs, and how these needs vary between different groups of women
- women's health in the workplace – for example, evidence on women’s workforce participation being impacted by general or female-specific health conditions
- evidence gaps – for example, aspects of health or medical research that neglects women’s perspectives or experiences and the consequences of this
- impacts of COVID-19 on women’s health – for example, evidence on how COVID-19 has impacted women’s health services, including innovation in service delivery

We asked organisations and experts to try and limit their responses to 10 pages to help ensure our analysis was manageable, but this was not enforced.

Data preparation

Overall, we received 506 submissions. Of these, 70 were not eligible for inclusion in this report as they were personal testimonies from members of the public.

The remaining 436 submissions were logged according to the type of organisation or expert responding. As shown in Table 1, just over a third came from the charity sector (34%), and over a fifth from academia (22%). We also received responses from industry, clinicians, professional bodies, pressure groups, NHS organisations, parliamentary groups, royal colleges, local government, think tanks, and others (such as workplace networks).

Table 1. Types of organisations and experts who submitted written evidence to inform the Women's Health Strategy for England

Respondent type	Count of eligible submissions	% of eligible submissions
Charity	148	34%
Academic	95	22%
Industry	42	10%
Clinician	32	7%
Professional body	30	7%
Pressure group	30	7%
NHS organisation	11	3%
Parliamentary	8	2%
Royal College	6	1%
Local Government	5	1%
Think Tank	4	1%
Other	25	6%

We also logged the main health conditions and topics covered in each submission. As shown in Table 2, nearly half of all submissions talked about fertility, pregnancy, pregnancy loss, and/or maternal health (45%), and over a third talked about women's mental health (35%). Other topics included menstrual health and gynaecological conditions (26%), healthy ageing and other conditions such as autism and dementia (26%), the menopause (18%), violence against women and girls (18%), sexual health and contraception (15%), and gynaecological and other cancers (13%).

Table 2. Main health topics discussed in the written evidence submitted by organisations and experts to inform the Women's Health Strategy for England

Overarching topic	**Count of eligible submissions**	**% of eligible submissions**
Menstrual health and gynaecological conditions	114	26%
Sexual health and contraception	67	15%
Fertility, pregnancy, pregnancy loss, and maternal health	196	45%
The menopause (including perimenopause)	80	18%
Gynaecological and other cancers	55	13%
Mental health (including addiction and substance misuse)	151	35%
Healthy ageing and other conditions (including non-female specific physical and neurological conditions)	113	26%
Violence against women and girls (including domestic abuse and sexual assault)	77	18%

Analysis

Each submission was reviewed in detail and logged by at least two individuals. Key findings from the submissions were extracted into a standardised template, with one template filled out for each topic. The template instructed reviewers to list the key barriers faced by women (and different groups of women) and the recommendations and suggestions put forward by organisations and experts to overcome these barriers. By taking this approach, we were able to capture insights in a consistent way and record the number of submissions that mentioned the same barriers and suggestions.

In analysing and writing-up these results, we:

- looked at whether and how the insights from organisations and experts aligned with what women told us directly through our public survey
- centred our overarching narrative around the most common additional barriers and suggestions identified by organisations and experts

- included a sample of barriers and suggestions put forward by a minority of organisations and experts, recognising that some aspects of women’s health will be more niche but still important

Caveats

When reading this report, it is important to note that:

- while we necessarily focus on what the evidence tells us about women’s experiences and women’s health (including non-binary and trans people), this does not mean that men do not experience some of the same barriers, or that the unique barriers faced by men are less important

- the sections that cover ‘suggestions moving forward’ represent the views of the organisations and experts who responded to this call for evidence; we recognise there may be alternate views on specific issues, and the inclusion of these suggestions does not mean they are endorsed or accepted by DHSC/government

- where organisations and experts have made factual statements - for example, about disparities in women’s health outcomes or gaps in medical curricula - we have tried to independently verify the accuracy of these points; however, it is possible that there may be alternative sources of information which show a different picture

Menstrual health and gynaecological conditions

In this section we briefly recap the main results from our public survey on menstrual wellbeing and gynaecological conditions. We then highlight commonalities and areas of additional focus identified by organisations and experts.

Recap of insights from our public survey

From our analysis of the results from the public survey, we found:

- gynaecological conditions was the topic respondents most wanted us to include in the Women's Health Strategy (63%); menstrual health was the 4th most selected topic (57%), and the 1st choice of topic for those aged 16 to 17

- less than 1 in 5 respondents said they have sufficient information on menstrual wellbeing (17%), and less than 1 in 10 said the same about gynaecological conditions such as endometriosis and fibroids (8%)

- women often have their symptoms and concerns dismissed by healthcare professionals as a 'natural' part of being a woman, and there is a lack of support in the workplace to help them manage the symptoms and impacts of conditions such as endometriosis and polycystic ovary syndrome

Insights from organisations and experts

The 114 submissions we received from organisations and experts on menstrual health and/or gynaecological conditions align with the insights captured through our public survey.

Additional areas of focus included:

- period poverty and period stigma

- gaps in clinician education and service provision

These are discussed in turn below.

Period poverty and period stigma

A common thread across submissions was that menstruation does not need to be heavy and painful for it to impact people's quality of life (including women, girls and people who menstruate).

Period poverty

Period poverty was one of the main examples provided, where individuals who cannot afford to buy period products are having to:

- 'make do' by using toilet paper or strips of cloth to absorb blood, or overusing single-use period products (which can lead to bacterial vaginosis, urinary tract infections, and toxic shock syndrome)

- rely on food banks to access period products for free, if they have been donated and are available

- beg for money or cut back on other essential items, such as food, to afford the cost of period pads or tampons

Organisations and experts noted that the causes of period poverty and wider poverty are intrinsically linked, and that beyond meeting a physical need, access to free period products for those in financial hardship was essential to their mental wellbeing and sense of dignity.

Period stigma

Period stigma was another example cited across submissions as having negative, yet unquantified, impacts on outcomes such as participation in education and the workplace.

Research and anecdotal evidence shared by organisations and experts pointed to some children and young people taking time off school or missing lessons because they:

- fear being teased or bullied about starting or being on their period, or 'being seen' with period products

- do not feel comfortable explaining to their teacher, often in front of their peers, why they need to use the toilet during lesson time to manage their period

- are not able to fully concentrate during lessons while they are menstruating

This sense of stigma, and the practice of 'menstrual concealment', is often perpetuated in the workplace. Organisations and experts shared examples of women fearing they would be perceived as ‘weak’, ‘flaky’, or ‘unreliable’ if they cited menstrual issues as a reason for not being as productive, needing a workplace adjustment, or taking time off.

Other examples included women being subject to disciplinary action when taking time off to manage their menstrual or gynaecological health, and women who resigned or left their profession due to the lack of support or misinformed attitudes they faced.

Gaps in clinician education and service provision

It is well documented that it can take several years for women to secure a diagnosis and/or receive treatment for certain gynaecological conditions.

There was a general feeling across submissions that part of this stems from gynaecological conditions being overlooked and/or not fully understood by healthcare professionals. Specific examples included:

- guidelines for diagnosing and managing endometriosis not being fully implemented in England, despite being issued by the National Institute for Health and Care Excellence (NICE) in 2017
- premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD) not being mentioned in the core curriculum for the Royal College of Psychiatrists, despite these conditions often manifesting with psychological symptoms such as anxiety and depression
- some healthcare professionals dismissing women’s concerns because they do not feel confident in differentiating between heavy periods (which are common and without cause for concern for many women), versus heavy periods that are indicative of other conditions such as endometriosis, fibroids, polycystic ovary syndrome, and pelvic inflammatory disease

As a result, women may be advised that their symptoms do not warrant further investigation or can simply be managed through lifestyle changes (such as exercise and diet).

While gynaecological specialists were identified as a potential safeguard / solution by some organisations and experts, this came with the caveat that they are currently a limited resource and not dispersed evenly across the country.

Others emphasised the need to ensure that service provision is linguistically and culturally relevant and appropriate. This tended to be emphasised in relation to refugees and asylum seekers, some of whom come from conservative countries where periods are not discussed, or where it is not safe to disclose that they are transgender to get advice on their menstrual and gynaecological health.

Suggestions moving forward

Organisations and experts put forward a range of proposals to improve outcomes in this area. This included, for example:

- reduce the cost of period products (such as pads and tampons) and build on the commitment made by the UK's Period Poverty Taskforce to provide free sanitary products within schools and colleges

- equip teachers with better knowledge and resources to educate all children on the practical and emotional aspects of managing menstrual symptoms

- identify opportunities to educate people outside of the school system (for example, the homeless, refugees, asylum seekers) on how to maintain good menstrual and gynaecological health, what is 'abnormal' for menstrual bleeding, and where they can seek professional support and advice

- review and improve healthcare professionals' education and training, to ensure they are better equipped to listen to women and identify and treat gynaecological conditions

- acknowledge the link between gynaecological conditions and mental health, combine diagnostic and treatment pathways, and ensure GPs and other professionals (such as psychologists, psychiatrists, gynaecologists, social workers, nurses, and family planning teams) are educated about premenstrual disorders

- for the government and NHS to recognise endometriosis as a chronic condition requiring long term support, and commit the resources needed to diagnose, treat and manage it

- implement NICE Guideline NG 73 and NICE Quality Standards QS 172 across the NHS in England to improve endometriosis care, reduce diagnosis times and avoid multiple repeat GP, hospital and A&E visits

- expand integrated care models, such as women's health hubs, appoint dedicated women's health leads across Integrated Care Systems (ICSs), and use community and voluntary sector organisations to better reach inclusion health groups

- for employers to acknowledge that gynaecological conditions can sometimes impair an individual’s ability to work, and to sanction the use of sick leave rather than annual leave to manage such conditions

Suggested areas for further research included:

- the impact of menstruation and gynaecological conditions on educational outcomes and attainment, and on workforce participation and sick absence rates
- the relationship between COVID-19, long-COVID and menstruation
- the links between menstruation, gynaecological conditions and mental health symptoms and outcomes
- the links between polycystic ovary syndrome and metabolic syndrome (a cluster of conditions that increase the risk of heart disease and type 2 diabetes)
- the causes of fibroids and why it develops more frequently in women from ethnic minority backgrounds, in particular women of African-Caribbean origin
- the ability of Femtech apps to help women understand their hormonal fluctuations and augment existing support
- the ways in which service provision can be more sensitive to the additional needs of inclusion health groups, including through community-based participatory research

Sexual health and contraception

In this section we briefly recap the main results from our public survey on sexual health, including contraception. We then highlight commonalities and areas of additional focus identified by organisations and experts.

Recap of insights from our public survey

From our analysis of the results from the public survey, we found:

- ‘sexual health including contraception’ was the 10th most popular topic respondents wanted us to include in the Women’s Health Strategy (21%)

- 78% of respondents felt comfortable talking to healthcare professionals about contraception and pregnancy; this decreased for younger women, women with disabilities, and those whose gender identity does not match their sex at birth

- women are often not given the opportunity by healthcare professionals to discuss the different types of contraception available, the side effects associated with hormonal contraceptives, and their preferred course of action

- while GP services often do not meet women’s sexual health and contraceptive needs it is difficult to access alternatives, such as sexual health clinics, because of waiting times and travel distance

Insights from organisations and experts

The 67 submissions we received from organisations and experts on sexual health and/or contraception align with the insights captured through our public survey.

Additional areas of focus included:

- the multiple forms of disadvantage faced by some groups of women

- the impacts of service fragmentation

These are discussed in turn below.

Multiple forms of disadvantage

Organisations and experts flagged that some groups of women are likely to experience greater barriers to being listened to by healthcare professionals or accessing the sexual and reproductive health services they need.

Examples, largely based on anecdotal evidence and direct engagement with specific groups of women, included:

- healthcare professionals advising girls with disabilities that they should not seek to get pregnant, or that they should consider getting an abortion if they do fall pregnant
- healthcare professionals not initiating discussions about sexual health with older women, due to presumptions about older people not being as sexually active
- women who have sex with women being misinformed about how sexually transmitted infections can be spread
- black women, women with disabilities, and girls in care feeling coerced into using long-acting reversible contraception
- healthcare professionals, including pharmacists, preventing or dissuading girls and women from using emergency contraception on cultural or religious grounds
- girls who are neuro-diverse, attend religious schools, and/or are taken out of school, not having access to the same level of unbiased, quality information on sexual health, contraception, and abortion
- women in coercive or abusive relationships not being able to exercise their right to terminate a pregnancy, due to difficulties in leaving the home to seek support in-person from healthcare professionals, have an assessment, and/or have a medical termination in a clinic or hospital setting
- women who are sleeping rough or involved in sex work feeling disincentivised from seeking help from health services due to previous negative interactions and feelings of being excluded by healthcare professionals
- women who are homeless not being able to travel to appointments, or being misinformed that proof of address is required to register to access services

A smaller number of submissions highlighted high rates of HIV in the transgender population due to sex work and unsafe sex-practices.

Impacts of service fragmentation and cuts

Many submissions said that the fragmentation of commissioning services has had a negative impact – with some tracing this back to the implementation of the Health and Social Care Act 2012, which split the commissioning and funding of contraception across three different routes (local authorities, NHS England, and Clinical Commissioning Groups). Many also commented on the impacts of cuts to the public health grant.

Such negative impacts included, for example:

- different routine datasets being collected across different commissioning and provider bodies, meaning that there is a lack of comparable data on where and how women are accessing sexual and reproductive health services, which can make it difficult to hold services accountable

- geographical disparities in the accessibility and quality of contraceptive care for women and, as mentioned in the previous section, access to gynaecological specialists

- difficulties in women accessing contraception for non-contraceptive purposes, such as intrauterine contraception to treat heavy menstrual bleeding

- service closures, reduced opening hours, reduced service provision and cuts to staff numbers - it is estimated that almost half of councils have reduced the number of sites delivering contraceptive services since 2015, and in some local authority areas routine oral contraception is not being provided to people over 25 years old

Some organisations and experts also reflected that the COVID-19 pandemic has contributed to further service fragmentation, in particular the capacity of outreach workers to accompany and support vulnerable women seeking contraceptive advice and care.

Suggestions moving forward

Organisations and experts put forward a range of proposals to improve outcomes in this area. This included, for example:

- take a user-centred approach to designing and developing holistic reproductive health services in partnership with women, emphasising the need to empower women to make their own choices

- increase funding for contraception and sexual health services

- increase use of virtual appointments and at-home abortions, where appropriate, to better enable certain groups of women to exercise their rights
- provide better education and guidance for healthcare professionals, including pharmacists, on providing women with unbiased information on the different types of contraceptives (including emergency contraception) available
- review the variation in Relationships and Sex Education taught across schools, to help ensure all young people can access unbiased and inclusive information
- make women's reproductive healthcare more broadly integrated into women's health pathways in the NHS
- appoint a single, accountable commissioner for women's health at national and ICS level, holding accountability for commissioning and outcomes in women's health

Suggested areas for future research included:

- why some groups of women are more or less likely to access different types of contraception and emergency contraception (including factors such as culture, religion, poverty, and distrust in healthcare professionals)
- women's experiences of contraception, in particular side effects experienced
- why some groups of women are more likely to contract sexually transmitted infections and HIV (in particular, black and minority ethnic women and trans women), and their experiences living with it
- the experiences of women who are living with or at risk of contracting HIV, including women who are pregnant, and trans women

Fertility, pregnancy, pregnancy loss and maternal health

In this section we briefly recap the main results from our public survey on fertility, pregnancy, pregnancy loss, and maternal health. We then highlight commonalities and areas of additional focus identified by organisations and experts.

Recap of insights from our public survey

From our analysis of the results from the public survey, we found:

- ‘fertility, pregnancy, pregnancy loss and post-natal support’ was the 2nd most popular topic selected for inclusion in the Women’s Health Strategy (55%), and the 1st choice among respondents aged 30 to 39

- the COVID-19 pandemic left some women unable to access fertility treatments, and unable to attend pregnancy-related appointments with their partner

- women felt that postnatal support was often too focussed on the health and wellbeing of the baby, sometimes to the exclusion of the mother

- women need more support in the workplace; suggestions included policies to enable women to attend appointments while undergoing IVF treatment, support for women who have experienced miscarriage or baby loss, and support for women seeking to return to the workplace and/or progress their careers after having a child

Insights from organisations and experts

The 196 submissions we received from organisations and experts on fertility, pregnancy, pregnancy loss, and/or maternal health align with the insights captured through our public survey.

Additional areas of focus included:

- inadequate information provision

- gaps in clinician knowledge and education

- disparities in access to fertility services

- pregnant women not being listened to
- inadequate perinatal and postnatal care
- baby loss and bereavement support
- disparities in maternal and neonatal outcomes
- workplace barriers faced by mothers, and women with fertility issues

These are discussed in turn below.

Inadequate information provision

Organisations and experts told us that there is a lack of high-quality and up-to-date information available to the public on topics such as:

- female and male infertility
- the impact of lifestyle factors (e.g., obesity, alcohol consumption) and pre-existing health conditions (e.g., fibroids, diabetes, polycystic ovary syndrome) on fertility and pregnancy outcomes
- options for fertility preservation, in particularly for those undergoing chemotherapy or gender-affirming hormone treatments
- the efficacy and safety of ‘add-on’ treatments sold by private fertility clinics
- maternal physical health after pregnancy and childbirth, including pelvic floor disorder and the safety of and alternatives to transvaginal mesh as a treatment option
- awareness of, and support for, perinatal and maternal mental health conditions

Gaps in clinician knowledge and education

There were three main areas where organisations and experts felt that clinician education and training must be improved:

- fertility: there were reports that some GPs lack a comprehensive understanding of the causes of infertility, miscarriages and their relationship with infertility, reasons for IVF failure, current research on new fertility treatments, and the safety of fertility add-on treatments, which can lead to women (and couples) being given patchy and/or inconsistent information and advice in primary care settings

- breastfeeding: some raised a concern that there is a lack of skilled, specialist breastfeeding support and training across the healthcare system, which could lead to pregnant women and new mothers receiving inaccurate or little advice through their breastfeeding journeys, including advice that they should not breastfeed when taking medicines that have been proven to be safe

- pregnancy and neonatal risks: in some medical settings there may be limited or unsatisfactory training around pregnancy/baby loss and an absence of standardised pathways for responding to risks, symptoms, or diagnoses - for example, there is no mandatory training on the antenatal management of women at risk of, or those carrying the group B strep infection for medical, midwifery, and nursing staff involved in maternity care despite this being a cause of serious infection in newborn babies in this country. Additionally, NICE guidelines have no clear maternity care pathway for deaf women, with many having their pregnancies labelled as high-risk due to a lack of deaf awareness among healthcare professionals

Disparities in access to fertility services

There was a consensus that while infertility is an issue affecting many people across the country, not everyone is in the same boat with regards to the treatment they can access.

One of the main reasons put forward to explain this was the fact that not all Clinical Commissioning Groups (CCGs) offer the full IVF provision recommended in NICE guidelines. This means that where you live in England can determine whether you are able to access NHS funded IVF treatment, with alternatives only being available to those with the financial means to go private.

Another reason was the general lack of funding for fertility services, which organisations said can lead to certain population groups – such as heterosexual couples – being prioritised above same-sex couples and single women who want to start a family. For example, lesbian couples are generally required to privately fund at least 6 cycles of Artificial Insemination (AI) using donor sperm from a licensed fertility unit before being offered further fertility treatment on the NHS. This was said by some organisations to tie into the belief that not being able to conceive naturally is a lifestyle choice.

Pregnant women not being listened to

Organisations and experts said that personalised care plans for pregnant women and compassionate interactions with midwifery services are essential to women feeling that they have control over their birth experiences, and to reduce the impact of birth trauma.

Currently, however, they reported that women often do not feeling heard during pregnancy and birth. Examples included:

- women being made to feel like a nuisance, or being patronised or dismissed, when raising concerns about reduced foetal movement or bleeding
- women not being believed when they say they are in labour
- women being denied requests for pain relief (particularly epidurals)
- women reporting but not being treated for subclinical levels of perinatal depressive symptoms

Linked to this was the point that some women feel, or fear, being judged when expressing their preferences. This was said to be heightened for women from lower socio-economic backgrounds and some inclusion health groups, who do not necessarily have access to the information they need to make informed decisions and are worried that they will be blamed for bad birth experiences if they make their own choices relating to their care and birth plan.

Organisations flagged that some of these issues were exacerbated by rules introduced during the COVID-19 pandemic, which prevented women from having the additional support of a birth partner at appointments and during labour, birth and the postnatal period.

Inadequate perinatal and post-natal care

Several organisations and experts highlighted issues in women’s access to and experiences of perinatal mental health care and postnatal care.

Examples included:

- a lack of coordination and communication across the healthcare system – with women seeking help from their GP, only to be told to seek help from their midwife, who then referred them back to their GP
- women’s physical healthcare following labour being brushed under the carpet, with issues such as incontinence and pelvic organ prolapse being viewed as a completely reasonable compromise should women choose to have children
- women's mental health and wellbeing not being prioritised, despite data showing that depression in pregnancy and postnatal depression is very common, with

suicide reported as the leading cause of direct deaths within a first year after the end of pregnancy

- women having symptoms of post-traumatic stress disorder (PTSD) dismissed or incorrectly labelled as post-natal depression
- women fearing that they will look like an incompetent mother or have their baby taken away if they disclose symptoms of mental illness

Baby loss and bereavement support

In terms of baby loss and bereavement, organisations and experts said there is a failure to recognise that each case is unique and, as such, the care needs of women and their partner/family will vary.

Support was said to be particularly lacking for women:

- who experience early pregnancy loss (during the first 23 weeks), with some minimising it as ‘not meant to be’ or ‘not a real baby’
- who experience the loss of a baby through separation or removal (by social services), and the trauma associated with it
- who terminate pregnancy   which often results in complex feelings of guilt, shame, blame, and judgement
- who have conditions such as endometriosis, which puts them at higher risk of miscarriage and ectopic pregnancy

The negative impact of the COVID-19 restrictions on women’s experiences of baby loss and access to support was also highlighted. Organisations shared accounts of women who had less time to spend time with their baby to make memories after bereavement, and of women and couples who were not able to benefit from the emotional and practical support of their friends and family members (in the same way they would have, prior to the pandemic).

Disparities in maternal and neonatal outcomes

A common thread was the need to address racial and socio-economic inequalities in maternal healthcare and outcomes in England, such as:

- black and Asian women being more likely to die during pregnancy and childbirth than white women

- black and Asian pregnant women being more likely to be admitted to hospital with COVID-19 than white women
- infant mortality being higher in the most deprived areas of England compared to the least deprived

A few organisations also raised the need to look at the additional barriers faced by women in inclusion health groups, for example:

- women from Gypsy, Roma and Traveller communities, who may face challenges such as living in accommodation that is situated close to rubbish dumps, or with no or limited access to running water, showers or toilets
- women in prison, who may be at an increased risk of toxic stress during pregnancy, and some of whom have reported being denied access vital pregnancy and postpartum care, and from seeking a second opinion to raise their concerns
- pregnant women who are sex workers and/or victims of trafficking, some of whom fear being arrested or charged with a criminal offence if they seek help

Workplace barriers faced by mothers and women with fertility issues

Organisations flagged that many employers and workplaces do not recognise infertility as a genuine medical issue, and the physical, mental, emotional, and financial strain that can be caused by fertility problems. This can leave women fearful that they will be discriminated against (e.g., overlooked for promotion) if they are open about wanting to start a family.

Organisations also reflected that the absence of pregnancy loss policies can contribute to women not being able to take time off to grieve (often for financial reasons), returning to work sooner than they would have liked, and feeling unsupported when they do return to work. Where policies are based on the stage of gestation at which pregnancy loss happens, this can place women who experience early pregnancy loss and miscarriage at a greater disadvantage in terms of the support available and can further minimise their experiences.

Suggestions moving forward

Organisations and experts put forward a range of proposals to improve outcomes in this area. This included, for example:

- update the NHS website on fertility/infertility, with signposting to reputable organisations such as the HFEA, and make non-digital copies accessible

- encourage and support all CCGs/ICSs in England to follow NICE guidelines when it comes to IVF provision, extend access to women who missed their chance to try for a baby during the pandemic, and equalise access for single women and women in same-sex relationships

- update the Human Fertilisation and Embryology Act 2008 to support the evaluation of technological and medical advances, support the sharing of routinely collected data across NHS services, quality improvement initiatives, and research studies, and enable HFEA's oversight of some currently unlicensed activity

- run information campaigns to reduce the stigma surrounding topics such as breastfeeding, infertility, early pregnancy loss, and stillbirth

- increase investment in midwifery services and maternal mental health provision

- consider strategies to support the FemTech sector in delivering collaborative innovation within the NHS and improving the personalisation of health advice provided to women in pregnancy

- encourage nursing and midwifery services to work with specialist deaf organisations to improve their deaf awareness and sign language skills

- roll-out training across the healthcare system (e.g., for staff in early pregnancy assessment services, gynaecology services, obstetrics, the ambulance service, GP surgeries), and across voluntary and community sector groups, to better support women with fertility or pregnancy related issues or trauma

- provide screened-off waiting areas for women going through miscarriage or pregnancy loss, separate from maternity and/or labour wards

- explore ways of improving bereavement support for those who have experienced baby loss, such as the implementation of the National Bereavement Care Pathway across all NHS trusts

- routinely collect and publish data on pregnancy loss, bereavement, and the mental and physical health of women during perinatal and postnatal periods

- advocate for the provision of pregnancy loss policies in all workplaces, including paid leave for employees who experience a miscarriage or stillbirth

Suggested areas for further research included:

- evaluate the efficacy of practice models, such as Continuity of Care

- investigate the causes of miscarriage and the effectiveness of tools to monitor a baby’s health in utero, and understand how infant deaths could be prevented

- investigate how the prenatal and postnatal environment influences infant development and parent-infant bonding

- evaluate the effectiveness of AI technologies to help predict which pregnancies will develop life threatening foetal growth restriction

- review the data and evidence on IVF add-on treatments

- understand any long-term impacts of receiving COVID-19 vaccines during pregnancy

- research that is midwife-led or done in collaboration with specialist, community and voluntary sector organisations, including pregnant and breastfeeding women, and women with different characteristics (e.g., to understand deaf women’s experiences of maternity care)

The menopause

In this section we briefly recap the main results from our public survey on the menopause. We then highlight commonalities and areas of additional focus identified by organisations and experts.

Recap of insights from our public survey

From our analysis of the results from the public survey, we found:

- menopause was the 3rd most selected topic for inclusion in the Women's Health Strategy overall, and the top choice among those aged 40 to 59
- less than 2 in 3 respondents felt comfortable talking to healthcare professionals about the menopause (64%); women often had their symptoms dismissed because they were written off as 'too young' to be going through the menopause or not displaying the 'obvious' symptoms such as hot flushes, and they felt they were provided with limited treatment options and often had their preferences ignored, particularly when requesting hormone replacement therapy (HRT).
- less than 1 in 10 respondents could access the information they need on the menopause (9%), and many called for open discussions of the menopause in the workplace to break the taboo surrounding this subject and to encourage managers and colleagues to better support them to manage their symptoms

Insights from organisations and experts

The 80 submissions we received from organisations and experts on the menopause align with the insights captured through our public survey.

Additional areas of focus included:

- gaps in clinician education and guidelines
- employment outcomes

These are discussed in turn below.

Gaps in clinician education and guidelines

Gaps in clinician education and guidelines were identified as a key barrier to effective menopause care. For example:

- menopause training is often not mandatory and relies on self-directed learning - this means that some medical students who are reliant on GP training placements to learn about the menopause, may not be trained by someone with sufficient information on the topic

- some healthcare professionals may be reluctant to prescribe HRT, because existing guidelines (including those issued by NICE) focus heavily on the risks associated with this course of treatment (in particular, breast cancer), rather than the benefits, which include decreased risk of osteoporosis

- there are a wide range of symptoms associated with the menopause, which can overlap with other conditions, and may lead some healthcare professionals to mis-prescribe anti-depressants to treat some symptoms, rather than focusing on identifying and treating the root cause

Employment outcomes

Organisations and experts highlighted that the troublesome symptoms associated with the menopause can impact a woman’s health and wellbeing in the workplace, with many noting that women often need to take time off work to manage their symptoms but are hesitant to explain the reason to their employer, due to embarrassment. These symptoms are wide ranging and go further than the more well-known physical symptoms like hot flushes – many organisations provided examples of how symptoms such as brain fog, memory loss and anxiety can have a direct and severe impact on women’s concentration, preventing many from being able to complete tasks at work.

In recent years, an increased rate of employment of women aged 50 and above means more women will experience menopause while in the workforce. Organisations and experts noted that good menopause care from employers – including not just specific policies, but more generally creating an atmosphere which tackles taboos and stigmas and raises awareness of the menopause – would lead to increased retention, increased productivity, and decreased absenteeism in the workforce.

Suggestions moving forward

Organisations and experts put forward a range of proposals to improve outcomes in this area. This included, for example:

- roll-out standardised menopause training to all practising GPs and practice nurses, with an emphasis on identifying the root causes of symptoms and how these symptoms overlap with other conditions
- provide integrated services that can respond to the varying needs of women across the life-course (e.g., services that bring together contraception, menopause and mental wellbeing)
- ensure every CCG/ICS has access to at least one specialist menopause service, providing specialist input for complex patients and support and education for local teams
- increase uptake of employer policies to support women going through the menopause in the workplace, and increased employer awareness of the legal responsibilities to support staff with menopause issues
- increase better provision and promotion of information on menopause symptoms, outcomes, and treatment options

Suggested areas for further research included:

- the wider benefits of using HRT in relation to osteoporosis and cardiovascular disease, and the impact of how early this is prescribed in the menopause cycle
- the impact of COVID-19 and long-COVID on menopausal women
- the reasons women from certain groups, including those from lower socio-economic backgrounds, are more likely to experience early menopause
- the relationship between early menopause and developing Alzheimer's disease

Gynaecological and other cancers

In this section we briefly recap the main results from our public survey on gynaecological and other cancers. We then highlight commonalities and areas of additional focus identified by organisations and experts.

Recap of insights from our public survey

From our analysis of the results from the public survey, we found:

- ‘womb, ovarian, cervical, vulval, and vaginal cancers’ was the 7th most popular topic selected for inclusion in the Women’s Health Strategy (30%); just 14% felt they had enough information on gynaecological cancers; and many were not able to access screening services in a timely manner during the pandemic, or experienced poor interactions with healthcare professionals while undergoing a smear test
- the topic ‘other cancers, such as lung cancer’ was considered to be of a lower priority for the Women’s Health Strategy (ranking 22nd out of 23 topics), though non-gynaecological cancers such as breast cancer and skin cancer did emerge through our thematic analysis of women’s personal testimonies; for example, some women felt they were dismissed when attempting to discuss a family history of breast cancer, or when raising concerns about lumps or moles

Insights from organisations and experts

The 55 submissions we received from organisations and experts on gynaecological, breast, and other cancers align with the insights captured through our public survey.

Additional areas of focus included:

- public awareness levels of cancers and their symptoms
- barriers to securing a diagnosis
- disparities in access to services and cancer outcomes
- impacts of COVID-19

These are discussed in turn below.

Public awareness of cancers and their symptoms

Organisations and experts emphasised the need to raise public awareness of:

- the risk factors for female cancers across the life course (for example, breast density and vulval skin conditions such as lichen sclerosus)
- the symptoms associated with different gynaecological cancers (cervical, ovarian, vaginal, vulval, womb) and how these can be detected
- how women can access support and treatment, and what they should expect to happen when they come forward (including personalised care plans and holistic needs assessments, providing the opportunity to discuss concerns around the consequences of treatment and impact on fertility and other aspects of life)

While there are examples of public information campaigns being successful in this area, there was a sense that these are often ‘one-off’ initiatives, and that more needs to be done to educate the public and sustain awareness in this area.

For example, one organisation shared research that found almost a third of women think cervical screening detects ovarian cancer, with many not recognising persistent bloating, pelvic / abdominal pain, urinary symptoms, and feeling full quickly / loss of appetite, as warning signs of ovarian cancer. This is particularly problematic given there is no screening programme for ovarian cancer (due to insufficient evidence that one would save lives), so early diagnosis depends on women knowing the symptoms so that they can seek help as soon as possible.

Organisations and experts said that awareness levels are also impeded by:

- conflicting evidence online and/or from healthcare professionals
- a lack of accessible information on new, emerging risk factors
- the knowledge of risk factors which women find difficult, or may be reluctant, to modify (such as drinking alcohol)

Barriers to securing a diagnosis

Organisations and experts reported that some women struggle to be taken seriously by healthcare professionals when discussing potential cancer symptoms. This includes, for example:

- cancer symptoms being dismissed as, or confused with, gynaecological conditions (such as endometriosis), irritable bowel syndrome (IBS), or mental ill health

- being told ‘not to worry’ because they do not fit the ‘typical’ profile of someone with a particular form of cancer (for example, women under 30 being advised they are too young to have breast cancer)

This can leave them feeling like timewasters, and hinder prompt and early diagnosis, with one organisation’s research finding that some women had to visit their GP three times or more before being referred for diagnostic tests.

Some organisations and experts also said GP training has inadequate coverage of:

- the difference between normal and abnormal appearances of the female genital tract
- symptoms/diseases caused by workplace exposure (e.g., mesothelioma)
- the symptoms of ovarian cancer and the referral pathway
- the risk factors associated with dense breasts which, though not abnormal, can make the identification of potential tumours more difficult

In relation to the last point, submissions also flagged that midwives have a great opportunity to promote self-breast examination, but that this is not included in midwifery undergraduate curriculum or NMC Future Midwife Standards.

Disparities in access to services and cancer outcomes

Organisations and experts highlighted data and research in England, which points to disparities in women’s access to services and cancer outcomes. For example:

- some migrant women are less likely to participate in cervical screening in England because awareness levels prior to migrating were low and information provision when registering with a GP was lacking
- some lesbian women have been told by healthcare professionals that they do not require a smear test, or have been refused one when trying to book an appointment, due to the false belief that these are only needed for women who are having penetrative sex with a man
- some women who have experienced trauma and/or sexual assault are less likely to attend cervical screenings due to a fear of becoming retraumatised
- women in deprived areas of England have lower 5-year survival rates after a diagnosis of ovarian cancer, compared to women in the least deprived areas

- emerging research suggests that minority ethnic women may develop breast, ovarian and uterine cancer on average 10 years younger than white women

Impacts of COVID-19

The COVID-19 pandemic had a negative impact on access to cancer services. Some organisations and experts conducted research to better understand the impacts on women, which identified:

- difficulties accessing cervical screening during lockdown
- women living with cancer reporting a significantly higher negative impact of the COVID-19 pandemic on their mental health, compared to men living with cancer
- for those living beyond cancer, delayed access to elective surgeries such as breast reconstruction following a mastectomy

Suggestions moving forward

Organisations and experts put forward a range of proposals to improve outcomes in this area. This included, for example:

- public campaigns to raise awareness of different cancer symptoms and risk factors and make better use of community and voluntary organisations to help reach different groups of women
- ensure screening services are trauma-informed to better support women who are at risk, or fearful of, being retraumatised
- ensure everyone with a cancer diagnosis can access personalised care, including a holistic needs assessment (HNA), care plan and health and wellbeing information in an integrated way
- work to clear the cancer backlog and invest in the cancer workforce to meet all health needs of women with cancer (screening programmes, referrals, diagnostic tests, treatment, and elective surgeries e.g., breast reconstruction)
- prioritise funding the development of Machine Learning models to ensure women with suspected ovarian cancer receive accurate diagnosis and avoid unnecessary surgical intervention for women with benign ovarian masses.

Suggested areas for further research included:

- the impact of interventions on reaching women from deprived communities, and with other protected characteristics
- make it the norm to disaggregate data by cancer type (rather than pooling all gynaecological cancers together given their varying diagnostic and treatment pathways) and by other characteristics such as ethnicity and sexual orientation
- research to better understand the genetic causes of cancers in ethnic minority women, especially those of South Asian origin
- significant investment in cancer research and clinical trials to develop better diagnostic tests and treatments (e.g., for ovarian cancer, secondary breast cancer)
- ensure trials look at how treatment will impact overall quality of life as well as how effective it is in combatting the cancer
- longitudinal data collection on cancer in non-symptomatic women

Mental health

In this section we briefly recap the main results from our public survey on mental health. We then highlight commonalities and areas of additional focus identified by organisations and experts.

Recap of insights from our public survey

From our analysis of the results from the public survey, we found:

- mental health was the 5th most popular topic selected for inclusion in the Women's Health Strategy (39%) and, while less common, thousands of respondents still called for alcohol, drugs and addiction to be covered (6%)

- just 3 in 5 respondents (59%) said they felt comfortable talking to healthcare professionals about mental health conditions; this was lower than when discussing their general physical health concerns (85%), and specific women's health topics such as menstrual wellbeing (77%) and the menopause (64%)

- women's experiences of not being listened to by healthcare professionals included accounts of having their mental health symptoms dismissed as 'all in their head' or not something to worry about (e.g., in the case of conditions such as premenstrual syndrome), or having their symptoms treated without investigation into the potential route cause (e.g., menopausal women being prescribed anti-depressants).

Insights from organisations and experts

The 151 submissions we received from organisations and experts on mental health and/or substance abuse align with the insights captured through our public survey.

Additional areas of focus included:

- the links between women's health conditions and mental health

- disparities in women's mental health outcomes

- women's experiences of mental health and substance abuse support services

These are discussed in turn below.

Links between women’s health conditions and mental health

From the evidence already discussed in previous chapters of this report, there is a clear need to better understand and acknowledge how mental ill health can stem from or interact with women’s health conditions across the life course.

To list a few examples:

- premenstrual dysphoric disorder, a severe form of premenstrual syndrome, can cause mood swings, feelings of hopelessness and anxiety, and suicidal thoughts

- depression during and after pregnancy is very common, women with bipolar disorder are at a higher risk of developing postpartum psychosis and postnatal depression, some women experience post-traumatic stress due to their birthing experience, miscarriage or neonatal death, and research points to suicide to be the leading cause of direct death in women the first year after pregnancy

- for women with pre-existing mental health conditions, additional guidance is required to make sure they are on the most appropriate medication while pregnant and/or breastfeeding, or that they are receiving the support they need if medical advice is to temporarily stop taking medication

- women in the typical menopause age bracket may find it more difficult to secure a mental health diagnosis, as symptoms such as mood swings are attributed to hormone shifts rather than conditions such as bipolar disorder; on the flip side, women going through the menopause may find that healthcare professionals decide to prescribe antidepressants to treat their low mood and anxiety, rather than medications such as hormone replacement therapy which can relieve a broader range of symptoms (including e.g., hot flushes and vaginal dryness)

Disparities in women’s mental health outcomes

In this country, women are more likely to experience common mental health conditions than men, with young women being particularly high risk. Women experience higher rates of PTSD, self-harm, suicidal ideation and eating disorders than men, and can also face additional vulnerabilities during the perinatal period.

Specific examples cited by organisations and experts included:

- black women are more likely than white women to experience a common mental health disorder, and ethnic minority women are more likely to access secondary mental health services through criminal justice pathways and through the Mental Health Act (as opposed to primary care)

- lesbian and bisexual women are more likely to have a long-term mental health problem than heterosexual women

- women with learning disabilities are more likely to report a mental health problem than peers without learning disabilities, and deaf or hard of hearing women are more likely to have a mental health problem than those with hearing

- women living in the lowest income households are more likely to self-harm than those from the highest income households

- in prison, women are more likely to have a mental health problem and to self-harm, compared to men

Some of the barriers faced by these groups were said to relate to structural inequalities, discrimination and bias in the healthcare system.

Experiences of mental health and substance abuse support services

Use of restraints

Evidence was shared on the disproportionate use of restraint on women and girls in Adult Mental Health Services and Child & Adolescent Mental Health Services, including face-down restraint, often by male members of staff.

While we cannot ascertain the reasons for this from the data available, a few submissions suggested this may point to gendered experiences of mental health services that could be retraumatising for women and girls who have experienced violence and abuse.

Eating disorders

Current data suggests that eating disorders affect more girls than boys. One main barrier that organisations and experts cited as preventing girls from getting the help they need is the lack of awareness and recognition on behalf of professionals, in primary care settings, that eating disorders are a very serious condition.

They shared accounts reported by women and girls, where they were told 'it’s just a phase', 'just eat a bit of toast', and 'you’re a nice size so you don’t have anything to worry about'. Some were also told they would need to lose more weight to be taken seriously. As a result, opportunities for early intervention and recovery were often missed.

Addiction and substance abuse

Societal attitudes towards women, and the perception that they should be ‘homemakers’ and caregivers, was one of the main barriers identified by organisations and experts as preventing some women from seeking help for addiction. Specifically, they reported that some women fear being stigmatised, with pregnant women and mothers expressing a concern that their child will be removed from their care. Other reported barriers included women who are stay-at-home mothers struggling to find alternative childcare arrangements and having less disposable income than men to spend on travel to treatment services.

When accessing services, organisations and experts reported that women may then experience additional barriers due to:

- a lack of trauma-informed ways of working with women who misuse alcohol and drugs, to understand potentially gendered drivers of addiction such as experiences of domestic and/or sexual abuse
- a lack of single-sex treatment facilities, with male-dominated treatment and health services being intimidating for some women who have experienced male violence
- a lack of understanding about how women's bodies process substances differently to men, which can affect the way they respond to treatment (for example, women produce less of the stomach enzymes responsible for metabolising substances, which may lead to a higher concentration of drugs in their body/blood, and more intense withdrawal symptoms)

Suggestions moving forward

Organisations and experts put forward a range of proposals to improve outcomes in this area. This included, for example:

- co-design policies, services and therapeutic options with women, and different groups of women, who experience poor mental health
- increase access to substance abuse treatment services (including community models) with female staff and women-only access points, and which can accommodate women without being separated from their children
- advocate for national and local suicide prevention strategies and action plans to acknowledge and respond to self-harm among young women and girls, with poverty considered as a central factor
- ensure all medical schools and foundation programmes provide teaching and clinical experience in eating disorders

- ensure schools and colleges refer to national guidelines on the safe teaching of mental health issues, which contains sections on teaching about eating disorders and self-harm, and that they make use of external expertise where appropriate

- ensure comprehensive implementation of the 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder' in every area

- ensure girls (and boys) experiencing mental ill health are supported as they transition into adulthood (and from child and adolescent mental health services to adult mental health services)

- review and, where appropriate, implement the commitments set out in the Women's Mental Health Taskforce report (2018)

Suggested areas for further research included:

- obtain better quality, timely data to understand how female self-harm and suicide rates are developing nationally, regionally and among specific groups

- longitudinal and experimental research into the impacts of social media use on eating disorders, involving experts in the field and people with lived experience to help identify appropriate solutions and safeguards

- a review to consolidate the evidence base on trauma-informed care in England, to inform guidance and resources

- research to better understand the impact of the pandemic on women's mental health, to inform targeted interventions

- research to improve understanding of foetal alcohol spectrum disorder prevalence rates

Healthy ageing and other conditions

In this section we briefly recap the main results from our public survey on healthy ageing and other conditions, such as autism and heart disease. We then highlight commonalities and areas of additional focus identified by organisations and experts.

Recap of insights from our public survey

From our analysis of the results from the public survey, we found:

- healthy ageing was the 9th most popular topic selected by respondents for inclusion in the Women's Health Strategy (23%) and the 1st choice among those aged 60 and over
- while less common, thousands of respondents still called for the strategy to cover topics such as autism and neurodiversity (10%), musculoskeletal conditions (8%), heart disease and stroke (7%), neurological conditions (7%), and diabetes (3%), and of the 2% of respondents who selected 'another topic not listed', suggestions included lipoedema and vitamin deficiencies
- across these topics, women and self-reported healthcare professionals called for further research, better recognition and understanding of how health conditions can manifest differently in men and women, how female-specific conditions can affect and interact with other health conditions, and the effectiveness of treatment options that have been disproportionately trialled on male participants

Insights from organisations and experts

The 113 submissions we received from organisations and experts on healthy ageing and other conditions align with the insights captured through our public survey.

Specific areas of focus included:

- the experiences of women later in life
- autism
- autoimmune conditions
- cardiovascular disease
- chronic and long-term conditions

- neurodegenerative diseases

These are discussed in detail below.

The experiences of women later in life

Women in England have a longer life expectancy than men, but they also spend a greater proportion of their lives in ill health and disability. Moreover, in recent years, healthy life expectancy has fallen for women, but has remained stable for men.

It is against this backdrop that organisations and experts flagged concerns about the healthcare systems inadequate focus on older women's healthcare needs and experiences. For example, they said that:

- a wide range of health issues for ageing women are poorly addressed due to a lack of information and advice being available for women later in life, and a poor understanding of this group's needs from healthcare professionals and wider society

- healthcare professionals do not consistently ask women about incontinence, while women are often reluctant to disclose such symptoms due to embarrassment or not realising treatment is available

- 1 in 2 women over 50 will break a bone because of osteoporosis, but there is a misconception that this is an unavoidable consequence of getting older; the links between menopause and osteoporosis risk are also not widely acknowledged

- hyperthyroidism in older women is often confused with symptoms relating to the menopause or dementia

- malnutrition is an issue for many ageing people, however public health messaging continues to focus on avoiding obesity

Some submissions also explored the impacts of digital exclusion on older women:

- while remote consultations have been used by many during the pandemic, older women may not know how to book a digital appointment, have access to the IT facilities needed to 'attend' a virtual appointment, and they may not be used to and feel comfortable talking to healthcare professionals virtually

- though there is a need to update and improve health information online, outreach to older women via targeted health campaigns (such as leaflets and through television programmes) should not be forgotten about

Autism

A few submissions noted the difficulties girls and women have in securing a diagnosis and support for autism, explaining that:

- girls and women are often better at 'masking' or ‘camouflaging’ their difficulties and symptoms relative to boys and men

- the guidelines used to diagnose autism contain questions which are based on symptoms predominantly displayed by males – as traits displayed by girls and women are typically deemed ‘socially acceptable’

This has led to girls and women being misdiagnosed with anxiety or other emotional disorders or diagnosed with autism much later in life than men.

Autoimmune conditions

A few submissions discussed gender-based disparities in autoimmune conditions such as diabetes, inflammatory bowel disease (IBS), multiple sclerosis (MS), and hypothyroidism. For example:

- research has found differences between men and women in the genetic signals influencing glucose and insulin levels, which could lead to differences in the response to treatment for diabetes, and black women are at a higher risk of living with diabetes than Asian and white women

- while the prevalence of inflammatory bowel disease is similar among men and women, there is a lack of research into how this impacts women’s menstrual health, fertility, the menopause and cervical screening

- MS is more common in women than men, and women often report that healthcare professionals, including GPs and neurologists, sometimes have little empathy or understanding for women who are struggling to cope with the impact MS has on significant stages in their life

- many women with hypothyroidism report being treated as hypochondriacs by healthcare professionals, as the symptoms of a poorly functioning thyroid manifests itself in so many ways

Cardiovascular disease

Organisations and experts pointed to the fact that women, on average, are diagnosed with heart disease years later than men. This often results in other chronic diseases being prevalent by the time of the diagnosis.

The reasons put forward in submissions to explain this included:

- heart attacks are often perceived as a male issue
- most acute coronary syndrome research has been done on males, which forms the basis of medical curricula and guidelines
- failure to acknowledge that several coronary heart disease risk factors (e.g., smoking, socioeconomic background and adiposity) have been shown to have a stronger effect on coronary artery disease risk in women compared to men
- a lack of research into potential symptoms such as indigestion and back pain
- a lack of awareness around how standard harm reduction procedures in men may fail to work in women (for example, women pose a higher risk of a bleed if given daily aspirin for reducing heart attack propensity)

Chronic and long-term conditions

A few submissions discussed gender-based disparities in chronic and long-term conditions such as chronic fatigue syndrome (also known as ME), chronic pain, long COVID, and vitamin B12 deficiency anaemia. For example:

- there has been little research into the effect of pregnancy and childbirth on women with chronic fatigue syndrome, healthcare professionals are currently not trained in how to care for women with this condition during pregnancy, and women with severe cases can find it difficult to access routine health appointments, including cervical smears
- chronic pain is more prevalent in women than men at every age, and women are more likely than men to experience high-impact chronic pain (the most severe form of which can impact daily activities such as self-care and work)
- current research suggests there is an increased risk of having long COVID for women, however there is a lack of understanding of its effects, including how it impacts menstrual cycles/bleeding, the menopause, and gynaecological conditions such as PCOS

- some women report being denied access to hydroxocobalamin injections to treat vitamin B12 deficiency anaemia, resulting in reliance on private clinics or online providers, with others commenting that the typical administration every 2-3 months is not enough to manage their symptoms

Neurodegenerative diseases

A few submissions discussed gender-based disparities in neurodegenerative conditions such as dementia and Parkinson’s disease. For example:

- dementia, and death from dementia, is more prevalent among women than men, but it is not clear how much of this is because women tend to live longer than men (and dementia tends to occur later in life), rather than sex-based differences in the causes of dementia

- women often wait longer to receive a diagnosis for Parkinson’s disease than men, with tremor usually being the dominant symptom, as opposed to changes in balance or posture which are more common among men

Suggestions moving forward

Organisations and experts put forward a range of proposals to improve outcomes across these areas. This included, for example:

- provide educational resources for women to make healthier choices throughout the life course, supporting prevention, promotion of healthy ageing, and support for relationship breakdowns and women experiencing bereavement

- ensure any public facing campaigns represent older women

- raise awareness of conditions that disproportionately affect women, and educate healthcare professionals and the public about how some conditions may present differently in female patients

- improve training and ongoing professional development for health care professionals (GPs and endocrinologists in particular) to effectively diagnose and treat women with hypothyroidism

- make resources available to support women with hypothyroidism with reliable information and social prescribing/ managed peer support networks

- ensure consistency between all genders when referring patients to neurology specialists by tackling the gender gap in timely access to services

Suggested areas for further research included:

- involve older women in research and calibrate results to look at differential impacts and whether different conclusions are needed for women of different ages
- support research to better understand women's lifelong health needs and risks, in childbearing years and as they age, including by increasing participation in research and clinical trials
- more research should be done to evidence the efficacy of workplace adaptations (co-developed with women) that support women, with particular consideration for long term conditions
- level up investment in research into the causes and management of musculoskeletal conditions
- ensure women are properly represented in clinical trials and research into coronary heart disease
- increase research into the impact of menstruation and menopause on MS
- conduct more research into autism so that diagnostic tools for autism can accurately diagnose girls as well as boys

Violence against women and girls

In this section we briefly recap the main results from our public survey on the health impacts of violence against women and girls. We then highlight commonalities and areas of additional focus identified by organisations and experts.

Note that the phrase ‘violence against women and girls’ refers to acts of violence or abuse that we know disproportionately affect women and girls. Crimes and behaviour covered by this term include rape and other sexual offences, domestic abuse, stalking, ‘honour’-based abuse, as well as many others, including offences committed online.

Recap of insights from our public survey

From our analysis of the results from the public survey, we found:

- the health impacts of violence against women and girls was the 8th most popular topic selected for inclusion in the Women’s Health Strategy (30%); it also featured in the top 5 topics selected by respondents aged 16-29, from the mixed/multiple ethnic group, and those who identified with a gender different to their sex at birth
- just 9% of respondents said they have enough information on how to access specialist services for matters such as female genital mutilation and sexual assault; in their personal testimonies, women also shared examples of not being able to access the limited support that was available to them as domestic abuse survivors

Insights from organisations and experts

The 77 submissions we received from organisations and experts on the health impacts of violence against women and girls align with the insights captured through our public survey.

Additional areas of focus included:

- the experiences of different groups of women
- physical and psychological impacts
- the need for a whole system approach

These are discussed in turn below.

The experiences of different groups of women

Organisations and experts highlighted the fact that some groups of women are more likely to experience social, cultural and/or structural inequalities that place them at higher risk of experiencing certain forms of violence and abuse than others.

For example:

- virginity testing and hymenoplasty are often carried out for cultural reasons among specific minority ethnic groups, and justified on the false and unscientific assumption that an intact hymen and subsequent bleeding after sexual intercourse is ‘proof’ of a woman’s prior virginity
- deaf women are more at risk of domestic abuse than their hearing peers, though access to specialist support in this area is limited
- disabled women experience higher rates of domestic abuse than non-disabled women, and disabled survivors report that healthcare professionals have assumed they will not be in sexual relationships, or cannot be subjected to sexual abuse
- lesbian and bisexual women are more likely to have experienced abuse than heterosexual women, and are more likely to have been abused by multiple perpetrators and in childhood
- older women who have suffered violence face additional barriers to getting support such as mobility issues, pre-existing health conditions, and abuse from adult children or their carer

Barriers when trying to leave an abuser and seek healthcare support can be particularly severe for those who have been subject to years of prolonged violence and abuse, are isolated within a particular community through language or culture, or those who are reliant on their abuser for their care or money.

Physical and psychological impacts

The health impacts of violence against women and girls are wide ranging. To give a few examples:

- mental health impacts can include post-traumatic stress disorder, depression, anxiety, low self-esteem and self-worth, guilt, and suicidality
- sexual violence can increase a woman’s risk for a range of physical health problems, including sexually transmitted infections or diseases, vaginal bleeding, urinary tract infection, miscarriage, and neonatal death

- hymenoplasty can result in complications such as bleeding, inflammation and infection (because the procedure is carried out in an area of the body that is susceptible to contamination from vaginal discharge, urine and faeces), as well as scarring in the vagina or near the perineum, which can cause perineal/vaginal laceration during the birth of a baby (affecting a woman’s long-term sexual health)

The need for a whole system approach

Given the wide-ranging impacts of violence against women and girls, organisations and experts emphasised the need for joined-up, holistic, and trauma-informed approaches across the health and care system. Importantly, this was flagged not only in relation to supporting survivors in their recovery, but also to help identify and therefore better support those who are still subject to violence and/or abuse.

Specific points included:

- the health services available for girls and women who experience abuse need to be joined-up to prevent them from being ‘bounced around’ services – including having to repeat and recount their traumatic experiences to multiple professionals, which can trigger upsetting memories

- some interactions with healthcare professionals have the potential to retraumatise survivors, such as the use of physical restraint in mental health services by male staff, and the process of administering a smear test

- the ability to access services should not be presumed; pregnant women who are sex workers and/or victims of trafficking may fear being arrested or charged with a criminal offence if they seek help, and some women in abusive relationships may not be able to freely attend appointments (e.g., to undergo medical abortion at a hospital or clinic)

Organisations and experts also highlighted the role of employers in supporting women through domestic abuse and in addressing inappropriate and discriminatory behaviours in the workplace (such as sexual harassment). For example:

- employers could – and should – take more actions to identify and mitigate the risks of all forms of workplace violence and aggression, to protect women’s physical and mental health at work

- workplaces and employers have a role to play in ensuring that women can seek help if they are being abused in other settings

- many women may lose their jobs because of an abuser sabotaging their ability to work, and the physical and mental impacts of domestic abuse can also serve as a barrier to women having secure employment

Suggestions moving forward

Organisations and experts put forward a range of proposals to improve outcomes in this area. This included, for example:

- legislate to ban virginity testing and hymenoplasty in England
- in line with NICE guidelines, Health Education England and Health Trusts should ensure that training on violence and abuse is embedded in training programmes, so that staff are equipped to enquire about violence and abuse
- ensure training of healthcare professionals covers how to safely ask about domestic abuse (including where there is no physical or sexual violence, but victims report symptoms such as mood swings, crying without reason, irritability, insomnia or permanent fatigue), and how to respond to disclosure in a supportive way to ensure women access the specialist services they need to escape and recover
- ensure all healthcare workers are trained to understand prostitution as a form of violence against women and girls and provide information about services to help women exit prostitution
- educate professionals to properly understand “honour” based abuse and best practice prevention and responses
- implement specialist girls’ and young women's services which respond holistically to domestic abuse and violence - recognising the additional and intersecting barriers that minoritised women face
- introduce guidance for workplaces on accommodating flexible/remote working during lockdowns and how to support the wellbeing of female staff at risk of domestic violence
- invest in community-based frontline specialist services
- ensure Relationships and Sex education is taught to all students (with no exemptions for individuals or institutions) to challenge the perception that a woman’s or girl’s worth is connected to virginity and that students have access to support

- further identify, acknowledge and document the psychological needs of asylum-seeking women and young girls affected by female genital mutilation, to ensure that documentary evidence is available in support of their asylum claims, and that they can access appropriate health and social care

- increase and maintain provision of trauma informed single-sex services

Suggested areas for future research included:

- increase intersectional research into the impact of health inequalities and violence against women and girls across the life course

- increase data collection on gender-based violence, and ensure this can be linked across the patient journey to join data across various touchpoints

Glossary

This glossary contains a brief definition of key terms referenced both in this report and in our report on the results of the 'Women's Health - Let's Talk About It' survey, including medical conditions and treatments, which some readers may be less familiar with. The definitions are correct at time of publication and should not be used for the purpose of self-diagnosing any symptoms you or others may be experiencing.

Term	Definition	Source
Adenomyosis	Adenomyosis is a condition where the endometrium (lining of the womb) is found deep in the myometrium (muscle of the uterus). It is not known exactly why adenomyosis happens, but it is likely that women with adenomyosis have a predisposition due to their genes, immune system and hormones. It can commonly cause painful and heavy periods.	NHS NORTH BRISTOL TRUST
Adiposity	Another term for obesity.	N/A
Anxiety	Anxiety is a feeling of unease, such as worry or fear, that can be mild or severe. There are multiple types of anxiety disorder, including generalised anxiety disorder (GAD) and social anxiety disorder (social phobia).	NHS
Asthma	Asthma is a common lung condition that causes occasional breathing difficulties. It affects people of all ages and often starts in childhood, although it can also develop for the first time in adults.	NHS
Atrial fibrillation	Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate.	NHS

Term	**Definition**	**Source**
Attention deficit hyperactivity disorder (ADHD)	Attention deficit hyperactivity disorder (ADHD) is a condition that affects people's behaviour. People with ADHD can seem restless, may have trouble concentrating and may act on impulse. People with ADHD may also have additional problems, such as sleep and anxiety disorders.	NHS
Autism	Autism is a lifelong developmental disability which affects how people communicate and interact with the world. Autism is a spectrum condition and affects people in different ways.	NATIONAL AUTISTIC SOCIETY
B12 deficiency	Vitamin B12 or folate deficiency anaemia occurs when a lack of vitamin B12 or folate causes the body to produce abnormally large red blood cells that cannot function properly. General symptoms of anaemia may include extreme tiredness, lack of energy, breathlessness, feeling faint, headaches, pale skin, noticeable heartbeats, tinnitus, loss of appetite and weight loss.	NHS
Bacterial vaginosis	Bacterial vaginosis (BV) is a common cause of unusual vaginal discharge. BV is not a sexually transmitted infection (STI), but it can increase a woman's risk of getting an STI such as chlamydia.	NHS
Chronic conditions	Chronic conditions are those which in most cases cannot be cured, only controlled, and are often life-long and limiting in terms of quality of life.	NHS WALES
Chronic kidney disease (CKD)	Chronic kidney disease (CKD) is a long-term condition where the kidneys don't work as well as	NHS

Term	Definition	Source
	they should. It's a common condition often associated with getting older.	
Cisgender	Relating to or being a person whose gender identity corresponds with the sex the person had or was identified as having at birth. For example, a person who was registered female at birth, and who identifies as a woman.	MERRIAM-WEBSTER
Clinical Commissioning Group	Clinical commissioning groups (CCGs) were established as part of the Health and Social Care Act in 2012 and replaced Primary Care Trusts on 1 April 2013. CCGs are groups of general practices (GPs) which come together in each area to commission the best services for their patients and population.	NHS England
Combined oral contraceptive pill	The combined oral contraceptive pill is often just called "the pill" or "birth pill". It contains artificial versions of female hormones oestrogen and progesterone, which are produced naturally in the ovaries. When taken correctly, the pill is over 99% effective at preventing pregnancy.	NHS
Contraception	Contraception refers to the methods that are used to prevent pregnancy. Some methods of contraception can also be used to prevent sexually transmitted infections (STIs).	Brook
Coronary heart disease (CHD)	Coronary heart disease (CHD) is the term that describes what happens when the heart's blood supply is blocked or interrupted by a build-up of fatty substances	NHS

Term	Definition	Source
	in the coronary arteries. It is a major cause of death in the UK and worldwide. CHD is sometimes called ischaemic heart disease or coronary artery disease.	
Depression	Depression is a common mental disorder. When someone is depressed, they feel persistently sad for weeks or months, rather than just a few days. Depression affects people in different ways and can cause a wide variety of symptoms.	NHS
Diabetes	Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are 2 main types of diabetes: type 1 diabetes – where the body's immune system attacks and destroys the cells that produce insulin, and type 2 diabetes – where the body does not produce enough insulin, or the body's cells do not react to insulin.	NHS
Domestic abuse	Domestic abuse is an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-partner, but also by a family member or carer.	WOMEN’S AID
Dyspraxia	Dyspraxia, also known as developmental co-ordination disorder (DCD), is a common disorder that affects movement and co-ordination. It affects both children and adults.	NHS
Eating disorders	An eating disorder is a mental health condition where one uses the control of food to cope with feelings and other situations.	NHS

Term	Definition	Source
	The most common eating disorders are: anorexia nervosa, bulimia, and binge eating disorder (BED).	
Ectopic pregnancy	An ectopic pregnancy is when a fertilised egg implants itself outside of the womb, usually in one of the fallopian tubes. The fallopian tubes are the tubes connecting the ovaries to the womb. If a fertilised egg or embryo gets stuck in them, it won't develop into a baby and the woman’s health may be at risk from rupture of the tube if the pregnancy continues to increase in size. It usually has to be removed using medicine or an operation.	NHS
Emergency contraception	Emergency contraception can prevent pregnancy after unprotected sex or if the contraception used has failed.	NHS
Endometriosis	Endometriosis is a condition where tissue similar to the lining of the womb starts to grow in other places, such as the ovaries, fallopian tubes and outside the reproductive tract, commonly the pelvis. Endometriosis can affect women of any age. For some women, endometriosis can have a big impact on their life and may sometimes lead to feelings of depression.	NHS
Epilepsy	Epilepsy is a common condition that affects the brain and causes frequent seizures. Seizures are bursts of electrical activity in the brain that temporarily affect how it works. They can cause a wide range of symptoms. Epilepsy can start at any age, but usually starts either in childhood or in	NHS

Term	Definition	Source
	people over 60.	
Fallopian tubes	The fallopian tubes are muscular tubes that sit in the lower abdomen/pelvis, alongside the other reproductive organs. There are two tubes, one on each side, that extend from near the top of the uterus, run laterally and then curve over and around the ovaries. The primary function of the fallopian tubes is to transport eggs from the ovary to the uterus.	VERYWELL HEALTH
Female sterilisation	Female sterilisation is an operation to permanently prevent pregnancy. The fallopian tubes are blocked or sealed to prevent the eggs reaching the sperm and becoming fertilised. Female sterilisation is more than 99% effective at preventing pregnancy.	NHS
Femtech	Femtech is a term applied to a category of software, diagnostics, products, and services that use technology to focus on women's health. This sector includes fertility solutions, period-tracking apps, pregnancy and nursing care, women's sexual wellness, and reproductive system health care.	SHE VALUES
Fibroids	Fibroids are non-cancerous growths that develop in or around the womb (uterus). The growths are made up of muscle and fibrous tissue and vary in size. They're sometimes known as uterine myomas or leiomyomas. Many women are unaware they have fibroids because they do not have any symptoms. The most common symptom experienced is heavy	NHS

Term	Definition	Source
	periods. Sometimes if fibroids are large, they cause pressure symptoms on other organs such as the bladder. In rare cases, further complications caused by fibroids can affect pregnancy or cause infertility.	
Fibromyalgia	Fibromyalgia, also called fibromyalgia syndrome (FMS), is a long-term condition that causes pain all over the body. Fibromyalgia has many symptoms, which tend to vary from person to person. The main symptom is widespread pain. It's not clear why some people develop fibromyalgia. The exact cause is unknown, but it's likely that several factors are involved.	NHS
Female genital mutilation (FGM)	Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut, injured or changed, but there's no medical reason for this to be done. FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. It's very painful and can seriously harm the health of women and girls. It can also cause long-term problems with sex, urinary symptoms, childbirth and mental health.	NHS
Gender does not match sex at birth	Gender does not match sex at birth is a term used to define when someone’s sex, assigned at birth (referring to the biological aspects of an individual as determined by their anatomy) does not match the gender they identify with.	OFFICE FOR NATIONAL STATISTICS
General practitioner (GP)	General practitioners (GPs) treat all common medical conditions and refer patients to hospitals	NHS HEALTH CAREERS

Term	Definition	Source
	and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.	
Gynaecologist	A doctor skilled in the treatment of women's diseases, especially those of the reproductive organs (see gynaecology below).	CAMBRIDGE DICTIONARY
Gynaecology	Gynaecology is concerned with the well-being and health of the female reproductive organs and the ability to reproduce. It includes endocrinology, female urology and pelvic malignancy. The specialty spans paediatric and adolescent gynaecological problems through to later years.	NHS HEALTH CAREERS
Heavy menstrual bleeding	*Heavy menstrual bleeding, also known as menorrhagia* is menstrual bleeding that lasts more than 7 days. It can also be bleeding that is very heavy, in which someone needs to change their tampon or pad after less than 2 hours.	CDC
HIV	HIV (human immunodeficiency virus) is a virus that damages the cells in your immune system and weakens your ability to fight everyday infections and disease. AIDS (acquired immune deficiency syndrome) is the name used to describe a number of potentially life-threatening infections and illnesses that happen when your immune system has been severely damaged by the HIV virus. While AIDS cannot be transmitted from 1 person to another, the HIV virus can.	NHS

Term	**Definition**	**Source**
Hormone replacement therapy (HRT)	Hormone replacement therapy (HRT) is a treatment to relieve symptoms of the menopause. It typically contains the hormones oestrogen and progestogen which are two of the main hormones that control reproduction. The amount of natural reproductive hormones changes around the time of the menopause. The main benefit of HRT is that it can help relieve most of the menopausal symptoms. It can also help prevent weakening of the bones (osteoporosis), which is more common after the menopause.	NHS
Hymenoplasty	Hymenoplasty (also known as hymenorrhaphy or hymen reconstruction or hymen repair) is a surgical intervention that involves reconstructing the hymen. There are a number of different techniques to achieve this but generally it involves stitching the torn edges of the hymen together with dissolvable stitches. The aim of the procedure is to ensure that the women bleeds when she next has sexual intercourse.	GOV.UK
Hypertension	Hypertension is a term used to describe high blood pressure. Hypertension rarely has noticeable symptoms. But if untreated, it increases the risk of serious problems such as heart attacks and strokes.	NHS
Hypothyroidism	An underactive thyroid gland (hypothyroidism) is where one's thyroid gland does not produce enough hormones. There's no way of preventing an underactive thyroid. Most cases are caused either by the immune system	NHS

Term	Definition	Source
	attacking the thyroid gland and damaging it, or by damage to the thyroid that occurs during some treatments for an overactive thyroid or thyroid cancer.	
Hysterectomy	A hysterectomy is a surgical procedure to remove the womb (uterus). Women are not able to get pregnant after this operation. Many women have a hysterectomy. It's more common for women aged 40 to 50. Hysterectomies are carried out to treat health problems that affect the female reproductive system, including heavy periods, long-term pelvic pain, fibroids and certain cancers.	NHS
Inclusion health groups	Inclusion health is a ‘catch-all’ term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences frequently lead to barriers in access to healthcare and contribute considerably to increasing health inequalities. People belonging to inclusion health groups frequently suffer from multiple health issues, which can include mental and physical ill health and substance dependence issues. This leads to extremely poor health outcomes, often much worse than the general population, and a lower average age of death.	GOV.UK

Term	Definition	Source
Integrated care	Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care.	NHS
Integrated care systems (ICS)	Integrated care systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.	NHS
Intrauterine device (IUD)	The intrauterine device (IUD), also known as the copper coil, is a method of non-hormonal contraception. It is a small T-shaped device made from plastic and copper that is fitted into the womb (uterus) to prevent pregnancy. This lasts from 5-10 years.	NHS
Intrauterine system (IUS)	The intrauterine system (IUS), also known as the hormonal coil, is a hormonal contraceptive inserted into the womb (uterus). It prevents an egg implanting and may prevent fertilisation. It tends to make periods much lighter and can be used to treat heavy periods. It is also sometimes used as part of HRT. It lasts for 3-5 years, depending on the brand.	NHS
In Vitro fertilisation (IVF)	In vitro fertilisation (IVF) is one of several techniques available	NHS

Term	Definition	Source
	to help people with fertility problems have a baby. During IVF, an egg is removed from the woman's ovaries and fertilised with sperm in a laboratory. The fertilised egg, called an embryo, is then returned to the woman's womb to grow and develop.	
Irritable bowel syndrome (IBS)	Irritable bowel syndrome (IBS) is a common condition that affects the digestive system. It causes symptoms like stomach cramps, bloating, diarrhoea and constipation. These tend to come and go over time, and can last for days, weeks or months at a time.	NHS
Learning disability	A learning disability affects the way a person understands information and how they communicate. This means they can have difficulty: understanding new or complex information; learning new skills; and/or coping independently. A learning disability can be mild, moderate or severe.	NHS
Lichen sclerosus	Lichen sclerosus is a skin condition that causes itchy white patches on the genitals or other parts of the body. It affects people of all ages, but it’s much more common in women over 50.	NHS
Mastectomy	A mastectomy is an operation to remove a breast. It's used to treat breast cancer in women and breast cancer in men.	NHS
Menopause	The menopause is when a woman stops having periods and is no longer able to get pregnant naturally. The menopause is a natural part of ageing that usually occurs between 45 and 55 years of	NHS

Term	Definition	Source
	age, as a woman's ovaries stop releasing eggs and then the woman's oestrogen levels decline. In the UK, the average age for a woman to reach the menopause is 51.	
Menstruation	See definition for periods.	
Mesothelioma	Mesothelioma is a type of cancer that develops in the lining that covers the outer surface of some of the body's organs. It's usually linked to asbestos exposure. Mesothelioma mainly affects the lining of the lungs (pleural mesothelioma), although it can also affect the lining of the tummy (peritoneal mesothelioma), heart or testicles.	NHS
Metabolic syndrome	Metabolic syndrome is the medical term for a combination of diabetes, high blood pressure (hypertension) and obesity. It puts someone at greater risk of getting coronary heart disease, stroke and other conditions that affect the blood vessels.	NHS
Migraine	A migraine is usually a moderate or severe headache felt as a throbbing pain on one side of the head.	NHS
Miscarriage	A miscarriage is the loss of a pregnancy during the first 23 weeks.	NHS
Multiple sclerosis (MS)	Multiple sclerosis (MS) is a condition that can affect the brain and spinal cord, causing a wide range of potential symptoms, including problems with vision, arm or leg movement, sensation or balance. It's a lifelong condition that can sometimes cause	NHS

Term	Definition	Source
	serious disability, although it can occasionally be mild.	
Musculoskeletal (MSK) conditions	Musculoskeletal (MSK) conditions affect the joints, bones and muscles, and also include rarer autoimmune diseases and back pain. More years are lived with musculoskeletal disability than any other long-term condition. There are more than 200 musculoskeletal conditions.	NHS ENGLAND
Myalgic encephalomyelitis or chronic fatigue syndrome (ME/CFS)	Myalgic encephalomyelitis, also called chronic fatigue syndrome or ME/CFS, is a long-term condition with a wide range of symptoms. The most common symptom is extreme tiredness.	NHS
Neurological conditions	Neurological conditions such as Parkinson’s disease, motor neurone disease, and epilepsy result from damage to the brain, spinal column or peripheral nerves. Some neurological conditions are life threatening, with many severely affecting an individual’s quality of life.	NHS ENGLAND
Non-binary	Gender identity refers to our sense of who we are and how we see and describe ourselves. Most people identify as "male" or "female". These are sometimes called "binary" identities. Some people do not define themselves as having a "binary" identity. For them the concept of gender is not relevant to their identity. They may use different terms, such as agender, gender diverse, gender non-conforming, to describe their identity. However, as a group, they are often called "non-binary".	NHS

Term	**Definition**	**Source**
Pelvic floor	The pelvic floor is made up of layers of muscles which support the bladder, bowel and uterus.	ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS
Pelvic organ prolapse	Pelvic organ prolapse is when one or more of the organs in the pelvis slip down from their normal position and bulge into the vagina. It can be the womb (uterus), bowel, bladder or top of the vagina. This occurs most usually sometime after childbirth. A prolapse is not life threatening, but it can cause pain and discomfort. Symptoms can usually be improved with pelvic floor exercises and lifestyle changes, but sometimes medical treatment is needed.	NHS
Perimenopause	Perimenopause means "around menopause" and refers to the time during which a woman’s body makes the natural transition to menopause, marking the end of the reproductive years. This can be a time where women experience symptoms of the menopause or their periods can become less frequent, before stopping. Perimenopause is also called the menopausal transition.	MAYO CLINIC
Periods	A period is the part of the menstrual cycle when a woman bleeds from her vagina for a few days. For most women this happens every 28 days or so, but it's common for periods to be more or less frequent than this, ranging from day 21 to day 40 of their menstrual cycle.	NHS
Physiotherapy	Physiotherapy helps to restore movement and function when someone is affected by injury, illness or disability. It can also	NHS

Term	Definition	Source
	help to reduce risk of injury or illness in the future. It takes a holistic approach that involves the patient directly in their own care.	
Polycystic ovary syndrome (PCOS)	Polycystic ovary syndrome (PCOS) is a common condition that affects how a woman's ovaries work. PCOS cannot be cured, but the symptoms can be managed. To be diagnosed with PCOS, women have two out of the three main features which are: irregular periods; excess androgen – high levels of "male" hormones in the body; and a polycystic appearance of the ovaries – where ovaries become enlarged and contain many fluid-filled sacs (follicles) that surround the eggs (but despite the name, women do not actually have cysts if they have PCOS).	NHS
Postcode lottery	The term postcode lottery describes a situation in which the standard of medical care, education, etc, received by the public varies from area to area, depending on the funding policies of various health boards, local authorities, etc.	COLLINS DICTIONARY
Postnatal	Relating to the period of time immediately after a baby has been born. Characteristically this is considered to be up to 6 weeks, but definitions of the time period can vary	CAMBRIDGE DICTIONARY
Postnatal depression	Postnatal depression is a type of depression that many parents experience after having a baby. It's a common problem, affecting more than 1 in every 10 women within a year of giving birth. It can also affect fathers and partners. Postnatal depression	NHS

Term	Definition	Source
	can start any time in the first year after giving birth.	
Premenstrual syndrome (PMS)	PMS (premenstrual syndrome) is the name for the symptoms women can experience in the weeks before their period. Most women have PMS at some point. A small number of women may experience more severe symptoms of PMS known as premenstrual dysphoric disorder (PMDD). Symptoms of PMDD are similar to PMS but are much more intense and can have a much greater negative impact on your daily activities and quality of life.	NHS
Relationships, sex and health education (RSHE)	It is a statutory requirement for schools in England to teach Relationships/ Relationships and Sex Education (RSE) and Health Education — sometimes abbreviated as 'RSHE'.	PSHE ASSOCIATION AND GOV.UK
Sexual health	Sexual health is an integral part of overall health, well-being and quality of life. It is a state of physical, emotional, mental and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity.	WORLD HEALTH ORGANISATION
Smear test	Cervical screening (a smear test) checks the health of a woman's cervix. The cervix is the neck of the womb with an opening into the vagina. It's not a test for cancer, it's a test to help prevent cancer. All women and people with a cervix aged 25 to 64 should be invited by letter.	NHS
Stroke	A stroke is a serious life-threatening medical condition that happens when the blood	NHS

Term	**Definition**	**Source**
	supply to part of the brain is cut off. Strokes are a medical emergency and urgent treatment is essential.	
Thrush	Thrush is a common yeast infection that affects men and women. It's usually harmless but it can be uncomfortable and keep coming back. It is not classed as a sexually transmitted infection (STI)	NHS
Triage	Triaging in healthcare settings is when patients are sorted based on their needs and involves the assignment of degrees of urgency to wounds or illnesses to decide the order of treatment of a large number of patients or casualties.	DENTAL REFFERALS.ORG
Toxic shock syndrome	Toxic shock syndrome (TSS) is a rare but life-threatening condition caused by bacteria getting into the body and releasing harmful toxins. It's often associated with tampon use in young women, but it can affect anyone of any age – including men and children.	NHS
Urogynaecologist	A health professional who works in the field of urogynaecology. Urogynaecology is a subspecialty of Gynaecology. It covers services that provide assessment, investigations and treatment for women with urinary incontinence, vaginal prolapse, recurrent urinary tract infections, bladder pain and pelvic floor injury after childbirth including faecal incontinence. It links with obstetrics, urology and colorectal services.	ROYAL COLLLEGE OF NURSING
Urinary tract infections (UTIs)	Urinary tract infections (UTIs) affect the urinary tract, including	NHS

Term	Definition	Source
	the bladder (cystitis), urethra (urethritis) or kidneys (kidney infection). UTIs can be treated with antibiotics, but these are not always needed.	
Virginity testing	Virginity testing, also referred to as hymen, ‘two-finger’ or vaginal examination, is an inspection of the female genitalia, intended to determine whether a woman or girl has had vaginal intercourse. The position of the World Health Organization and the Royal College of Obstetricians and Gynaecologists is that virginity tests have no scientific merit or clinical indication as it is not possible to tell whether a woman has had intercourse through this type of examination.	GOV.UK

www.gov.uk/dhsc