



Women's Health Strategy for England

Presented to Parliament
by the Secretary of State for Health and Social Care
by Command of Her Majesty

August 2022

Please note this is an updated version of the Women's Health Strategy for England. The previous version was laid in July 2022 and withdrawn August 2022.

CP 736



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ISBN 978-1-5286-3665-0
E02760367 08/22

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of Her Majesty's Stationery Office

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MINISTERIAL FOREWORD

This country's health and care system belongs to us all, and it must serve us all. However, sadly, 51% of the population faces obstacles when it comes to getting the care they need.

Although women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men.

Not enough focus is placed on women-specific issues like miscarriage or menopause, and women are under-represented when it comes to important clinical trials. This has meant that not enough is known about conditions that only affect women, or about how conditions that affect both men and women impact them in different ways.

We also know that there are disparities in women's health across the country. Smoking in pregnancy is one example of this. While progress has been made in reducing rates of smoking in pregnancy to 9.6% of deliveries, the headline figure masks significant geographical differences, with prevalence ranging from 1.8% in Kensington to 21.4% in Blackpool.

There are also far too many cases where women's voices have not been listened to; indeed the responses to our call for evidence found 84% of respondents felt that this was the case. One of the most tragic moments in both of our roles was hearing the heartbreaking stories in the Ockenden Review which highlighted shocking failings in maternity care. Here, as in so many cases, women were not listened to; one mother said she felt like a 'lone voice in the wind'.

This is the government's first Women's Health Strategy for England and shows how we will right these wrongs. It sets out how we will improve the way in which the health and care system listens to women's voices, and boost health outcomes for women and girls. It takes a life course approach, focused on understanding the changing health and care needs of women and girls across their lives, from adolescents and young adults to later life.

We published the call for evidence last year, and we are so grateful to everyone who made their voice heard. It's brilliant that we have received almost 100,000 responses from women across the country, and over 400 written submissions from organisations and experts in health and care.

We have used these responses to shape this document, to make sure it reflects the voices of women across the country. This is a 10-year strategy, that sets out a range of commitments to improve the health of women everywhere, including a plan to transform women's health content on the NHS website, a definition of trauma-informed practice for the health sector and plans to increase female participation in vital research.

It also includes the appointment of Professor Dame Lesley Regan as a Women's Health Ambassador for England, who will shortly be joined by a deputy Women's Health Ambassador. They will both help us to keep up this momentum and better reach women and girls across the country.

If we get this right, and put this landmark strategy in place, then we can lay the foundations for change and end the injustices that have persisted for too long.

Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care

Maria Caulfield MP, Minister of State for Health

WOMEN'S HEALTH AMBASSADOR FOREWORD

I am honoured to be taking up the position as the first Women's Health Ambassador for England. Having spent my career working with and caring for women, I see this newly created role as a unique opportunity to 'get it right' for women and girls.

In the 2014 chief medical officer's annual report - *The health of the 51%: women*¹ - we identified the widening disparities for girls and women during their adolescent, reproductive and post-reproductive years. The issues raised then remain relevant today, and in some cases health disparities have widened and been further exaggerated by the pandemic. The *Better for Women* report published in 2019 by the Royal College of Obstetricians and Gynaecologists highlighted the need to adopt a life course approach, emphasising the importance of preventative health interventions, instead of focussing on the treatment of established disease.²

This first Women's Health Strategy for England is the next step on the journey to reset the dial on women's health. The call for evidence, which informs the ambitions of the strategy, reiterates what I hear repeatedly from women - that our healthcare systems are failing them because NHS services are not designed to meet women's day to day needs. All too often it forces women to navigate their way around multiple different health professionals and facilities trying to access basic services to maintain their health and wellbeing. The irony is that their care can easily be provided more conveniently and at significantly lower cost during a single visit to a women's health hub or centre, if we adopt a 'one-stop-shop' model.

My initial priorities will be to tackle health issues that affect most women for long periods of their lives, which if left untreated can limit a woman's ability to attend school, go to work, or undertake their caring responsibilities. Most women will menstruate for nearly 40 years, and most women require reliable contraception (which is also a highly cost-effective intervention) for most of this time to prevent unplanned pregnancies. Contraception is frequently used as a first-line treatment for menstrual problems, but many women meet barriers in accessing the method of their choice due to siloed commissioning.

¹ DHSC, **chief medical officer annual report 2014: women's health**, published December 2015

² RCOG, **Better for women, 2019**, published December 2019

Miscarriage is a common complication of pregnancy and yet it remains a taboo subject, rarely discussed due to embarrassment, distress, and even shame. Almost all women will experience menopause, and menopause symptoms can severely impact a woman's quality of life. Although women usually live longer than men, they spend considerably more time in poor health. We must ensure that our goal is to prioritise quality and longevity of life.

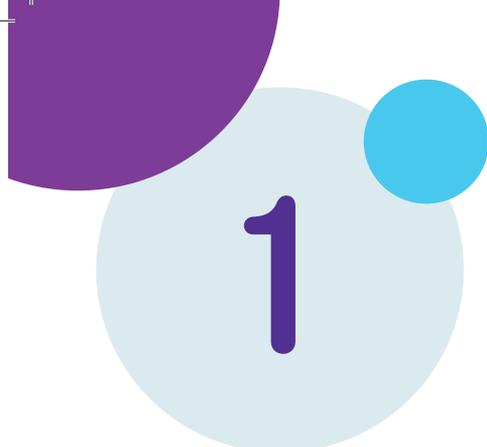
I am looking forward to developing a plan for the short-, medium-, and long-term actions we will need to take to improve women's health across the life course. Most importantly I view this strategy as the beginning, which we can amend and add to our priorities as we gain more experience of implementing the changes needed.

To achieve sustainable change and improvement, it is important to recognise that better health for women extends beyond our health and social care system. Every sector in society has a role to play and I hope we will persuade many others to collaborate with us and contribute to achieving this goal.

I look forward to working with women, girls, charities, health services, policy makers, the government, and the many other partners needed to implement this strategy effectively.

When we get it right for women, everyone in our society benefits.

Professor Dame Lesley Regan DBE MD DSc FRCOG



1

INTRODUCTION

Why do we need a Women's Health Strategy?

While women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men.³ And while women make up 51% of the population, historically the health and care system has been designed by men, for men.

This 'male as default' approach has been seen in research and clinical trials, education and training for healthcare professionals, and the design of healthcare policies and services. This has led to gaps in our data and evidence base which mean that not enough is known about conditions that only affect women, for example menopause or endometriosis. It has meant that not enough is known about how conditions that affect both men and women impact them in different ways, for example cardiovascular disease, dementia, or mental health conditions. It has also resulted in inefficiencies in how services are delivered, for example we know that many women have to move from service to service to have their reproductive health needs met, and women can struggle to access basic services such as contraception.

The impact of failing to put women at the heart of health services has been clear to see through the number of recent high profile independent reports and inquiries. This has included the report of the Independent Medicines and Medical Devices Safety Review (IMMDS Review) which considered how the health system in England responds to reports from patients about side effects from treatments,⁴ the report of the independent inquiry into the issues raised by convicted breast surgeon Ian Paterson,⁵ and recently, the final report of the Ockenden Review, which was an independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust.⁶

As these independent reports have shown, too often it is women whom the healthcare system fails to keep safe and fails to listen to.

³ ONS, **Health state life expectancies: UK: 2018 to 2020**, published March 2022

⁴ DHSC, **Independent Medicines and Medical Devices Safety Review report**, published July 2020

⁵ DHSC, **Report of the Independent Inquiry into the issues raised by Paterson**, published February 2020

⁶ DHSC, **Final report of the Ockenden review**, published March 2022

These high-profile incidents were the focus of much national attention and conversation and have rightly triggered extensive work to improve things for the women and families affected. However, we have heard very clearly that women and girls across the country do not feel well served by the healthcare system as it is.

On 8 March 2021, the government launched a 14-week call for evidence⁷ to inform the development of this strategy. The call for evidence had 3 parts:

- 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 for individuals and organisations 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

We received 110,123 responses, of which 97,307 were from individuals who told us that they lived in England and wanted to share their own experiences, the experiences of a female family member, friend or partner, or their reflections as a health or care professional. We also received 436 written responses from organisations and individuals with expertise in women's health.

Through the call for evidence we heard about women's experiences at every stage of their interactions with the healthcare system, from initial discussion of symptoms to further appointments, discussion of treatment options, and follow up care. Women said they were often not listened to or told that heavy and painful periods are 'normal' or that the woman will 'grow out of them', and many women told us about waiting years before receiving a diagnosis for conditions such as endometriosis. Women also told us about their struggles to access high quality information on women's health issues, such as advice on accessing the right form of contraception for them. We also heard about the impacts that women's health issues such as heavy menstrual bleeding, fertility treatment or menopause can have on women's participation in the workplace and ability to go about their daily life.

The findings from the call for evidence are summarised throughout this strategy and the full findings from the public survey and written submissions can be found in full in the call for evidence consultation response.⁸ The findings of the focus group study can be found on the University of York PREPARE website.⁹ We are extremely grateful to all the individuals and organisations who responded to our call for evidence which provides a strong mandate for change and is reflected in this strategy.

⁷ DHSC, **Women's Health Strategy: call for evidence**, published March 2021, updated April 2022

⁸ DHSC, **Women's Health Strategy: call for evidence**, published March 2021, updated April 2022

⁹ University of York, **Women's priorities for women's health: a focus group study**, published December 2021

The 6-point plan

We have a clear ambition that, within the next 10 years, our Women's Health Strategy for England will have boosted health outcomes for all women and girls, and radically improved the way in which the health and care system engages and listens to all women and girls.

We will achieve this by taking a life course approach, focusing on women's health policy and services throughout their lives, embedding hybrid and wrap around services as best practice, boosting the representation of women's voices and experiences in policy making and at all levels of the health and care system. We will bring together everyone across the healthcare system to act as the catalyst for the long-term change we all want to see.

The strategy builds on Our Vision for the Women's Health Strategy for England, which was published in December 2021 and set out our ambitions for improving the health and wellbeing of women and girls in England based on the life course approach, and resetting how the health and care system listens to women.¹⁰



Recent achievements

Addressing all of this is a significant challenge, but we are not at a standing start. The government has been taking action to begin to address the issues and disparities women face, including:

- setting out our approach to reducing waiting times and improving patient experience across all specialty areas, including gynaecology and urogynaecology through the Delivery Plan for Tackling the COVID-19 Backlog of Care, published in February 2022, which sets out our approach to driving efficiency and innovation within the system¹¹
- establishing a Maternity Disparities Taskforce to tackle disparities in outcomes and experiences of care for women and babies by improving access to pre-conception and maternity care for women from ethnic minorities and those living in the most deprived areas
- investing £127 million to increase and support the maternity NHS workforce and to increase neonatal care capacity over the next year. This is on top of £95 million investment into recruitment of an additional 1,200 midwives and 100 consultant obstetricians

¹⁰ DHSC, **Our Vision for the Women's Health Strategy for England**, published December 2021

¹¹ NHSE, **Delivery plan for tackling the COVID-19 backlog of elective care**, published February 2022 and updated May 2022

- establishing the UK Menopause Taskforce to drive forward the work on improving healthcare support for women, raise levels of awareness in the population and among healthcare professionals, encourage workplace support and consider where further research is needed to address gaps in the evidence base
- reducing the cost of, and improving access to, hormone replacement therapy (HRT) by identifying ways to support the HRT supply chain and addressing shortages some women face on a limited number of products, and by reducing the cost of HRT through a new bespoke HRT pre-payment certificate which we will introduce by April 2023
- banning virginity testing and hymenoplasty in the UK through the Health and Care Act 2022.¹² Virginity testing and hymenoplasty are forms of violence against women and girls and such practices will not be tolerated in the UK
- enhancing women's reproductive wellbeing in the workplace through the Health and Wellbeing Fund 2022 to 2025. The fund supports voluntary, community and social enterprise organisations to expand and develop projects to support women experiencing reproductive health issues such as the pregnancy loss or menopause to remain in or return to the workplace¹³
- banning the availability of 'Botox' and cosmetic fillers to under 18s for cosmetic purposes and banning adverts for cosmetic surgery that target under-18s
- investing £302 million in family hubs and the start for life programme, including the creation of a network of family hubs in 75 upper-tier local authorities across England, bespoke parent-infant relationship and perinatal mental health support, and the establishment of breastfeeding support services
- providing protections to the millions of people who experience domestic abuse through the Domestic Abuse Act 2021¹⁴
- abolishing the tampon tax, removing VAT from women's sanitary products, and rolling out of free sanitary products in schools, colleges and hospitals
- introducing the Online Safety Bill, to make the UK the safest place in the world to be online. The bill will restrict exposure to legal but harmful content, such as exposure to self-harm, harassment and eating disorders content

¹² HM Government, **Health and Care Act 2022**

¹³ DHSC, **VCSE Health and Wellbeing Fund 2022 to 2025: women's reproductive wellbeing in the workplace**, published May 2022

¹⁴ HM Government, **Domestic Abuse Act 2021**

This strategy sets out how we will go further, with our six-point long-term plan for transformational change:

1. Ensuring women's voices are heard – tackling taboos and stigmas, ensuring women are listened to by healthcare professionals, and increasing representation of women at all levels of the health and care system.
2. Improving access to services – ensuring women can access services that meet their reproductive health needs across their lives, and prioritising services for women's conditions such as endometriosis. Ensuring conditions that affect both men and women, such as autism or dementia, consider women's needs by default and being clear on how conditions affect men and women differently.
3. Addressing disparities in outcomes amongst women – ensuring that a woman's age, ethnicity, sexuality, disability, or where she is from does not impact upon her ability to access services, or the treatment they receive.
4. Better information and education – enabling women and wider society to easily equip themselves with accurate information about women's health, and healthcare professionals to have the initial and ongoing training they need to treat their patients knowledgeably and empathetically.
5. Greater understanding of how women's health affects their experience in the workplace – normalising conversations on taboo topics such as periods and the menopause to ensure women can remain productive and be supported in the workplace, and highlighting the many examples of good practice by employers.
6. Supporting more research, improving the evidence base and spearheading the drive for better data – addressing the lack of research into women's health conditions, improving the representation of women of all demographics in research, and plugging the data gap and ensuring existing data is broken down by sex.

The strategy goes on to set out our approach to priority areas related to specific conditions or areas of health where the call for evidence highlighted particular issues or opportunities:

- menstrual health and gynaecological conditions
- fertility, pregnancy, pregnancy loss and post-natal support
- menopause
- mental health and wellbeing
- cancers
- the health impacts of violence against women and girls
- healthy ageing and long-term conditions

The 10-year timeframe of this strategy recognises that achieving our ambitions requires long-term cultural and system changes. There are a number of areas where we can be clear that what change needs to and will happen, and in others more work will need to be done to develop solutions, which will be delivered in the longer term.



Our top commitments

There are a number of immediate steps that we are taking to improve the experience and outcomes for women. These are:

- appointing the government's first ever Women's Health Ambassador for England, Professor Dame Lesley Regan, to champion women's voices and take forward a programme of work to support delivery of the Women's Health Strategy, eradicating deep seated biases and driving forward the system-level changes needed to close the gender health gap
- working with the NHS to create a clinical women's health lead in NHS England to provide support to the Women's Health Ambassador, and to work with the Department of Health and Social Care in developing longer-term plans for women's health
- encouraging the expansion of women's health hubs around the country and other models of 'one-stop clinics', bringing essential women's services together to support women to maintain good health and create efficiencies for the NHS. We will establish a women's health accreditation mechanism to recognise commissioners and providers who offer services in these ways and promote best practice across the country
- investing in research on women's health issues. Through the National Institute for Health and Care Research (NIHR) we are commissioning a new Policy Research Unit dedicated to reproductive health, subject to receiving high-quality applications. This will undertake research to inform government policy in areas such as menstrual health, gynaecological conditions, and menopause¹⁵
- improving the quality of health and health service data collected within NHS services, as well as processes to link data collected across the NHS, the Department of Health and Social Care, and NHS England
- the General Medical Council (GMC) will be introducing the Medical Licensing Assessment for the majority of incoming doctors including all medical students graduating from academic year 2024/2025 and onwards. Within this assessment, there are a number of topics relating to women's health. This will encourage a better understanding of women's health among doctors as they start their careers in the UK.

¹⁵ NIHR, **Policy Research Programme - Invitation to Tender National Institute for Health and Care Research (NIHR) Policy Research Units**, published July 2022

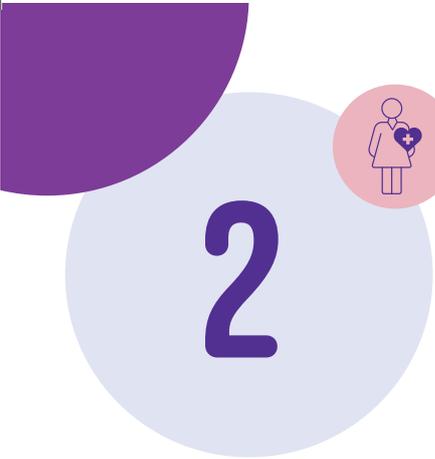
- improving care for women who experience pregnancy and baby loss, including by introducing a pregnancy loss certificate in England as recommended by the interim update of the independent Pregnancy Loss Review. This voluntary scheme will enable parents who have experienced a loss before 24 weeks of pregnancy to record and receive a certificate to provide recognition of their loss
- transforming the NHS website into a world-class, first port of call for women's health information, by updating existing content and adding new pages – such as for adenomyosis - where needed, and bringing together third party new and existing content to create a trusted, comprehensive guide to women's health

Implementing the strategy

Throughout this strategy, we point to actions that government will take. But we are clear that the government alone cannot meet our ambitions and embed the change set out in this strategy. We therefore also set out steps that we will take alongside other organisations including NHS England, the NIHR, the National Institute for Health and Care Excellence (NICE) and Health Education England, and the important role of other external organisations, such as the medical royal colleges, employers, industry, and the voluntary sector.

We will also continue our engagement directly with women, including through community groups and charities. We saw a huge level of support during the call for evidence and development of the vision and the strategy. The same level of collaboration and partnership will be just as important for realising our ambitions. The Women's Health Ambassador and her deputy will be key to driving this engagement with professional bodies and the wider public.

A delivery plan will be developed to track implementation of the strategy and the final chapter sets out our plans for implementing the actions set out in this strategy and for monitoring implementation.



2

WOMEN'S HEALTH ACROSS THE LIFE COURSE

The Women's Health Strategy is informed by the life course approach. Unlike a disease-orientated approach, which focuses on interventions for a single condition often at a single life stage, a life course approach focuses on understanding the changing health and care needs of women and girls across their lives. It aims to identify the critical stages, transitions, and settings where there are opportunities to promote good health, to prevent negative health outcomes, or to restore health and wellbeing.

This approach has already been adopted by the World Health Organization¹⁶ and the Royal College of Obstetricians and Gynaecologists in their report *Better for Women*.¹⁷

Our ambition is for women's health policy and services to be based on the life course approach, and for care to be wrapped around the needs of individual women and girls, rather than based around one specific issue or condition.

¹⁶ WHO, **The life-course approach: from theory to practice**, published June 2021

¹⁷ RCOG, **Better for women, 2019**, published December 2019

Women's health across the life course



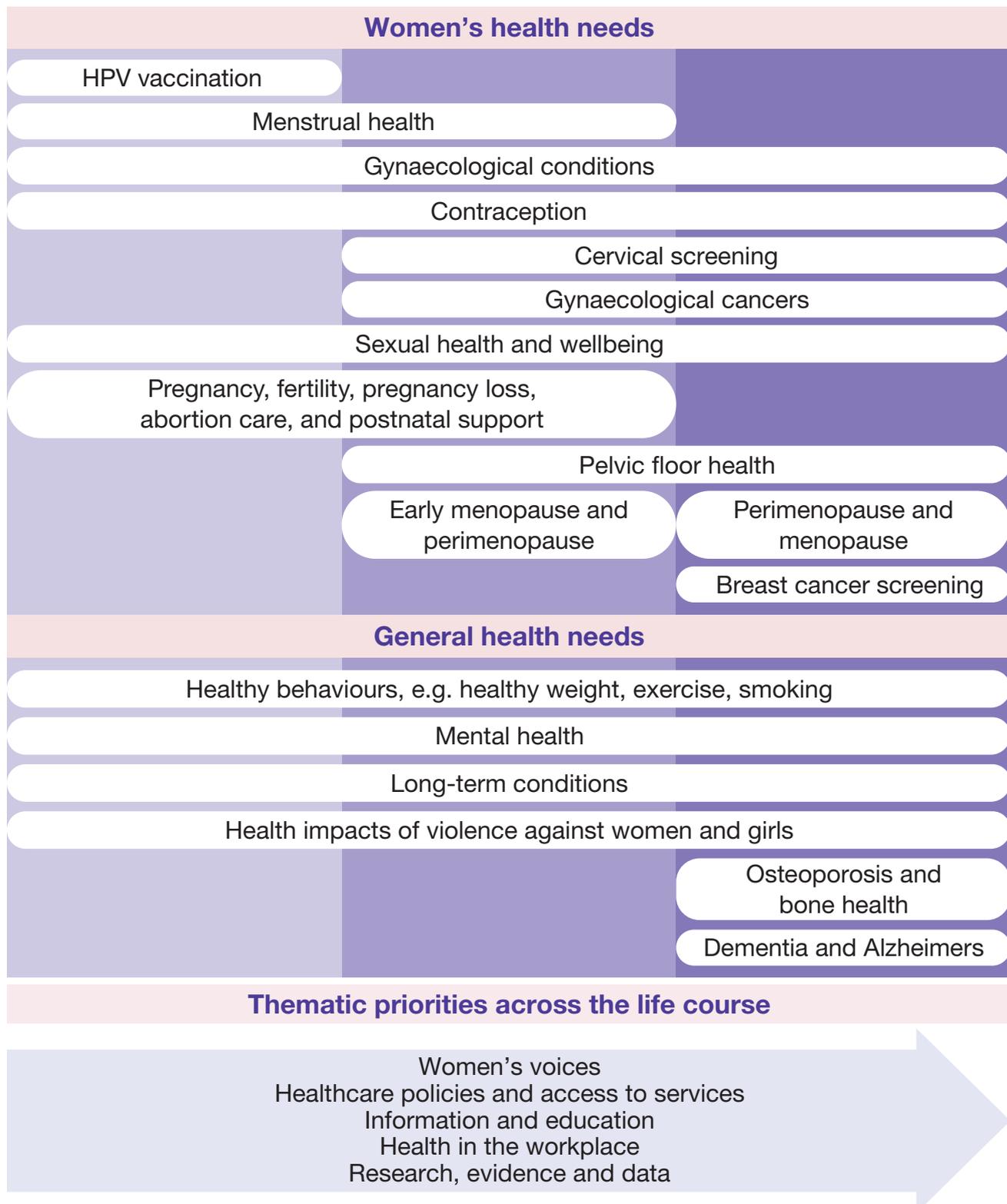
ADOLESCENTS AND YOUNG ADULTS
PUBERTY-24



MIDDLE YEARS
25-50



LATER YEARS
51+



3



WOMEN'S VOICES

What we've heard

In the call for evidence public survey, 84% of respondents said that there had been instances in which they had not been listened to by healthcare professionals. We heard about women's experiences at every stage of the journey, from initial discussion of symptoms to further appointments, discussion of treatment options, and follow up care. We heard concerns from women about not being listened to in instances where pain is the main symptom, for example, being told that heavy and painful periods are 'normal' or that the woman will 'grow out of them'. While this was not limited to women's health issues, a significant volume of responses focused on gynaecological symptoms.¹⁸ The survey and written submissions also highlighted that pregnant women and new mothers often reported negative interactions with healthcare professionals, and do not feel their needs are always listened to, particularly in specific situations such as during childbirth. This reinforces what we have heard through other independent reports and inquiries, including the report of the IMMDS Review,¹⁹ the report of the Paterson Inquiry,²⁰ and more recently the final report of the Ockenden Review.²¹

In the call for evidence, we heard the importance of listening to a more diverse range of women in all aspects of our work including the development and implementation of healthcare policies and services. Some written submissions called for more accountability and leadership for women's health at a national and system level, for example dedicated women's health leads. We also heard calls for more diverse leadership and representation of women and other under-represented groups at all levels of the health and care system, for example in leadership positions and on boards, and involvement of women in the development of curricula and training, and in research pathways.

¹⁸ Many of the questions in the survey were negatively phrased (for example, 'have you had any experiences of not being listened to?') because we wanted to test the assumption that women have not felt listened to, and to build our understanding of where improvements can be made. While the evidence in this section does focus on negative interactions, this should not be interpreted as a criticism of all health and care professionals or representative of every experience, as the survey did not ask about positive experiences. Additionally, although our survey had a large sample size, some women may have been more inclined to respond if they had personal negative experiences they wanted to share.

¹⁹ DHSC, **Independent Medicines and Medical Devices Safety Review report**, published July 2020

²⁰ DHSC, **Report of the Independent Inquiry into the issues raised by Paterson**, published February 2020

²¹ DHSC, **Final report of the Ockenden review**, published March 2022

Our 10-year ambitions

Our ambitions are:



women and girls feel listened to and have their concerns taken seriously at every stage of their journey, from initial discussion of symptoms to further appointments, discussion of treatment options, and follow up care. There is an end to taboos and stigmas which reinforce beliefs among women, health and care professionals and wider society that health problems or painful symptoms - in particular 'hidden pain' which could be a symptom of gynaecological conditions - are normal and something to be endured



women and girls report better experiences of procedures and are well-informed about the care they can expect, for example conversations on pain relief before a hysteroscopy procedure or intrauterine device (IUD) fitting, or being offered a chaperone for intimate examinations. Disparities in experiences of services and procedures are reduced, especially for women from under-served and seldom-heard groups



personalised care and shared decision making are embedded in all areas of women's health, for example in management of long-term gynaecological conditions and gynaecological procedures, learning from best practice in maternity care



there is more research into women's experiences of health and care. We have a better understanding of why and how women do not feel listened to and healthcare professional's perspectives on listening. As a result, we have a better understanding of the most effective solutions



there is increased leadership, accountability and representation of women and women's health expertise in all forums where decisions are made in the health and care system. This includes at national level, system and local level. There is also enhanced representation of women and women's health expertise in the commissioning of research, design of curricula for healthcare professionals, policy making, and in the commissioning and delivery of services

Actions we are taking

Listening to, and working with, women and girls to implement the strategy

We have appointed Professor Dame Lesley Regan as the Women's Health Ambassador for England. The ambassador will lead a programme of work to support delivery of the Women's Health Strategy. They will focus on raising the profile of women's health, increasing awareness of taboo topics, and bringing in a range of voices to implement the strategy. We will also appoint a deputy Women's Health Ambassador, who will work collaboratively with the ambassador to help increase awareness and build relationships with community groups and women and girls across the country.

We are working with the ambassador to develop plans for working with women, girls and stakeholders to implement the strategy. A core part of the ambassador's role is to bring in a diverse range of voices including those of individual women, and voluntary sector organisations. This will include reaching groups that were less well-represented in the call for evidence.

Representation of women and women's health expertise

NHS England will have a women's health lead. They will provide support to the Women's Health Ambassador, and work with the Department of Health and Social Care in developing longer-term plans for women's health.

We also recommend that Integrated Care Systems (ICSs) take into account the ambitions and actions set out in this strategy when developing their local plans.

We are also working with NHS England and our other arm's-length bodies (ALBs) to increase the representation of women from a wide range of backgrounds at senior including board level across the health and care system, including within the Department of Health and Social Care as well.

Shared decision making, consent, and personalised care

We will support implementation of evidence-based best practice that improves women's experience and outcomes, including shared decision making and personalised care. Shared decision making supports people to make informed decisions in relation to their health and care.²² Patient decision aids and conversation aids have also been found to improve people's experience of informed decision making.²³

²² NHSE **Shared decision making**

²³ Stacey D and others, **Decision aids for people facing health treatment or screening decisions**, **Cochrane Database of Systematic Reviews**, published April 2017

Maternity care is leading the way in implementing informed decision making in women's health, including through digital tools. NHS Digital is developing a series of tools, called iDecide, to better support informed decision making in labour.²⁴ The NHS England Maternity Transformation Programme is prioritising embedding informed decision making for all women during pregnancy and childbirth.²⁵ The final report of the Ockenden Review also outlines the importance of personalised maternity care.

Within menopause care, the NHS England Menopause Pathway Improvement Programme is developing decision support tools to help women understand their symptoms better and to inform discussions with healthcare professionals.

We will work with NHS England to embed shared decision making more widely in women's health, for example in relation to gynaecological conditions such as endometriosis, and gynaecological procedures. We will also consider how to improve how women and healthcare professionals' access to accredited shared decision making resources produced by organisations such as NICE, NHS England and royal colleges.

We are also committed to increasing the proportion of women with long term conditions accessing personalised care. Personalised care provides opportunities for improving women's experiences, as personalised care means people have choice and control over the way their care is planned and delivered.²⁶ We have recently set out our ambition for 4 million people to benefit from personalised care by March 2024, including pregnant women.

We will also work with the ambassador and other key organisations to consider what more we can do to improve women and girls' experiences of services, building on work already underway across the system.

We are also pleased that the Royal College of Obstetricians and Gynaecologists guidelines on outpatient hysteroscopy are being updated, and that the Royal College of Obstetricians and Gynaecologists is producing a good practice paper on pain relief and informed decision making for outpatient hysteroscopy procedures, which will be published shortly.

In addition, the Royal College of Obstetricians and Gynaecologists has been commissioned by the Getting it Right First Time (GIRFT) programme to develop consent guidance for 9 gynaecological procedures as part of the High Volume Low Complexity Programme, which is supporting elective recovery and the development of standardised patient pathways across regions.²⁷ These are:

1. Outpatient hysteroscopy
2. Outpatient operative hysteroscopy
3. Operative hysteroscopy under general or regional anaesthesia

²⁴ NHSE **Choice and personalised care in maternity services**

²⁵ NHSE **Maternity Transformation Programme**

²⁶ NHSE **Personalised care**

²⁷ GIRFT **High Volume Low Complexity (HVLC) programme**

4. Diagnostic laparoscopy.
5. Laparoscopic sterilisation.
6. Total laparoscopic hysterectomy.
7. Vaginal hysterectomy and repair.
8. Endometrial ablation under general anaesthetic.
9. Outpatient endometrial ablation.

We are pleased that the Faculty of Sexual and Reproductive Healthcare (FSRH) has published an updated statement on pain associated with IUD insertion,²⁸ and has consulted on an updated standard on obtaining consent in sexual and reproductive healthcare services.²⁹

We will set out our plans for sexual and reproductive health later this year. This will include a focus on increasing access and choice for all women who want contraception, including long-acting reversible contraception (LARC), and for improving women's experiences including during fitting and removal of an IUD or intrauterine system (IUS).

Research and evidence

In the call for evidence, we heard about women's experiences of not feeling listened to. However, it was not always clear why this occurs, or what the best solutions are for improving women's experiences. There is a particular gap in understanding healthcare professional's perspectives on this, as less than 2% of respondents to the public survey were from health and care professionals. We are furthering our understanding of patient and healthcare professional perspectives by commissioning research in this area through the NIHR, including:

- primary research into healthcare professionals' perspectives of listening to women in primary care, with a focus on menstrual and gynaecological symptoms, to better understand the issues and inform new policies and actions. This follows an initial evidence review that identified very few studies relevant to this topic³⁰
- a qualitative study on experiences of urogynaecology services. This study is examining interactions with clinicians and services covering a range of conditions, including pelvic organ prolapse and incontinence. Findings will be reported in early 2023³¹

In addition, an important part of the ambassador's role will be engaging with healthcare professionals to better understand their perspectives.

²⁸ FSRH, **Pain associated with insertion of intrauterine contraception**, published June 2021

²⁹ FSRH, **Public Consultation: Updated Service Standard on Obtaining Valid Consent in Sexual and Reproductive Healthcare Services 2021**, published December 2021

³⁰ Briscoe S and others, **Primary care clinicians' perspectives on interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions**, published June 2022

³¹ NIHR, **Funding and Awards: A qualitative study of people's experiences of urogynaecology health services in the UK**, start date March 2021

4



INFORMATION AND AWARENESS

What we've heard

Through the call for evidence, we heard of the importance of high-quality information provision, from school education through to support for adults. Overall, family or friends was the main source of health information (74%), followed by Google (71%), other online search engines and blogs (69%), GPs or healthcare professionals (59%) and the NHS (54%). Respondents to the public survey placed importance on making sure that the relationships, sex, and health education (RSHE) curriculum in schools is taught to both girls and boys, so that boys are also educated on female health conditions and sexual and reproductive health. Respondents who were teachers reflected they were not always adequately equipped to teach certain topics effectively and would like to see modern teaching tools including webinars.

We also heard calls for more trusted and easier to understand information regarding a range of women's health issues such as fertility,³² the menopause, gynaecological conditions, and cancers. Organisations raised the issue of barriers to accessing information which are greater for some groups of women and girls due to biases. We heard that information should be made available in a range of formats that are accessible, such as blogs or social media. Organisations also noted the importance of providing alternative ways for women who may face digital exclusion to access up-to-date information on conditions and treatment options. Organisations also raised the importance of public information campaigns, in partnership with community and voluntary organisations, to provide high-quality and up-to-date information on women's health conditions.

³² We recognise that fertility problems affect both men and women. Responses to the call for evidence focused on women's experiences of infertility and fertility treatment.

Our 10-year ambitions

Our ambitions are:



girls and boys receive high-quality, evidence-based education on women's health from an early age. Everyone's awareness of women's health is increased, and women's health issues such as menstrual health, contraception and menopause are no longer taboo subjects anywhere in society. Society is better able to support women across their lives, including at home, in schools, and in workplaces



women and girls are empowered through access to education and information to maintain their health and wellbeing, and make informed decisions about their healthcare throughout their lives. This means they are aware of health issues they may face throughout their lives, how to seek help, and what steps they can take to best manage their symptoms or condition. When women and girls do seek help for a specific health or care need, they are well-informed about the support and care they can expect from the health and care system



information is accessible to all women and girls, in particular under-served populations or those who need materials in alternative and non-digital formats. This means that information is tailored to the different needs of different women, for example, ensuring that older women and women experiencing homelessness are not excluded from information or services that are only provided in a digital form

Actions we are taking

Education in schools, colleges and universities

The government's introduction in 2020 of compulsory RSHE in all schools was an important milestone in increasing knowledge of female health conditions among both girls and boys.³³ Pupils are now taught about several areas of women's health, including menstruation, contraception, fertility, pregnancy, and the menopause. When teaching RSHE, schools should seek to avoid segregating lessons, as educating both girls and boys on women's health will help to improve the population's awareness and reduce stigma and taboos surrounding these topics.

The Department for Education are monitoring RSHE implementation and findings from their research will be published in early 2024. The evaluation will look at how schools have implemented the curriculum, while understanding barriers to implementation. This will inform any further support offers. Alongside this, we will work with the Department for Education to understand women's health topics that teachers feel less confident in teaching, and work to improve provision of high-quality teaching resources.

³³ Department for Education, **Statutory guidance. Relationships and sex education (RSE) and health education**, published June 2019

The Department for Education is making sure the RSHE curricula continues to evolve and reflects emerging priorities. For example, following the government banning virginity testing and hymenoplasty in the UK through the Health and Care Act 2022,³⁴ the teacher training modules will be updated and the Department for Education will work with stakeholders to produce other support materials for teachers, for example interactive training and webinars.

The Department for Education is also working with stakeholders to produce additional non-statutory guidance covering specific topics mentioned by the Ofsted review into sexual abuse in schools and colleges,³⁵ including non-consensual making and sharing of images.

It is also important that high-quality information on women's health is provided throughout further and higher education. We will work with stakeholders to consider how information provision in secondary schools, colleges and universities can be improved.

NHS website

In the call for evidence, we heard that the NHS website is a trusted source of health information, with 54% of respondents citing NHS, including 111 and NHS website, as a source for health information. We want the NHS website to be the first port of call for women and girls seeking health information, advice and signposting to reliable sources.

We will work with NHS Digital, who operate the NHS website, on an ambitious programme to transform women's health content on the NHS website. As a first step, we will improve existing pages on women's health conditions to ensure they contain the most up to date evidence and advice.

As part of this work, we will improve signposting to other reliable sources of information and support including charities' websites and health apps. NHS Digital will also improve the search function and navigation of women's health content on the NHS website to make it easier for women and girls to find relevant information.

We will also add additional pages on the NHS website to include women's health issues and conditions that are not there currently, for example adenomyosis, a condition where the inner lining of the uterus grows into the muscle wall of the uterus and results in painful and heavy menstrual bleeding.

We will work with NHS Digital to better understand the best way to ensure that women and girls get the information they need about their health from the NHS website, including considering whether to establish a central women's health area as suggested in the call for evidence.

³⁴ HM Government, **Health and Care Act 2022**

³⁵ Ofsted, **Review of sexual abuse in schools and colleges**, published June 2021

Language matters, and concern has been raised about removing language around biological sex and women, for example referring to 'pregnant people'. Such an approach has the potential for unintended adverse health consequences. The government has been clear that we must not countenance the erasure of women from our public discourse or our legislation.³⁶ We will work with NHS bodies to ensure that women are properly represented in communications and guidance, and that there is appropriate use of sex-specific language to communicate matters that relate to women's and men's individual health issues and their different biological needs.

Providing health information through a range of channels and formats

In the call for evidence public survey, we heard that popular sources of information also include online blogs and search engines (69% of respondents), and social media (39% of respondents), particularly for younger respondents to the survey.

In partnership with YouTube, NHS Digital is developing credible, clinically safe health information that will appear as a top search result for UK audiences. This will include priority topics that came out of the call for evidence, including information on less well-known gynaecological conditions.

We will work with the Women's Health Ambassador to raise awareness of women's health symptoms and conditions, and tackle taboos that prevent women accessing care. We will partner with key stakeholders, including the voluntary sector and industry, to provide accurate health information and destigmatise women's health conditions. For example, digital health technologies have an important role in supporting women's access to high-quality health information, and can support women with tracking symptoms, providing advice on self-care and when to seek support from healthcare professionals, and ultimately improving health outcomes for women.

This work will also include a focus on reaching under-served populations, including older women and those who are digitally excluded. We will ensure information is provided in non-digital formats across a range of women's health conditions. We will explore how we can capitalise on points of interaction that women have with the healthcare system and wider public services, to provide high-quality health information, for example NHS health checks, postnatal checks with GPs and health visitors, and through family hubs.

We also know that health and care professionals are an important source of health information, cited by 59% of survey respondents. Chapter 8 sets out our plans to support health and care professionals to provide up-to-date information and advice on women's health.

³⁶ UK Parliament, **Review of legislative drafting, statement UIN HCWS47**, statement made May 2022

5



ACCESS TO SERVICES

What we've heard

In the call for evidence, we heard the importance of women and girls being able to access services that meet all their reproductive health needs from adolescence through to menopause, from the routine (for example, choosing the right contraception for them) to the more specific (for example, specialist endometriosis care). We heard that it can be difficult for women to access the women's health services they need in ways that are convenient to them.

We heard that fragmented commissioning and delivery of sexual and reproductive health services negatively impacts women's access to services, in particular access to contraception. Some written responses highlighted barriers to women accessing contraception for non-contraceptive purposes, for example LARC to treat heavy menstrual bleeding. Many survey responses and written submissions called for more joined-up and holistic provision through one-stop women's health clinics or women's health hubs. We also heard concerns about geographical variation in access to some services, for example menopause clinics and NHS-funded fertility treatment. Some responses called for work to ensure national guidelines are fully and consistently implemented. We heard concerns that the coronavirus (COVID-19) pandemic made it more difficult to access some services such as cervical screening or LARC. We also heard of some positive changes, for example the offer of virtual or telephone appointments alongside face-to-face appointments.

Our 10-year ambitions

Our ambitions are:



women and girls can access services that meet their needs across the entire span of their life course - from adolescence through the middle and reproductive years to menopause and the post reproductive era, including for general health conditions and disabilities



there is a system-wide approach to women's reproductive health based on reproductive wellbeing and supporting individual choice.³⁷ This means national and local policies and services are centred on women and girl's needs, and reflect the life course approach, rather than being organised around a specific health issue or the needs of commissioners



women and girls have more of their health needs met at one time and in one place, through the development of local pathways that bring together and improve access to services, for example, into women's health hubs. There are clear pathways between primary, community and secondary care settings, delivered for example through the expansion of community diagnostic centres and surgical hubs, and women and girls can access secondary care and specialist services for conditions such as endometriosis when needed. Achieving this ambition will require partnership working across all policy, commissioning, and delivery partners

Actions we are taking

Improving access to women's health services and tackling inefficiencies

Driving innovation and collaborative delivery of women's health services will be a key way of improving access and experience for women, tackling inefficiencies in the system, and addressing the elective backlog.

We have been encouraged to see how women's health hubs and similar models of 'one-stop clinics' are being created around the country, including in Liverpool, Manchester, Sheffield, Hampshire, and Hackney. These models provide integrated women's health services at primary and community care level, where services are centred on women's needs, and reflect the life course approach, rather than being organised by individual condition or issue.

³⁷ As set out in the Reproductive Health Consensus Statement, PHE, **Reproductive health: what women say**, published June 2018

For example, hub models can provide management of contraception and heavy bleeding in one visit, integrate cervical screening with other aspects of women's health care, or manage menopause at the same time as contraception provision for women over 40. A key aim of hub models is to improve women's access to the full range of contraceptive methods, and in particular LARC. We welcome this focus as a way of improving access for women and improving efficiency in the system. Contraception is a public health intervention with a highly compelling economic case. Public Health England (PHE) has previously developed a tool that estimates for every £1 invested in publicly funded contraception, the public sector will get a £9 return on investment (ROI).³⁸

Women's Health Hubs in action - Liverpool

Local authority and NHS commissioners have worked together to combine budgets and jointly set up a network of women's health hubs across the city. An initial pilot took place in one primary care network (PCN) in the north of the city, which allowed for testing of different approaches to service provision. This has been followed by a city-wide rollout, with there now being a network of women's health hubs across the city's 9 PCNs.

The hubs are hosted in GP practices and offer a range of NHS and local authority commissioned services, including LARC fitting and removal, cervical screening, psychosexual services, and treatment for menopause and heavy menstrual bleeding.

A 'hub and spoke' model allows for women to access both within their own network, and to venture outside of it. 'Hubs' identified in each of the PCNs are commissioned to deliver the bulk of LARC provision and condition management. 'Spoke' practices still offer basic advice and support, and refer women into the hubs and can book their LARC appointments. A strategic training group led by Liverpool Women's Hospital and Axa Sexual Health has helped to deliver training in LARC fitting for nurses and GPs working in the hubs.

The introduction of a women's health hub model has led to an improvement in access to services, with a growth in the total number of appointments available and an increase in LARC prescribing rates. Liverpool saw a rapid recovery in LARC prescribing and latest data suggests it has a GP LARC rate that is higher than any it has previously recorded, including pre pandemic.

Liverpool City Council have published a case study of the work in Liverpool to share insight and lessons learnt with other commissioners and providers.³⁹

³⁸ PHE, **Contraceptive services: estimating the return on investment**, published August 2018

³⁹ PCWHF **The Women's Health Hub Toolkit: an example of success from Liverpool**

We are supportive of the expansion of women's health hubs and 'one-stop clinics' and strongly encourage local commissioners and providers to consider adopting these models of care, ensuring that existing resources are being used efficiently to deliver high quality care to women.

We also encourage local commissioners and providers to refer to best practice materials, for example the Primary Care Women's Health Forum's women's health hub toolkit to support local commissioners and providers.⁴⁰

To support the expansion of these new models, we have commissioned the NIHR-funded Birmingham, RAND Europe and Cambridge Rapid Evaluation Centre to carry out scoping work for an evaluation of existing women's health hubs.⁴¹ This is expected to conclude in early 2023. We will work to integrate these learnings into future national policy development and to share best practice with local systems to support the development and implementation of new local models across the country.

We will also establish a women's health accreditation mechanism to recognise commissioners and providers who offer services in these ways and promote best practice across the country.

Greater collaboration between local authorities and the NHS and co-commissioning of women's reproductive health and sexual health services will be important to delivering integrated provision at a local level, particularly regarding contraception where responsibility is shared by local authorities and the NHS. The provisions in the Health and Care Act 2022 support greater collaboration between commissioners.⁴²

We will also set out our plans for sexual and reproductive health later this year. This will include a focus on encouraging collaboration and improving access to services and treatment, including increasing access and choice for all women who want contraception.

We will also commission a new reproductive health experiences survey every 2 years beginning this year. This will gather data on women's experiences across all areas of reproductive health. This will include areas such as menstrual health, contraception, pregnancy planning, and menopause. This follows a pilot survey which was commissioned by Public Health England in 2021. We will also make the survey tool available to local systems and will encourage use of the new survey locally to better understand their population's health needs and experiences, and to inform local commissioning of services.

⁴⁰ PCWHF **The Women's Health Hub Toolkit**

⁴¹ NIHR, **Funding and Awards: Women's Health Hubs**, start date March 2022

⁴² HM Government, **Health and Care Act 2022**

Improving access to NHS services

We are investing record amounts in improving access to NHS services, which will benefit everyone, including women.

We have invested at least £1.5 billion, announced in 2020, to create an additional 50 million general practice appointments by 2024. We are doing this by increasing and diversifying the workforce, enabling a wider range of staff to deliver more capacity and new services. This includes recruiting 26,000 more primary care professionals to deliver appointments, support GPs, and deliver new and enhanced services. These roles will also support the creation of multi-disciplinary teams in general practice, delivering better care for those with long-term and complex conditions. We also made an additional £520 million available during the pandemic to improve access and expand general practice capacity during the pandemic.

Within community pharmacy, the progesterone-only contraceptive pill has been available to women to purchase over the counter in pharmacies since 2021 and access to wider oral contraception through pharmacies is currently being piloted.⁴³

Women are waiting longer than ever for their care, and gynaecology waiting lists grew significantly during the pandemic. We are committed to reducing waiting times and improving patient experience across all specialty areas, including gynaecology and urogynaecology.

The Delivery Plan for Tackling the COVID-19 backlog of Care, published in February 2022, sets out plans to reduce waiting times and improve patient experience for patients across all specialty areas, including gynaecology and urogynaecology.⁴⁴ This includes plans to:

- communicate better with patients about treatment options and establish a network for people waiting a long time, including through the My Planned Care patient platform⁴⁵
- roll out up to 160 community diagnostic centres across the country to help clear backlogs of people waiting for clinical tests, many for gynaecological pathways, for example ultrasound scanning, blood tests, and hysteroscopy to investigate heavy menstrual bleeding or post-menopausal bleeding
- roll out surgical hubs across the country. We are increasing activity through dedicated and protected surgical hubs, which conduct planned procedures only. These might exist within a hospital as a distinct unit or ringfenced theatre or they might have been established on a separate site. Surgical hubs are focusing on providing high volume low complexity surgery, as recommended by the Royal College of Surgeons of England

⁴³ NHSE **NHS Community Pharmacy Contraception Management Service Pilot: Access to Ongoing Management of Oral Contraception (Tier 1)**

⁴⁴ NHSE, **Delivery plan for tackling the COVID-19 backlog of elective care**, published February 2022 and updated May 2022

⁴⁵ NHS **My Planned Care**

NHS England is also implementing the national rollout of the Getting it Right First Time (GIRFT) High Volume Low Complexity Programme.⁴⁶ Gynaecology is one of 6 specialties being prioritised through this programme, which supports the establishment of surgical hubs for high-volume procedures and the development of standardised patient pathways.

The GIRFT programme will work with the Royal College of Obstetricians and Gynaecologists and others to consider how surgical hubs can work in gynaecology as a specialty.

⁴⁶ GIRFT High Volume Low Complexity (HVLC) programme

6



DISPARITIES IN HEALTH OUTCOMES BETWEEN WOMEN

What we've heard

In the call for evidence, we heard that women's experiences of health and services varied by characteristics such as age, ethnicity, gender identity, and disability status. In the public survey, we heard that women with an existing health condition or disability were also less likely to feel comfortable talking to healthcare professionals about some topics, for example contraception and pregnancy (where 77% felt comfortable vs 82% of respondents who did not have an existing health condition or disability).

In the written submissions, we also heard that some groups of women face additional barriers regarding access to, and experience of, services, and that there are disparities in health outcomes. For example, organisations also told us that disabled women often find themselves unable to access some in-person services. We also heard that women in particular groups or settings, such as women experiencing homelessness, refugees, asylum seekers and women in prisons, face additional barriers to accessing healthcare, and have poorer health outcomes compared with women in general. We heard about disparities in health outcomes between different demographic groups. For example, organisations told us that lesbian and bisexual women can face stigmatisation when accessing healthcare, for example experiencing discrimination in sexual health clinics and having poorer experiences with fertility services than heterosexual women. Additionally, although maternal deaths are very rare, there are disparities in this area, with black and Asian women being more likely to die during pregnancy, childbirth and the year following childbirth than white women. We also heard that there are disparities in access to services and health outcomes that stem from economic and geographical disparities, for example, differences in life expectancy across socio-economic groups.

Our 10-year ambitions

Our ambitions are:

- 

disparities in access to services, experiences of services and outcomes are tackled. Women with additional risk factors or who face additional barriers have equitable access to services. All women can access health and care services that are free from stigma and discrimination, and their experiences of the healthcare system are supportive, positive, and sensitive to additional needs they may have
- 

all women, across all demographic groups, have access to high quality health information, know their health care options and where to seek support. Women are not excluded from information or services that are only provided in a digital form
- 

there is a renewed focus on tackling disparities at a whole society level in all health programmes, for example through implementation of the health mission in the white paper, *Levelling Up the United Kingdom*⁴⁷
- 

health and care professionals feel supported and able to handle the complexity of needs that people in inclusion health groups often face, and are enabled to provide the best health and care possible
- 

through more research and engagement, we have a better understanding of health disparities between different groups of women. In developing solutions, policymakers, commissioners and providers of healthcare services work together to identify opportunities to include diverse women's voices in policy development and service design, and make sure they are heard

Actions we are taking

Tackling health disparities

We know that health disparities are felt experienced by different groups of women, for example, maternity services for black and Asian women, and fertility access for lesbian, gay and bisexual women. We are tackling these disparities, including through the Maternity Disparities Taskforce, with a focus on women living in the most deprived areas and ethnic minority women.

Women in the most vulnerable and under-served groups may not have engaged, or have been able to engage, with the call for evidence. For example, information about sexual orientation was not collected in our public survey, so we are limited in the conclusions we can draw about the experiences of lesbian, gay and bisexual women from that analysis. We also know for many vulnerable women, such as those experiencing homelessness or

⁴⁷ DLUHC, *Levelling Up the United Kingdom*, published February 2022

seeking asylum in the UK, digital exclusion is a real challenge and therefore participation in online surveys is unlikely. We recognise the need to do more to ensure that women at risk of social exclusion are represented and have their voices heard. This engagement and representation are crucial to understanding the health and care needs of women and girls in under-represented groups, which in turn is critical to improving the system to better meet their needs.

We will work with the Women's Health Ambassador and deputy Women's Health Ambassador to address the gaps in the insight gathered through the call for evidence. We are committed to ensuring that under-represented groups and groups that experience health disparities are listened to in the implementation of this strategy.

The Office for Health Improvement and Disparities (OHID) was established in October 2021 with a focus on improving the nation's health and supporting the public to live more of life in good health and tackling health disparities that exist across the country. OHID's aim is to address health disparities at each life stage, including socio-economic and geographic disparities and will as well as the disparities experienced by inclusion health groups, such as people sleeping rough and asylum seekers.

NHS England is mobilising Core20PLUS5, an approach that defines the target population and clinical areas for focused action on healthcare disparities across the NHS, including continuity of maternity care.⁴⁸ The Core20PLUS5 name refers to the most deprived 20% of the population of England (the Core20), and other population groups identified by local population health data, such as ethnic minority groups and inclusion health groups (the PLUS groups), among whom women may experience particular challenges with access to, or significantly worse outcomes of, care. The NHS has also set out actions and plans to address health disparities within local maternity systems in guidance for maternity systems.⁴⁹

The sections below set out actions we are taking in relation to particular groups of women who face additional barriers. We will work with the Women's Health Ambassador to explore other groups of women to focus on who are not mentioned below, such as women with disabilities.

Women in inclusion health populations

'Inclusion health' is a catch-all term used to describe people who are socially excluded. This term can include a number of groups; for example, people experiencing homelessness, people in contact with the criminal justice system, vulnerable migrants and asylum seekers, and Gypsy, Roma and Traveller communities. People in inclusion health groups typically experience multiple risk factors for poor health, stigma and discrimination, and are poorly represented in data. These factors result in barriers to accessing healthcare, differences in experience of the health and care system and extremely poor health outcomes, often considerably worse than those of the general

⁴⁸ NHSE **Core20PLUS5 – An approach to reducing health inequalities**

⁴⁹ NHSE, **Equity and equality: Guidance for local maternity systems**, published September 2021

population. These can include much lower life expectancies and higher instances of mental health and substance misuse issues. Women in inclusion health groups often experience severely poor health outcomes. For example, women sleeping rough, on average, die almost 40 years earlier⁵⁰ than women in the general population, and Gypsy, Roma and Traveller women are 20 times more likely than the wider population to have experienced the death of a child.⁵¹ It is vital that we address these stark disparities and improve health outcomes for women in these groups.

The government is addressing disparities in healthcare experiences and outcomes for women in inclusion health groups. For example, the National Women's Health and Social Care Review Group, a partnership between NHS England and Her Majesty's Prison and Probation Service, was convened in January 2021 to undertake an 18-month review that will aim to improve the health and wellbeing of women in prison. The review seeks to reduce disparities, improve outcomes for women in prison and upon their release and ensure equity of access to the full range of high-quality health and social care services for women in prison. The review is being informed by women who are experts by experience at every stage, to ensure their views are heard and feed directly into recommendations for change. The outcomes of the review, including recommendations for implementation will be reported in summer 2022.

We will continue to work across government, with NHS England and the voluntary sector to raise awareness of the health and care needs of women and girls at risk of social exclusion. For example, we have published the women's health migrant health guide,⁵² a free-to-use online resource to support practitioners in caring for patients from overseas, and cross government work is ongoing to ensure the health and care needs of women seeking asylum are met. Further work could include best practice guidance to health and care services, such as GPs and pharmacies, to support socially excluded women, including women experiencing homelessness and rough sleeping.

Women who are serving, or have served in the armed forces

In the call for evidence, 1% of respondents selected veteran's health as a topic for inclusion in the strategy. The government is committed to making the UK the best place in the world to be a veteran. Within this context, it is important to ensure that the needs of female veterans are considered by default. The government recognises that female members of the armed forces community, those that currently serve or those that have served, can face a unique set of challenges accessing healthcare that are separate from their male counterparts.

⁵⁰ ONS, **Deaths of homeless people in England and Wales: 2019 registrations**, published December 2020

⁵¹ Woman and Equalities Committee, **Tackling inequalities faced by Gypsy Roma and Traveller communities**, published March 2019

⁵² OHID, **Women's health: migrant health guide**, published July 2014 and updated September 2021

In partnership with the Office for Veterans' Affairs and the Ministry of Defence, NHS England has established a multi-agency health improvement group for women who are serving and those that have served. An ambitious work programme is in place to ensure that women receive targeted and appropriate healthcare throughout their serving life and as veterans, based on the health needs of these women, the unique experiences they have had, and the potential physical and mental combat related injuries they may have incurred.

In addition, the Veterans' Health Innovation Fund 2022 to 2023 will be considering initiatives that help identify and/or provide solutions to disparities in female veterans' health and health care.⁵³

NHS England have also commissioned a review of the national and international research and literature in relation to the musculoskeletal (MSK) problems to understand the physical impact of serving on women including the prevalence and impact of MSK problems with a focus on the associated health outcomes during and after service.

Mental health is just as important as physical health and NHS England has introduced several services to meet the needs of veterans and their families. This includes Op COURAGE: The Veterans Mental Health and Wellbeing Service for veterans.⁵⁴ As part of the care and support available through this service, Op COURAGE works with several charities and local organisations to provide help with wider health and wellbeing needs, such as for drug and alcohol addiction. From April 2023, NHS England will be re-launching an integrated Op COURAGE service which brings together the currently three separate veteran mental health services into a single service.

Autistic women and girls

Autism and neurodiversity were chosen by 10% of respondents to the survey, to be included in the Women's Health Strategy. It is important that we address the under-identification of autism in women and girls, as well as the additional health and care disparities they may face throughout their lives. The NICE guideline on autistic spectrum disorder in under 19s recommends that, when considering the possibility of autism, healthcare professionals should be aware that autism may be under-recognised in girls leading to under diagnosis.⁵⁵

In addition, as set out in the National Autism Strategy, in 2021 to 2022 we invested an additional £13 million funding to test and improve different diagnostic pathways, which included looking at pathways that could work for women and girls as part of the wider work on improving diagnostic pathways.⁵⁶ We are building on this with a further investment of £2.5 million to test and implement the most effective autism diagnosis pathways for children and young people in 2022 to 2023.

⁵³ DASA and Cabinet Office, **Veterans' Health Innovation Fund**, published July 2022

⁵⁴ NHSE, **Mental health support for veterans, service leavers and reservists**, published August 2021

⁵⁵ NICE, **Autism spectrum disorder in under 19s: recognition, referral and diagnosis**, published September 2011 and updated December 2017

⁵⁶ DHSC and DfE, **National strategy for autistic children, young people and adults: 2021 to 2026**, published July 2021

We have also invested £1.4 million to trial and develop the Oliver McGowan mandatory training in learning disability and autism, to ensure health and social care staff have the requisite skills and knowledge to provide safe, compassionate, informed care. The training is intended to ensure that all health and social care staff have the skills and knowledge to provide safe, compassionate, and informed care. It is also an important way in which we can address significant and persistent disparities in health and care outcomes for women with a learning disability and autistic women.

7



HEALTH IN THE WORKPLACE

What we've heard

In the call for evidence public survey, just over 1 in 3 respondents felt comfortable talking about health issues with their workplace (35%), and around 1 in 2 said their current or previous workplace had been supportive with regards to health issues (53%). Respondents to the public survey called for flexible working arrangements and inclusive working environments which allow women to discuss health issues openly and improve managers' and employers' understanding of symptoms. Access to good occupational health services, mental health support, line manager training and workplace adjustments were perceived to be ways to create a working environment which is conducive to managing a health condition or maintaining good health at work, in addition to tackling stigmas and taboos around menstruation, menopause and gynaecological conditions so that women feel able to speak up and access support.

In the written submissions, organisations recommended employers introduce or improve their workplace provisions and policies to better support women in different situations. This included helping women to manage the impact of symptoms of menstrual health problems, conditions such as endometriosis or menopause in the workplace, and supporting women and partners undergoing, fertility treatment or who have experienced a pregnancy loss. We also heard that the majority of unpaid carers are women and of the impact that unpaid caring roles can have on health and wellbeing. These can include women who miss out on opportunities to progress in their career, or experience burnout and mental health issues as a result, or find it more difficult to attend appointments for their own health needs.

Our 10-year ambitions

Our ambitions are:



health conditions and disabilities are no longer a barrier to women's participation or a positive experience in the workplace. Women feel able to speak openly about their health and to be confident that they will be supported by their employer and workplace colleagues, with an end to taboos. This includes for less well-known, invisible or undiagnosed conditions where pain may be the primary symptom, for example heavy menstrual bleeding or endometriosis



women experiencing women's health issues such as period problems, endometriosis, fertility treatment, miscarriage, menopause feel well supported in their workplaces. Women also feel supported for general health conditions and disabilities that may impact women in the workplace such as cardiovascular disease, musculoskeletal conditions or mental health problems



through information and awareness workplace colleagues feel better equipped to support their female colleagues



employers feel well-equipped to support their female employees. Employers are encouraged to implement national policy and best practice, for example a culture of flexible working, and to offer evidence-based workplace support, for example high-quality occupational health services to support those managing long-term conditions, and workplace policies for issues such as menopause. There is greater recognition that there is no 'one-size-fits-all' approach to supporting health in the workplace, and that needs will vary by different workplace settings and relationships



the Civil Service, NHS and social care lead the way in tackling taboos and supporting women's health in the workplace. Within health, both NHS and social care workforces are predominantly female, and it is vital that we can recruit, retain and support our workforces to reach their full potential



employers and colleagues are better informed on the potential impact of caring responsibilities on participation in the workplace and other aspects of carers' lives. Unpaid carers - who are predominantly female - feel better supported to manage work, caring responsibilities, and other aspects of their lives

Actions we are taking

Support for women's health issues in the workplace

The theme of the Health and Wellbeing Fund 2022 to 2025 is women's reproductive wellbeing in the workplace.⁵⁷ The Health and Wellbeing Fund is run jointly by the Department of Health and Social Care and NHS England, and provides an opportunity to collaborate with voluntary, community and social enterprises (VCSE) who are often the experts on particular issues and communities. The fund launched in May 2022 and is inviting applications from VCSE organisations for projects that can provide a holistic support offer to assist women experiencing reproductive health issues for example menstrual health and gynaecological conditions, fertility problems, pregnancy loss or menopause, to remain in or return to the workplace. The projects funded will help to build the evidence base and spread best practice.

The Civil Service provides a range of support in the form of workplace adjustments for long term health conditions and disabilities including for those conditions specifically experienced by women. The Civil Service recently became one of the largest employers to sign the Wellbeing of Women menopause workplace pledge. This follows the launch of the Civil Service menopause workplace policy in December 2021 to better support staff and ensure we can retain talent.

NHS England has also recently signed the menopause workplace pledge. NHS England is also supporting the NHS workforce through delivery of the 7 areas of the Our NHS People Promise.⁵⁸ These themes have come directly from those who work in the NHS and offer significant benefits for women working in the NHS.

The Women's Health Ambassador will also work across government to further raise awareness and tackle taboos surrounding women's health issues in the workplace. This will include working with employers to encourage implement evidence-based workplace policies and other appropriate support, for example for women experiencing menstrual health problems, and for women and partners undergoing fertility treatment or who have experienced pregnancy loss.

Chapters 11 to 17 set out further actions we are taking in relation to specific health issues and conditions, particularly on workplace support for the menopause.

⁵⁷ DHSC, **VCSE Health and Wellbeing Fund 2022 to 2025: women's reproductive wellbeing in the workplace**, published May 2022

⁵⁸ NHSE **Our NHS People Promise**

Support for all health conditions and disabilities

We are improving support for disabled people and people with health conditions in the workplace, which will also benefit women with physical and mental health conditions. This includes investing £1.3 billion to expand or extend employment support for disabled people and people with health conditions to enable them to enter and stay in work, including measures to reduce ill-health related job loss as set out in the government's response to the health is everyone's business consultation.⁵⁹

Many women experience health conditions which impact their participation in the workplace. Some health conditions are more prevalent in women such as MSK conditions, and women may come up against more taboos than men when discussing their health at work.

Access to quality occupational health services can play an important role to support women to thrive in work. The response to the health is everyone's business consultation sets out our plans for increasing access to employer-provided occupational health for the small-to-medium sized enterprises and self-employed organisations, to support innovation and build capacity in the occupational health market and around the guidance needed on how employers can best support people to remain in work.

Flexible working is another key component of the government's work which will benefit women experiencing health conditions or with caring responsibilities. The government recently consulted on ways to make flexible working the default and will respond to the consultation in due course.

The government will launch a new call for evidence looking at the sorts of 'informal' flexibility people may need to help them live their lives in the best way they can – both at work and at home. This will help establish how important this sort of flexibility can be for women and others in managing health conditions at work.

Support for unpaid carers

Overall, women are more likely to take on caring roles than men. Carers UK estimates that of the 6.5 million unpaid carers in the UK, 58%, or 3.34 million, are women.⁶⁰

Through engagement undertaken as part of the People at the Heart of Care white paper, we have heard that unpaid carers value services and support provided for them and the people for whom they care, such as respite and breaks but that these are not always easy to access.⁶¹ We have committed to investing up to £25 million to work with the sector to kick start a change in the services provided to support unpaid carers – looking at interventions that support unpaid carers, which could include respite and breaks, peer group and wellbeing support, and new ways to combine these to maximise their impact.

⁵⁹ DWP and DHSC, **Government response: Health is everyone's business**, published July 2021 and updated October 2021

⁶⁰ Carers UK **Facts & figures**

⁶¹ DHSC, **People at the Heart of Care: adult social care reform**, published December 2021

It is also important that carers are supported to provide care as they would wish, and to do so in a way that supports their own health and wellbeing and other life chances. The government response to the consultation on carer's leave⁶² was published in September 2021. This set out that carer's leave will be a 'day 1' right, available to all employees who are providing care for a dependant with a long-term care need. Eligible employees will be entitled to one week of unpaid leave per year, which will be available to take flexibly in individual or half days.

The Economic and Social Research Council (ESRC) is part of UK Research and Innovation (UKRI) and in collaboration with other European funders have commissioned research to understand inequities in employment, social participation and health between carers and non-carers, including sex-based differences.⁶³

⁶² BEIS, **Carer's leave consultation**, published March 2020 and updated October 2021

⁶³ UKRI **Inequalities in informal caregiving over the adult life course in Europe**

8



EDUCATION AND TRAINING FOR HEALTH AND CARE PROFESSIONALS

What we've heard

Through the call for evidence, we heard the need for healthcare professionals to receive better education and training on women's health conditions, and to be better supported to deliver the best health and care possible.

Some respondents to the survey called for better education on women's health conditions and treatment options, in particular the causes of infertility and miscarriage, the menopause and HRT. As the main access point into health services for many, there was a particular emphasis on education for GPs. Some responses called for compulsory training for GPs on women's health, to help create a supportive and informed environment in which women would feel comfortable coming forward to discuss issues. Some respondents to the survey also suggested training to improve how healthcare professionals listen to, communicate with and treat women.

Written submissions also highlighted the importance of providing education, training and guidance to health professionals, with a number of specific suggestions being made. For example some organisations called for 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. Organisations also called for more education and training for healthcare professionals on identifying and treating gynaecological conditions, causes of infertility, breastfeeding support, pregnancy and neonatal risks such as group B strep infection, and menopause care.

Our 10-year ambitions

Our ambitions are:



all healthcare professionals are well informed about the importance of women's health and are enabled to provide or direct women towards the best care possible, including information on how to stay well, self-care, and advice on treatment options throughout the life course



undergraduate curricula for all healthcare professionals include teaching and assessment on women's health. Curricula for specialist training - for example general practice, physiotherapists, or emergency medicine training - include teaching and assessment on women's health where relevant. This reflects that teams in both primary and secondary are becoming increasingly multi-disciplinary and with a broader skills mix



there are improvements in lifelong learning opportunities for all healthcare professionals to enhance their knowledge and skills in women's health. Continuing professional development activities take different forms across different healthcare professions, and we would like Health Education England, professional bodies and other providers to review their resources to identify where content on women's health could be added, strengthened, or distributed more effectively. Healthcare professionals are supported to undertake additional training and continuous professional development



NICE guidelines for women's health issues are developed where they do not currently exist and existing guidelines are updated rapidly in response to new evidence, and guidelines are implemented into practice. Guidelines are presented in an interactive format to support healthcare professionals to provide high-quality, cost-effective care



curricula, further education and training, and NICE guidelines reflect the diversity of society, for example by reflecting sex- or ethnicity-based differences in symptoms or response to treatment for general health condition or disabilities. Where there are clear gaps in the evidence base in these areas, we want to see work to fill these gaps and ensure the findings are effectively communicated to frontline healthcare professionals

Actions we are taking

Improving education and training on women's health

The Women's Health Ambassador will work with regulators, professional group leaders, royal colleges and other stakeholders to improve healthcare professional education and training on women's health. We will encourage more world-leading best practice, building on good progress already underway. This will have an initial focus on women's health topics such as gynaecological conditions and menopause.

Undergraduate and postgraduate education

Undergraduate medical curricula for people training to be doctors are set by individual medical schools, with the General Medical Council's (GMC) Outcomes for Graduates ensuring that all doctors have the requisite set of skills required to progress into specialty training. The GMC will be introducing the Medical Licensing Assessment for the majority of incoming doctors including all medical students graduating from academic year 2024/2025 and onwards.⁶⁴ Within this assessment, there are a number of topics relating to women's health. This will encourage a better understanding of women's health among doctors as they start their careers in the UK.

Similarly, higher education institutions develop the curricula content that enables their nursing, midwifery, and allied health professional students to meet the regulators' outcome standards. They cover the skills and approaches a health care practitioner must develop in order to ensure accurate and timely diagnoses and treatment plans for their patients. For example, pre-registration nurses will participate in specific sessions on women's health, the standards for midwives include a domain which covers universal care for all women and new-born infants. Many other professions also have women's health content in their curricula or assessment, for example curricula for diagnostic radiographers and sonographers include content on gynaecology and breast imaging and where relevant obstetric screening and diagnosis. Therapeutic radiography curricula include treatment for breast and gynaecological cancers.

Community pharmacists and their teams are uniquely placed to provide support and expert advice on medicines as well as wider health advice and support to women at all stages of their lives. We are looking at ways to enable community pharmacies to offer a wider range of services, for example the progesterone-only contraceptive pill has been available to women to purchase over the counter in pharmacies since 2021, and access to wider oral contraception through pharmacies is currently being piloted,⁶⁵ increasing choice for women in the ways in which they can access contraception.

⁶⁴ GMC **Medical Licensing Assessment**

⁶⁵ NHSE **NHS Community Pharmacy Contraception Management Service Pilot: Access to Ongoing Management of Oral Contraception (Tier 1)**

The pharmacy regulator, the General Pharmaceutical Council (GPhC), has highlighted issues relating to women's health, for example the key role pharmacy professionals play in safely dispensing sodium valproate, an anti-epileptic medication, given that children born to women who take valproate during pregnancy are at significant risk of birth defects and persistent developmental disorders. In addition, community pharmacists are now able to offer women additional support with their epilepsy medication through the New Medicine Service to provide specific advice when they start a new medicine which will include responding to their concerns about their wider health needs.⁶⁶

Women's health is also embedded into the Royal College of General Practitioners (RCGP) curriculum for trainee GPs, including gynaecology, sexual health and breast health. The curriculum also covers the health care needs of women across all diseases seen in primary care as it is important women are treated holistically. This ensures that all future GPs receive education on women's health.

The COVID-19 pandemic highlighted the need for generalist skills among healthcare professionals. Enhanced 'generalism' for doctors in foundation and specialty training is a wraparound professional development offer designed by Health Education England to enhance current specialty training which takes place across the first 5 years of postgraduate medical training.⁶⁷ This will help doctors identify where a patient is experiencing multiple health issues and may need the care of more than one specialist. This work will contribute to women's health where there are health disparities affecting women, or where they have complex multiple long-term conditions.

Further training and lifelong learning

Improvements to curricula and assessment will ensure that the next generation of healthcare professionals are better educated in women's health. However, it is also vital that currently practicing health and care professionals are supported to continuously learn and update their knowledge in women's health. Between 2020 to 2021 and 2022 to 2023, we are investing an additional £210 million funding in learning and development for frontline NHS staff. This investment provides a £1,000 personal development budget for every nurse, midwife, and allied health professional working in the NHS to support their continuing professional development such as upskilling within current roles, training in new specialties, or undertaking leadership courses.

Within adult social care, our social care reform package outlined in *People at the Heart of Care* includes £500 million investment from between 2022 to 2023 and 2024 to 2025 for the social care workforce to have the right training and qualifications, and feel recognised and valued for their skills and commitment.⁶⁸ We will work towards this through a new Knowledge and Skills Framework (KSF) within a career structure that supports learning and development and helps the workforce to achieve their career goals. We are also

⁶⁶ NHSE, **Advanced Service Specification – NHS New Medicine Service (NMS)**, published October 2021

⁶⁷ HEE **Enhancing Generalist Skills: Educational development offer**

⁶⁸ DHSC, **People at the Heart of Care: adult social care reform white paper**, published December 2021 and updated March 2022

funding tailored training places for different social care professions, along with portable care certificates and a digital skills passport so the workforce can evidence their skills and experience when switching employers.

Many healthcare professionals build knowledge throughout their careers by developing specialist skills. We would like to see further opportunities from professional bodies, Health Education England and the NHS to support the development and recognition of new skills in women's health such as the development of accessible, multi-professional credentials to recognise skills in women's health to support new models of care.

New credentials focused on women's health have already been piloted or are in development. These support additional training and regulation in areas of high patient need. For example, Health Education England is developing Pelvic Health modules, and has commissioned the development of credentials in perinatal mental health and advanced practice mammography. The Breast Clinicians credential has already been developed and piloted for 2 cohorts, and the Obstetric Physician credential has been developed and delivered. This will standardise and improve training in these areas of women's health and recognise the work of all healthcare professionals working in these areas.

There are also existing multi-professional credentials in integrated sexual and reproductive health, such as the Faculty of Sexual and Reproductive Health Diploma, which is an important component of women's health.

NICE guidelines

NICE provide authoritative, evidence-based guidelines for healthcare professionals on best practice. Guidelines are developed by experts based on a thorough assessment of the available evidence and through extensive engagement with stakeholders. NICE guidelines are often the first port of call for healthcare professionals, and it is vital that they reflect the most up to date evidence.

NICE is taking a more co-ordinated approach to guidelines on women's health and is currently updating its guidelines on topics such as the diagnosis and management of menopause, and intrapartum care, and is developing a guideline on familial ovarian cancer. NICE's updated guideline on antenatal care was published in August 2021 and focuses on women-centred care and informed shared decision making while aiming to improve the consistency of care across the country.⁶⁹ NICE also recently published its guideline on the prevention and non-surgical management of pelvic floor dysfunction in women aged 12 or over, which includes recommendations on how to raise awareness of the condition.⁷⁰

Following advice from topic experts, NICE has begun a review of its guideline on endometriosis to consider whether it should be updated. NICE will also consider the development of a guideline on polycystic ovary syndrome (PCOS) through the established processes for identifying and prioritising guidelines.

⁶⁹ NICE, **Antenatal care**, published August 2021

⁷⁰ NICE, **Pelvic floor dysfunction: prevention and non-surgical management**, published December 2021

We need to ensure that NICE guidelines are easily accessible to healthcare professionals. NICE guidelines only make a difference for patients if they are put into practice. We will work with NICE on implementation of their 5-year strategy, The NICE Strategy 2021 to 2026,⁷¹ to ensure that guidelines are easily implemented and accessible to healthcare professionals, as well as commissioners of local services.

Best practice resources for healthcare professionals

Professional bodies and other organisations have developed evidence-based resources and materials to support healthcare professionals to translate guidance into deliver of care.

The RCGP has developed a women's health toolkit which aims to support practising GPs.⁷² This resource is continually updated to ensure GPs have the most up-to-date advice to provide the best care for their patients. Within this, RCGP has worked in partnership with Endometriosis UK to develop a menstrual wellbeing toolkit for GPs and other healthcare professionals.⁷³ The Primary Care Women's Health Forum (PCWHF) also produces training materials to bring guidance into practice for primary care in a range of formats. This covers a range of women's health issues including the menopause, menstrual disorders, vulval and ovarian cancer.

The Royal College of Nursing has also produced a women's health pocket guide for nurses and midwives working with women.⁷⁴ Many charities have resources for healthcare professionals to support them to deliver best practice in prevention, early diagnosis and management. For example, Cancer Research UK have a range of resources for healthcare professionals covering evidence for interventions which increase uptake of screening and resources to help healthcare professionals carry out those activities.⁷⁵

We will work with the Women's Health Ambassador and key stakeholders to promote and improve the accessibility of existing guidelines and evidence-based resources available to healthcare professionals, and to consider where new resources are needed.

Ensuring education, training and guidelines reflect the diversity of society

We will work with education institutions, professional bodies, and other stakeholders to consider how evidence on sex-based differences in general health conditions can be included in undergraduate and postgraduate education and training. This is important for tackling disparities between men and women, and ensuring that women receive the best care possible.

⁷¹ NICE, **The NICE strategy 2021 to 2026**, published April 2021

⁷² RCGP **Women's health toolkit**

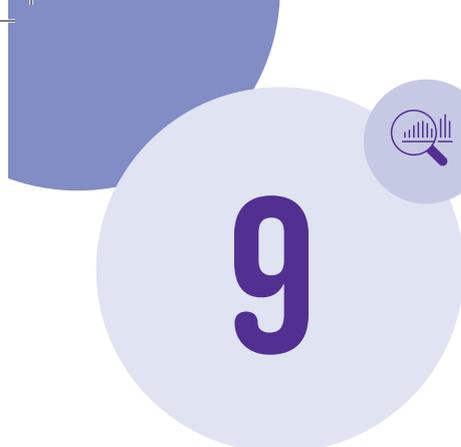
⁷³ RCGP **Menstrual Wellbeing Toolkit**

⁷⁴ RCN, **Women's Health Pocket Guide**, published November 2020

⁷⁵ CRUK **Health Professional resources**

In areas where there is evidence of sex differences in symptoms, diagnosis, or treatment, these are reflected in NICE guidelines. For example, the NICE guideline on autistic spectrum disorder in under 19s recommends that clinicians should pay attention to the under-diagnosis of girls when assessing for suspected autism.

However, we know that there are research gaps on how conditions manifest and are experienced differently by men and women, and between different groups of women, meaning that guidelines cannot always account for the diverse experiences of women. NICE guidelines often make recommendations for areas of future research, including if more research is needed into differences between men and women. Chapter 9 sets out our plans for tackling these gaps in research and evidence.



9

RESEARCH AND EVIDENCE

What we've heard

In the call for evidence, we heard that there is limited research into women's health issues and calls for more research into health issues specific to women, such as the menopause, fertility, pregnancy, and gynaecological conditions. This included research into causes and treatments of conditions, and into women's experiences of health conditions and health services. Some responses also called for more research into the relationship between women's health issues and other health issues or conditions, for example, the relationship between COVID infection and/or 'long COVID' and women's health issues such as menstrual cycles and menopause.

Responses to the public survey and written submissions spoke of the importance of ensuring a diverse range of women are represented in clinical trials and studies for both women's health and general health issues or conditions. Some responses reflected that historically, women have not been represented in all research studies. Examples were given of groups of women that have been less likely to be included in research, such as pregnant women, women from ethnic minorities and lesbian and bisexual women.

We also heard a desire for more women to be working in senior research roles, and for the outcome of research to be accessible and widely disseminated to diverse women, practitioners, policymakers, and the general public.

Our 10-year ambitions

Our ambitions are:



our aim is that health and care research which should, but does not, take into account sex differences does not receive public funding. We will encourage all publicly-funded health research to include data on the sex breakdown of participants, keep progress under review and consider the need for further action



research is representative of society, with increased participation of women and other groups who have historically been under-represented in research. Funders and researchers address barriers that may prevent under-represented women from participating in research, including women from ethnic minority groups, pregnant women and lesbian and bisexual women



research studies and trials into general health issues and conditions routinely collect demographic data on research participants, for example data on sex and ethnicity. Where this information demonstrates disparities in women's outcomes for general health conditions, further work is prioritised to address the differences and improve outcomes for women



women's voices and priorities are at the heart of research, from identification of research need, through to participation in research, dissemination of research findings, and putting research findings into practice



there is more research into women's health issues, for example gynaecological conditions, menstrual health, fertility, pregnancy, menopause, and post-reproductive health, which leads to a greater understanding of conditions that impact women and how we can meet women's health needs



there is support and encouragement for female researchers at each stage of their career to address barriers to career progression for women. There is greater representation of women and expertise in the health of women in decisions on research prioritisation and funding



research findings reach an even broader audience, including women, the public, clinicians, and policymakers to further improve the impact of research and ensure findings inform healthcare practice and policy. Research funders continue to work together to identify opportunities to align and join up in women's health research. This will ensure that diverse women's voices will be heard, and their experience of the healthcare system will be improved, with better outcomes

Actions we are taking

Encouraging high quality research

High quality research which represents a range of women and health issues is vital for evidence-based policy-making and clinical decisions. We are taking action through the NIHR, the nation's largest funder of health and care research which spends £1 billion from the Department of Health and Social Care budget on research every year, and through UKRI, a national funding agency investing nearly £8 billion per year in research and innovation in the UK and internationally, sponsored by the Department for Business, Energy and Industrial Strategy. Within UKRI, the Medical Research Council (MRC) funds the highest volume of research relevant to women's health. Over the 5-year period 2017 to 2021, MRC spent £96 million on its women's health portfolio.

We will also look for ways to encourage research into those areas identified through the call for evidence written submissions analysis as suggested areas for further research. These centred on women's health issues such as miscarriage or menopause, and on women's experiences of general health conditions such as cardiovascular disease or mental health conditions.

Research into women's health

We will work with the NIHR to improve women's health research. We have already launched several research calls, including an NIHR rolling call which is open for researchers to submit applications that address research recommendations identified in NICE guidance, including those on women's health.⁷⁶ We know these are important first steps to encourage more research into women's health conditions.

Through the NIHR we are commissioning, subject to receiving high-quality applications, a new Policy Research Unit dedicated to reproductive health. This unit will be one of a set of policy research units covering a range of health and care subjects. It will undertake research to inform government policy in areas such as menstrual health and gynaecological conditions, and menopause.⁷⁷ The commissioning process will start in Summer 2022 and the unit is expected to operate from January 2024. The new unit will complement the existing unit dedicated to pregnancy and neonatal health.

To improve our understanding of research gaps, the NIHR will undertake further analysis of their portfolio, and in the longer term, explore mechanisms across the NIHR to address these gaps. This builds on recent work commissioned by the UK Clinical Research Collaboration and funded by the NIHR and Wellcome to evaluate UK pregnancy research needs and priorities.⁷⁸

⁷⁶ NIHR, **NIHR NICE rolling call**, published April 2022

⁷⁷ NIHR, **Policy Research Programme - Invitation to Tender National Institute for Health and Care Research (NIHR) Policy Research Units**, published July 2022

⁷⁸ RAND Corporation, **Pregnancy research review**, published 2020

The NIHR has made significant investments into research on a wide range of women's health conditions, including gynaecological conditions, pregnancy, and menopause. This includes a £1.9 million study to develop treatments for postmenopausal women⁷⁹ and a £2 million randomised control trial on endometriosis to examine the effectiveness of surgery compared to non-surgical interventions to manage chronic pelvic pain in women.⁸⁰ The NIHR has also made large investments across NIHR infrastructure, including Biomedical Research Centres and NIHR Applied Research Centres, with dedicated themes to women's health, including reproductive health, perinatal women's health and metabolism and endocrinology.

Participation of women in research studies and trials, and understanding sex-based differences

The NIHR is leading work to improve the diversity of research participants. For example, the NIHR equality and data reporting system includes data on sex (both in terms of researchers and participants in studies).⁸¹ The NIHR equality, diversity and inclusion strategy, which is expected to be published in autumn 2022, will outline next steps in addressing disparities, including widening participation of research for under-served groups, including women.

The NIHR ensures the public and patients are involved across the entire research cycle. NIHR are also actively improving participation in research through implementation of its INCLUDE guidance.⁸² This guidance aims to improve inclusion of under-represented groups in clinical research through a framework of questions to guide funders, researchers, and delivery teams as they design and assess research proposals.

Saving and Improving Lives: The Future of UK Clinical Research Delivery⁸³ sets out our UK-wide vision for clinical research. One of the priorities within this is people-centred research, which will encourage research to include individuals who will most benefit, including women. NHS England is also committed to increasing participation of women and other under-represented groups in research by launching the Find, Recruit and Follow Up activity.

The Medical Research Council (MRC) is currently exploring the development of policy to promote the consideration of sex and other diversity characteristics in the design, conduct and analysis of all human participant studies. Possible measures include, for example, ensuring that women and men are given equal opportunity to participate where this is appropriate to the research project, and ensuring analyses involves a wide range of groups and backgrounds, including those currently under-represented.

⁷⁹ NIHR, **Funding and Awards: Using hormones to improve reproductive health**, start date October 2015

⁸⁰ NIHR, **Funding and Awards: ESPriT2: A multi-centre randomised controlled trial to determine the effectiveness of laparoscopic treatment of isolated superficial peritoneal endometriosis for the management of chronic pelvic pain in women**, start date January 2021

⁸¹ NIHR, **Diversity Data Report**, published December 2021

⁸² NIHR, **Improving inclusion of under-served groups in clinical research: Guidance from INCLUDE project**, published August 2020

⁸³ DHSC, **Saving and Improving Lives: The Future of UK Clinical Research Delivery**, published March 2021

A related initiative is to promote the inclusion of both sexes in the design of animal studies. Within biomedical research, female animals are underrepresented in preclinical studies, including illnesses that disproportionately affect women (for example, stroke, depression, and anxiety), and the effect of sex as a variable in basic research is frequently overlooked in single-sex animal and in vitro studies.^{84 85} The MRC has recently launched a new requirement to consider both sexes in experimental design of animal studies.⁸⁶

However, we know there is more that can be done to improve the participation of women in different types of research, and to improve our understanding where there are sex-based differences in health conditions and disabilities that affect both men and women.

As a first step, the Department of Health and Social Care's chief scientific adviser, Professor Lucy Chappell, will lead a roundtable with researchers in autumn 2022 to explore the best ways to tackle the under-representation of women in research, including women from ethnic minority groups, older women, lesbian and bisexual women, pregnant women, and disabled women. In the long-term, we will seek to understand any complex system-wide barriers that may prevent pregnant women from participating in research.

We will also work with the NIHR to understand where there are gaps in our knowledge of sex-based differences in health conditions, symptoms, and outcomes.

We, along with the NIHR, have a long term aim to explore how we can encourage researchers to disaggregate research findings by sex. This will also help us understand sex-based differences in health conditions. As part of this, we will work with research funders to explore how females are included across different types of research, including discovery science and early phase clinical work.

Supporting women in research

The NIHR published its first Diversity Data Report⁸⁷, which set out the initial baseline for promoting equality, diversity and inclusion and addressing inequalities, forming the benchmark for further reporting and to enable the tracking of progress of the equality, diversity and inclusion actions that are underway. There are a number of areas that the NIHR identify as needing action, including the number of women applying for career awards, with particular concern that the number of applicants decreases with the seniority of award. There has already been some progress made, including removing any barriers for researchers making applications and where necessary introducing new policies and interventions. However, there is more to do.

⁸⁴ Zucker, I. and Beery, A., **Males still dominate animal studies**, Nature, 465, 690, published June 2010

⁸⁵ Shah K and others, **Do you know the sex of your cells?** Am J Physiol Cell Physiol, 306(1):C3-18, published January 2014

⁸⁶ UKRI, **Use of both sexes to be default in laboratory experimental design**, published March 2022

⁸⁷ NIHR, **Diversity Data Report**, published December 2021

The NIHR will build on this work in their upcoming equality, diversity and inclusion strategy so that the researcher career development pathway provides support for women at each stage of their journey. This will help ensure that there are enhanced opportunities for women and other groups of researchers who are currently under-represented in some NIHR awards and on panels assessing research applications.

Maximising the impact of research

It is crucial that national policy and clinical practice is informed and updated by robust research and that women's health research is effectively disseminated to women, practitioners, and the public. The NIHR is taking steps to make women's health research as accessible as possible, including proactively sharing with key groups and individuals, such as through evidence summaries on women's health and care and care and decision making in pregnancy, which draw on NIHR research.^{88 89}

The NIHR has also commissioned work to understand how people from under-represented communities access and use research evidence relating to health.⁹⁰ The study will help the NIHR develop ways to improve the accessibility of evidence for members of the public.

⁸⁸ NIHR, **Women's Health**, published January 2021

⁸⁹ NIHR, **Care and decision-making in pregnancy: research reveals the support women need**, published February 2022

⁹⁰ OSF **Understanding how patients and members of the public access and use research evidence relating to health: A scoping review**

10



DATA AND DIGITAL

What we've heard

In the call for evidence, we heard that when data is collected, it should be categorised and analysed by demographic characteristics such as ethnicity, age, sex, and geography. This is to understand where disparities in health outcomes and experiences exist, how they vary between different groups, their causes, and how to tackle them (both through policy and clinical interventions). Written submissions drew attention to gaps in the quality and granularity of health-related data - in particular, in relation to specific conditions, violence against women and girls, fertility, medicines or medical devices.

The written submissions also raised the subject of 'FemTech', which 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. Respondents also suggested further research into digital technologies which help women understand their own bodies better, and for more work to 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.

Our 10-year ambitions

Our ambitions are:

- 

organisations involved in health and care decision making and service delivery have access to the high-quality data required to understand and tackle disparities in women's access to services, experiences of services and health outcomes
- 

we make better use of data already captured to improve women's health outcomes and reduce disparities between different groups of women, for example data gathered during pregnancy which can be an indicator of future health risks. This includes making better use of women's voice and experience data, for example data collected through surveys and patient feedback
- 

gaps in women's health data are better understood, and so we can tackle sex-based data gaps. Existing datasets are improved, and new datasets are established with the aim of improving women's health outcomes, reducing disparities, and supporting a life course approach for women's health
- 

health data is collected, categorised, and analysed by relevant demographic characteristics such as ethnicity, age, sex, disability, and geography. There is consistency in how sex is defined and recorded in health datasets. This allows policy makers and the health service to better understand gaps in the data, where there are disparities, and for more effective commissioning and delivery of health services
- 

there is greater use of digital health technologies to empower women, such as period tracking or menopause apps, while giving women fair access to clinically safe technologies, whether diagnostic, therapeutic, or preventive
- 

there is closer working and collaboration between with the digital health technology sector – especially FemTech – to deliver collaborative innovation within the NHS in areas such as menstrual problems, access to contraception, fertility and pregnancy complications, to plug evidence gaps, and reach a wider audience, particularly women in inclusion health groups

Actions we are taking

Health and care data

System-wide changes are needed to ensure we have high-quality data to improve our understanding of women's health experiences and outcomes. This includes improving public trust in the health and care system's use of data, building our analytical and data science capability, and modernising the data infrastructure to break down organisational siloes and improve data linkage.

The government's strategy, *Data Saves Lives: reshaping health and social care with data*, sets out our plans to unleash the potential of data in health and social care, focusing on improving health outcomes and reducing disparities.⁹¹

To improve the quality of health and health service data collected within NHS services and the ability to link data collected across the NHS, the Department of Health and Social Care and NHS England is exploring how data concerning people's protected characteristics (including sex) could best be standardised. When carrying out this work, it will be critical that the Department of Health and Social Care and NHS England work closely with the Government Statistical Service harmonisation team, based within the Office of National Statistics, who are developing updated harmonised standards for ethnicity data collection across government (as well as long-lasting health conditions data and mental health data). Milestones and timelines for the Government Statistical Service work are set out in the harmonisation team workplan published in February 2022.⁹² We will commission a reproductive health experiences survey every 2 years, beginning this year, to tackle the gap in data collection specifically relating to women's experiences across all areas of reproductive health. This will include areas such as menstrual health, contraception, pregnancy planning, and menopause. This will be used to inform future policy development and support work to this strategy by improving our ability to monitor changes and disparities in women and girls' access to and experience of reproductive health services.

To support work to develop the delivery plan and implementation framework for this strategy, we will undertake a mapping exercise to identify what data is collected, where there are gaps, and how we can fill those gaps. More detail on implementation is set out in chapter 18.

In the longer term, we will explore how data collection for other areas of women's health can be improved, for example data on gynaecological conditions such as endometriosis.

⁹¹ DHSC, **Data saves lives: reshaping health and social care with data**, published June 2022

⁹² Government Analysis Function, **Government Statistical Service (GSS) Harmonisation Team workplan**, published February 2022

Digital health technologies

Digital health technologies, or HealthTech, are crucial tools to getting the women's health agenda right. This is a growth industry, including all areas of health and social care from primary care and triage, remote treatment and monitoring, self-care and wellness, screening and diagnosis and community engagement. In 2020, the UK was third in the world for digital health investment, only behind the US and China, and in 2021, there were just over 4,000 start-ups and scaleups operating in HealthTech in the UK. FemTech - technologies that specifically focus on women's health related topics, such as fertility, period tracking, pelvic health and sexual wellness - is a growing area of digital health. These technologies can empower women to have fair access to clinically safe technologies, whether diagnostic, therapeutic or preventive, to ultimately improve health outcomes for women.

We want to see greater use of digital technologies to empower women by de-mystifying and simplifying the process for companies to scale and launch their products in the UK.

NHS England is working with NICE and the Medicines and Healthcare products Regulatory Agency (MHRA) through the Accelerated Access Collaborative, to speed up the access to technologies that are proven to be safe and effective by patients. We are also launching a pilot to assess the feasibility of an Early Value Assessment process for 10 Digital Health Technologies for clinical and cost effectiveness. Products assessed through this process that are found to demonstrate a sound level of evidence for clinical and cost effectiveness will receive a conditional recommendation from NICE for use in the NHS, pending a full NICE assessment. Evaluation of the pilot will occur towards the end of the year, ahead of the launch of the full policy framework in spring 2023.

The new NHS Innovation Service has been developed by the Accelerated Access Collaborative to increase and accelerate the uptake of impactful innovations into the NHS and social care by providing innovators with information and coordinated support, enabling them to navigate the health and care system and deliver innovations to clinicians and patients faster.⁹³ The NHS Innovation Service builds on the work of HealthTech Connect, bringing organisations together to collaborate around the needs of innovators. There are 10 partner organisations in the new NHS Innovation Service, working together to support innovators to scale their products in the NHS, including NICE, NHS Supply Chain and the 15 academic health science networks operating across the country.⁹⁴

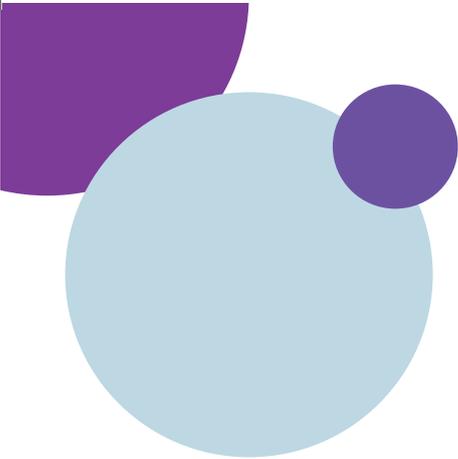
NHS England is also implementing the 5 national commitments from the Digital Clinical Safety Strategy. Accelerating the adoption of digital technologies to record and track implanted medical devices through the continuation of the Scan4Safety programme will improve safety and traceability of devices including those used in women's health.

We are committed to the NHS Long Term Plan⁹⁵ objective of enabling women to access their maternity records digitally to support personal and safe decision making throughout their maternity journey. NHS England is working to update plans and timescales for delivering this in the context of the revised strategy to deliver broader implementation of electronic patient records across care settings. In 2021 to 2022, NHS England invested £40.8 million across 128 units and Trusts, which will help to address the varying levels of digital maturity within trusts across England and put in place elements of the digital foundations that services require.

⁹³ NHS Supply Chain » **HealthTech Connect and NHS Innovation Service**

⁹⁴ The AHSN Network, **The AHSN Network home page**

⁹⁵ NHSE, **NHS Long Term Plan**, published January 2019



PRIORITY AREAS

In the previous chapters, we have set out our approach to the cross-cutting themes of women's voices, information and awareness, access to services, disparities in health outcomes between women, health in the workplace, education and training for health and care professionals, research and evidence, and data and digital. These are relevant to the health of women and girls across the life course and are areas where we aspire to make systematic changes that will improve women's health outcomes and experiences over the long-term. Responses to the call for evidence also highlighted issues specific to certain conditions or areas which will require targeted action. Our plans in these priority areas are set out in the next chapters.

11



MENSTRUAL HEALTH AND GYNAECOLOGICAL CONDITIONS

What we've heard

In the call for evidence public survey, gynaecological conditions were the top topic that respondents picked for inclusion in the strategy, with 63% of respondents selecting this. Menstrual health was the 4th most selected topic, with 47% of respondents selecting this.

Access to information was a key issue, with only 8% of respondents feeling that they had access to enough information on gynaecological conditions, such as endometriosis and fibroids, and only 17% of respondents feeling that they had enough information on menstrual wellbeing. We heard concerns that women had not been listened to in instances where pain is the main symptom, for example, being told that heavy and painful periods are 'normal' or that the woman will 'grow out of them'. Women also told us about speaking to doctors on multiple occasions over many months or years before receiving a diagnosis for conditions such as endometriosis. Linked to diagnosis times, many responses called for better education for healthcare professionals and improved service provision. Organisations also raised concerns about the normalisation of symptoms, for example issues such as incontinence and pelvic organ prolapse being viewed as normal and something to be accepted after childbirth.

Organisations also raised the issue of period poverty and limited access to menstrual products that some girls and women experience, and that access to period products is important for mental wellbeing and sense of dignity. We also heard from organisations about period stigma, which can negatively impact women and girls' participation in education and work.

Gynaecological conditions are conditions that affect the female reproduction organs, including for example heavy menstrual bleeding, premenstrual syndrome (PMS), premenstrual dysphoric disorder (PMDD), endometriosis, adenomyosis, fibroids, and polycystic ovary syndrome (PCOS). Urogynaecological conditions include urinary incontinence, vaginal prolapse, and recurrent urinary tract infections. Gynaecological cancers, for example, cervical or ovarian cancer, are included in chapter 15 on cancers.

Our 10-year ambitions

Our ambitions are:

- 

girls and boys receive high-quality, evidence-based education on menstrual and gynaecological health from an early age. Across the population, there is increased awareness, and menstrual health and gynaecological conditions are no longer taboo subjects in any aspect of society
- 

women and girls are empowered to stay well throughout their lives, including through self-care. Women and girls have an awareness of the different gynaecological conditions such as endometriosis and PCOS, and less well-known conditions such as adenomyosis, and an understanding of what a normal menstrual cycle should look like for them. Women and girls know where, when and how to seek help for menstrual or gynaecological symptoms, and what support and care they can expect
- 

all women and girls can access high-quality, personalised care within primary and community care, including access to contraception for the management of menstrual problems and gynaecological conditions. Where more specialist care is needed, women and girls can access diagnostic and treatment procedures in a timely manner.
- 

women and girls with severe endometriosis experience better care, where diagnosis time is reduced on the journey from initial GP appointment through to final diagnosis
- 

women and girls report improved experiences of care and of gynaecological procedures, in particular experiences of pain during procedures such as hysteroscopy and IUD fittings. Disparities in access to care and experiences of care are tackled
- 

healthcare professionals in primary care are well-informed and trained in menstrual and gynaecological health and can offer women and girls evidence-based advice and treatment
- 

NICE guidelines for gynaecological conditions are developed where they do not currently exist and existing guidelines are updated rapidly in response to new evidence, and guidelines are implemented into practice. Guidelines are presented in an interactive format to support healthcare professionals to provide high-quality, cost-effective care
- 

women and girls with menstrual and gynaecological conditions are supported to reach their full potential in education and the workplace. Education institutions and employers are well-equipped to support their students or workforce, and are encouraged to implement evidence-based support such as workplace policies
- 

there is more research into menstrual and gynaecological conditions to better understand causes, treatments, and impacts on wider health and quality of life

Actions we are taking

Information and awareness

We will work to improve the provision of high-quality information about menstrual health, gynaecological symptoms, conditions and cancers, recognising that in the call for evidence these were areas where fewest people felt they had enough information.

We are improving education and information provision on menstrual health and gynaecological conditions through the introduction of RSHE in schools,⁹⁶ and through our planned improvements to the NHS website, which will focus on menstrual health and gynaecological conditions as a priority. The government is fully funding access to free period products in schools and colleges across England, for girls and women that need them. Organisations can order period products online from the supplier, phs. This scheme has been in place since January 2020 and is currently funded until 2025.

The Women's Health Ambassador will also have a crucial role to increase public awareness of menstrual health and gynaecological conditions, including by working in partnership with the voluntary sector and industry. This will include a focus on tackling taboos that contribute to the normalisation of symptoms and can prevent women from seeking help, for example for very painful periods or incontinence following childbirth.

Improving healthcare advice and support for menstrual health, gynaecological conditions, and urogynaecological conditions

We are working to ensure women and girls can access the healthcare services they need. Chapter 5 sets out our plans for improving women and girls' access to services. We recognise the vital role that contraception plays in managing menstrual and gynaecological conditions, in addition to pregnancy prevention. We will set out our plans for sexual and reproductive health later this year. This will include a focus on increasing access and choice for all women who want contraception, including LARC.

The Delivery Plan for Tackling the COVID-19 backlog of Care, published in February 2022, sets out plans to reduce waiting times and improve patient experience for patients across all specialty areas, including gynaecology and urogynaecology.⁹⁷ This includes plans to:

- communicate better with patients about treatment options and establish a network for people waiting a long time, including through the My Planned Care patient platform⁹⁸

⁹⁶ Department for Education, **Statutory guidance. Relationships and sex education (RSE) and health education**, published June 2019

⁹⁷ NHSE, **Delivery plan for tackling the COVID-19 backlog of elective care**, published February 2022 and updated May 2022

⁹⁸ NHS **My Planned Care**

- roll out up to 160 community diagnostic centres across the country to help clear backlogs of people waiting for clinical tests, many for gynaecological pathways, for example ultrasound scanning, blood tests, and hysteroscopy to investigate heavy menstrual bleeding or post-menopausal bleeding
- roll out surgical hubs across the country. We are increasing activity through dedicated and protected surgical hubs, which conduct planned procedures only. These might exist within a hospital as a distinct unit or ringfenced theatre, or they might have been established on a separate site. Surgical hubs are focusing on providing high volume low complexity surgery, as recommended by the Royal College of Surgeons of England

NHS England is implementing the national rollout of the Getting it Right First Time (GIRFT) High Volume Low Complexity Programme.⁹⁹ Gynaecology is one of 6 specialties being prioritised through this programme, which supports the establishment of surgical hubs for high-volume procedures, and the development of standardised patient pathways. As part of this work, the Royal College of Obstetricians and Gynaecologists has been commissioned to develop consent guidance for 9 gynaecological procedures.¹⁰⁰

The GIRFT programme will work with the Royal College of Obstetricians and Gynaecologists and others to consider how surgical hubs can work in gynaecology as a specialty.

NHS England is also working to reduce waiting times and improve patient experience within gynaecology services, including:

- supporting providers to roll out 'patient-initiated follow up', which gives patients and their carers the flexibility to arrange their follow-up outpatient appointments as and when they need them
- developing national guidelines on first outpatient consultations offered through virtual routes where appropriate, which will increase patient choice

For endometriosis, NHS England is updating the service specification for severe endometriosis in 2022 to 2023.¹⁰¹ Service specifications are important for defining the standards of care expected from organisations commissioned by NHS England to provide specialist care. This update will ensure that specialist endometriosis services have access to the most up to date evidence and advice, and will improve standards of care for women with severe endometriosis.

⁹⁹ GIRFT **High Volume Low Complexity (HVLC) programme**

¹⁰⁰ The 9 gynaecological procedures are: Outpatient hysteroscopy, outpatient operative hysteroscopy, operative hysteroscopy under general or regional anaesthesia, diagnostic laparoscopy, laparoscopic sterilisation, total laparoscopic hysterectomy, vaginal hysterectomy and repair, endometrial ablation under general anaesthetic, and outpatient endometrial ablation.

¹⁰¹ NHSE **E09. Specialised Women's Services**

In addition, following advice from topic experts, NICE, which provides evidence-based guidelines for healthcare professionals on best practice, has begun a review of its guidelines on endometriosis to consider whether it should be updated. This year NICE will also consider the development of a guideline on PCOS through its usual process for identifying and prioritising guidelines.

For fibroids, NICE's recommendation of the use of relugolix with estradiol and norethisterone acetate means that women with uterine fibroids will benefit from access to a ground-breaking new oral medicine to improve their symptoms.

NICE also recently published its guideline on the prevention and management of pelvic floor dysfunction in women aged 12 or over, which includes recommendations on how to raise awareness of the condition.

NHS England is also working to improve services for pelvic floor. Through the perinatal pelvic health programme NHS England is working to improve prevention and identification of mild to moderate pelvic floor dysfunction around birth. NHS England is also leading work through the pelvic floor health programme for stress urinary incontinence and pelvic organ prolapse. This includes work on pelvic floor registry with NHS Digital to track patient outcomes for safer care, improving patient experience of care, and increasing understanding of pelvic floor health.

NHS England has also established a network of specialist centres to provide comprehensive treatment, care and advice for those affected by implanted mesh. There are now 9 specialist centres in operation across England.¹⁰²

The MHRA have also consulted on the reclassification of Aquiette 2.5mg Tablets, which are used to treat long-standing symptoms of an overactive bladder, which are not adequately controlled by bladder training alone.¹⁰³ The MHRA are currently analysing the responses to this consultation and will announce the outcome in due course. Subject to the outcome of the consultation, this change would provide women who use this medicine with a choice in whether they obtain their supplies via prescription or buying from a pharmacy. This would improve access to this type of treatment for some women and increase patient choice.

¹⁰² NHSE **Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse**

¹⁰³ MHRA, **Consultation on proposal to make Aquiette 2.5mg Tablets (oxybutynin hydrochloride) available from pharmacies**, published April 2022

Research and evidence

Through the NIHR, we have commissioned several research studies into menstrual health and gynaecological conditions, including:

- in September 2021, the findings of a study exploring what happens in primary care when women present with endometriosis-like symptoms were published.¹⁰⁴ We will use the findings to inform our understanding of barriers to diagnosing endometriosis
- a £1.9 million randomised control trial to understand the effectiveness and acceptability of different treatments for heavy menstrual bleeding including uterine fibroids.¹⁰⁵ Information from this and other randomised control trials looking at treatments for heavy menstrual bleeding could help women and health professionals to make more informed choices about help for this condition at its outset¹⁰⁶
- we are commissioning, subject to high-quality applications, a study which will develop and validate a patient reported outcome measure (PROM) for patients being treated for pelvic floor disorders to inform clinical effectiveness trials, following a recommendation from the report of the IMMDS Review¹⁰⁷

In addition, through UKRI, the Medical Research Council (MRC) has invested in the MRC Centre for Reproductive Health, which aims to understand the causes of reproductive health disorders to design interventional and preventative therapies.¹⁰⁸ The centre advocates for increased awareness of women's health and works together with patients and healthcare professionals to influence the prioritisation of future research. The centre also co-funds the EXPPECT Centre for Endometriosis¹⁰⁹ which is advancing research into endometriosis and its management.

We will also look for ways to encourage research into those areas identified through the call for evidence written submissions analysis as suggested areas for further research. For menstrual health and gynaecological conditions these areas 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

¹⁰⁴ BJGP, **Navigating possible endometriosis in primary care: a qualitative study of GP perspectives**, published September 2021

¹⁰⁵ NIHR, **Funding and Awards: Ulipristal acetate versus conventional management of heavy menstrual bleeding: a randomised controlled trial and exploration of mechanism of action**, start date October 2014

¹⁰⁶ NIHR, **Funding and Awards: A multicentre randomised controlled trial comparing laparoscopic supra-cervical hysterectomy with second generation endometrial ablation for the treatment of heavy menstrual bleeding**, start date January 2014

¹⁰⁷ NIHR, **Patient reported outcome measures (PROMs) for pelvic floor disorders commissioning brief**, published December 2021

¹⁰⁸ UKRI **MRC Centre for Reproductive Health**

¹⁰⁹ EXPPECT **Excellence in Pelvic Pain and Endometriosis Care and Treatment**

- the links between menstruation, gynaecological conditions and mental health symptoms and outcomes
- the links between PCOS 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 and 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



12

FERTILITY, PREGNANCY, PREGNANCY LOSS AND POSTNATAL SUPPORT

What we've heard

In the call for evidence public survey, fertility, pregnancy, pregnancy loss and postnatal support was the second most selected topic that respondents picked for inclusion in the Women's Health Strategy, with 55% of respondents selecting this. Responses to the call for evidence covered a wide range of issues, including contraception, preconception health, fertility and infertility, pregnancy loss and stillbirth, birth trauma, support for expectant and new mothers and their partners, and patient experience and safety. Information was a key theme, with calls for more education for young people on fertility and infertility as well as pregnancy prevention, the impact of lifestyle factors and pre-existing conditions on fertility and pregnancy outcomes, and more information on maternal physical health after pregnancy.

Access to NHS-funded fertility services was another key theme. Written submissions from organisations raised concerns regarding inconsistent implementation of fertility treatment guidelines and varying funding levels across local areas, meaning that where you live and whether you are in a heterosexual relationship can affect your level of access to NHS-funded IVF provision. Another key issue raised was miscarriage and pregnancy loss. Women who responded to our public survey shared accounts of the devastating impact of pregnancy loss and the variation in the level of support available from healthcare services. We also heard concerns that postnatal support was often too focussed on the health and wellbeing of the baby, sometimes to the exclusion of the mother.

Some written submissions also focused on the ways in which pregnancy provides opportunities to support improvements to women's health, for example advice on smoking and maintaining a healthy weight. Many of the written submissions also spoke of the importance of continuing to tackle disparities in maternal and neonatal outcomes.

Our 10-year ambitions

Our ambitions are:



girls and boys receive high-quality, evidence-based education from an early age on fertility, contraception and pregnancy planning, maternity care and pregnancy loss. These issues are no longer taboo subjects in any part of society

For fertility, contraception and preconception:



women are supported through high-quality information and education to make informed decisions about their reproductive health, including if and when to have a child. All women who want contraception are able to access their preferred type of contraception in a convenient way. Women and their partners are supported to optimise their health and wellbeing prior to conception to improve pregnancy outcomes and to give their child the best start in life



over the life of this strategy we will work with NHS England to address the current geographical variation in access to NHS-funded fertility services across England. Female same-sex couples are able to access NHS-funded fertility services in a more equitable way. There is an end to non-clinical eligibility criteria, through an assessment of current criteria and updated commissioning guidance. There is improved evidence-based information about privately funded fertility treatment 'add-ons' so patients are better able to make informed choices

For pregnancy and maternity care:



the NHS is the best place in the world to give birth through personalised, individualised, and high-quality care. Women are treated as equal partners in the planning of their care throughout pregnancy, labour and the postnatal period. Their personalised care and support plans are dynamic and responsive to changes in their clinical needs and choices, and women are supported to make informed decisions during labour



disparities in outcomes and experiences of care for mothers and babies are reduced, and all women to receive equitable maternity care that is responsive to their individual needs and choices



all women with significant medical conditions that pre-date or arise in pregnancy will receive timely specialist care and advice before, during and after pregnancy



NHS maternity services will be aspirational workplaces in which multi-disciplinary teams work in safe environments and cultures of mutual respect where continuous learning for improvement is the norm

For pregnancy loss:



there are improvements in care pathways for women and their partners who experience pregnancy loss – to support them through bereavement and through future pregnancies, especially if they have experienced multiple early pregnancy losses. Every woman and their partner who needs it should have access to bereavement support and it is our ambition that every maternity service should have a bereavement specialist midwife

Actions we are taking

Contraception

Women on average will require contraception for 30 to 40 years of their lives and it is vital that women can access the full range of contraceptive methods in a convenient way. Contraception plays a vital role in supporting women and partners to fulfil their pregnancy intentions including the prevention of pregnancy, the timing of pregnancy, and spacing of pregnancies. Contraception also has an important wider role in women's lives, for example managing symptoms of menstrual problems, gynaecological conditions and perimenopause. Through management of gynaecological conditions contraception also supports women and girls to reach their full potential in education or the workplace.

Contraception also has a strong economic case. PHE previously developed a tool that estimates for every £1 invested in publicly funded contraception, the public sector will get a £9 return on investment (ROI).

Providing contraception in maternity settings has an even greater estimated ROI, at £32 savings to the public sector for every £1 invested,¹¹⁰ and for many women will offer greater convenience as it saves women from needing to arrange an appointment with their GP or other healthcare provider.

Information about contraception after childbirth should be offered in the antenatal period to support informed decision-making. This enables women to plan any subsequent pregnancy and reduce short inter-pregnancy intervals, which are associated with poorer pregnancy outcomes.¹¹¹

We are encouraged to see examples local areas providing contraception in maternity settings and encourage local commissioners and providers to consider implementing this service.

We will set out our plans for sexual and reproductive health later this year. This will include a focus on increasing access and choice for all women who want contraception, including LARC, and for improving women's experiences including during fitting and removal of an IUD or IUS.

¹¹⁰ PHE, **PHE women's reproductive health programme 2020 to 2021**, published July 2021

¹¹¹ RCM, **Short birth spacing increases risks**, published October 2018

Postnatal contraception in action - North West London

Women in England wanting to access contraception after giving birth can face barriers in accessing this service including maternity services often not being commissioned to provide contraception, and the need to arrange an appointment with a GP or sexual health service.

A study with women in North West London who had just given birth found that 33% of pregnancies were unplanned, 51% of women had not planned future contraception yet 42% wanted to take home contraception after the birth of their child. In follow up surveys, over half of women were using no contraception after 7 months. Regional data showed 5% had a second birth within a year, and 3% were estimated to have become pregnant and had a termination within a year.

In North West London, a regional collaboration across maternity services, sexual health, local authorities and commissioners came together in 2020 to introduce a contraception offer within maternity services. The new service model offers contraception counselling and information to all women during antenatal care, and women are offered a choice of contraception, compatible with breastfeeding, before they left maternity services.

Central to this model has been training all midwives and obstetricians to provide contraception counselling and a core group in each trust to fit contraceptive implants and coils. Staff were trained in sexual health clinics using new curriculums developed by the FSRH for maternity staff, with funding from local charities and the ICS.

Initial follow-up of a cohort over a year shows 28% of women took contraception home, with the progesterone only pill and contraceptive implant being the most popular options. Those who went home with contraceptive implants had high levels of continued use at 1 year. 97% of women were satisfied with this service.

Evaluation of contraception provision and access is being undertaken through a regional quality improvement project. The effect on unplanned pregnancy and spacing of births will be evaluated with service level activity monitoring data to calculate cost savings to the ICS.

Fertility care

We recognise this is an important issue for anyone struggling to have children, and we are clear that patients' access to NHS fertility treatment should only be based on clinical factors. We are committed to ensuring the system offers effective care and support for women across the county, regardless of sexual orientation or other non-clinical factors, and to transparency over what patients can expect from the NHS.

We will work with NHS England to review and address the current geographical variation in access to NHS-funded fertility services across England to ensure all NHS fertility services are commissioned in a clinically justifiable way.

To support this, we will remove non-clinical access criteria to fertility treatment, such as one partner having a child from a previous relationship, to create more equality in access to fertility services.

We are also aware that the interpretation and implementation by the NHS of the access criteria for female same-sex couples has also been variable, placing greater financial burdens on female same-sex couples, and, in some instances, lead to difficult choices about family formation. We will relieve those additional burdens, so that there is no requirement for self-funding and the NHS treatment pathway for female same-sex couples will start with 6 cycles of artificial insemination, prior to accessing IVF services if necessary.

We are also committed to greater transparency of the provision of IVF services across the country and will therefore explore mechanisms to publish data nationally on provision and availability of IVF.

In parallel, NICE is updating its guideline on fertility problems: assessment and treatment, which will consider whether the current recommendations for access to NHS-funded treatment are still appropriate.¹¹² This is expected to be ready in 2024.

We will improve information provision regarding fertility over the next 2 years. We will work with NHS England and the Human Fertilisation and Embryology Authority (HFEA), the regulator of the UK fertility sector, to promote easily accessible information to women. This will be done by working with trusted healthcare professionals, by updating the NHS website on fertility, and improving the signposting to other trusted resources such as the HFEA website. The HFEA will also continue to work with royal colleges and professional groups to consider how best to improve understanding among healthcare professionals about infertility, so that referrals to treatment services are quicker and easier for women.

We will consider whether any change to regulatory powers is necessary to cover fertility treatment add-ons, in light of the HFEA's report following their current stakeholder dialogue about priorities for reform of the Human Fertilisation and Embryology Act, which is due at the end of 2022.

¹¹² NICE, **Fertility problems: assessment and treatment**, in development

Maternity care

The NHS England Maternity Transformation Programme¹¹³ is delivering the Better Births¹¹⁴ vision for maternity services across England, which is for maternity services to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.

Through the work of the NHS England Maternity Transformation Programme and the NHS Long Term Plan,¹¹⁵ we have made good progress towards reducing stillbirths and neonatal deaths. Since 2010, there has been a 25% reduction in the stillbirth rate, a 36% reduction in the neonatal mortality rate¹¹⁶ and 17% reduction in maternal mortality.¹¹⁷

Despite the reductions in stillbirth, neonatal mortality and maternal mortality rates seen since 2010, MBRRACE-UK surveillance reports show us that women and babies of black or Asian ethnicity or those living in the most deprived areas are more likely to die from causes linked to pregnancy and birth compared to women living in the least deprived areas. To address these disparities, local maternity systems received £6.8 million of funding in 2021 to 2022 to co-produce and implement their equity and equality action plans, including the implementation of continuity of carer for black, Asian and mixed ethnic groups and those living in the most deprived areas.

The NHS has also set out actions and plans to address health disparities within local maternity systems in guidance for local maternity systems.¹¹⁸ This outlines that all maternity systems should consider the impact of women's language during the antenatal risk assessment process and should refer to the interpretation and translation services to support women.

The Maternity Disparities Taskforce is tackling disparities in outcomes and experiences of care for mothers and babies by improving access to effective pre-conception and maternity care for women from ethnic minorities and those living in the most deprived areas. This taskforce is also addressing the wider social determinants that are linked to poorer outcomes such as low income and housing and health behaviours such as smoking, drinking and obesity in pregnancy.

Reports and investigations into maternity services have underlined the importance of listening to women and their families and providing safe, personalised care for all women.

¹¹³ NHSE **Maternity Transformation Programme**

¹¹⁴ NHSE, **Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care**, published February 2016 and updated in 2017

¹¹⁵ NHSE, **NHS Long Term Plan**, published January 2019

¹¹⁶ for babies born after 24 weeks gestation

¹¹⁷ MBRRACE-UK, **Saving Lives, Improving Mothers' Care**, published November 2021

¹¹⁸ NHSE, **Equity and equality: Guidance for local maternity systems**, published September 2021

The final report of the Ockenden Review¹¹⁹ contains 66 local actions for learning for Shrewsbury & Telford NHS Hospitals Trust, 15 immediate and essential actions for the maternity system and 3 key asks for the Secretary of State for Health and Social Care. NHS England will develop a refreshed delivery plan for maternity and neonatal services that bring together actions required following the final report of the Ockenden Review, the upcoming report into East Kent, and NHS Long Term Plan and NHS England Maternity Transformation Programme deliverables. It will set clear priorities to continue to deliver our maternity and neonatal safety ambitions and provide more personalised care

In March 2022 we announced an additional £127 million for maternity services across England, investing in our NHS workforce and improving neonatal care. This is on top of £95 million investment this year which included increasing the establishment of midwifery roles by 1200 and obstetric consultant roles by 100.

Personalised maternity care

We will prioritise personalised maternity care so that women are empowered to make purposeful choices during pregnancy and childbirth. Personalised maternity care is central to our ambition to make the NHS the best place in the world to give birth. Personalised maternity care means care is centred on the woman, her baby and her family; based around her needs and decisions, where there has been genuine choice, informed by unbiased, evidence-based information.¹²⁰ The final report of the Ockenden Review also outlines the importance of personalised maternity care and listening to women with their voices heard.

Several programmes of work are supporting the expansion of personalised maternity care and ensuring women's voices are at the heart of maternity care, including:

1. The roll-out of midwifery continuity of carer, prioritising those most likely to experience health disparities. Midwifery continuity of carer facilitates personalised care and supports planning based on informed decision making. The final report of the Ockenden Review includes an action that midwifery continuity of carer should only continue where staffing meets safe minimum requirements on all shifts. NHS England has issued guidance to inform NHS trusts of this process.¹²¹
2. 15 maternal medicine networks are being established across England to reduce rates of maternal mortality.¹²² The maternal medicine networks are responsible for ensuring that all women in the network's area with significant medical problems will receive timely specialist care and advice before, during, and after pregnancy. This includes better co-ordination with primary and emergency care. A joint NHS England, integrated care board and Ministry of Defence maternal medicine network has also been established as a pathfinder to ensure women who are serving in the armed forces have personalised and continuity of care.

¹¹⁹ DHSC, **Final report of the Ockenden review**, published March 2022

¹²⁰ NHSE, **Personalised care and support planning guidance: Guidance for local maternity systems**, published March 2021

¹²¹ NHS, **Letter regarding Ockenden - Final report**, published April 2022

¹²² NHSE, **Maternal medicine networks: service specification**, published October 2021

3. As part of NHS England's iDecide project, which has been co-designed by women and healthcare professionals, NHS Digital is developing a series of decision making tools to better support informed decisions in labour by supporting women and their families to record their wishes and consent.¹²³
4. We provided £5 million in 2021 to 2022 to the Avoiding Brain Injury in Childbirth Collaboration¹²⁴ which includes the Royal College of Obstetricians and Gynaecologists, Royal College of Midwives and the Healthcare Improvement Studies Institute at the University of Cambridge. The collaboration is working to build consensus on a new approach for improved identification, escalation and action on foetal deterioration in labour and a new protocol for complications that can arise with positioning of the baby at caesarean section, specifically when the foetal head becomes impacted in a woman's pelvis. We are currently developing a final pilot programme for 2022 to 2023 to develop and test a delivery model for training of the trainers and for site level training ahead of implementation of a national improvement programme across maternity services in England.

Support for new mothers and parents

The 1001 days from conception to age 2 are crucial for development and impact a child's health for the rest of their life. It is also essential that we support mothers and new parents during this significant stage of life. As part of the government's commitment to supporting families and levelling up communities across the country, we recently announced £302 million investment in family hubs and the start for life programme.

The package includes an £82 million to create a network of family hubs in 75 upper-tier local authorities across England, £100 million for bespoke parent-infant relationship and perinatal mental health support, and £50 million to establish breastfeeding support services. The investment in breastfeeding support services will help ensure that all mothers can meet their breastfeeding goals. The public health benefits of breastfeeding for child and maternal health are significant and well established, with potential benefits including reduced risk of infections (such as gastrointestinal and respiratory tract infections), childhood obesity and maternal breast cancer. Different mothers and babies will have different needs, so this investment will increase the range of advice and specialist support that is available, ensure support is available face to face, over the phone and digitally – including at antisocial hours, and reach families where they are – whether that's at home, in family hubs or in hospital settings. Chapter 14 on mental health sets out our actions on perinatal mental health.

We are working closely with the Department for Education to evaluate the impact of the £302 million investment in family hubs and start for life services on key outcomes for babies and families including outcomes related to child health and development, maternal health and reducing disparities. We have included the 6 to 8 week postnatal check in the GP contract since 2020 to 2021, and provided £12 million to support implementation. This

¹²³ NHSE **Choice and personalised care in maternity services**

¹²⁴ THIS.Institute **Avoiding Brain Injury in Childbirth**

is a separate appointment to the 6 to 8 week baby check which focuses on the mother's physical and mental health and general wellbeing. The appointment uses open questioning and provides an important opportunity to identify women with postnatal mental or physical, including pelvic health, concerns and to begin conversations about family planning or the ongoing management of emerging issues like diabetes and hypertension.

Miscarriage and pregnancy loss

Since 2016, the government has provided more than £250,000 to SANDs, the Stillbirth and Neonatal Death charity, to work with other baby loss charities and royal colleges to produce and support the roll-out of a National Bereavement Care Pathway¹²⁵ to reduce the variation in the quality of bereavement care provided by the NHS. The pathway sets out 9 bereavement care standards which include bereavement care training for staff, bereavement leads in every healthcare setting where a pregnancy or baby loss may occur and bereavement rooms available and accessible in hospitals. Every NHS Trust in England has expressed an interest with SANDs in joining the National Bereavement Care Pathway programme and around 65% of trusts are now members. We encourage all trusts to become members of the pathway and adopt the bereavement care standards.

Parents whose babies are stillborn (born without signs of life after 24 weeks gestation) must legally register the stillbirth and a certificate of registration of stillbirth is issued to the parents. When a pregnancy ends before 24 weeks' gestation there is no formal process for parents to legally register their baby. Some bereaved parents find this to be distressing, although some parents may find it equally distressing if they were required to legally register the loss when they did not wish to do so. The Pregnancy Loss Review has examined the impact on families of not being able to formally register a baby loss and whether it would be beneficial to introduce a registration or certification of loss scheme to recognise what has happened and to help parents who are grieving.

An interim update from the review leads, Samantha Collinge and Zoe Clark-Coates MBE, recommended that the government should introduce a voluntary scheme to enable parents who have experienced a pre-24 weeks pregnancy loss to record and receive a certificate to provide recognition of their baby loss. The purpose of recording and issuing of a certificate is to provide comfort and support by validating a loss. The certificate will not be a legal document, but will be an important acknowledgement of a life lost. The government has accepted this recommendation and we will introduce a pregnancy loss certificate in England.

The final report of the Pregnancy Loss Review is expected to be published later this year, and the government will consider the report's additional recommendations.

We will also give further consideration to the recommendations in the Lancet series on miscarriage.¹²⁶ We await the publication of the Royal College of Obstetricians and Gynaecologists updated guideline on recurrent miscarriage which was out for consultation last year. We will encourage NHS services to implement the new guideline once finalised.

¹²⁵ NBCP **National Bereavement Care Pathway home page**

¹²⁶ The Lancet, **Miscarriage matters**, published April 2021

As part of the Signs of Life project, clinical guidance has been developed which aims to support healthcare professionals in the assessment and documentation of signs of life in extremely preterm births and increase the consistency of the registration of births and deaths and reduce the confusion and distress experienced by parents.¹²⁷

We will continue to work across government to assess what more could be done to support bereaved families. We will also work across government and the voluntary sector to consider how we can strengthen workplace support for women and partners affected by pregnancy loss and stillbirth.

Abortion services

Under the 1967 Abortion Act, women have access to safe, legal and regulated abortion services. The wellbeing and safety of women and girls accessing abortion services has been, and will continue to be, our first and foremost priority. We will set out our plans for sexual and reproductive health later this year, including ensuring women can continue to access robust and high-quality abortion services.

Medicines in pregnancy

Improving the safety of medicines in pregnancy and ensuring that women have high quality, accessible information to support informed decisions about their healthcare remains a priority.

The MHRA-led Safer Medicines in Pregnancy and Breastfeeding Consortium brings together 16 leading organisations under a common pledge to meet the information needs of women and healthcare professionals, through accessible, clear and consistent advice.¹²⁸ Membership spans the NHS, regulators, and leading third sector and charitable organisations. The consortium is working to improve the quality and consistency of information on the use of medicines in pregnancy and breast-feeding, including COVID-19 vaccines.

The NICE guideline on antenatal care,¹²⁹ which was updated last year, recommends that healthcare professionals ask women about current and recent medicines at the first antenatal appointment, and that a referral is made to an obstetrician or other relevant doctor if there are any medical concerns or if review of current long-term medicines is needed.

Sodium valproate is a drug that is authorised to treat epilepsy and bipolar disorder. It is also a known teratogenic medicine, which means that if taken during pregnancy, it can have harmful effects on the foetus and increase the risk of a child being born with physical birth defect and neurodevelopmental disorders. However, for some women sodium valproate may be the only effective treatment for their epilepsy or bipolar disorder.

¹²⁷ NPEU, **Signs of Life: UK clinical guidance**, published November 2020

¹²⁸ MHRA, **Safer Medicines in Pregnancy and Breastfeeding Consortium information strategy**, published January 2021

¹²⁹ NICE, **Antenatal care**, published August 2021

We are working to ensure that sodium valproate is only used where clinically appropriate, and to improve patient safety for women and girls for whom there is no alternative medicine. Since 2018, sodium valproate must not be used by any woman or girl able to have children unless she has a Pregnancy Prevention Programme in place.¹³⁰ This is designed to make sure patients are fully aware of the risks and the need to avoid becoming pregnant. It includes the use of highly effective contraception for people for whom pregnancy is a possibility and completion of a signed risk acknowledgement form when their treatment is reviewed by a specialist, which must take place at least annually.

NHS England and the MHRA have a programme in place to ensure that sodium valproate is used safely and only prescribed where clinically appropriate. This covers a broad range of areas, including reducing prescribing and seeking safer alternatives to sodium valproate, pregnancy prevention and contraception, informed consent and shared decision making, and improving data collection through the Medicines and Pregnancy Registry.

The government will shortly publish the results of a 6-week consultation on original pack dispensing and supply of medicines containing sodium valproate¹³¹ that we carried out in partnership with the MHRA. This included a proposal that medicines containing sodium valproate must be dispensed in the original manufacturer's packaging, which would ensure that women and girls, and particularly those of child-bearing age, always receive patient information about taking the medicine while pregnant.

Research and evidence

Through the NIHR, we have commissioned research into maternal and neonatal health focussing on the safety of maternity services for women and babies, including:

- a £5 million Policy Research Unit¹³², dedicated to maternal and neonatal health and care research based at the University of Oxford. This is researching high priority areas around 5 themes of: preconception health and prevention; pregnancy loss, and perinatal morbidity and mortality; women's experiences of care and its impact on their health; neonatal care; and health systems
- a £2.1 million randomised controlled trial to understand if having hysteroscopic removal of fibroids and polyps increases the live birth rate in women with infertility and recurrent miscarriage¹³³

¹³⁰ MHRA, **Valproate Pregnancy Prevention Programme**, published September 2018

¹³¹ DHSC, **Closed consultation - Original pack dispensing and supply of medicines containing sodium valproate**, published November 2021

¹³² NPEU **Policy Research Unit in Maternal and Neonatal Health and Care**

¹³³ NIHR, **Funding and Awards: HELP Infertility? (Hysteroscopic Excision of Leiomyoma and Polyp in Infertility): two randomised controlled trials**, start date April 2020

- a research study to understand how to improve care for parents following mid-trimester pregnancy loss. This research aims to support healthcare professionals in providing high quality personalised care for women and their families¹³⁴

We will also look for ways to encourage research into those areas identified through the call for evidence written submissions analysis as suggested areas for further research. For fertility, pregnancy, pregnancy loss and postnatal support these areas included:

- the efficacy of practice models, such as continuity of carer
- the causes of miscarriage
- the effectiveness of tools to monitor a baby's health in utero, and understand how infant deaths could be prevented
- how the prenatal and postnatal environment influences infant development and parent-infant bonding
- the effectiveness of AI technologies to help predict which pregnancies will develop life-threatening foetal growth restriction
- the evidence on IVF add-on treatments
- any long-term impacts of receiving COVID-19 vaccines during pregnancy

¹³⁴ NIHR, **Funding and Awards: Optimising care for parents experiencing mid-trimester pregnancy loss by reducing variation in policy and practice**, start date October 2021



13

MENOPAUSE

What we've heard

In the call for evidence public survey, menopause was the third most selected topic that respondents picked for inclusion in the Women's Health Strategy, with 48% of respondents selecting this. We heard the importance of women being provided with information about the menopause before they experience it, so they recognise symptoms and know how to seek support. In the public survey, only 9% of respondents said they have enough information about the menopause, and less than 2 in 3 (64%) of respondents felt comfortable talking to healthcare professionals about the menopause.

Many respondents reported finding it difficult to access appropriate menopause care. This was reported as being due to a lack of recognition of symptoms from both women and healthcare professionals, with some written submissions noting that symptoms of the menopause can be confused with other conditions, such as women sometimes being prescribed anti-depressants rather than menopause treatments. We also heard about a reluctance among some healthcare professionals to prescribe HRT for menopause symptoms, with some written responses concerned that current clinical guidelines focus too heavily on risks and not on the benefits of HRT. Through written submissions, organisations called for better training for healthcare professionals.

Support for menopause in the workplace was also an important theme, with many respondents and organisations describing a lack of support at work and a feeling that the menopause is a 'taboo' subject that cannot be talked about openly, which made management of symptoms even more difficult. Some organisations also outlined how this can contribute to productivity and retention issues if women reduce hours or leave the workforce. These could increase over time as the number of women aged 50 and over participating in employment increases.

Our 10-year ambitions

Our ambitions are:



everyone - girls and boys - is well-informed about the menopause from an early age. Awareness across the whole population of the menopause is increased, and the menopause is no longer a taboo subject in any part of society



women going through the perimenopause and menopause can recognise symptoms and know their options including self-care and where to seek support



women can access high quality, personalised menopause care within primary care, and if needed, specialist care in a timely manner, and disparities in access to menopause treatment are reduced. Women are able to access the full range of treatment options, including contraception for the management of menopause symptoms. All menopausal women for whom HRT is suitable for are able to access HRT and at a reduced cost



women and girls experiencing early menopause, whether naturally or as a side effect of medical treatment, can access specialist and personalised support, including support for mental health, and fertility, and bone health



healthcare professionals in primary care are well-informed about the menopause and able to offer women evidence-based advice and treatment options including HRT and alternatives



other healthcare professionals - for example cardiologists or neurologists - have a basic understanding of menopause including awareness of symptoms and future health risks associated with menopause, and signpost women to appropriate support



women are supported to remain in the workplace during the menopause, and employers are well-equipped to support their workforce during the menopause. Employers are encouraged to implement evidence-based workplace support for the menopause, including introducing workplace menopause policies



there is increased research into the menopause, including different treatments options, and impacts of menopause or menopause treatment on future health risks

Actions we are taking

The UK Menopause Taskforce

It is vital that we take a holistic approach to menopause. For that reason, we established the UK Menopause Taskforce in February 2022. The taskforce is improving holistic support for the menopause across the UK through its focus on 4 key areas: healthcare provision, education and awareness for the population and healthcare professionals, workplace support, and research, evidence and data. To support these efforts and maximise the taskforce's impact, the Women's Health Ambassador is a member of the taskforce.

Information and awareness for women, girls, and wider society

It is important that girls and boys are educated about the menopause from an early age, and that there is awareness among the whole population to help break down taboos and stigmas.

The inclusion of menopause in the relationships, sex and health education (RSHE) curriculum in schools is an important step in educating the next generation on the menopause.¹³⁵

The menopause page on the NHS website has recently been updated¹³⁶ to include the most up to date, evidence-based information on menopause. This includes information about symptoms, where to seek treatment, lifestyle changes which may help with symptoms, and signposting to other helpful resources.

Improving healthcare advice and support

The NHS Menopause Pathway Improvement Programme is working to improve clinical care for menopause in England. This programme launched in 2021 and brings together NHS England, the Department of Health and Social Care, menopause specialists and other key stakeholders.

The programme is developing optimal care pathways for women experiencing the menopause, in line with the recommendations set out in the NICE guideline on menopause diagnosis and management, which represents best practice in menopause care.¹³⁷ This includes developing decision support tools and self-care guides for women, which will help women to record their symptoms, understand their options including self-care and treatments such as HRT, and aid conversations with healthcare professionals. Within this work there is a focus on ensuring that care pathways and resources are accessible to and support those from different backgrounds and experiences. An engagement group with public and patient involvement is being established to support this work.

¹³⁵ Department for Education, **Statutory guidance. Relationships and sex education (RSE) and health education**, published June 2019

¹³⁶ NHS, **Menopause**, last reviewed May 2022

¹³⁷ NICE, **Menopause: diagnosis and management**, published November 2015 and updated December 2019

Education and training for healthcare professionals is another important part of this programme. NHS England is working with Wellbeing of Women to develop an awareness raising package among key healthcare professionals, for example those who carry out health checks, pharmacists, general consultations, to ensure more women are advised to seek support earlier in their menopause.

The government is also reducing the cost of HRT prescriptions. We will introduce a new bespoke HRT pre-payment certificate (PPC) by April 2023. People who hold an HRT PPC will be able to access as many NHS prescriptions for HRT medicines licensed for treatment of the menopause as they need for an annual cost of just 2 single item prescription charges (currently £18.70).

The director general of the Vaccine Taskforce, Madelaine McTernan, was appointed in April 2022 to identify ways to support the HRT supply chain and address shortages some women face on a limited number of products. Actions taken to date have improved the position and we will take forward her recommendations for ongoing work to work with the sector to minimise both short term supply shocks and longer-term supply issues.

The MHRA recently held a public consultation on the reclassification of Gina 10 microgram vaginal tablets, a vaginal oestrogen product used to treat vaginal atrophy in postmenopausal women, meaning women in the UK could access this treatment at a pharmacy without requiring a prescription.¹³⁸ Following analysis of consultation responses, the MHRA has announced that Gina 10 microgram vaginal tablets will be reclassified and women in the UK will be able to access Gina 10 microgram vaginal tablets without requiring a prescription for the first time. This change will provide women who use this medicine with a choice in whether they obtain their supplies via prescription or buying from a pharmacy. This would improve access to this type of treatment for some women and increase patient choice.

The MHRA is also reviewing the evidence on blood clot risks with different HRT combinations and routes of administration and whether the relevant product information - the summary of product characteristics for prescribers and patient information leaflet - needs to be updated.

NICE is updating the guideline on menopause, to ensure it continues to reflect the latest evidence. NICE will update its recommendations on the long-term risks and benefits of HRT, cognitive behavioural therapy (CBT) for the management of menopausal symptoms, and managing urogenital atrophy as part of the guideline update. The revised guideline is expected to be published in autumn 2023. NICE and the MHRA will work closely together as the guideline recommendations are with the aim to ensure that there is clear and consistent advice to patients and health and care professionals on the risks and benefits of HRT, and that any safety advice is appropriately reflected in the guideline.

¹³⁸ MHRA, **Proposal to make Gina 10 microgram vaginal tablets (Estradiol) available from pharmacies**, published February 2022

Workplace support

We are working across government to improve workplace support so that the menopause does not negatively impact women's experiences at work, and to better support employers. Women over the age of 50 represent the fastest growing segment of the workforce and it is vital that we, and business, work to retain this talent.

Within the healthcare system, the NHS Menopause Improvement Programme is developing a model of workforce support that champions staff wellbeing so that women can remain and thrive in the workforce through and beyond their menopause. This will include national menopause guidance for the workplace, developed in partnership with menopause and workforce experts, that will be pioneered in the NHS and then shared with other sectors.

Within the Civil Service, we launched a menopause workplace policy in December 2021 to better support staff and ensure we can retain talent. The Civil Service recently became the largest employer to sign the Wellbeing of Women Menopause Workplace Pledge,¹³⁹ which is a public commitment to making our organisation a supportive and understanding place for employees going through the menopause. We hope the demonstration of this commitment through signing the pledge will encourage other employers to do the same.

Many organisations have introduced workplace policies and other forms of support such as menopause champions, training for employees and line managers, and signposting employees to occupational health services. Flexible working and other adjustments such as changes to temperature, ventilation or lighting can also help women manage the impact of menopause symptoms in the workplace. Organisations such as the Chartered Institute of Personnel and Development (CIPD) and the Advisory, Conciliation and Arbitration Service (ACAS) have produced resources to support employers and employees, and we encourage businesses to implement evidence-based support.

The recently published government response¹⁴⁰ to the independent, government-commissioned report into menopause in the workplace¹⁴¹ commits to working with employer groups and other stakeholders to consider what more we can do to improve support and tackle taboos and stigmas in the workplace. This will include launching an employer-led, government-backed, communications campaign on menopause in the workplace. The UK Menopause Taskforce will support this work with employers to develop and deliver this campaign. The response also set outs that we will look to incorporate menopause awareness into the health pillar of the government's 'Mid-life MOT', a free online support tool to encourage people in their 40s to 60s to plan ahead in the key areas of work, wellbeing and money.¹⁴²

¹³⁹ Wellbeing of Women **Menopause Workplace Pledge**

¹⁴⁰ DWP, **Menopause and the Workplace: How to enable fulfilling working lives: government response**, published July 2022

¹⁴¹ Phoenix Group, **Menopause and employment: how to enable fulfilling working lives**, published Nov 2021

¹⁴² Your Pension **The midlife MOT: take control of your future now**

Research and evidence

Through the NIHR we have commissioned research into menopause, including a randomised control trial looking at the effectiveness of different hormone treatments for women with premature ovarian insufficiency.¹⁴³

As part of its thematic focus on research, evidence and data, the June meeting of the UK Menopause Taskforce considered the evidence base on the menopause and where there are evidence gaps. The taskforce has identified some priorities for menopause research, which will feed into a menopause research prioritisation exercise that the NIHR will commission. This prioritisation exercise will also consider research recommendations from a range of experts such as NICE, including NICE's recent recommendation for further research into testosterone as a treatment for menopause symptoms.¹⁴⁴

We will also look for ways to encourage research into those areas identified through the call for evidence written submissions analysis as suggested areas for further research. For menopause these areas 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

¹⁴³ NIHR, **Funding and Awards: Hormone therapy for premature ovarian insufficiency: randomised trial and long-term evaluation**, start date April 2020

¹⁴⁴ NICE, **NICE sets out further details on menopause guideline update**, published May 2022

14



MENTAL HEALTH AND WELLBEING

What we've heard

In the call for evidence survey, mental health was in the top 5 topics selected by respondents for inclusion in the Women's Health Strategy, (selected by 39% of respondents), and this was consistent across every age group. Overall, 65% of respondents felt, or were perceived to feel, comfortable talking to friends about mental health conditions. This dropped to 52% of respondents feeling comfortable talking to family members. Only 34% of respondents said that they, or the woman they had in mind, had access to enough information on mental health conditions; however, this varied by age and health status.

Mental health was a common example used when respondents were asked to give an example of an area in which they felt that they had not been listened to by a healthcare professional. We heard from respondents that mental health should be given equal consideration to physical health, and that a focus should be given to disparities to access and experiences of mental health care, particularly for women from ethnic minority backgrounds and women who have faced problems with addiction and homelessness. Responses also highlighted the impact of domestic abuse and violence against women and girls on the mental health of women across the life course. Some organisations also flagged that perinatal and postnatal mental health needed more attention and support from healthcare professionals. Many respondents flagged that they would like to see improved access to mental health services, and that they had particularly struggled to access mental health services and support during the pandemic. More specifically, respondents highlighted that better mental health support in the workplace would help them, or had helped them, to reach their full potential.

Our 10-year ambitions

Our ambitions are:



preventing the onset of mental health conditions wherever possible, addressing disparities in outcomes, and ensure equitable and timely access to specialist support for those who are struggling with their mental health. Our plans must take account of differential experiences of women if we are to successfully reduce disparities in mental health outcomes



everyone is empowered to take action to protect and promote better mental health and wellbeing through improved mental health 'literacy' within the general population. This includes gendered dimensions to mental health literacy, such as improving the visibility of how mental ill health can stem from and interact with health conditions typically experienced by women across their life course



there is improved awareness of the effects of alcohol misuse on mental health. As part of this, we are developing the first UK-wide clinical guidelines on managing alcohol misuse which we expect will be published this year



there is a broader and deeper understanding of the causes of differential mental health outcomes between men and women, to ensure national and local partners are equipped to develop tailored plans and interventions which meet the needs of different population groups. This includes conditions with higher rates of prevalence in women, such as eating disorders, and more common mental health conditions such as anxiety and depression¹⁴⁵



there is better tailored research, information and services which support all women and girls across their life course with their mental health

Actions we are taking

Improving mental health and wellbeing

We recently held a mental health and wellbeing call for evidence seeking views on taking a cross-society approach to promoting wellbeing, preventing mental health conditions, intervening earlier, improving treatment, and supporting people with mental health conditions to live well.¹⁴⁶ We are currently analysing responses to the call for evidence and will set out our plans in due course.

¹⁴⁵ NHS Digital, **Adult Psychiatric Morbidity Survey: Mental Health and Wellbeing, England, 2014**, published September 2016

¹⁴⁶ DHSC, **Mental health and wellbeing plan: discussion paper and call for evidence**, published April 2022

We are committed to our ambitious plans to expand and transform NHS mental health services backed by £2.3 billion more in real terms per year by 2023 to 2024 – with a planned update to the NHS Long Term Plan¹⁴⁷ later this year considering the impact of the pandemic on the delivery of wider NHS commitments to transforming mental health services.

We are now working with many different stakeholders to set a shared vision for change that can be 'made real' in each local area through the establishment of ICSs as set out in the Health and Care Act 2022,¹⁴⁸ to transform lives and livelihoods and level up the country. This will build upon the significant work to date to improve outcomes in mental health, including the work of the Women's Mental Health Taskforce, the Five Year Forward View for Mental Health,¹⁴⁹ the NHS Long Term Plan, and the COVID-19 mental health and wellbeing recovery action plan.¹⁵⁰

We set up the Women's Mental Health Taskforce in response to evidence of deteriorating mental health among women and poor outcomes experienced by some women in mental health services. The Mental Health Taskforce report found that there are a number of women's health factors that contribute to adverse outcome for women's mental health, including those stemming early in life from lack of confidence or self-esteem, body image issues, or bullying.¹⁵¹ Work is underway by organisations including NHS England to reduce disparities, provide safer, gender-focused inpatient care, and provide training to health professionals on gender and trauma-informed care. As well as this, our once in a generation proposed reforms to the Mental Health Act 1983¹⁵² will give patients greater choice and autonomy over their care and treatment and help address racial disparities in detention rates.

Women are one of our priority groups when promoting our flagship health and wellbeing resource, Better Health: Every Mind Matters,¹⁵³ given the higher prevalence rates of mental health issues reported. Over the coming months, we will be developing tailored content for the platform to support issues which affect women's mental health that have been raised through this consultation, such as menopause.

We have developed a whole-system approach to mental health and wellbeing, and we are co-ordinating action across different departments to tackle risk and protective factors which impact mental health, including those identified in the Women's Mental Health Taskforce Report. Our COVID-19 Recovery Action Plan included funding for Local Authority programmes, including those targeted at parents, victims of domestic abuse and more generally creating spaces which provide mental health and wellbeing support for women.

¹⁴⁷ NHS, **Long Term Plan**, published January 2019

¹⁴⁸ HM Government, **Health and Care Act 2022**

¹⁴⁹ NHSE, **The Five Year Forward View for Mental Health**, published February 2016, updated September 2017

¹⁵⁰ DHSC, **COVID-19 mental health and wellbeing recovery action plan**, published March 2021, updated April 2021

¹⁵¹ DHSC, **The Women's Mental Health Taskforce report**, published December 2018

¹⁵² HM Government, **Mental Health Act 1983**

¹⁵³ NHS **Better Health: Every Mind Matters**

A cross-government ministerial group has been created to oversee progress on the Recovery Action Plan and ensure that future work on mental health and wellbeing across Government reflects the need to tackle risk factors and promote protective factors. For further information on what the government is doing now to support the nation's mental health and wellbeing, you can read the mental health and wellbeing discussion paper.¹⁵⁴

Young women and girls

It is crucial that we meet the mental health and wellbeing needs of young women and girls. Young women and girls are reporting increasing levels of 'probable mental disorders' and self-harm.¹⁵⁵ The compulsory relationships, sex and health education (RSHE) curriculum¹⁵⁶ in schools teaches pupils about mental health and factors that may affect wellbeing. This includes learning about the early signs of mental wellbeing concerns, including common types of mental ill health (for example, anxiety and depression), and learning about the impact of unhealthy comparison with others online, including through setting unrealistic expectations for body image and how to be a discerning consumer of information online.

Poor body image can lead to anxiety, depression and eating disorders. Over half of 15 year old girls think their body is not about the 'right size', which is clearly an issue. These subjects will also support pupils by promoting pupils' self-control and ability to self-regulate, as well as strategies for doing so. To support the RSHE curriculum we have also produced lesson plans and resources covering body image in a digital world.

All state schools will have the opportunity to train a senior mental health lead by 2025 in how to lead a 'whole school' approach to promoting positive mental health and wellbeing.

We are committed to improving access to eating disorder services. Eating disorders can affect people of all ages, ethnicities, and backgrounds. However, eating disorder charity Beat estimate from the most recent prevalence data that approximately 75% of those affected by an eating disorder are female.¹⁵⁷

Last year we published our COVID-19 mental health and wellbeing recovery action plan¹⁵⁸, backed by a one-off targeted investment of £500 million for 2021 to 2022. As part of this we invested £79 million extra to significantly expand children's mental health services. This enabled around 22,500 more children and young people to access community health services, 2,000 more to access eating disorder services and a faster growth in the number of mental health support teams in schools and colleges to over 500 by 2024. £110 million of the extra £500 million was invested to support the expansion of adult community mental health services, including for eating disorders.

¹⁵⁴ DHSC, **Mental health and wellbeing plan: discussion paper**, updated April 2022

¹⁵⁵ NHS Digital, **Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017 survey**, published September 2021

¹⁵⁶ Department for Education, **Statutory guidance. Relationships and sex education (RSE) and health education**, published June 2019

¹⁵⁷ Beat **Prevalence in the UK**

¹⁵⁸ DHSC, **COVID-19 mental health and wellbeing recovery action plan**, published March 2021

We have also acted to protect under 18s from the effects of non-surgical cosmetic procedures. In October 2021, the government passed the Botulinum Toxin and Cosmetic Fillers (Children) Act,¹⁵⁹ which prohibits the availability of 'Botox' and cosmetic fillers (commonly known as 'dermal fillers') to under 18s for cosmetic purposes. The procedures will still be available to people under 18 but only in cases where the treatment has been approved by a doctor. Their administration may then only be carried out by an 'approved person' (doctor, dentist, pharmacist, nurse).

Adverts for cosmetic surgery that target under 18s have now been banned. The new rules from the Committee of Advertising Practice cover both surgical and non-surgical interventions and will bar ads on all media – ranging from social media sites like Facebook, TikTok and Instagram to billboards and posters, newspapers, magazines and radio as well as social influencer marketing – that are aimed at under-18s or likely to have a particular appeal to that age group.

Also, the government acknowledges the possible link between digitally altered body images and mental health, including the potential harms such a link may cause. The government will consider further proposals to tackle body image issues related to digitally altered images, such as mandatory kite marks, as part of the Online Advertising Programme and our future plans for mental health. The government's priority will be ensuring that any intervention is evidence-based and makes a real and positive difference and will set out its approach in due course.

Perinatal mental health

We are committed to addressing perinatal mental health problems. Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. The NHS Long Term Plan extends this to the first 2 years, in line with the cross-government ambition for women and children focusing on the 1001 critical days from conception to age 2.

As part of the government's commitment to supporting families and levelling up communities across the country, we recently announced £302 million investment in Family Hubs and the Start for Life programme.

The package includes £100 million for bespoke parent-infant relationship and perinatal mental health support. This investment will help nurture parent-infant relationships and improve perinatal mental health support for women with mild to moderate mental health difficulties

The NHS is committed to increasing access to NICE-approved psychological therapies, and NHS England will also be disseminating a refreshed Positive Practice Guide for local systems focused on providing effective support to women experiencing common mental health disorders in the perinatal period. It contains essential information for healthcare professionals working with expectant parents experiencing mental health problems.

¹⁵⁹ HM Government, **The Botulinum Toxin and Cosmetic Fillers (Children) Act 2021**

We are increasing provision of specialist community perinatal mental health services, which provide care and treatment for women with moderate to severe or complex mental health needs and support the developing relationship between mother and baby. They also offer women with mental health needs advice for planning a pregnancy. The Long Term Plan commits to at least 66,000 women with moderate to severe or complex perinatal mental health needs having access to specialist community care, and rolling out Maternal Mental Health Services. These will integrate maternity, reproductive health and psychological therapy for women experiencing moderate to severe or complex mental health needs directly arising from trauma or loss.

Substance misuse and mental wellbeing

Responses to the call for evidence highlighted the need for better access and join up of substance misuse treatment with other health services, particularly mental health, domestic abuse services, and maternity and perinatal services.

We are raising awareness of the risks of drinking alcohol. Women can access information and advice to help consume less alcohol via the 'Better Health' campaign which includes online tools such as the Drinks Tracker app and the 'How Are You' health quiz. The Start for Life website provides information for pregnant women, to support them in reducing the risks of alcohol-related harm.

Through the 10-year drug strategy, published in 2021,¹⁶⁰ we are making the largest ever single increase in drug and alcohol treatment and recovery funding, with £780 million of additional investment over 3 years, between 2022 to 2025. Of this, £532 million will be invested to rebuild local authority commissioned substance misuse treatment services in England. This will benefit people seeking treatment for alcohol misuse, as alcohol and drug services are commissioned together. This is in addition to the money local authorities already spend on substance misuse services from the public health grant.

The drug strategy committed to ensuring better integration of services, to make sure that people's physical and mental health needs are addressed, to reduce harm and support recovery. Work in this area will benefit women affected by substance misuse (including alcohol), as many of the physical and mental comorbidities seen commonly among those affected by drug misuse, are also common among those with alcohol-related comorbidities. Ongoing work on ICSs is also aimed at achieving better joined-up care for those with a substance misuse problem, including women.

The drug strategy also committed to rebuilding the professional workforce of the substance misuse treatment sector. As part of this, we are developing workforce standards, including an expectation that the workforce is trained to have the breadth of skills to respond to the clinical complexities and co-morbidities, including different mental health conditions, substance misuse and homelessness.

¹⁶⁰ Home Office and other departments, **From harm to hope: A 10-year drugs plan to cut crime and save lives**, published December 2021 and updated April 2022

We are developing the first UK-wide clinical guidelines on managing alcohol misuse. They provide guidance on women specific needs, including pregnancy and parental alcohol use, domestic abuse, and physical and mental health comorbidities.

Research and evidence

Through the NIHR we have commissioned a £7.3 million Policy Research Unit dedicated to mental health policy research, based at University College London.¹⁶¹ This is researching a number of high priority areas including the impact of the COVID-19 pandemic on mental health care, screen time and young people's mental health, and the Mental Health Act review.

We will also look for ways to encourage research into those areas identified through the call for evidence written submissions analysis as suggested areas for further research. For mental health and wellbeing these areas included:

- understand how female self-harm and suicide rates are developing nationally, regionally and among specific groups
- 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
- the evidence base on trauma-informed care in England, to inform guidance and resources
- the impact of the pandemic on women's mental health, to inform targeted interventions
- foetal alcohol spectrum disorder prevalence rates

¹⁶¹ UCL Mental Health Policy Research Unit



15

CANCERS

What we've heard

In the call for evidence public survey, gynaecological cancers, such as 'womb (uterus), ovarian, cervical, vulval, and vaginal cancers' were the 7th most popular topic selected for inclusion in the strategy (30%). Overall, only 14% of respondents felt they had enough information on gynaecological cancers, and this drops to 5% of respondents aged 16 to 17 and 7% of respondents aged 18 to 19 and 20 to 25. Some respondents said they 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.

Responses to the written submissions also focused on information and awareness as an important theme. For example, organisations emphasised the need to raise public awareness of the risk factors for female cancers across the life course, the symptoms associated with gynaecological cancers, and how women can access support and treatment. We also heard from organisations about barriers to securing a diagnosis such as symptoms being dismissed or confused with gynaecological conditions, irritable bowel syndrome (IBS), or mental ill health. We also heard the importance of better understanding and tackling disparities in access to services and cancer outcomes.

Our 10-year ambitions

Our ambitions are:



women and girls are better educated on cancers from a young age, aware of their risk factors and symptoms for various cancers and know how to maintain good health to reduce these risks. For example, this includes women knowing how to be breast aware, women with a family history of BRCA gene being aware of early screening offers and all women and girls seeking advice from a health professional if they experience symptoms that aren't normal for them



we achieve 90% uptake for both HPV doses for the routine adolescent vaccination programme offered to children in year 8, with the ambition of reaching a future where, due to a combination of HPV vaccination and cervical screening almost no-one develops cervical cancer



uptake of national vaccination and screening programmes is increased to reduce future cases of cancer and maximise early diagnosis. This will be supported by the digital transformation of screening programmes and better access to data on protected characteristics, as well as through greater accessibility and flexibility in accessing screening services



there is continued commitment to improvements in early diagnosis of and survival from cancer as set out in the NHS Long Term Plan¹⁶² - 75% of people with cancer will be diagnosed at stages 1 and 2 by 2028, up from 55%, and that 55,000 more people each year will survive their cancer for at least 5 years after diagnosis. There is also increased use of non-specific symptom pathways, which offer a single point of access to a diagnostic pathway for all patients with symptoms that could indicate a range of cancers



all patients have access to the most appropriate treatments and that everyone with a cancer diagnosis gets the personalised support they need before, during and after treatment and beyond. This includes people undergoing cancer treatment being routinely offered treatment to preserve fertility in line with NICE guidelines and ensuring no local time limits should be applied to reconstructive surgery



research enables us to better understand the causes, identification of, and treatments including side effects of treatment, for poorly understood cancers, to reduce risk, improve early diagnosis, and subsequent health outcomes and quality of life

¹⁶² NHS, **Long Term Plan**, published January 2019

Actions we are taking

Awareness-raising

Raising awareness is vitally important, as is the experience of women when they do come forward to seek help, including a clear route to diagnosis for people with non-specific symptoms who may still be at risk of being diagnosed with cancer. Public campaigns play a crucial role in driving earlier diagnosis by increasing awareness of symptoms that could indicate cancer and encouraging people to come forward when they experience them.

We are currently evaluating the results of a major new campaign earlier this year to increase the number of those eligible attending their cervical screening in England. The Help Us Help You – Cervical Screening Saves Lives campaign, urged individuals not to ignore their cervical screening invite, and if they missed their last one, to book an appointment with their GP practice or sexual health clinic now. We will continue to use learning from our campaigns to inform future awareness raising approaches. The Women's Health Ambassador will have a role in raising awareness of women's health issues including greater awareness of cancer symptoms and encouraging people to attend screening, in alignment with any campaigns that we or the NHS have planned.

Vaccinations

Cervical cancer – HPV vaccination

Human papillomavirus (HPV) is recognised as a necessary cause of cervical cancer, and high-risk human papillomavirus DNA is found in over 99% of all cervical cancers. HPV is also causally associated with less common cancers, including cancer of the vulva, vagina and anus, as well as some head and neck cancers. Vaccination against HPV protects against these cancers, and the UK aims to achieve a standard of 90% uptake for both HPV doses for the routine adolescent programme offered to children in year 8, aligned with the World Health Organization target. In the 2020 to 2021 academic year HPV vaccine coverage increased significantly in relation to the previous year.

In 2008, the UK was one of the first countries to successfully introduce a routine HPV vaccination programme for girls aged 12 to 13 in school along with a catch-up programme for girls aged from 13 to under 18 years. Subsequently the programme was extended to boys of the same age in 2019 and has significantly helped to protect against the cancers caused by HPV, including 95% of cervical cancers. Young people who were eligible for HPV vaccination in school but who missed it can still be vaccinated on the NHS for free, up to their 25th birthday, to ensure they are protected.

Since then, millions of doses of HPV vaccine have been given to young women in this country and over 80% of women aged 15 to 24 at the present time have received the vaccine. Early evidence on the impact of the national HPV immunisation programme has shown a reduction in high-risk HPV infections, genital warts and pre-cancerous lesions among vaccinated cohorts.¹⁶³ Herd protection among unvaccinated groups is also now

¹⁶³ UKHSA, **Human papillomavirus (HPV): the green book, chapter 18a**, published March 2013

emerging globally, including in the UK. In addition, a study published in the *Lancet* in 2021 identified that women who were offered the HPV vaccination between the ages of 12 and 13 years were found to have cervical cancer rates 87% lower than in previous generations.¹⁶⁴ The study also shows the potential for HPV vaccination, when combined with cervical screening, to reduce cervical cancer to the point where almost no-one develops it. The NHS vaccination programme will help to accelerate the control of cervical cancer in women and offers the potential for the elimination of HPV caused cancers in the UK.

Screening and diagnostics

Cervical screening

We introduced primary HPV testing in the cervical screening programme in England in 2019. Evidence shows that using HPV primary screening within the NHS Cervical Screening Programme offers a more sensitive and effective way to let individuals know whether they have any risk of developing cervical cancer than the previous method (cytology alone). If no high risk HPV is detected (high risk HPV is found in 99.7% of cervical cancers), an individual's chances of developing a cancer within 5 years are very small.

We are piloting research into the accuracy and acceptability of an HPV self-sampling test so women can undertake screening for cervical cancer in the comfort of their home. The research is in its early stages and is being piloted in women who have delayed or turned down a healthcare professional taken sample. The findings from this evaluation will be used to inform any recommendation made by the UK National Screening Committee. Self-sampling could lead to an increase in uptake as it will reduce some of the barriers that prevent people from attending for screening, including availability of appointments, physical disability, and past trauma.

We are ensuring that transgender men and non-binary people with female reproductive organs are aware of cancer symptoms which may impact them, as well as receiving screening invites and being able to access screening services for cervical screening, as well as breast cancer screening. A new NHS Cervical Screening Management System to replace the current call/recall system for cervical screening is in development. This system will support the option for a GP or sexual health provider to manually opt-in eligible transgender men and non-binary people so that they also receive an automatic screening invitation to participate in the NHS Cervical Screening Programme.

¹⁶⁴ Falcaro M and others, **The effects of the national HPV vaccination programme in England, UK, on cervical cancer and grade 3 cervical intraepithelial neoplasia incidence: a register-based observational study**, published November 2021

Targeted and stratified screening

Targeted and stratified screening is a tool alongside our national population screening programmes, which will create more personalised, more predictive, and more targeted programmes. We are reforming the UK National Screening Committee so that it can make recommendations on targeted and stratified screening alongside population level programmes. These recommendations will provide the footing for screening to be targeted at groups of women who have been identified at an increased risk compared to the general population.

This would mean the type of screening test and frequency of testing would be based on individual risk. In the future, both these strategies will allow the NHS to provide more personalised screening programmes, based on predictive analysis of individual risk factors, potentially leading to better outcomes. This will benefit some women, for example groups of women with a family history of cancer, for example having a variant of the BRCA gene can greatly increase a woman's chance of developing breast cancer and ovarian cancer. It is important that women are aware of screening options.

The NHS is already using targeted case finding to prioritise people at the highest risk of certain cancer types for surveillance and other testing, supporting earlier diagnosis. Lynch syndrome and BRCA testing are examples of where this approach is being used.

Recovery of screening and diagnostic services

NHS England has made a significant investment in screening via elective recovery funding, and in diagnostic services more generally to build resilience and capacity, including new models of care. This includes a £38 million investment in breast screening, and a £21 million capital investment to improve capacity for mammography screening.

We are also announcing further investment of £10 million in the breast screening programme. Through this we will provide 25 new mobile breast screening units to be targeted at areas with the greatest challenges of uptake and coverage. This will provide extra capacity for services to recover from the impact of the pandemic, boost uptake of screening in areas where attendance is low, tackle health disparities and contribute towards higher early diagnosis rates in line with the NHS Long Term Plan.

We are using the lessons learnt from the pandemic to transform the way we deliver screening services and make them more accessible to underserved communities. For example, some appointments can now be held over the phone or via video call rather than face-to-face meetings, and active follow up is taking place with women who do not book or attend appointments.

Faster diagnosis

The NHS is setting up non-specific symptom pathways to provide a new route to diagnosis for patients who do not fit clearly into a single 'urgent cancer' referral pathway, but who are nonetheless at risk of being diagnosed with cancer.

A best practice timed pathway for gynaecological cancers has been developed and is scheduled for publication shortly, which will help to shorten diagnosis pathways and improve people's experiences of care.

Non-specific symptom pathways will also support the NHS to meet the new Faster Diagnosis Standard which was introduced from October 2021 and aims to ensure that patients who are referred from general practice or a screening service have a definitive diagnosis or ruling out of cancer within 28 days.

Care and treatment

Improving treatment outcomes

Ensuring that all patients have access to the best treatments is a strategic priority for the NHS. NHS England has recently commissioned 5 new national clinical audits, via the Healthcare Quality Improvement Partnership (HQIP) to help increase consistency in access to treatment and improve outcomes. These are in addition to the 5 existing national clinical audits for cancer. The new audits include a specific audit on ovarian cancer and one on metastatic breast cancer. The latter will form part of a single integrated programme alongside an audit of primary breast cancer in women and men of all ages, building on success and learning from the National Audit of Breast Cancer in Older Patients.¹⁶⁵

Support and follow up

It is vital that everyone living with a cancer diagnosis gets the personalised support they need before and during their treatment and beyond. The NHS is committed to ensuring that every patient with cancer gets a personalised plan based on an assessment of their clinical and other needs.

In addition, the NHS is supporting patients to take greater ownership of their follow-up care through the roll out of Personalised Stratified Follow Up pathways which provide a rapid route back into the system if they notice any worrying changes or need to seek help. The pathways are being implemented across all Cancer Alliances for breast, colorectal and prostate cancers, and are being extended to additional cancer types, including womb cancer.

¹⁶⁵ NABCOP, [National Audit of Breast Cancer in Older Patients home page](#),

Breast health

We are working to improve breast health among women, as well as improving prevention, diagnosis, treatment and support for women with breast cancer. About 1 in 8 women are diagnosed with breast cancer during their lifetime.

NHS England is working to ensure women can access the best treatments possible for breast cancer. All completed NICE appraisals of breast cancer medicines since March 2018 have recommended the use of the medicines which are now routinely available for clinicians to use in the treatment of NHS patients. NICE has recently published final draft guidance which recommends pembrolizumab in combination with chemotherapy as another immunotherapy option for people with triple negative breast cancer that has spread to other parts of the body.¹⁶⁶

Women who have had a mastectomy as part of their breast cancer treatment can choose to have a breast reconstruction. NHS England has asked Cancer Alliances to work with their local systems so that wherever possible surgery is now happening with immediate breast reconstruction, and to seek opportunities to provide reconstruction for those women who have not yet had the procedure following previous breast surgery during the pandemic.

The NHS Cancer Programme has made it clear to systems that no local time limits should be applied to reconstructive surgery, and certainly not where that reconstructive surgery has been delayed as a result of the pandemic.

Future plans

We recently held a cancer call for evidence seeking views on future priorities for cancer over the next 10 years.¹⁶⁷ The call for evidence sought views across a number of areas including early diagnosis, workforce, innovation, data, new treatments, patient experience and prevention. We are currently analysing responses to the call for evidence and will respond in due course.

Research and evidence

Through the NIHR, we have commissioned research into cancers, including:

- a £5 million Policy Research Unit dedicated to cancer awareness, screening and early diagnosis, based at Queen Mary University of London.¹⁶⁸ This is researching high priority areas including identification of risk factors for late stage or emergency presentation of cancer, barriers of participation in cancer screening, and investigation of potential early markers of cancer and new screening tests.

¹⁶⁶ NICE, Pembrolizumab plus chemotherapy for untreated, triple-negative, locally recurrent unresectable or metastatic breast cancer, published June 2022

¹⁶⁷ DHSC, **10-Year Cancer Plan: Call for Evidence**, updated March 2022

¹⁶⁸ Cased **The Policy Research Unit in Cancer Awareness, Screening and Early Diagnosis**

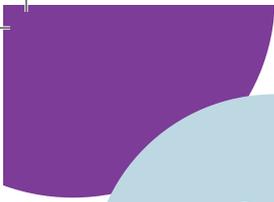
- a study to understand barriers to early diagnosis of womb cancer and an assessment of the accuracy of non-invasive detection tools for womb cancer

In screening specifically, there is ongoing research to use genetics in the breast cancer screening programme, and for use in a potential screening programme for familial ovarian cancer. The UK National Screening Committee is commissioning a modelling exercise to consider the type and frequency of screening tests offered to individuals based on age and vaccination status. In addition, modelling will consider the value of future research in HPV screening and areas it would be worth increasing research efforts. It is anticipated that the project will report to the Committee in 2024.¹⁶⁹

We will also look for ways to encourage research into those areas identified through the call for evidence written submissions analysis as suggested areas for further research. For cancers these areas included:

- the impact of interventions on reaching women from deprived communities, and with protected characteristics such as ethnicity and disability status
- disaggregating data by cancer type, as opposed to 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
- research and clinical trials to develop better diagnostic tests and treatments for example, for ovarian cancer and secondary breast cancer
- ensuring trials look at how treatment will impact overall quality of life as well as how effective it is in combatting the cancer
- research and longitudinal data collection on cancer in non-symptomatic women

¹⁶⁹ DHSC and other Departments » **UK National Screening Committee**



16

HEALTH IMPACTS OF VIOLENCE AGAINST WOMEN AND GIRLS

What we've heard

In the call for evidence public survey, the health impacts of violence against women and girls was the 8th most selected topic that respondents picked for inclusion in the Women's Health Strategy (30%). It also featured in the top 5 topics selected by respondents aged 16 to 29 and from the mixed/multiple ethnic group. In the public survey, only 9% of respondents said they had enough information about specialist services such as sexual assault referral centres and female genital mutilation (FGM) clinics.

Responses from organisations and experts highlighted that some groups of women are at higher risk of experiencing certain forms of violence and abuse than others, for example disabled women experience higher rates of domestic abuse than non-disabled women, and lesbian and bisexual women are more likely to have experienced abuse than heterosexual women. Responses highlighted that the health impacts of violence and abuse, including domestic abuse, are wide ranging and extensive and can have long-term impacts on women and girl's physical and mental health. Submissions from organisations also noted the particular need for healthcare professionals to be able to understand and spot the signs of domestic abuse in order to support women and girls, the specific needs of victims including having access to trauma-informed services, and how employers can do more to support victims of abuse both in and out of the workplace.¹⁷⁰

¹⁷⁰ While we use the term 'violence against women and girls', throughout this strategy, this refers to all victims of any of these offences.

Our 10-year ambitions

Our ambitions are:

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women and girls who are victims of violence and abuse are supported by the healthcare system and in the workplace, and the healthcare system takes an increased role in prevention, early identification and provision of support for victims. There is a wider acknowledgement and understanding that violence and abuse is a public health issue, as well as a criminal justice issue
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there is greater awareness among the general population of healthcare services that can provide specialist treatment and support for victims of sexual violence and FGM such as sexual assault referral centres and FGM clinics
- 

the health and care system prioritises the prevention and reduction of violence against women and girls, and has an increased role in prevention, early intervention (including through identification of perpetrators), and supporting victims of violence and abuse. This includes targeted interventions to support those groups of women that are disproportionately affected by violence against women and girls, including victims of domestic abuse and violence
- 

NHS services and staff are able to support victims of violence and abuse and are well-equipped with the knowledge and skills to identify and respond to victims and perpetrators. Health and care workers understand the impact of trauma and have the tools available to engage in trauma-informed practice
- 

NHS and social care staff who are victims of violence against women and girls are better supported in the workplace and are aware of how to access any support they may need. Health employers and colleagues feel well-equipped to support fellow staff and to implement evidence-based policies and other support
- 

learnings and recommendations from the Domestic Homicide Review¹⁷¹ that relate to health organisations are taken forward and embedded into the healthcare system at a national and local level
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robust research is carried out to understand the immediate and long-term physical and mental implications of violence against women and girls, as well as the ways to prevent violence and abuse against women and girls

¹⁷¹ Home Office, **Domestic homicide review**, published June 2013 and updated March 2022

Actions we are taking

Tackling violence against women and girls is a top priority for the government, and we must have a zero-tolerance approach across all of society, including the healthcare system.

Supporting victims

As part of the government's Tackling violence against women and girls strategy,¹⁷² we committed to working with new integrated care systems (ICSs), including work identifying potential perpetrators and supporting victims. We committed to working with NHS England to review and build on their workforce policies to ensure safe, effective processes are in place to support staff affected by violence against women and girls, and other forms of violence and abuse, and that staff understand how these issues affect them as individuals and how to access any support they may need. We also committed to exploring how victim support services for victims of sexual violence and domestic abuse can be enhanced. As a result, the Health and Care Act 2022¹⁷³ requires the joint forward plan for an integrated care board and its partners to set out any steps it proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

We know that violence against women and girls disproportionately impacts some groups of women, and to combat this NHS England will appoint a National Clinical lead and a dedicated team to lead a programme on Domestic and Sexual Abuse this year. We will also work with NHS England and other partners across the healthcare system to improve support for health and care staff affected by violence against women and girls.

NHS England is piloting health-led approaches to violence reduction with ICSs, focused on tackling broad issues such as gang violence, child exploitation, grooming, drugs and alcohol misuse, and knife crime. By March 2023, we will be able to start assessing whether these health-led approaches are effective in improving outcomes for people who have experienced violence, or who are at risk of violence.

We will publish a definition of trauma-informed practice for use in the health and social care sector and will work to encourage its adoption. Trauma-informed practice means being sensitive to the trauma that service users may have experienced and actively seeking to prevent re-traumatisation. This can help to address some of the barriers those affected by trauma can experience when accessing the care and services they need. Publishing the definition will provide the health and social care sector with a consistent foundation on which to build trauma-informed practice into their services and systems. This is the first step towards improving the evidence base to better understand the impact of trauma-informed practice.

The call for evidence identified that awareness was very low for NHS services for victims

¹⁷² Home Office, **Tackling violence against women and girls strategy**, published July 2021 and updated November 2021

¹⁷³ HM Government, **Health and Care Act 2022**

of violence or abuse, such as sexual assault referral centres and FGM clinics. In February this year the NHS launched a 3-month campaign to raise awareness of sexual assault referral centres and will raise awareness of FGM among healthcare professionals who are involved in women's health screening services, so they know how to identify FGM, how to provide a sensitive service and where to refer women for expert services. We will work with the Women's Health Ambassador to consider what more we can do to raise awareness of existing support and work on trauma-informed practice.

The Ministry of Defence will launch a campaign based on the principles of the sexual assault referral centre campaign tailored to serving personnel and families and staff. It will include a clear referral pathway for armed forces serving personnel, veterans and their families into NHS sexual assault services.

In the Tackling Domestic Abuse Plan,¹⁷⁴ the Home Office committed to invest up to £7.5 million into domestic abuse interventions in healthcare settings. This is important as the NHS is often the first point of contact for women who have experienced violence against women and girls.¹⁷⁵ We have also committed to work with the NHS National Safeguarding Steering Group, to embed meaningful learning and action with the healthcare system from recommendations in the domestic homicide reviews at a national and local level.

The Domestic Abuse Act 2021¹⁷⁶ will transform our response to victims and ensure perpetrators are brought to justice, introduced a wide-ranging statutory definition of domestic abuse which incorporates a range of abuses beyond physical violence, including coercive or controlling behaviour, emotional and economic abuse. The Home Office has now published statutory guidance on domestic abuse to support the implementation of the definition.

A codeword scheme, Ask for ANI (Action Needed Immediately), has been developed by the Home Office to provide a discreet way for victims of domestic abuse to signal that they need emergency help from the safety of their local pharmacy. The scheme has been developed with the help of partners including the domestic abuse sector, pharmacy associations and the police and was launched across the UK on 14 January 2021. Over half of UK pharmacies are now enrolled in the scheme and more than 100 people from across the UK have been supported by pharmacists to access emergency help from the police or domestic abuse services.

Domestic abuse is an important public health issue that contributes to suicide. It is not just victims of abuse that appear to be at higher risk of suicide, but also children and young people who witness domestic abuse and are victims in their own right, and perpetrators themselves.¹⁷⁷ We will look at the role that family hubs might play in supporting women and children affected by domestic abuse.

¹⁷⁴ Home Office, **Tackling Domestic Abuse Plan**, published March 2022 and updated May 2022

¹⁷⁵ Identification & Referral to Improve Safety (IRIS), **Domestic abuse and health**, published November 2019

¹⁷⁶ HM Government, **Domestic Abuse Act 2021**

¹⁷⁷ McManus S and others, **Intimate Partner Violence, Suicidality, and Self-Harm: A Probability Sample Survey of the General Population in England**, Preprints with The Lancet, published March 2022

Parental substance misuse and conflict

We know there is a complex interrelationship between substance misuse and domestic abuse, though it is never an excuse or justification for perpetrating this heinous crime. Building on the perpetrator pillar of the Tackling Domestic Abuse Plan, we will work alongside the Home Office to ensure the health system continues to play an important role in the prevention, identification and support for victims and perpetrators of violence against women and girls.

Parental conflict is understood as 'conflicts that occur between parents/carers that are frequent, intense and poorly resolved,'¹⁷⁸ and can have negative impacts on children's welfare. Parental conflict is different from domestic abuse because there is not an imbalance of power, neither parent seeks to control the other, and neither parent is fearful of the other. Evidence suggests that where parental substance misuse and parental conflict is not addressed, it can result in intergenerational patterns of harmful behaviours, including substance misuse and domestic abuse.^{179 180}

To improve outcomes for families affected by parental substance misuse and parental conflict, along with the Department for Work and Pensions, we have invested £7.2 million between 2018 to 2022 in the Children of Alcohol Dependent Parents programme. The programme contributes to meeting the health and social needs of women and supporting the prevention of perpetrator behaviour. This is done by engaging families early, reducing the risk of escalating conflict, and improving the quality of whole-family, multi-agency support that families receive. All local authorities can invest their funding from the drug strategy into interventions aimed at children and families, over the next 3 years.¹⁸¹

We will support work across government to share and embed learning from the independent national evaluation of the programme. We will also launch a national online resource hub, which will provide a single point of access for resources that have been developed through the programme, to support local authorities to develop services for families affected by parental substance misuse. We are also looking at the role that family hubs can play in supporting parents and families in accessing support and treatment for substance misuse.

Virginity testing and hymenoplasty

Virginity testing and hymenoplasty are both forms of violence against women and girls and are harmful practices which stem from dangerous misconceptions about a woman's sexuality. Such practices will not be tolerated in the UK and we have banned them through the Health and Care Act 2022.

¹⁷⁸ DWP, **Examination of the Links Between Parental Conflict and Substance Misuse and the Impacts on Children's Outcomes**, published April 2021

¹⁷⁹ Child Development, **How can genetically-informed research help inform the next generation of inter-parental and parenting interventions?** published February 2017

¹⁸⁰ Journal of the American Academy of Child and Adolescent Psychiatry, **Exploring the psychosocial and behavioral adjustment outcomes of multi-type abuse among homeless young adults**, published January 2009

¹⁸¹ Home Office, **10-year drug strategy**, published December 2021

We have developed safeguarding guidance for agencies and those working on the front line that will sit alongside the legislation. Banning these practices will only go so far in beginning to tackle the harmful misbeliefs that surround a woman's virginity, and we are developing an awareness raising programme with the Department for Education, the Home Office and other key stakeholders. We will consult later this year on the need for protection orders for virginity testing and hymenoplasty.

Research, evidence and data

The NIHR has launched a research call to understand what interventions prevent male violence against women and girls and what are the resulting health impacts.¹⁸² This will help us understand what works to prevent male violence against women and girls, which will support us in tackling the root causes of violence against women and girls.

The government, through UK Research and Innovation, has funded the Violence, Abuse and Mental Health Network, which aims to understand, prevent and reduce the impact of violence and abuse on mental health.¹⁸³ The network is looking at women's mental health and differences between men and women in experiences of multiple traumas and mental health problems.

The National Drug Treatment Monitoring System¹⁸⁴ data helps drug and alcohol treatment demonstrate the outcomes it achieves. The new data items introduced in April 2022 will record information where domestic abuse victimisation or perpetration has been identified and help to monitor where appropriate action and support is offered, both to the victims of domestic abuse, and to perpetrators.

Earlier this year the Office for National Statistics (ONS) published a comprehensive list of data sources relating to violence against women and girls.¹⁸⁵ We are working with the ONS to explore how insight from health data can be improved to improve the lives of victims and reduce the prevalence of violence against women and girls. The new information generated will be used to improve services and experience of service for women and girls and inform interventions around violence against women and girls.

We will also look for ways to encourage research into those areas identified through the call for evidence written submissions analysis as suggested areas for further research. For the health impacts of violence against women and girls these areas included:

- the impact of health disparities and violence against women and girls across the life course
- data collection on sex-based violence and links across the patient journey

¹⁸² NIHR, **22/23 Interventions to prevent male violence against women and girls**, opens March 2022

¹⁸³ VAMHN **Violence, Abuse and Mental Health Network: Opportunities for Change**

¹⁸⁴ NDTMS **National Drug Treatment Monitoring System home page**

¹⁸⁵ ONS, **Violence against women and girls: Data landscape**, latest data released November 2021

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HEALTHY AGEING AND LONG TERM CONDITIONS

What we've heard

In the call for evidence public survey, healthy ageing was the ninth most popular topic for consideration in the strategy (23%). Many respondents also called for the strategy to cover specific long-term conditions including neurodiversity (10%), musculoskeletal conditions (8%), heart disease and stroke (7%), and neurological conditions (7%).

In the written submissions, organisations raised concerns that the healthcare system doesn't focus enough on older women's healthcare needs and experiences. We heard about the importance of health promotion activities and there was a desire to keep women more informed about how to ensure better physical health into older age.

In the call for evidence, we heard examples of general health conditions for which respondents and organisations thought that the services could be improved, including musculoskeletal conditions such as osteoporosis, heart disease and stroke, diabetes, dementia, vitamin deficiencies, and neurodiversity. Some of these conditions can present differently in women compared to men, meaning women can face additional barriers to referral and diagnosis in these areas – particularly as diagnostic tests are often based on research largely done on male samples. Both members of the public and organisations suggested further research and improved data collection on health conditions that may affect men and women differently. This was seen as important for better diagnosis and treatment to help women manage their conditions.

Long term conditions, or chronic conditions, are conditions for which there is currently no cure, and which are managed with drugs and other treatment. These include conditions such as cardiovascular disease, diabetes, arthritis and osteoporosis.

Our 10-year ambitions

Our ambitions are:

- 

women's healthy life expectancy is improved and the gap between the most and least deprived areas is closed. Disparities among different groups of women are reduced, with the ambition that everyone has 5 extra years of healthy life expectancy by 2035
- 

women are better supported to maintain good health throughout their lives and have the information and support they need to make healthier choices. Women are well-informed on potential health risks in later life including long term conditions, as well as women's health issues such as breast cancer and menopause
- 

healthcare strategies, policies and programmes for long term health conditions and disabilities consider any women-specific issues by default, and take a life course approach to women's health, considering wider determinants of health
- 

healthcare professionals are well-informed, via undergraduate and postgraduate education and further training, about differences between women and men in risk factors, presentation and treatment for long term health conditions and disabilities
- 

there is increased participation of women in research into long term conditions and disabilities, and research into sex-based differences in general health conditions. There is routine disaggregation of health data by sex and other demographic characteristics
- 

women have improved experiences and outcomes with MSK conditions that disproportionately affect women, such as osteoporosis and fragility fractures. There will be a greater focus on identifying those at particular risk and on both primary and secondary prevention, thereby addressing the treatment 'gap' that exists currently
- 

women are well-informed about cardiovascular risk factors and how to maintain cardiovascular health across the life course. Women with cardiovascular disease have improved care and outcomes aligned with the NHS Long Term Plan¹⁸⁶ ambitions for enhanced diagnostic support in the community, better personalised planning and increasing access to cardiac rehabilitation
- 

greater numbers of women are participating in dementia research, in addition to other previously under-represented groups. There is improved awareness of dementia risk factors and experiences of care for all people with dementia including women

¹⁸⁶ NHS, **Long Term Plan**, published January 2019

Actions we are taking

Maintaining good health

We are working to narrow the gap in healthy life expectancy between local areas where it is highest and lowest by 2030, and to increase healthy life expectancy overall. The white paper, *Levelling Up the United Kingdom*,¹⁸⁷ reaffirms the government's existing commitment for 5 extra years of healthy life by 2035.

We will work with the Women's Health Ambassador to raise awareness of risk factors for long term conditions and cancers, and the links with women's health issues across the life course. For example, we know that women with PCOS are at higher risk of developing type 2 diabetes and cardiovascular disease,¹⁸⁸ and that alcohol consumption and obesity are risk factors for breast cancer.¹⁸⁹

We are already taking action in a number of these areas to support women to maintain their health across the life course.

Physical activity

It is important that we address differences in physical activity across the life course between men and women, and between groups of women, as this helps guard against bone density loss which lowers the risk of fractures and osteoporosis and can also reduce the rate of decline in mobility, strength, dexterity and cognition.

We provide free apps to promote physical activity such as Couch to 5K and Active 10.¹⁹⁰ There have been over 5 million downloads of the Couch to 5k app, and more women than men download these apps. The Sport England This Girl Can campaign has also inspired millions of women to take action, return to or increase their levels of physical activity.

Women will be a target group in a £3 million national 'reconditioning programme'.¹⁹¹ The programme has been established to support older people to build up strength and resume some of the activities they used to do before the COVID-19 pandemic.¹⁹² The programme will be trialled locally through local authorities and ICSs. This work will reduce falls and health and social care need among the older adult population and improve our understanding of which interventions are most effective.

The Health Promotion Taskforce has also been established to drive a cross-government effort to improve the nation's health. The taskforce will identify opportunities to take action across government to improve health and reduce health disparities.

¹⁸⁷ DLUHC, **Levelling Up the United Kingdom**, published February 2022

¹⁸⁸ NICE, **Polycystic ovary syndrome**, last revised February 2022

¹⁸⁹ NHS, **Breast cancer in women** » Causes, last reviewed October 2019

¹⁹⁰ NHS, **Better Health** » Get active

¹⁹¹ DHSC, **People at the Heart of Care: adult social care reform white paper**, published December 2021 and updated March 2022

¹⁹² PHE, **Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults**, published August 2021

Obesity

In 2019 67% of men and 62% of women were classed as overweight or obese. However, obesity (including morbid obesity) was more common in women (29%) than men (26%).¹⁹³

We are implementing initiatives to support people living with excess weight and obesity to lose weight and maintain healthier lifestyles. The adult weight management services grant invested £30.5 million to local authorities in England who accepted the grant, to provide additional behavioural weight management services in 2021 to 2022. The NHS Weight Loss Plan app¹⁹⁴ works to support users to start healthier eating habits, be more active and start losing weight, and tends to have more women users than men.

Smoking

In 2019, the government set the bold ambition for England to be Smokefree by 2030 – reducing smoking rates to 5% or less. On 9 June 2022, Dr Javed Khan OBE published his Independent Review on Smokefree 2030¹⁹⁵, providing the government with a wide range of recommendations for how we can achieve this ambition. The government will now carefully consider the recommendations set out in this review.

Smoking during pregnancy increases the risk of stillbirth, miscarriage and sudden infant death, while babies born to mothers who smoke are more likely to be born underdeveloped and in poor health. Smoking in pregnancy remains prevalent, as 9.6% of mothers were smokers at the time of delivery in 2020 to 2021.¹⁹⁶ While progress has been made, this figure masks significant disparities, with prevalence ranging from 1.8% in Kensington to 21.4% in Blackpool.¹⁹⁷ We are working closely with NHS England on the Long Term Plan commitment to embed stop-smoking services within maternity services.

Dementia

It is estimated that 65% of people living with dementia are women.¹⁹⁸ According to ONS data, in 2020 the leading cause of death for females in England was dementia and Alzheimer's disease.¹⁹⁹

It is important that we understand the risk factors for dementia. While there is no certain way to prevent all types of dementia, there is good evidence that a healthy lifestyle can help reduce the risk of developing dementia. It is also important that we consider the impact of sex, geography and ethnicity on dementia risk factors, diagnosis and research.

¹⁹³ NHS Digital, **Statistics on Obesity, Physical Activity and Diet, England**, published May 2020

¹⁹⁴ NHS, **Better Health** » Lose weight

¹⁹⁵ DHSC, **The Khan review Making smoking obsolete**, published June 2022

¹⁹⁶ NHS Digital, **Statistics on Women's Smoking Status at Time of Delivery: England Quarter 4, 2020-21**, published July 2021

¹⁹⁷ OHID **Local Tobacco Control Profiles**

¹⁹⁸ Alzheimer's Society, **Why is dementia different for women?** published September 2018

¹⁹⁹ ONS Nomis, **Mortality statistics** - underlying cause, sex and age, latest data released July 2021

Long term conditions

Prevention is not always possible, so early diagnosis and appropriate management of long-term conditions is key to ensuring good outcomes.

Musculoskeletal conditions

We are addressing both the prevalence and disparities in MSK conditions such as osteoarthritis, back pain, inflammatory arthritis and osteoporosis. MSK conditions are more common in women, affecting 35% of women and 28% of men,²⁰⁰ and prevalence is higher in areas experiencing higher levels of deprivation.²⁰¹

Supporting women to be active, maintain a healthy weight and to not smoke will help to keep muscles and bones healthy. Vitamin D is needed to keep muscles and bones healthy, and maintaining a good vitamin D status throughout life may help to reduce the risk of MSK conditions. We recently held a vitamin D call for evidence to seek views on how to improve the vitamin D status of the population in England and reduce disparities.²⁰²

NHS England is addressing health disparities for those with MSK conditions through the NHS Best MSK Health programme, including those related to sex. We are working with NHS England to improve access to high quality, integrated, sustainable, secondary fracture prevention services. These services help prevent fragility fractures through identifying, assessing and initiating treatment in those at increased risk. To help ensure that women at risk of fragility fracture receive appropriate care to help live healthier lives for longer, the Quality and Outcomes Framework (QOF) will continue to incentivise general practices to improve the quality care of care they provide to patients. This is done by requiring the GP to maintain a register of those with a confirmed diagnosis of osteoporosis and a fragility fracture in the age groups 50 to 75 and 75 and over.

NICE recently recommended the first new osteoporosis drug treatment of its kind for over a decade, romosozumab, which has been shown to be effective in preventing fractures in postmenopausal women with severe osteoporosis - those who had had a major osteoporotic fracture in the last 24 months.²⁰³ This is set to potentially benefit thousands of women.

Cardiovascular disease

We are working to reduce the incidence of cardiovascular disease (CVD), and to ensure women do not delay accessing care.

The NHS Long Term Plan sets out the ambition to prevent 150,000 heart attacks, strokes and cases of dementia. CVD is a condition which impacts both men and women but is not always perceived to be a condition that also affects women, and where there has

²⁰⁰ Venus Arthritis, **The State of Musculoskeletal Health**, published 2021

²⁰¹ NHS Digital, **Health Survey for England 2018: Longstanding Conditions**, published December 2019

²⁰² OHID, **Closed consultation Vitamin D: call for evidence**, updated May 2022

²⁰³ NICE, **Romsozumab for treating severe osteoporosis**, published May 2022

been less research on the sex differences on presentation, diagnosis and treatment. NHS campaigns such as 'Help Us Help You' target female audiences to ensure women do not delay accessing care.

The NHS Health Check is offered every 5 years to all people aged 40 to 74, who do not have a current diagnosis of CVD. The check aims to prevent heart disease, stroke, type 2 diabetes and some cases of dementia and kidney disease by assessing the top risk factors for these conditions. This information is used to raise awareness, encourage behavioural changes, and enable people to access clinical care that will help them to remain healthy.

The 2021 NHS Health Check Programme review found that the programme is achieving its objectives and that women are more likely than men to attend a check, but it could go further to improve its impact.²⁰⁴ We are implementing recommendations from the review and supporting local areas to recover this service, after it was largely suspended due to the COVID-19 pandemic.

In addition, the NHS community pharmacy blood pressure checks service introduced October 2021 creates wider access to blood pressure monitoring closer to home in an informal environment that some women may find easier to access.²⁰⁵

Diabetes

We want to better understand how diabetes affects men and women differently. While diabetes is more prevalent in men than women, there are specific risks during pregnancy, including pre-eclampsia and caesarean section in mothers, and congenital anomaly and neonatal intensive care admission in infants. To address this, NHS England is offering continuous glucose monitoring to pregnant women with type 1 diabetes.

Women with PCOS have an increased risk of developing metabolic syndrome which may lead to high cholesterol and/or type 2 diabetes. The NHS Diabetes Prevention Programme identifies people at risk of developing type 2 diabetes and refers them on to a 9-month evidence-based lifestyle change programme.²⁰⁶ The programme has also expanded its eligibility criteria so that women with a history of gestational diabetes, who are at a much higher likelihood of developing Type 2 diabetes, can access support.

Research and evidence

We recognise there is a gap in our systematic understanding of where there are disparities between men and women in general health conditions and disabilities that are not specific to women, for example MSK conditions or dementia, and how these interact with other demographic characteristics. Chapter 9 sets out our plans for addressing gaps in research and evidence.

We will also look for ways to encourage research into those areas identified through the call for evidence written submissions analysis as suggested areas for further research.

²⁰⁴ OHID, **NHS Health Check Programme review**, published November 2020, updated December 2021

²⁰⁵ NHSE **NHS Community Pharmacy Blood Pressure Check Service**

²⁰⁶ NHSE **NHS Diabetes Prevention Programme**

For healthy ageing and long-term conditions these areas included:

- women's lifelong health needs and risks, in childbearing years and as they age
- the efficacy of workplace adaptations that support women, with particular consideration for long-term conditions
- the causes and management of musculoskeletal conditions
- coronary heart disease in women
- the impact of menstruation and menopause on multiple sclerosis



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IMPLEMENTATION AND MONITORING PROGRESS

This strategy sets out our ambitions for improving the health and wellbeing of women and girls in England over the next 10 years, and the actions we are taking now.

Implementation

We are incredibly grateful for the support that we have received from a huge range of individuals and organisations during the call for evidence and the development of the vision and strategy. This same spirit of collaboration will be just as important throughout implementation.

The Department of Health and Social Care and our arm's-length bodies (ALBs), other government departments and agencies, commissioners and providers of health and care services, professional bodies, research institutions, employers, industry, the voluntary sector and every individual – including men and boys – all have a role to play in helping us realise our ambition to improve the health of women and girls in England.

For many areas, central government will not be the delivery body or may not be able to reach some groups of women and girls as effectively as others can. We are committed to working in partnership with others so that delivery happens at the right level and is led by the right organisations or people.

The Women's Health Ambassador and the deputy Women's Health Ambassador will lead engagement with women and other key stakeholders, including regional engagement with system leaders. This will begin to address gaps in insight from the call for evidence by hearing from healthcare professionals and groups of women whose voices were not as well-represented in the call for evidence. This will also help us to identify where we can work collaboratively with stakeholders such as the voluntary sector, industry and others, to deliver the ambitions and actions set out in the strategy.

We will continue to engage over the life of the strategy to ensure that our policy development and programmes of work remain informed by insight from women's experiences.

We will also continue to use the findings from the call for evidence to inform current and future work through the strategy to improve women's health and reduce disparities.

Monitoring progress

To ensure we can monitor the effectiveness of this work, we will develop a delivery plan for the commitments set out in this strategy.

The delivery plan will be underpinned by an implementation framework.

The implementation framework will set out our:



This framework will enable us to:

- check activities are being implemented as intended, and understand how delivery has worked in reality
- check that key metrics are heading in the right direction
- encourage consistency across data collected by local partners, to feed into an overarching picture of the progress being made
- identify data gaps that have the potential to be filled by improving existing data sources, or commissioning new research

To support work to develop this framework and our delivery plan we will first undertake a data mapping exercise to identify what data we collect that can be used to monitor success and where there are gaps.

Governance

The implementation of this strategy will be overseen by a cross-government delivery board reporting to Department of Health and Social Care Ministers.

Reporting on progress

Much of the change we want to see will take place over the long term and may also be subject to new funding opportunities. We also need the Women's Health Ambassador to have enough time to reach the many groups of women and girls and other key stakeholders to understand their issues and to develop partnerships to deliver change. Equally, we also want to maintain momentum. The government will therefore aim to publish a report on progress in delivering our commitments and the outcomes achieved in 3 years.

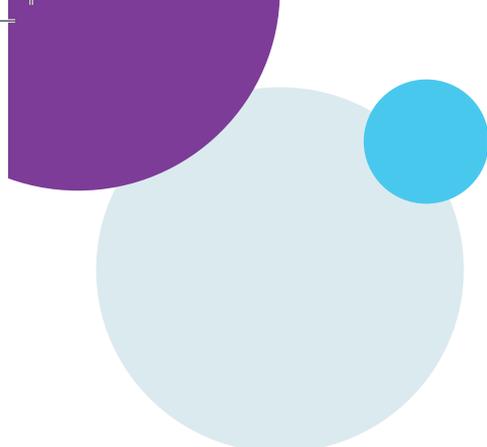
Longer-term plans

The specific actions that we commit to in this document represent significant progress and lay the foundations for sustained improvements in the health of women and girls. In many cases they will take time to show progress and will not in themselves deliver all of our ambitions. Our intention is therefore for the strategy to not just be a moment in time. We have made our ambitions long-term in nature and would like to see them delivered over the course of the next decade. This will require investment and concerted action over the life of the 10-year strategy.

In other areas we need to first work to fill gaps in the evidence, for example, improving our understanding of where there are the greatest disparities between men and women for general health conditions, so that we can target future action to where it will have the most impact.

Through the engagement led by the Women's Health Ambassador, we may also identify additional priority areas for action.

We will therefore continue to invest in new programmes of work to improve women's health throughout the life of the strategy as new funding opportunities arise. This will enable us to build on the actions that we have set out in this document.



GLOSSARY

This glossary contains a brief definition of key terms and acronyms referenced in the strategy, including medical conditions and treatments, which some readers may be less familiar with. The definitions are correct at time of publication.

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.	North Bristol NHS Trust
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
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
Breast cancer	Breast cancer is the most common type of cancer in the UK. Most women diagnosed with breast cancer are over the age of 50, but younger women can also get breast cancer.	NHS

Term	Definition	Source
Cervical screening	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
Dementia	Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of brain functioning. There are many different causes of dementia, and many different types.	NHS
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
Eating disorders	An eating disorder is a mental health condition where one uses the control of food to cope with feelings and other situations. The most common eating disorders are: anorexia nervosa, bulimia, and binge eating disorder (BED).	NHS

Term	Definition	Source
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.	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 people over 60.	NHS
FemTech	Female technology (FemTech) refers to electronic devices, software, or other technology relating to women's health, for example software that records information about menstruation and fertility.	Cambridge Dictionary
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 periods.	NHS
Female genital mutilation (FGM)	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. 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
General practitioner (GP)	GPs treat all common medical conditions and refer patients to hospitals 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.	NHS health careers

Term	Definition	Source
Gynaecological cancers	Cancers that start in a woman's reproductive system are called gynaecological cancers. There are 5 gynaecological cancers: cervical, ovarian, womb, vaginal and vulval cancers.	Cancer Research UK
Gynaecology	Gynaecology is concerned with the wellbeing 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
HealthTech	Health technology (HealthTech) is a generic term for any intervention that can be used to promote health and prevent, diagnose or treat disease for rehabilitation or long-term care. The term encompasses drugs, devices, clinical procedures and healthcare settings.	Segen's Medical Dictionary
Hormone replacement therapy (HRT)	HRT is a treatment to relieve symptoms of the menopause. It typically contains the hormones oestrogen and progestogen which are 2 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
Human papillomavirus (HPV)	HPV is the name of a very common group of viruses. They do not cause any problems in most people, but some types can cause genital warts or cancer.	NHS
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

Term	Definition	Source
Hymenoplasty	Hymenoplasty is a surgical intervention that involves reconstructing the hymen. It is usually performed with the aim of ensuring the women bleeds when she next has sexual intercourse. Hymenoplasty is a harmful practice which stem from dangerous misconceptions about a woman's sexuality and was banned in the UK through the Health and Care Act 2022.	GOV.UK and legislation.gov.uk
Hysteroscopy	A hysteroscopy is a procedure used to examine the inside of the womb (uterus). It's carried out using a hysteroscope, which is a narrow telescope with a light and camera at the end. It can be used to investigate symptoms or problems, diagnose conditions and treat conditions or problems.	NHS
Intrauterine device (IUD)	The 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 to 10 years.	NHS
Intrauterine system (IUS)	The 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 to 5 years, depending on the brand.	NHS
In vitro fertilisation (IVF)	IVF is one of several techniques available 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.	NHS

Term	Definition	Source
Irritable bowel syndrome (IBS)	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
Long term condition	Long term conditions, or chronic conditions, are conditions for which there is currently no cure, and which are managed with drugs and other treatment. These include conditions such as cardiovascular disease, diabetes, arthritis and osteoporosis.	The King's Fund
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 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.	NHS
Menstruation	See definition for periods.	-
Medicines & Healthcare products Regulatory Agency (MHRA)	MHRA is an executive agency, sponsored by the Department of Health and Social Care. It regulates medicines, medical devices and blood components for transfusion in the UK.	GOV.UK
Miscarriage	A miscarriage is the loss of a pregnancy during the first 23 weeks.	NHS

Term	Definition	Source
Musculoskeletal (MSK) conditions	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
National Institute for Health and Care Excellence (NICE)	NICE's role is to improve outcomes for people using the NHS and other public health and social care services.	NICE
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
Obesity	The term obese describes a person who's very overweight, with a lot of body fat. It's a common problem in the UK that's estimated to affect around 1 in every 4 adults. It's very important to take steps to tackle obesity because, as well as causing obvious physical changes, it can lead to a number of serious and potentially life-threatening conditions.	NHS
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

Term	Definition	Source
Perimenopause	Perimenopause is when you have symptoms before your periods have stopped. You reach menopause when you have not had a period for 12 months.	NHS
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
Polycystic Ovary Syndrome (PCOS)	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 2 out of the 3 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	NHS
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 can start any time in the first year after giving birth.	NHS
Premature Ovarian Insufficiency (POI)	POI occurs in women under the age of 40, when their ovaries no longer produce normal amounts of oestrogen and therefore may not produce eggs. This means that their periods stop (or become irregular) and they may experience symptoms of the menopause.	Patient

Term	Definition	Source
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, wellbeing and quality of life. It is a state of physical, emotional, mental and social wellbeing in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity.	World Health Organization
Stroke	A stroke is a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off. Strokes are a medical emergency and urgent treatment is essential.	NHS
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 College of Nursing
Virginity testing	Virginity testing is the examination of the female genitalia, with or without consent, for the purpose, or purported purpose, of determining virginity. Virginity testing is a harmful practice which stem from dangerous misconceptions about a woman’s sexuality and was banned in the UK through the Health and Care Act 2022.	GOV.UK and legislation.gov.uk

