



Royal College of
Obstetricians &
Gynaecologists

Better for women

Improving the health and wellbeing of girls and women

December 2019



Within this document we use the terms *woman* and *women's health*. However, it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.



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Foreword

Why do we need a national women's health strategy?

During the last 50 years women's role in UK society has changed significantly. Women number 51% of the population, and account for 47% of the workforce, yet still undertake the majority of unpaid caring roles and influence the health behaviors of their families and the rest of society.

My generation of doctors were mostly trained to work in a disease intervention service. We learnt how to recognise signs and symptoms which led to the diagnosis of a problem which we then tried to treat. We told our patients what to do and for the most part they followed our advice.

As a trainee, the diverse challenges of bringing new life into this world, helping women to resolve menstrual period or fertility problems, overcome the trauma of stillbirth or recurrent miscarriages and access safe abortion, attracted me to the specialty of obstetrics and gynaecology. I was fascinated by the choices which my patients were faced with and wanted to help them achieve the best possible outcomes.

Later I gained a wider perspective: that women's health extends far beyond reproduction and that I had an opportunity that no other medical specialty is offered. To provide advice and care for girls and women across their life course that helps them to remain healthy and not just to intervene when they experience problems. I learnt that the health and wellbeing of the woman sitting in front of me in the clinic, was determined largely by her ability to access information and make decisions about her own health. And that when she is empowered to make her own choices she becomes a willing partner in achieving better outcomes for herself and her family. In short, she becomes part of the solution.

Since the publication of Better Births in 2015 we have made significant progress in improving maternity outcomes in the UK. We must maintain our efforts and be determined to reach the ambitious targets we have set for ourselves. But there is so much more to women's health than becoming pregnant and delivering a healthy baby.

There is a whole life course to consider. The 21st century has brought us the largest generation of adolescent girls in history and educating them to optimise their health is key. My own generation of women are likely to live

for longer in the post reproductive era than they spent in their reproductive phase. Their expectation is to have quality of life as well as longevity. They are looking to us to help them achieve this.

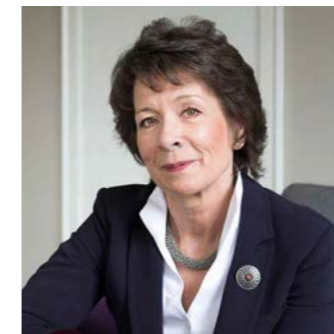
The importance of partnering with women and helping them to make good choices is at the very heart of this proposal. We simply cannot afford to waste such an important contribution and must seize each and every opportunity to support girls and women to live healthy lives and encourage them to become advocates and ambassadors for each other and avoid poor health outcomes wherever possible.

Designing our healthcare services around the needs of women is imperative to ensure that no one is left behind or falls through the cracks. Currently, health and social inequalities in our society are rife and are contributing to the UK's high unplanned pregnancy rate, poor maternal outcomes and high obesity rates, to name just a few. To combat this, everyone – including the UK Governments, the NHS, Royal Colleges, local authorities, women and many other stakeholders – must engage and contribute to this vital goal.

The United Nation's Sustainable Development Goal 5 is to 'achieve gender equality and empower all girls and women by 2030'. The clock is ticking and there is no time to waste. I believe that this report can play a part in achieving this important goal. Evidence shows that healthy women are the cornerstone of healthy societies.¹ As Dr Flavia Bustreo, former Assistant Director-General at the World Health Organisation said: "The right to health is a human right and the health of a nation is determined by the health of its girls and women".

These are some of the many reasons why we must ensure that women's health secures a place at the top of the healthcare and wider political agenda.

When we get it right for girls and women, everyone benefits.



A handwritten signature in black ink that reads "Lesley Regan".

Professor Lesley Regan
President RCOG

¹ World Bank Blogs, Healthy women are the cornerstone of healthy societies (2017)



**Executive summary
and recommendations**

Executive summary and recommendations

A strategic approach is required across the life course to prevent predictable morbidity and mortality and to address the determinants of health specific to women's health.

Primary aim – the creation of NHS-led Women's Health Strategies

Recommendation 1: We are calling for the creation of national strategies for women's health based on a life course approach to address the following areas of unmet need:

- Access to reliable information on women's health
- Easy access to contraception, abortion and fertility services
- Learning from indicators in the reproductive years to influence future health
- Violence against girls and women
- Prevention and early diagnoses of gynaecological cancers across the life course
- Keeping women in the workforce

These will steer the UK away from providing a disease intervention service towards a preventative health service which addresses the determinants of health as well as major causes of morbidity and mortality.

The aim is to ensure that women's health and wellbeing — not just their reproductive health during pregnancy — become priorities throughout their lives. Chapter one outlines this life course approach.

We want this document to underpin the creation of Women's Health Strategies across the UK.

NHS England (NHSE), NHS Wales, NHS Scotland and Health and Social Care Northern Ireland should each be responsible for the creation of a Women's Health Strategy, with the overarching aim of improving the health outcomes of all girls and women. The RCOG will work with the NHS and other stakeholders to develop and realise this ambition.



Access to reliable information on women's health

Recommendation 2: Young people should be educated from an early age about women's health.

- Age-appropriate sex education should be mandatory in all schools for all girls and boys.
- We welcome the new UK Relationships and Sex Education (RSE) and health curriculums which will cover menstrual health, contraception, healthy relationships including Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ+), violence against women, female genital mutilation (FGM), the importance of good diet, physical activity and the impact of smoking and alcohol, all of which are crucial to women's health.
- To deliver this effectively, government education departments across the UK must provide consistent Relationships and Sex Education training for teachers. This needs to include giving teachers the tools that they need to feel confident using anatomically correct terms for female body parts. Government education departments must collaborate with medical colleges to collate and disseminate accurate, accredited sources of information on girls' and women's health to teachers across the country.
- The Office for Standards in Education, Children's Services and Skills (Ofsted) should evaluate the quality of the content and delivery of Relationships Education and RSE in primary and secondary schools. This should be regularly evaluated, to enable consistent improvement. Ofsted also need to publish data on the number of children currently being withdrawn from this education. This should include analysis of the reasons behind the withdrawals and plans for increasing the numbers of children taking part.
- There should be greater investment in school nurses to enable them to provide vital education and support to young people.

Recommendation 3: To reduce health inequalities, all women should have access to and be provided with the information that they need to stay healthy.

- The Government Equalities Office should work with public health bodies across the UK and charities specialising in women's health to create a strategy to improve the dissemination of information to all girls and women especially those with protected characteristics, from disadvantaged backgrounds, marginalised communities, those with disabilities, visual impairments or language barriers or those living in institutionalised settings.
- The UK Governments should collect and monitor data on patients' sexual orientation and gender identity to identify inequalities in LGBTQ+ patient experience and outcomes and develop targeted services and initiatives to address these.¹
- The RCOG's Gynaecology and Maternity Standards, which set out frameworks for commissioners and service providers of high-level service standards that aim to improve outcomes and reduce variation in care, should be enacted in all settings to ensure that women receive the best possible care wherever they are.

Capitalising on the excellent NHS UK website, we need to strive for world-leading health information delivered to women through different ways that is easily accessible wherever they are as part of our health service.

Recommendation 4: The NHS website should become the world's best source of information for girls, women and clinicians.

- NHS Digital should work with Royal Colleges and charities specialising in women's health to ensure that the NHS UK website link to all of the relevant support networks and tools available for girls and women. This information is accredited, trusted, co-produced with girls and women and developed in line with National Institute for Health and Care Excellence (NICE) guidelines. It would come at no added cost to stretched NHS budgets.
- NHS UK should consolidate information on women's health for clinicians. This will provide evidence-based guidance to enable easier diagnosis or referral, and direct clinicians to NICE and other guidelines and appropriate support networks for patients. All healthcare professionals should be sign-posted to this resource.

Easy access to contraception, abortion and fertility services

Pregnancy should occur if and when women want to be pregnant.

Recommendation 5: Accessing the full range of contraception methods should be as easy as possible for all women.

- Missed opportunities and barriers to women accessing contraception, in particular long-acting reversible contraception (LARC), and contraceptive advice and counselling need to be addressed. The RCOG supports Public Health England's (PHE) planned efforts to increase uptake of LARC in general practice as part of its action plan on women's reproductive health (due to be published in 2020). Furthermore, we support calls from the Faculty of Sexual and Reproductive Healthcare (FSRH) for funded training on contraception and the introduction of incentives to provide LARC in general practice.

The NHS should provide family planning information and services including LARC to the 680,000 women delivering their babies in the NHS every year before they leave the place of delivery.

Recommendation 6: Post-pregnancy contraception should be a key part of the maternity pathway.

- NHS England, NHS Scotland, NHS Wales and Health and Social Care Northern Ireland must embed immediate post-pregnancy contraception maternity pathways and support for all women. Until 100% implementation has been achieved, clear referral pathways into general practice or sexual and reproductive healthcare clinics should be provided. All midwives and allied professions should be trained to provide this important aspect of this holistic maternity pathway and reproductive care.

Recommendation 7: Make access to progestogen-only (POP) contraceptives and emergency hormonal contraception (EHC) as easy as possible for all women.

- Given the long safety track-record for the progestogen-only oral contraceptive pill (POP), the Medicines and Healthcare Products Regulatory Agency (MHRA) should reclassify POP from 'prescription-only' to 'pharmacy product'. Girls and women should also be able to order them online.
- The MHRA should ensure that oral EHC is reclassified to the General Sales List to enable it to be sold straight off the shelf without consultation. It should be made available, free of charge, over the counter throughout the UK. The RCOG supports FSRH calls for individuals, including under-18s, to have full access to free emergency contraception at time and place of need.

The fragmentation of sexual and reproductive services is a barrier to better women's health and requires systems leadership.

Recommendation 8: Introduce mandated co-commissioning of SRH services across the UK.

- NHSE and local authorities must deliver a joined up approach to commissioning to end the fragmentation of services and to ensure that women can get their sexual and reproductive health care needs met in one place, as acknowledged in the Government's response to the Health and Social Care Committee's report on sexual health (published October 2019). This includes the whole range of SRH services, such as contraception, cervical cancer screening, and treatment and advice about the menopause. This would be cost-effective for the NHS in the long-term whilst providing girls and women with high-quality and efficient health care. The RCOG is committed to working with local authorities in England, NHS England and Clinical Commissioning Groups (CCGs) to make joined up commissioning a reality. Integrated, holistic commissioning of SRH services is supported by FSRH, the Royal College of General Practitioners (RCGP), the Royal College of Pathologists and the Academy of Medical Royal Colleges.

Funding for SRH has been reduced and is subject to further cuts when local authorities are forced to rationalise their budgets.

Recommendation 9: Increase public health and sexual health budgets in real terms.

- The UK Government must ensure that there is a real terms increase in public health budgets and each of the devolved Governments must ring-fence funding for SRH services. Resources need to be prioritised to the locations and services that require the most investment. This includes services which provide contraception and gynaecological cancer screening services.

Access to women's health services in community settings should be evaluated as part of the NHS Long Term Plan's integrated care services (ICS).

Recommendation 10: Women's health one-stop clinics should be established in local community hubs and training on women's health should be delivered to support primary and community care.

- NHSE must implement and fund one-stop women's health clinics into Integrated Care Systems (ICS) in England. Where possible, clinics should be made available at weekends and out-of-hours. This will ensure a more joined-up approach to women's health, diminish unnecessarily long referral times and ensure that women receive the best possible care by providing all of their healthcare needs in one location and at one time. This approach will require NHSE to work with Health Education England (HEE) and local providers to ensure that the right workforce is available at the right time in the right place. A similar approach should be adopted in Wales, Scotland and Northern Ireland as part of their integration plans.
- HEE should ensure that education and training to support better care of women is prioritised in the delivery of primary and community training hubs for both GP training and the wider primary care workforce. This training resource should be placed within all local ICS structures and tailored to suit the health needs of the local population. Health Education Improvement Wales, NHS Education for Scotland and the Northern Ireland Medical and Dental Training Agency should also ensure that primary care clinicians have robust training in women's health.

Recommendation 11: All women should be able to access abortion care easily and without fear of penalties or harassment.

- The General Medical Council (GMC) should review the Undergraduate medical curriculum to include the importance of abortion care to students. The RCOG will teach abortion skills as a part of its core curriculum and assess those skills through examination.
- The Department of Health and Social Care (DHSC) must review and expand the definition of "home" under the Abortion Act 1967. The DHSC should also consider allowing women to take mifepristone, the first drug used to effect early medical abortion, at home.

- Independent Sector Providers and NHS England, NHS Scotland, NHS Wales and the Health and Social Care Board must work together to secure indemnity cover for healthcare professionals across sectors. This will allow an open door between the independent sector and the NHS, allowing greater opportunities for training in these essential skills.
- CCGs must commission abortion care services which implement, or are seeking to implement the recommendations of the 2019 NICE guidance on abortion care. This will ensure women have a choice of procedure and guarantee quick access to services.
- NHS England specialised services must continue their work to introduce regional centres where access to abortion care for women with complex co-morbidities is available.
- The UK and devolved governments must legislate to introduce access zones around abortion care providers.
- The RCOG must continue to work with partner organisations to advocate for the decriminalisation of abortion up to 24 weeks across the UK.

For those couples who have difficulty conceiving, access to fertility services is patchy and there is variation in the treatments provided.

Recommendation 12: End postcode lotteries in IVF treatment and offer all eligible women three full cycles of IVF.

- CCGs must follow the NICE Guidelines on Fertility that cover diagnosing and treating fertility problems. This will lead to a reduction in variation in practice and improve the way fertility problems are investigated and managed. This will help to remove the current variation in IVF funding around the country and end postcode lotteries.

- England, Wales and Northern Ireland must offer women the same opportunities for IVF treatment as in Scotland and follow the NICE Fertility Guideline which recommends that women under 40, who have been trying to get pregnant for two years, should be offered three full cycles of IVF. CCGs, NHS Wales and Northern Ireland's Health and Social Care Board must commission fertility services in order to ensure that all women have access to appropriate fertility treatment and care.

Learning from indicators in the reproductive years to influence future health

Recommendation 13: Introduce a life course approach to preventing non-communicable disease in women and their children supported by data collection before, during and after pregnancy.

- The data collected during pregnancy should be used more effectively to help identify indicators for future health. Data regarding women's general health and lifestyle habits including whether they smoke, how much they drink, their body mass index (BMI) and mental health concerns should be collected and monitored throughout the pregnancy and beyond. All health data collected should be made accessible for the woman as well as clinicians and should be updated by both parties regularly.
- Maternity and sexual and reproductive health data can be integrated by the inclusion of outcomes such as the London Measure of Unplanned Pregnancy in the antenatal booking history which can be used to monitor the effectiveness of pre-conception and family planning services and identify areas for action.
- The RCOG supports the work of the Maternity Transformation Programme towards interoperable, digitised maternity records, accessible by healthcare professionals and women alike. This programme of digitisation will help realise our ambition for more effective use of data collected during pregnancy, to help identify and prevent the future onset of disease. For example, GPs would be able to access maternity records at the time of the six week maternal health check

and beyond, to enable discussion with women about the potential future impact of any health problems they experienced during pregnancy. Women would be much more aware of their own health risks and therefore better able to manage their own health and raise any concerns with healthcare professionals in the future.

Recommendation 14: UK Governments should take strong action to improve the health of pregnant women and their babies.

- The introduction of mandatory fortification of all flour and gluten-free products with folic acid would reach women most at risk in our society who have poor diet and low socioeconomic status, as well as those women who may not have planned their pregnancy.
- We support the UK Government's Green Paper's smoke-free by 2030 ambition. This can be achieved by following the recommendations of the Smoking in Pregnancy Challenge Group led by Action on Smoking and Health (2018 Report).
- Pre-conception public health should be prioritised to improve the health of women planning pregnancy. Women should be offered advice on body weight and lifestyle in primary care, such as during pre-conception counselling and appointments about contraception. A structured weight-loss programme and a referral to a dietician or an appropriately trained healthcare professional may be recommended where appropriate. This should be delivered by Primary Care Networks in England, included in Scotland's Health Promoting Health Services, placed into the Welsh Government's 'Healthier Wales' plans and considered by Northern Ireland's Transformation Advisory Board. Attention to pre-conception optimisation of pre-existing medical conditions is essential to complement this approach and will help to reduce the number of maternal deaths.

At present, women leave their place of birth and re-enter primary care with sub-optimal data transfer between services. The postnatal GP check is an important milestone at which to optimise future health but at present due to time pressure and variable training this is not capitalised on.

Recommendation 15: Improve identification of women at risk from mental and physical health issues at the six week postnatal check.

- The RCOG welcomed the UK Government's recent focus on perinatal mental health. We must ensure that opportunities are not missed to prevent physical and mental problems in preparation for future pregnancies or to improve her health for later life. The RCOG supports the NCT's Hidden Half campaign that calls for improved guidance, tools and education for healthcare professionals in primary care on best practice around maternal mental health. There also needs to be a better joined up approach to data sharing about known vulnerable women between primary and secondary care services. All clinicians should be made aware of local support groups for these patients to make redirection as seamless as possible.

Women at risk of future cardiovascular disease can be identified from pregnancy complications such as hypertension in pregnancy. However, evidence has emerged that women's cardiovascular disease and in particular myocardial infarction is underdiagnosed causing excess mortality.

Recommendation 16: End the data gender gap.

- There must be renewed effort to tackle the gender data gap by funding more studies which focus on women's health and responses to treatment to eliminate the gender bias evident in diagnosis, treatment and medical research.

Violence against women

Violence against women is a determinant of women's health and has a significant impact on physical and mental health. It is hoped that Relationships and Sexual Education in schools will start to change our culture for good. The RCOG proposes collaborative action with the UK's largest employer, the NHS.

Recommendation 17: End violence against girls and women via an improved collaborative approach, better IT systems and mandatory training with the NHS as an exemplar.

- NHS Trusts and Health Boards must implement mandatory training in gender based violence. This training should be undertaken every three years and apply to all hospital staff.
- The RCOG encourages NHS Trusts and Health Boards to adopt innovative and sensitive ways to ensure that women can indicate in confidence that they are a victim or at risk and can get support easily. Any interventions that prevent women from reaching crisis point should be welcomed to ensure that every woman gets the support that they need.
- NHS Digital and NHS Wales Informatics Service should work with clinicians to improve IT systems used to record and submit cases of female genital mutilation (FGM) in England and Wales. It must be as easy as possible for healthcare professionals to use, so that all cases and girls at risk are documented and safeguarded. Mandatory reporting of FGM must extend to Northern Ireland and Scotland's Female Genital Mutilation (Protection and Guidance) Bill (introduced in May 2019) must be revised to include mandatory reporting of FGM to the police as is the case in England and Wales.

Prevention of mortality from gynaecological cancers across the life course

The cervical screening program has reduced mortality, however there is room for improvement.

Recommendation 18: Increase uptake in cervical screening amongst disadvantaged and marginalised women.

- Every person with a cervix needs to be screened. Health care professionals should use every opportunity to encourage women to undergo cervical screening and reassure them about the benefits of screening and the realities of the procedure. In turn, this will help to increase rates of attendance.
- PHE, Health Protection Scotland, Public Health Wales and the Public Health Agency (Northern Ireland) must improve the uptake of cervical screening among LGBTQ+ people. This could include raising awareness around the causes of cervical cancer.
- Human papillomavirus (HPV) primary home-test screening should be implemented by the respective UK Government administrations without delay.

Recommendation 19: Increase uptake in cervical screening by ending fragmentation and harnessing technologies.

- The UK Government should implement the recommendations of Sir Mike Richard's report on screening programmes in England without delay. The devolved Governments must also take note of the recommendations in the report.

- This includes the proposal to make NHS England responsible for oversight of cancer screening programmes, removing the existing fragmented governance arrangements, and creating a new national director for screening. In addition to this, it will be vital that the new director for screening works closely with the national clinical director for maternity and women's health to ensure a joined-up approach to women's health.
- Given the current backlog of cytology samples awaiting analysis, the director for screening must work with HEE to closely monitor the recruitment and retention of the cytology workforce and ensure a system-wide response to workforce demand issues within screening services.
- The ongoing work of NHSX (a cross-governmental unit to drive digital transformation of the NHS and social care) on developing a new IT system for the cervical screening programme must be given the highest priority. This will mean that patient data can be shared quickly and efficiently between services across the country and will help to mitigate health inequalities and increase uptake amongst all women. Systems should also be able to communicate with women quickly and easily via texts, internet and emails to further increase uptake.
- The UK Government, alongside the future director of screening, must prioritise securing extra funding for screening programmes. It is clear that the screening service needs greater investment to ensure it can manage any welcome increase in demand, provide results within agreed timescales and utilise the best possible technology.

Recommendation 20: Improve early diagnosis and treatment of gynaecological cancers.

- The UK Government must fund an ongoing ovarian cancer audit to continue to build understanding and substantially improve survival rates. Healthcare Quality Improvement Partnership (HQIP) could lead this UK-wide project, building on the expertise and knowledge of the Ovarian Cancer Audit Feasibility Pilot.
- PHE, Health Protection Scotland, Public Health Wales and The Public Health Agency (Northern Ireland) must prioritise campaigns targeting the public and healthcare professionals in primary care to increase awareness of gynaecological cancer symptoms including postmenopausal bleeding (PMB). All women who present with PMB must be referred for further investigation.

Keeping women in the workforce

As 51% of the population, women are vital to the UK's workforce and productivity. However, despite welcome measures such as shared parental leave, many aspects of health service delivery see women's ability to stay in the workforce negatively impacted.

Recommendation 21: Women's health issues should be embedded in workplace policies.

- The challenges of common debilitating women's health issues – heavy menstrual bleeding, pelvic pain due to fibroids or endometriosis and the menopause – should be recognised in workplace policy and processes.
- For example, the UK Governments should introduce a requirement for mandatory menopause workplace policies to help keep women in work and to break the stigma associated with menopause. These policies should detail the reasonable measures that should be available for women experiencing symptoms, including flexible working patterns and workplace adjustments to make the physical office environment more comfortable. HR departments should offer training and support to line managers. All workplaces should have guidance about the menopause readily available if women request it – the signs and symptoms, self-help advice for women, and where to seek professional help. As one of the world's largest employers, the NHS should create robust policies and set an example for all employers to follow.
- There have already been several cases where women have been successful at employment tribunals related to the menopause, arguing discrimination under the Equality Act 2010. By implementing comprehensive menopause policies employers can both enhance the working lives of women and reduce their risk of legal challenges.

Access to primary care is difficult in many areas for men and women, reducing access to the advice and treatment needed to stay healthy and active.

Recommendation 22: Appointment times at GP services should increase to 15 minutes.

- The RCOG supports RCGP's calls for 15 minute appointments as standard in general practice, with longer for those patients with complex health needs.¹ Too many women are spending years in pain and discomfort because appointment times are too short and demands on the time of doctors and other healthcare professionals are too great. This makes women less likely to talk about their issues. It is also not cost-effective as women often require multiple appointments before diagnosis and treatment.

Pelvic floor dysfunction affects large numbers of women. Five million women in the UK are estimated to suffer from urinary incontinence with other forms of pelvic floor dysfunction causing faecal incontinence and sexual dysfunction. These all affect women's quality of life and ability to stay in work.

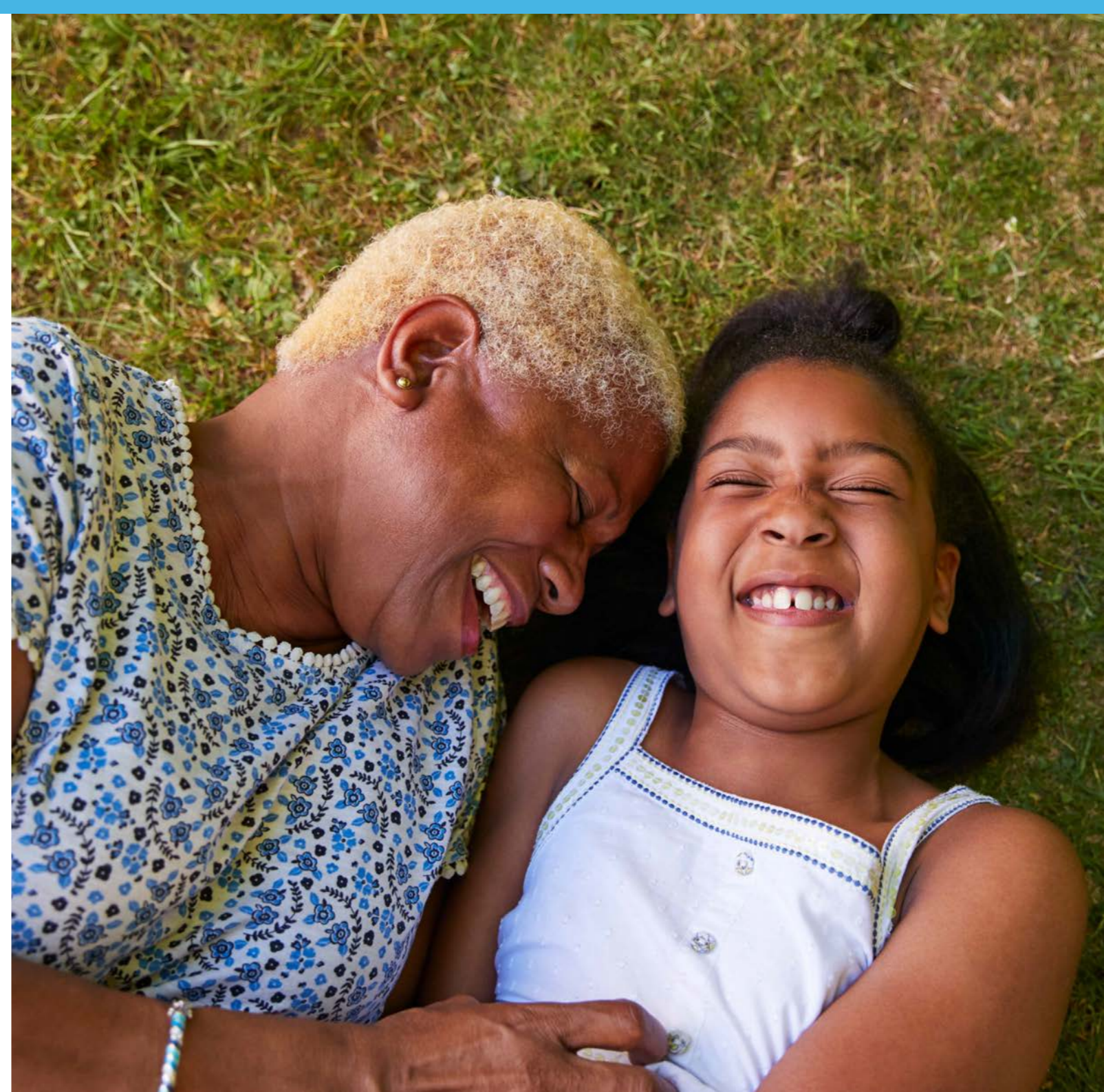
Recommendation 23: Increase awareness of pelvic floor dysfunction.

- Public Health England, and respective devolved nation bodies, should create a Taskforce to consider ways of raising awareness of urinary and faecal incontinence and prolapse in women, and improving signposting to resources, self-help information and treatment pathways which alleviate these conditions.

References

¹ Stonewall, LGBT in Britain Health Report (2018)

² RCGP, Fit for the Future: a Vision for General Practice (2019)



A photograph of a woman with long, wavy hair hugging a young child from behind. They are both smiling and appear to be on a beach. The image is overlaid with a semi-transparent teal gradient. The text "A life course approach" is written in white, bold, sans-serif font on the right side of the image.

**A life course
approach**

A life course approach

During every woman's life, there are opportunities to help her improve her physical and mental health and wellbeing. Women have predictable long-term reproductive healthcare needs and more frequent interactions with health services than men.

While women number 51% of the population they represent a much higher proportion of the primary carers in society and exert a strong influence on the health behaviors of their families and local communities.

Adopting a life course approach provides an insight into the impact of the many biological, behavioral and social determinants of health and wellbeing. Not only do events occurring at each stage of an individual woman's life have an impact on the quality of the next stage, but there is clear evidence of a strong intergenerational transmission of both good and bad health behaviours and outcomes.

Most importantly, a life course perspective offers us the potential for early intervention to reduce the risk of certain diseases from developing.

In contrast to sporadic disease episodes, women have reproductive and sexual health needs that unfold across their life course. The vast majority of women want to enjoy healthy sexual relationships and have control of their fertility in order to decide if, when and how often they want to become pregnant. This requires timely and accurate sexual health education and access to effective contraception.

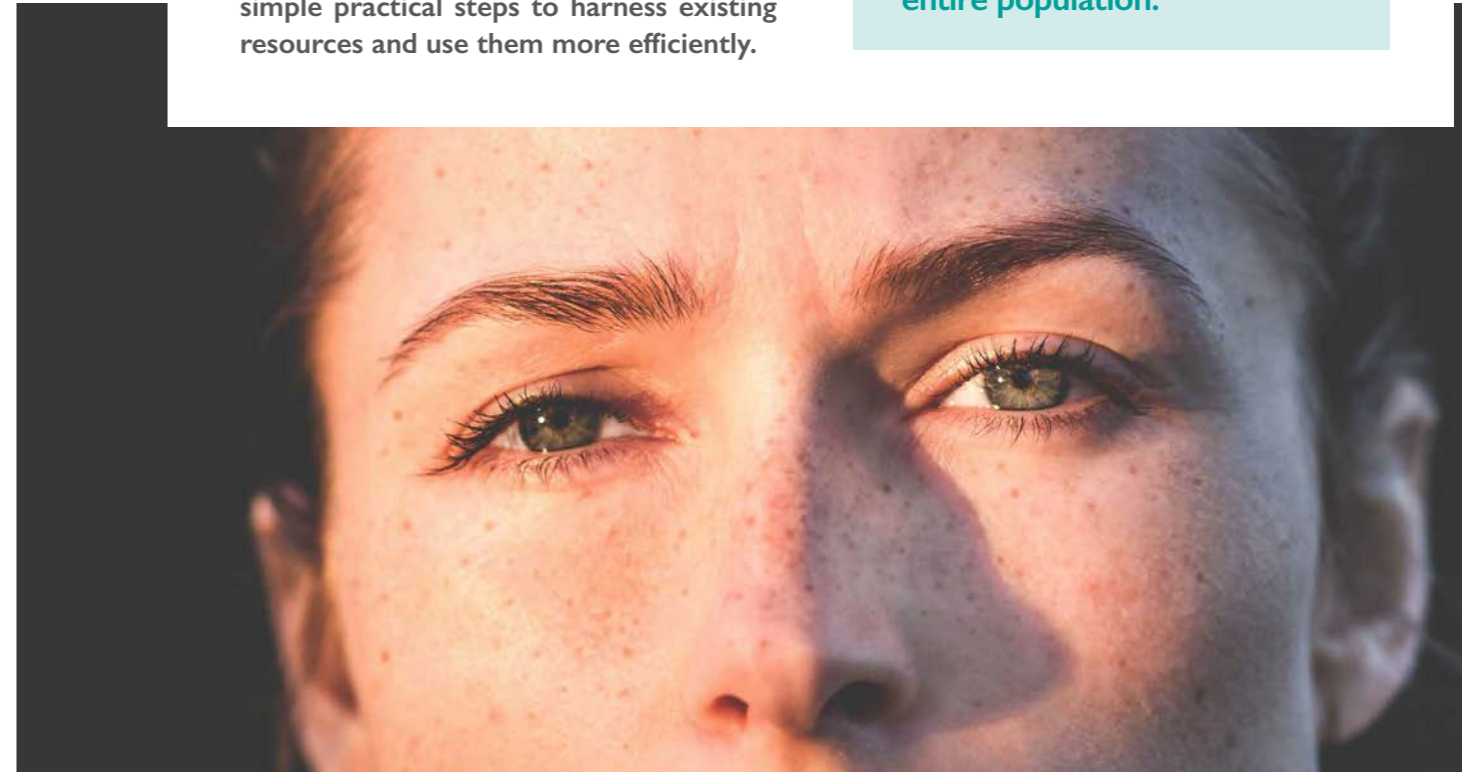
The trend towards earlier sexual activity and deferred childbearing means that most women in the UK now require reliable reversible contraception for up to three decades. We know that the physiological demands of pregnancy can be viewed as an early stress test. For many women pregnancy can identify an increase in their risk of future chronic diseases such as diabetes, heart disease and mental health problems. A growing number of older women are now seeking assisted conception as their fertility declines with age and nearly one in five women

will remain childless, either through choice or circumstance. There is an inevitability that women will become menopausal and require help with chronic disease management and the onset of frailty in their later years.

We need to use this wealth of knowledge and data collected throughout women's lives by healthcare professionals to develop improved services for women that avoid wasted resources and deliver better outcomes. This is neither rocket science nor blue-sky aspiration.

It can be achieved by placing women and their predictable needs at the centre of our service planning and taking some simple practical steps to harness existing resources and use them more efficiently.

Good healthcare for women as they age requires a level of service integration but the payback to the NHS is potentially enormous. Not only by dealing with entirely predictable issues in a timely and cost effective manner, but by exploiting the opportunities these routine encounters provide to pass on effective public health information and amplify these messages to the entire population.



It is important to acknowledge the progress that is being made in improving pregnancy outcomes. Political leaders, policy makers, clinicians and other stakeholders have shown a commitment and determination to improve standards in maternity care and safety across the UK. However, there is so much more involved in improving women's health and wellbeing

than focussing exclusively on the pregnant woman and her baby. Indeed, sustainable improvements in maternity care will never be achieved until we recognise, tackle and resolve all of the determinants of health and wellbeing throughout women's lives and place girls and women at the centre of our health systems.

There are three key stages in a woman's life course: adolescents and young adults, the middle and reproductive years and the later years. However, we recognise that many issues in women's health may be present in several life stages, such as those related to menstruation, control of fertility and mental health.



Adolescents and young adults

Puberty to 25 years: This is a crucial stage in the female life course with the onset of menstruation, sexual activity and fertility. High quality relationship and sex education (RSE) delivered at school and endorsed by parents about what to expect, how to deal with problems that may develop and how they can be resolved is key. Preventive health strategies such as HPV vaccination and chlamydia screening not only avoid diseases in later life but additionally offer the opportunity to discuss pre-conception health interventions such as diet, physical activity, contraception, healthy sexual relationships, folic acid intake, avoiding smoking, sexually transmitted infections (STIs), excess alcohol and obesity. These are all fundamentals of good pre-conception care but are all too often missed until a woman presents in pregnancy. That 45% of pregnancies in the UK are unplanned emphasises the need for a new approach.

The middle and reproductive years

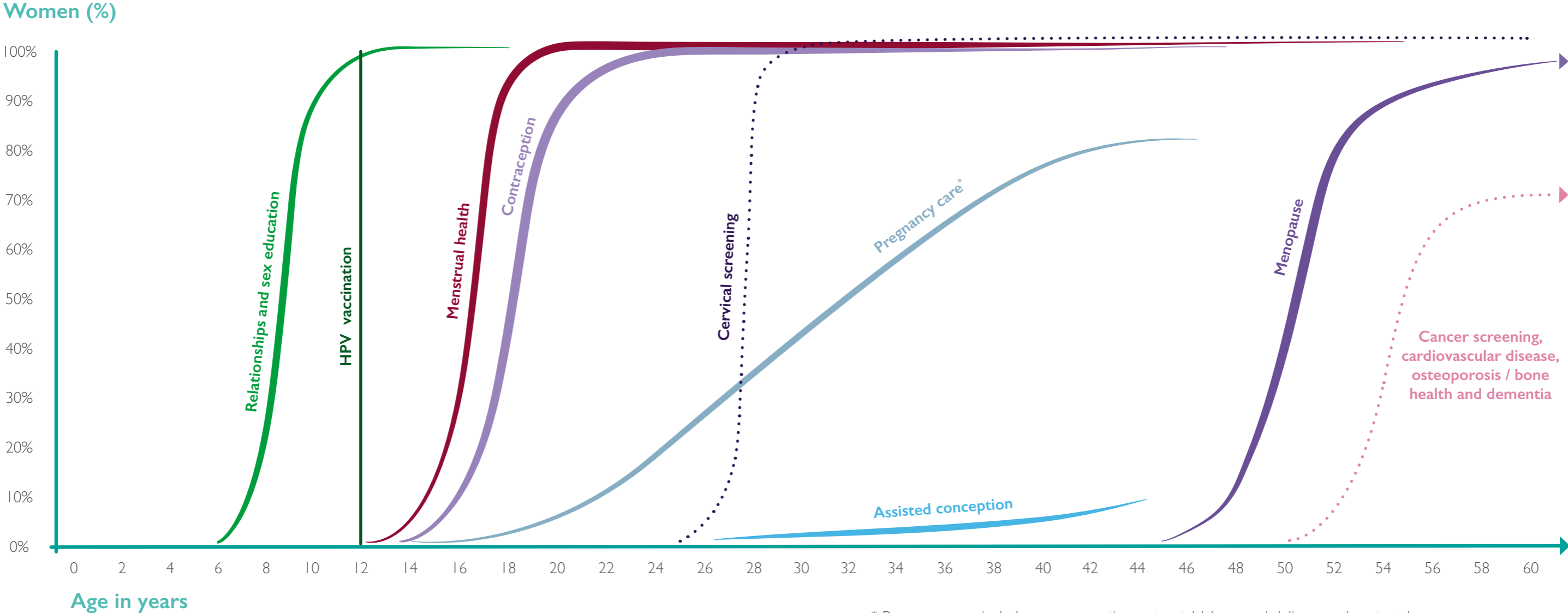
From 25 to 50 years: In addition to the ongoing need for contraception and promoting healthy lifestyle advice, many women will require specific help to manage menstrual disorders such as heavy bleeding and pelvic pain. Contact with women via the cervical screening programme provides another opportunity to encourage planning for healthy pregnancies to prevent avoidable complications. Some women will require specialist advice for medical disorders that may be exacerbated by pregnancy. The lessons learnt from a woman's response to being pregnant will have an influence on her health in later life e.g. diabetes, high blood pressure, urinary incontinence, mental health. It is crucial that we reintroduce opportunities for all women to undergo a health check following pregnancy to ensure that future pregnancy complications and preventable health problems in later life are avoided.

The later years

From 51+ years: Historically, this stage of a woman's life course has received little attention and many women find themselves without support from health care services until they present with an acute episode or medical problem. Managing the transition through the menopause including treatment of symptoms where appropriate, provides further opportunities to promote healthy lifestyles and decrease the likelihood of the early onset of chronic diseases such as osteoporosis, cardiovascular disease, frailty and dementia.

This graph illustrates the reproductive and sexual health needs of women as they unfold across the life course.

By recognising when women will need particular interventions, and how these interventions interact together, health services more effectively support women to optimise their health throughout their lives.



* Pregnancy care includes pre-conception, antenatal, labour and delivery and postnatal care

By adopting a life course approach to the delivery of women's health services, we have the opportunity to improve outcomes and save valuable NHS resources. To do a better job for less money is an attractive proposal. We must seize this opportunity and maximise its impact by encouraging women to be aware of the role they can play as an advocate for their own and their family's health.

As we considered ways to implement the life course approach, a number of themes emerged which were common to each stage of women's lives:

1. Women cannot always find accurate information.

Women's health is still not talked about openly and honestly and some girls and women are unaware of symptoms, treatments and where to seek support. Issues like periods and the menopause remain taboo subjects, meaning myths persist and women lack confidence to seek help. Women need reliable, accurate education and information about all aspects of women's health, to overcome stigmas, reduce health inequalities and increase awareness about common, treatable health conditions.

2. The NHS remains largely an intervention service, not a prevention service. Opportunities are frequently missed to empower girls and women.

Prevention and early intervention represent good value for money. Well-chosen interventions implemented at scale help avoid poor health, reduce demand on public services and support economic growth. However, there is often a failure to take a preventative approach to women's health. Much more needs to be done to support women to lead healthy lives, from an early age, to avoid the onset of ill-health both now and in the future.

3. Many women's healthcare services are fragmented and difficult to access.

Sexual and reproductive health (SRH) services in England are currently commissioned and delivered by a variety of organisations. This means that women's SRH services are not routinely provided together. Women often have to book multiple appointments with many different providers to get the care and support that they need. For many women access to fundamental women's services, such as contraception and abortion, is difficult. We need to ensure the integration of services, putting an end to fragmentation and postcode lotteries, and improving women's health. This is the only way to make a sustainable improvement to women's health.

RCOG recommendation

We are calling for the creation of national strategies for women's health based on a life course approach.

This will help move the UK away from a disease intervention service towards a preventive health service and ensure that women's health and wellbeing — not just their reproductive health during pregnancy — becomes a priority throughout their lives. We want this document to underpin the creation of Women's Health Strategies across the UK, to improve outcomes for women and save valuable resources. The RCOG will work with the NHS and other stakeholders to develop and realise this ambition.

A life course approach to women's health offers a more unified and woman-centred approach to health promotion, disease prevention and management. It has been proven to have important implications for the short, medium and long term, in terms of individual satisfaction, population health gain and significant economic savings to our NHS healthcare delivery.

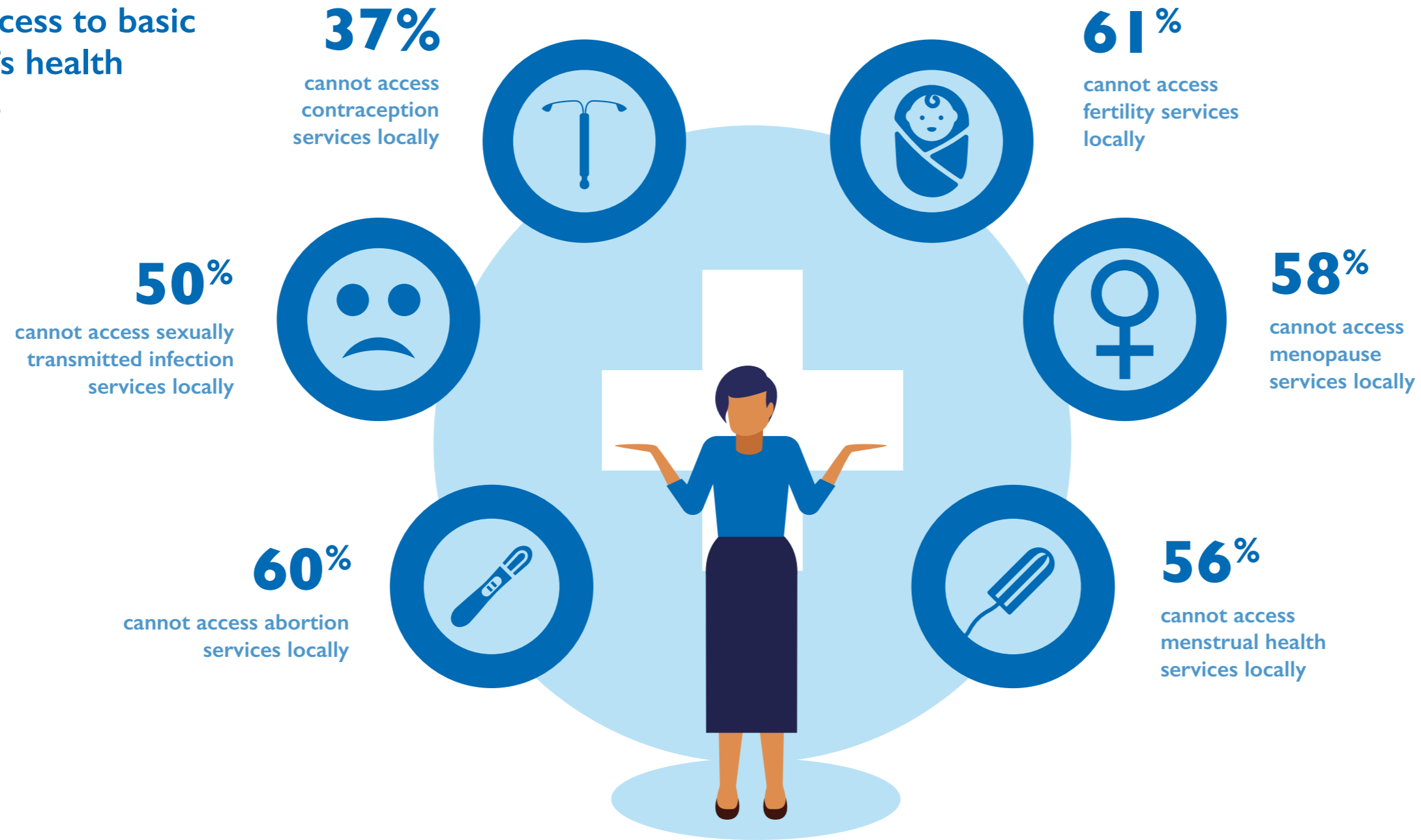
We simply cannot afford not to adopt a life course approach to women's health.



What women are saying

Results of an RCOG commissioned survey
of 3,021 women aged between 18 and 65
across the UK undertaken by Censuswide
in August 2019

Poor access to basic women's health services

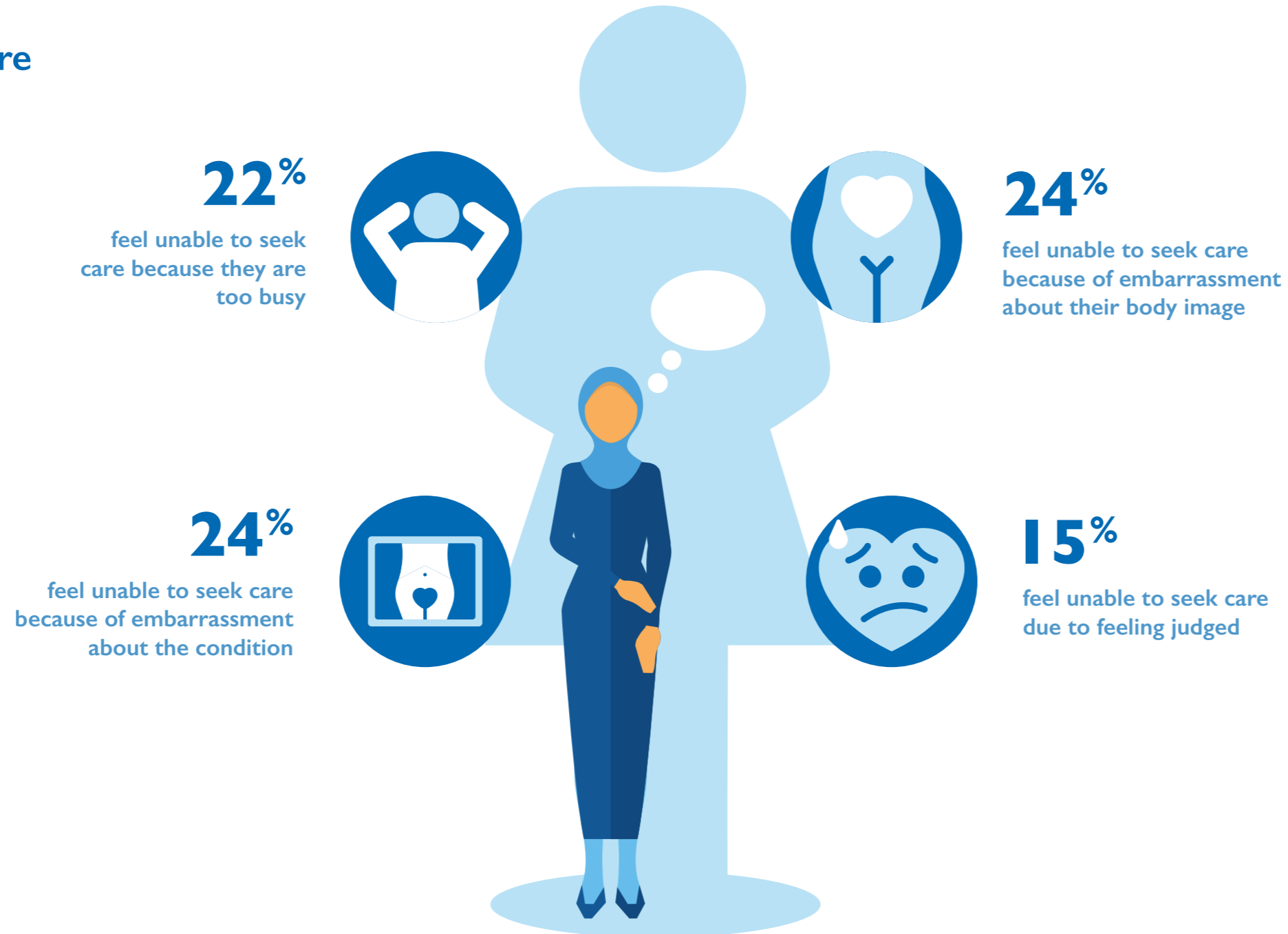


What does this mean?

Poor access to basic women's health services leads to a rise in unplanned pregnancies, abortions, poor patient experiences and increases damaging postcode lotteries.

It is essential that we develop a more integrated approach to the delivery of women's healthcare services.

Barriers to care

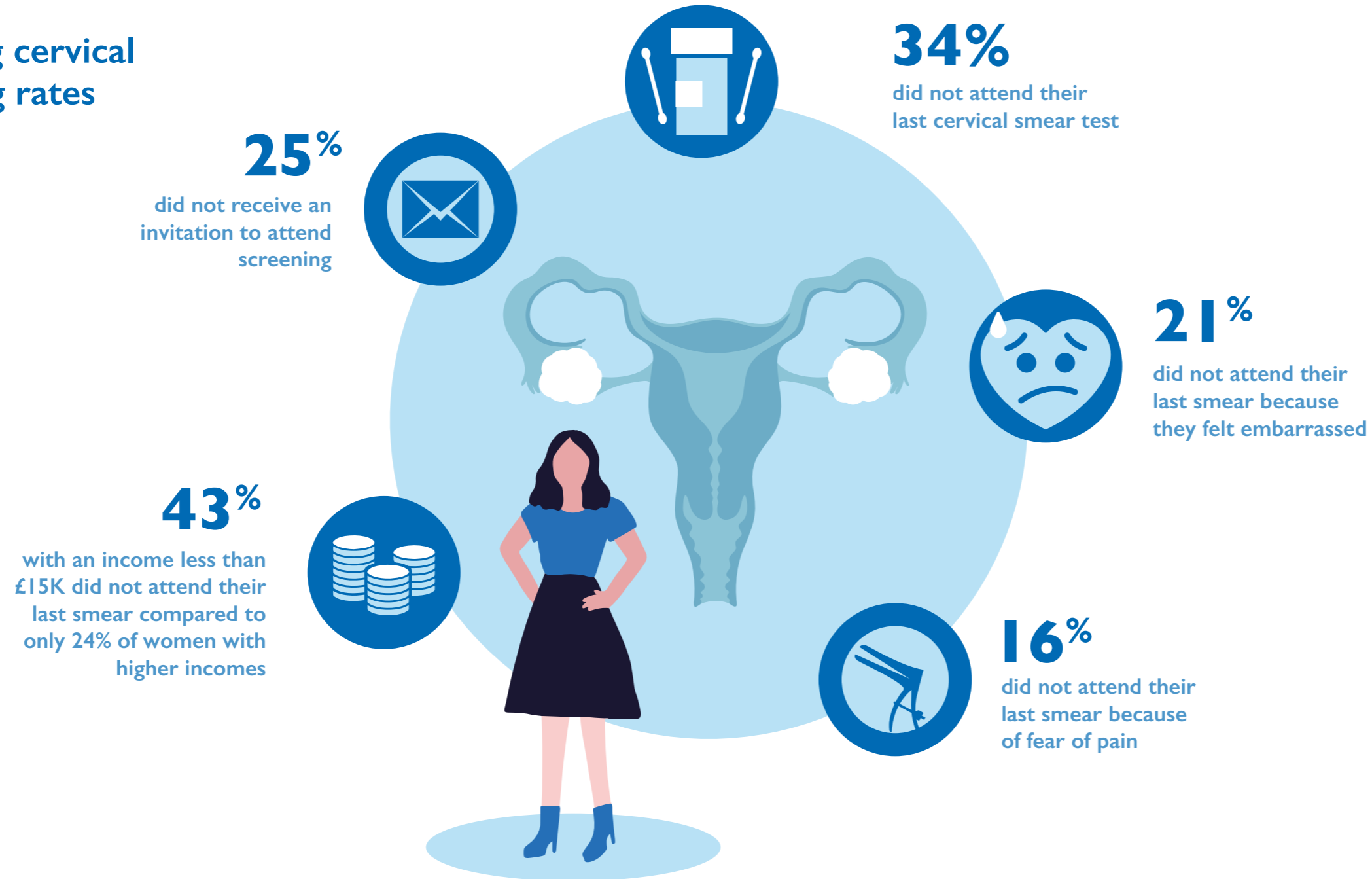


What does this mean?

Girls and young women should feel confident talking about their bodies, knowing what is 'normal' and seeking advice about common health problems from a young age.

We must provide easily accessible, reliable information and robust education.

Declining cervical screening rates



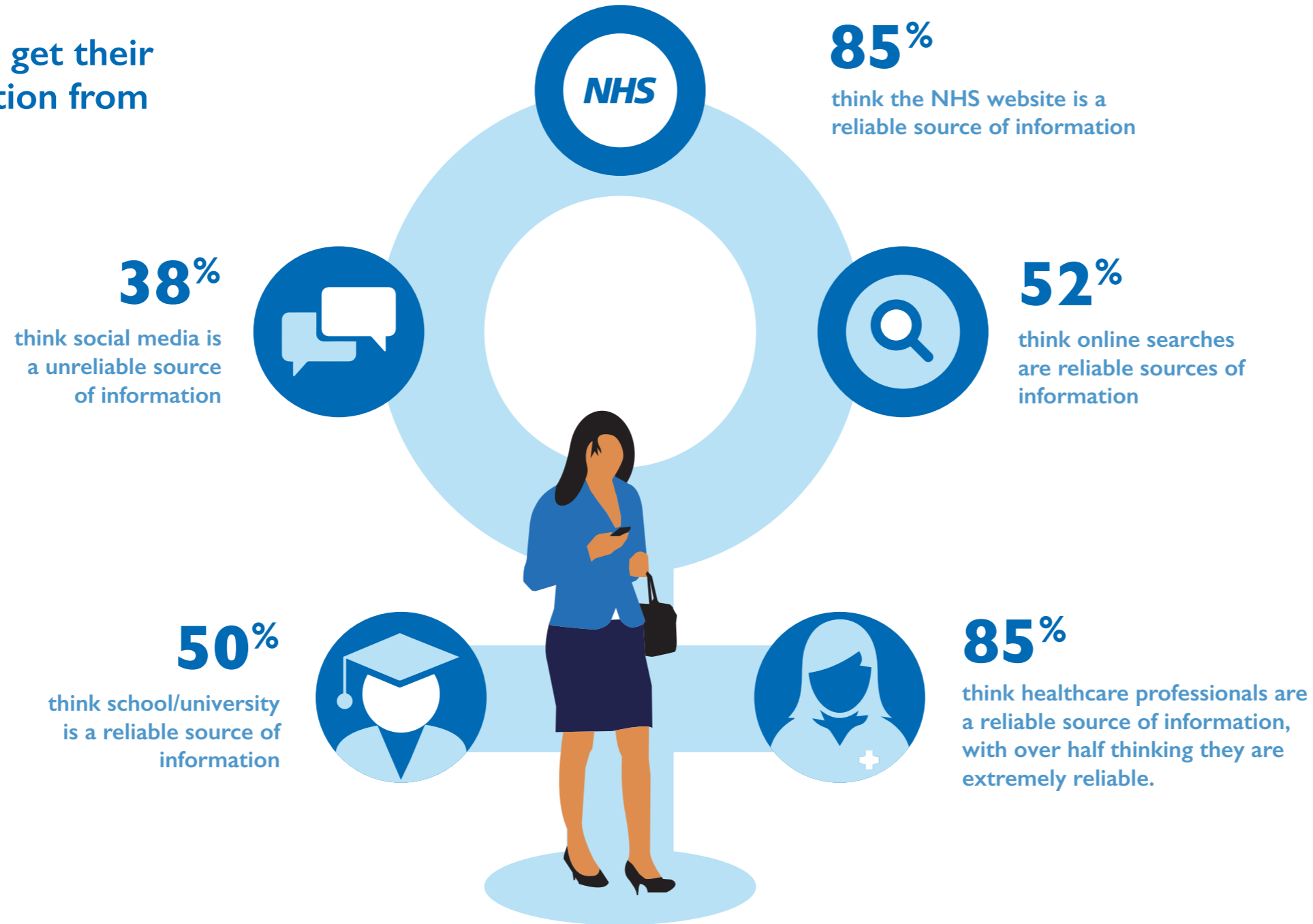
What does this mean?

The cervical screening programme is highly effective and capable of preventing 70% of cervical cancer deaths. Current uptake of the smear test is at a 20 year low.

Deaths from cervical cancer are predicted to rise by 143% - from 183 in 2015 to 449 in 2040.

Health services must make it as easy as possible for all women to access smear testing.

Where women get their health information from



What does this mean?

Women's health should be discussed openly in educational settings with children and young people learning about their health as they do other life stages.

With easily accessible and reliable information, women can take control of their own health.

Since the NHS UK website is the most trusted place to go to for information, the UK Government must ensure that it is the world's best source of information for girls and women.

How do we make things better for women

45%

think that drop-in facilities would improve their access to women's services



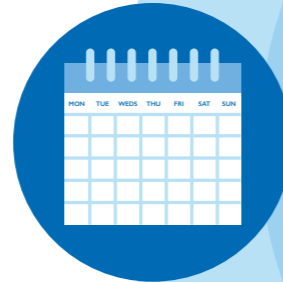
48%

think that a one-stop-shop clinic for all routine women's health services would improve access



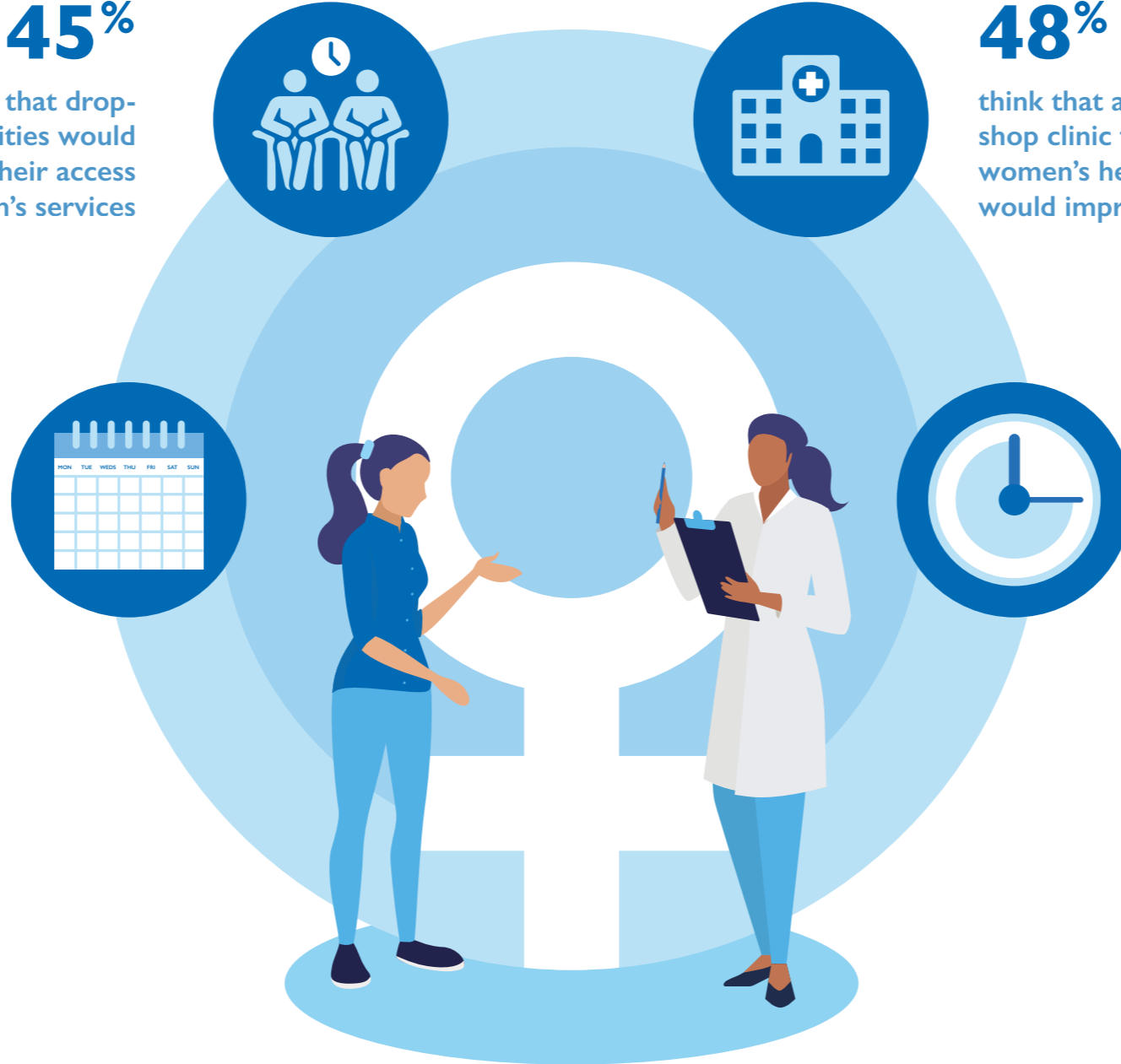
42%

think that more flexible appointment times would improve their access to women's services



35%


think that more time with healthcare professionals would improve their use of services



What does this mean?

Girls and women should be able to access all of their healthcare needs in one location and at the same time.

Where possible, services should be made available at the weekends and out-of-hours.



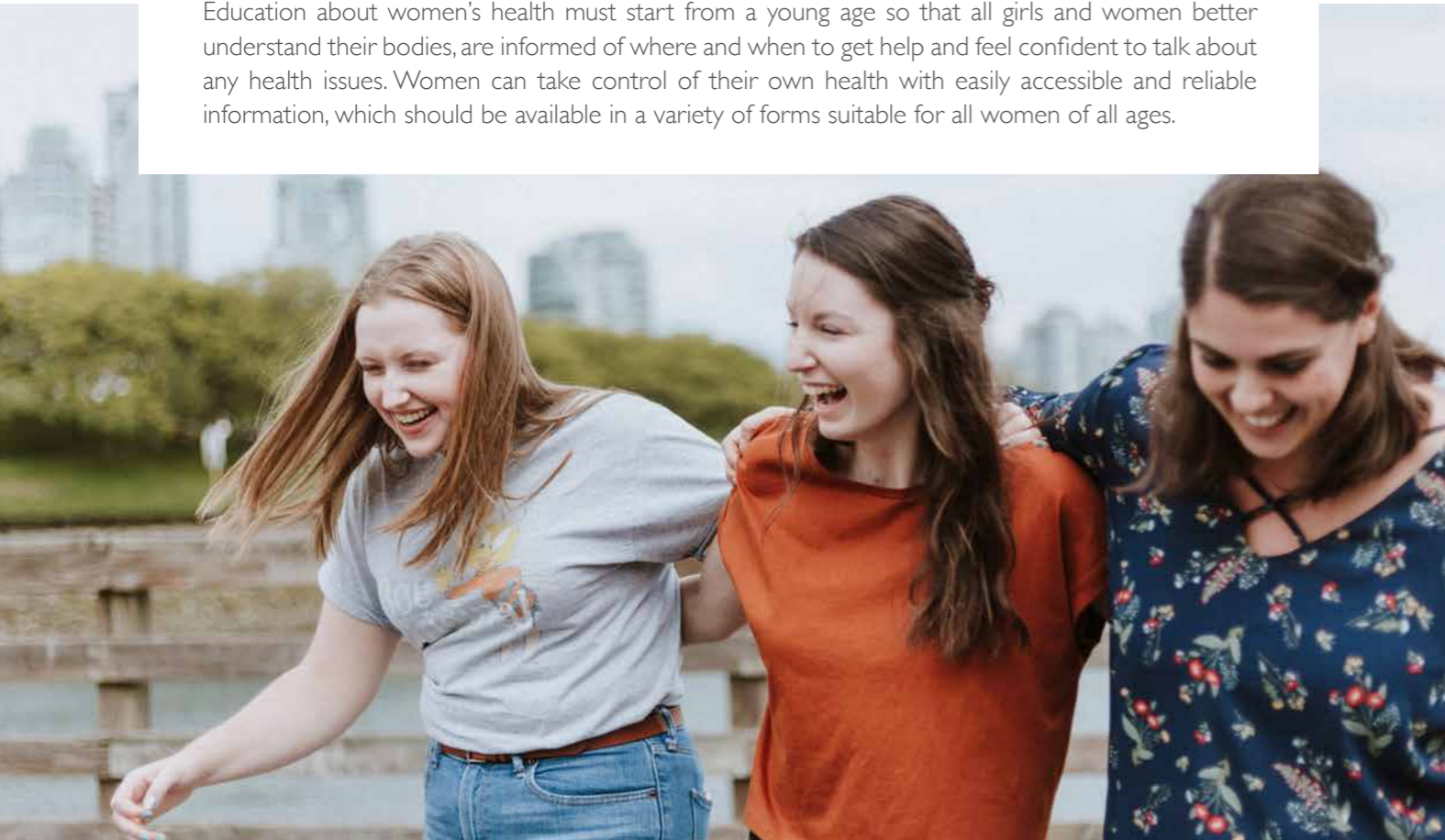
**Access to accurate
education and
information**

Introduction

Women should feel confident to seek advice about common health problems, such as heavy menstrual bleeding, menstrual and non-menstrual pelvic pain and the side effects of the menopause, so that they can take control of their own health.

However, we know that many women do not talk openly about their health or seek support when required due to embarrassment, common stigmas, fear of pain and a lack of reliable information.

Education about women's health must start from a young age so that all girls and women better understand their bodies, are informed of where and when to get help and feel confident to talk about any health issues. Women can take control of their own health with easily accessible and reliable information, which should be available in a variety of forms suitable for all women of all ages.



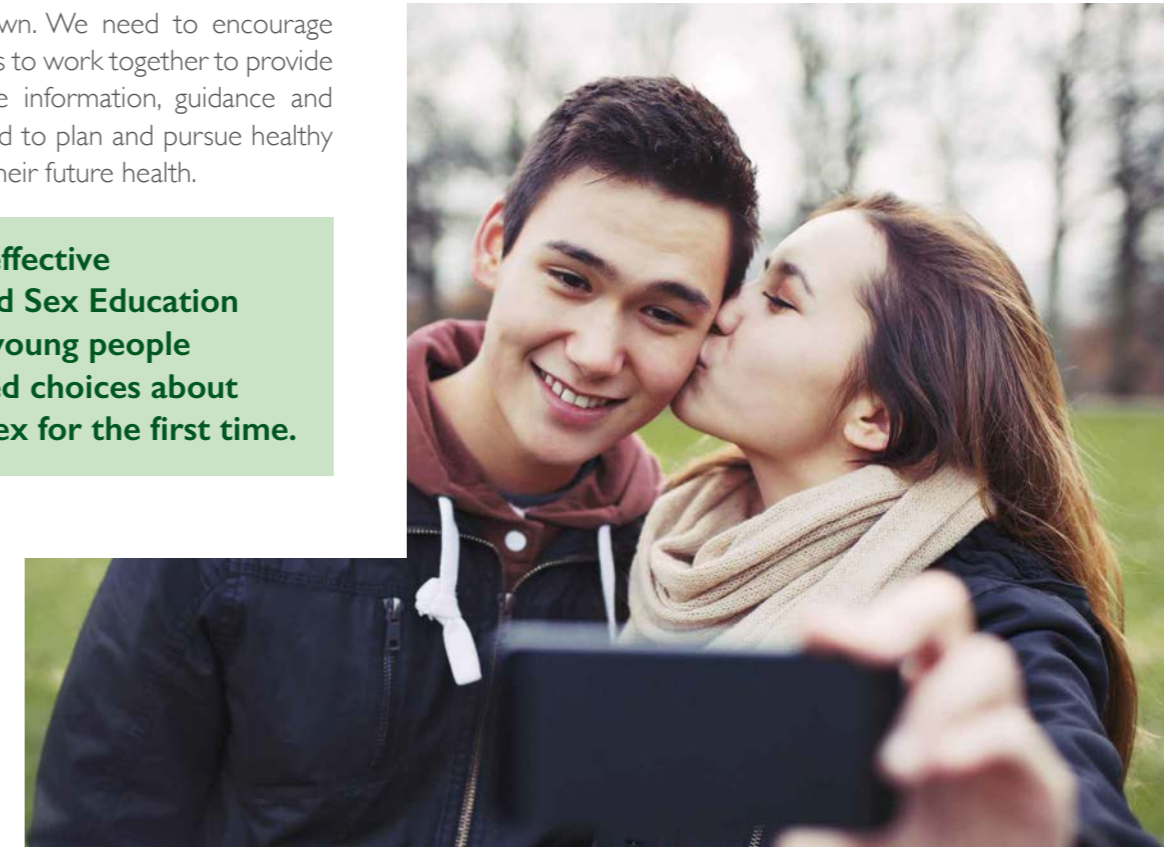
The importance of education

Learning about human biology, safe sex and respectful relationships at school is key to promoting healthy behaviours and tackling taboos.

Learning about human biology, safe sex and respectful relationships at school is key to promoting healthy behaviours and tackling taboos. Responses to the National Survey of Sexual Attitudes and Lifestyles indicate that 16 – 24 year olds prefer to source their sex and relationship education from three sources - schools, parents and healthcare workers - and we must not let them down. We need to encourage these three contributors to work together to provide young people with the information, guidance and practical tools they need to plan and pursue healthy lifestyles and optimise their future health.

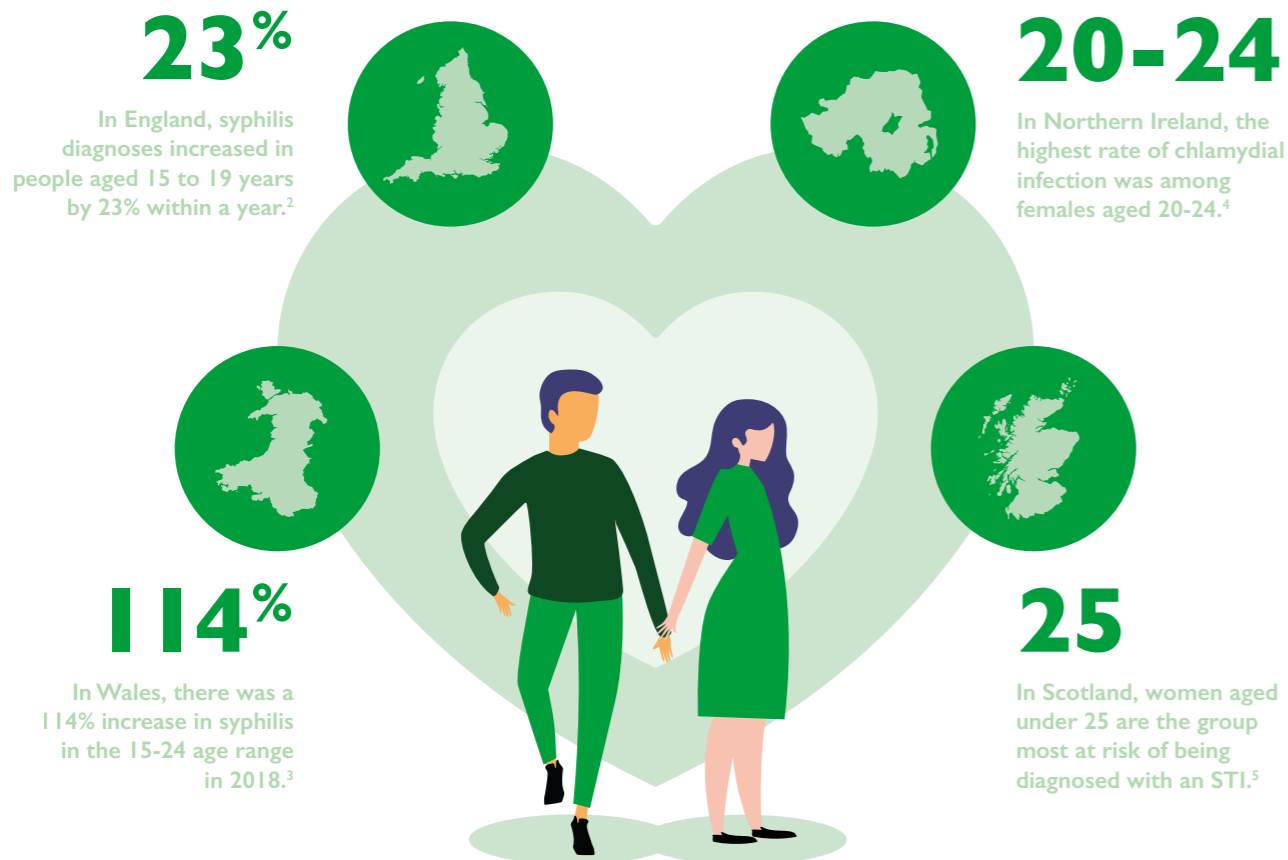
Not surprisingly, this lowers the number of unplanned pregnancies and reduces the likelihood of developing a sexually transmitted infection (STI). Perhaps most importantly, evidence shows that RSE delays the age of first sexual intercourse.¹

It is clear that effective Relationship and Sex Education (RSE) leads to young people making informed choices about when to have sex for the first time.



The importance of robust education supported by schools, families, parents and healthcare professionals cannot be overestimated.

While some headway has been made in educating young people about sex, relationships, planning a family and general health, there is still much progress to be made. Currently, for many girls and boys the education they receive is patchy and where it does exist, it often needs improvement. This is evidenced by the high unplanned pregnancy rate of 45%, together with recent reports of a rising number of STIs among young people throughout the UK.



This is of concern not just for the immediate health of young people but for the potentially damaging impact that pelvic infection may have on a young woman's future fertility if STIs are not diagnosed and treated promptly. It also points to the need for more education to ensure that young people understand the importance of using barrier contraception to prevent STI transmission. A further concern is the growing problem that women are facing regarding access to sexual health services – see chapter five.

In 2019, the Department for Education announced that Relationships Education (RE) for primary pupils and RSE for secondary pupils will become compulsory from September 2020. Additionally, all schools will be required to teach Health Education.⁶ This Health Education syllabus will include practical advice on how to maintain a healthy weight through nutrition and physical activity and the importance of avoiding smoking and drug use. The focus must be on emphasising to young people the positive impacts of taking healthy decisions now on their physical and mental health in later life.

School nurses play an important role in supporting RSE and providing general health advice to many young people.

They will also play a crucial role in encouraging and supporting young people to take up the human papillomavirus (HPV) vaccine which, from September

2019, was made available to all 12- and 13-year-old girls and boys in school Year 8. This vaccination will help to protect girls and boys against cancers caused by HPV, including the majority of cervical cancers, and some cancers of the mouth, throat, anal and genital areas.⁷ It is therefore concerning that there has been a fall in the number of nurses and health visitors working in schools across England in recent years, from around 3,000 in 2010 to 2,800 in 2018.⁸ Given the important contribution they undoubtedly make, this trend should be reversed.

Education at school is also key to the development of positive or negative body image⁹ and an understanding of what is 'normal'.

Developing a negative body image or low self-esteem as a child can have a lasting impact - low self-esteem has been shown to lower aspirations in school, contribute to risky behaviours such as drug abuse, alcohol misuse and unsafe sex and may lead to eating disorders, self-harm and poor mental health.¹⁰



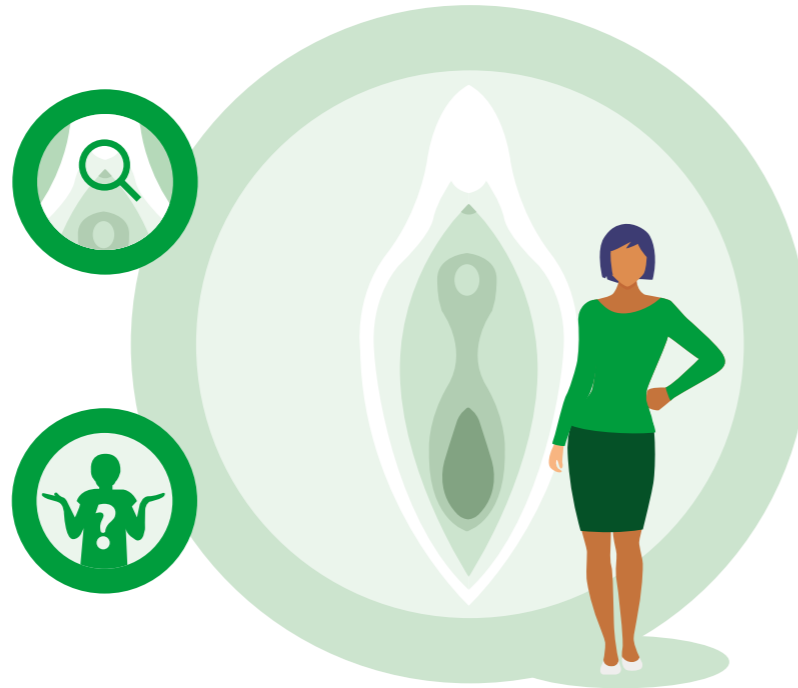
YouGov research published in 2019¹¹ demonstrates that there is still a significant lack of awareness about the female body and what is 'normal'. For instance, there is widespread ignorance about the anatomy of female genitalia among both women and men. The survey found that:

1/3

A third of both women and men did not know what the clitoris was.

50%

Half of Britons could not identify or describe the function of the urethra (58%), labia (47%) or vagina (52%).



One of the consequences of this lack of awareness is a rising number of girls and women requesting labiaplasty, a plastic surgery procedure to reduce or reshape the folds of skin surrounding the vulva. These girls and women have no underlying medical condition but wish to alter the appearance of their genitals because their perception is that their external genitalia look 'abnormal'.¹²

The widespread use of social media does appear to have fostered a culture of over-sharing, and may lead to a distorted view of reality. As a result, body dissatisfaction – which can have harmful emotional,

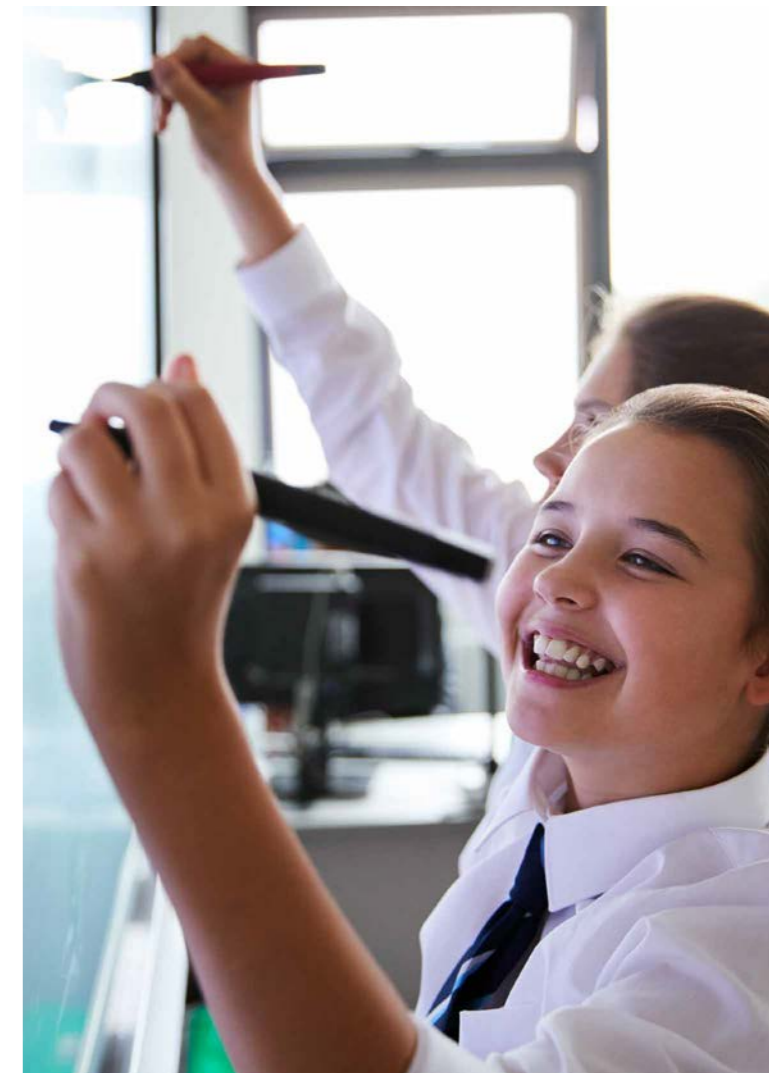
psychological and physiological effects - is becoming more prevalent amongst young people and may develop into more serious mental health issues such as eating disorders.

It is estimated that eating disorders affect over one million people in the UK and that a majority of the sufferers are female.¹³ Although bulimia nervosa is more prevalent than anorexia nervosa, both disorders may be accompanied by severe depression and anxiety, while some sufferers also engage in self-harm and substance abuse.

Women who develop an eating disorder often experience health complications later in life such as menstrual irregularities, delays in conceiving, infertility, mental health disorders and osteoporosis.¹⁴

Good Practice Example: Education for Choice, UK medical schools project

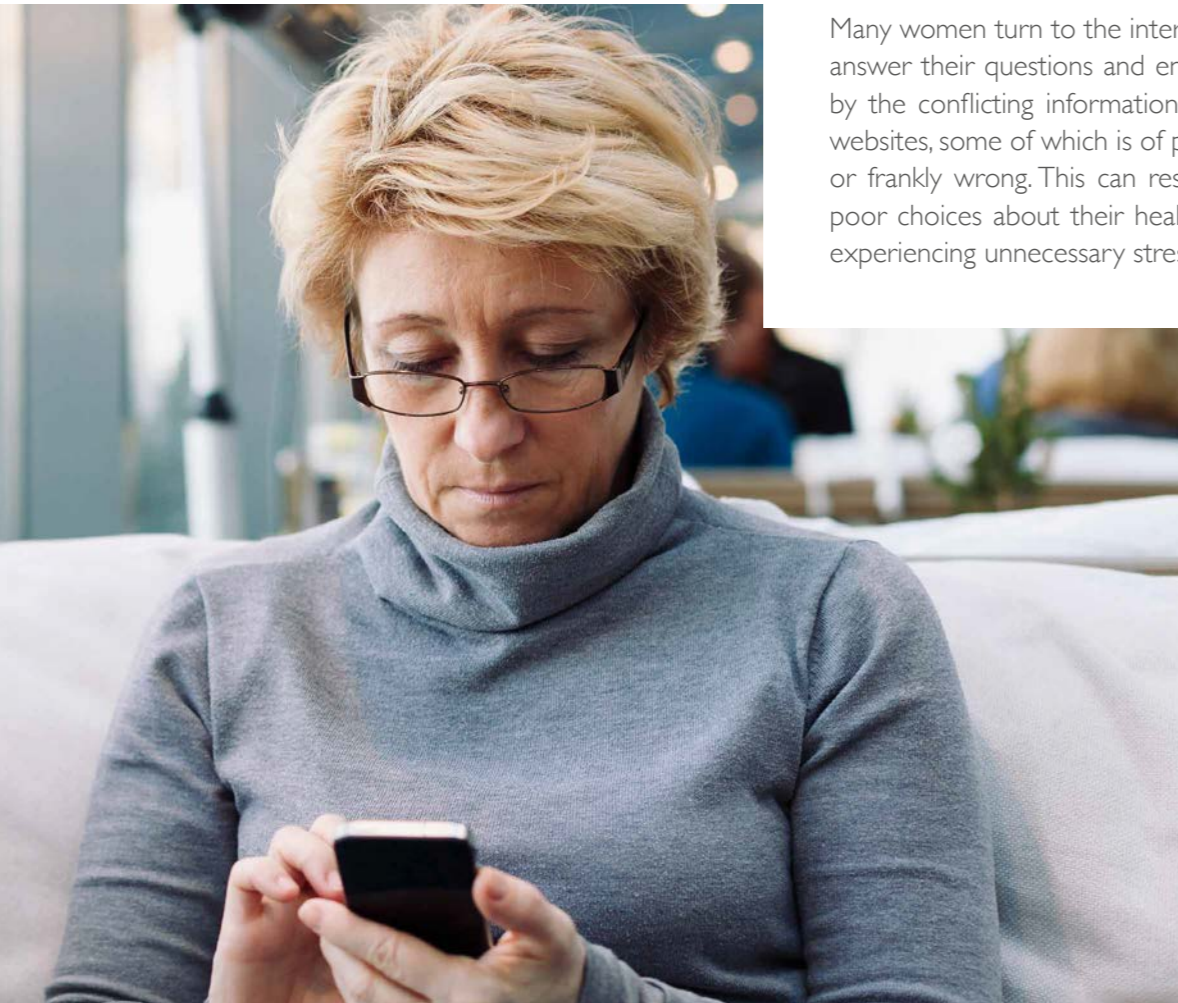
Education for Choice is supported by UCL Medical School London, Doctors for Choice UK, Brook, the RCOG and The Faculty of Sexual and Reproductive Healthcare (FSRH). The project consists of a one-hour session for secondary school students, facilitated by trained medical students, on the practical aspects of pregnancy decision making, contraception and abortion. The sessions are designed to be evidence-based, non-judgemental and inclusive for all students, providing them with practical information and reliable resources for pregnancy prevention and decision-making. UCL students have been facilitating sessions in London (Camden, Islington and Hackney) schools since 2017, with very positive feedback. Young people have responded well to being taught by people closer to their age who are removed from every day school life and the teachers have been impressed with the usefulness and professionalism of the sessions.



The need for accurate information

Many girls and women seeking information about their health discover an overwhelming amount of information available to them. This information comes from a multitude of different sources and is of variable quality.

Many women turn to the internet or social media to answer their questions and end up feeling confused by the conflicting information posted on unreliable websites, some of which is of poor quality, inaccurate or frankly wrong. This can result in women making poor choices about their health and treatment and experiencing unnecessary stress and worry.



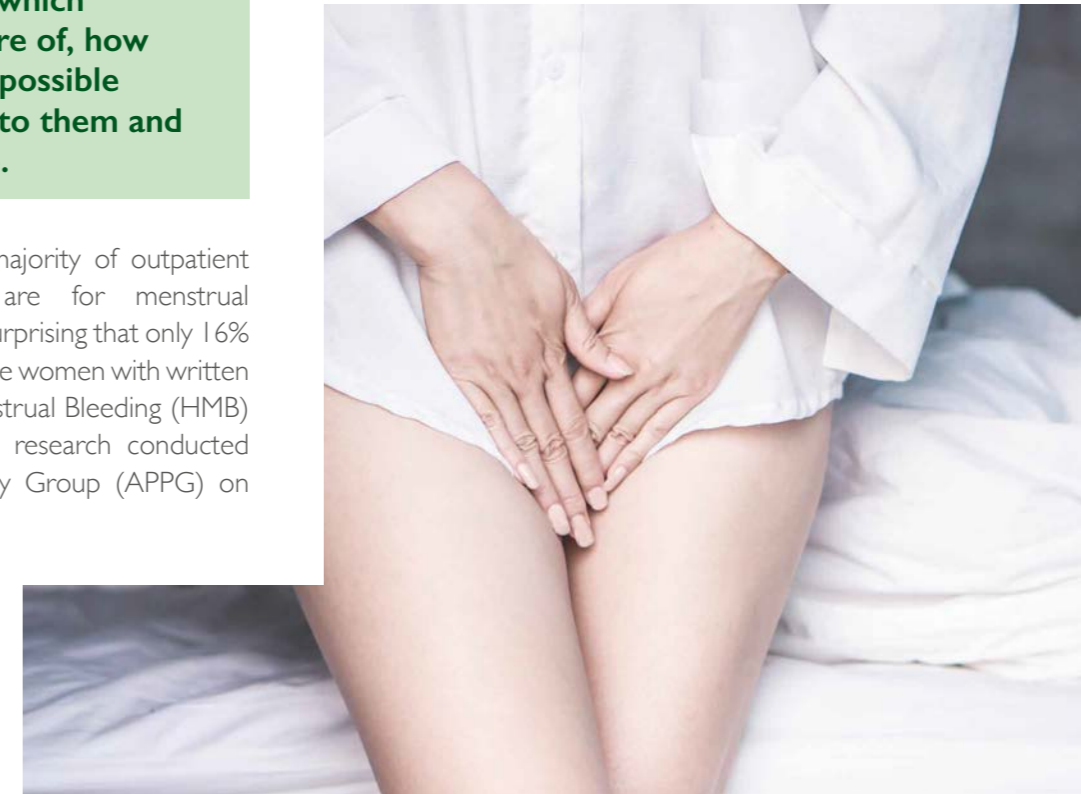
Information about menstrual health

Despite the fact that most adolescent girls and women will experience menstruation on a monthly basis for up to 40 years of their lives, many remain unaware of just how common menstrual health disorders, or problem periods, are.

As a result, many women struggle to access reliable information to understand their entirely predictable menstrual health needs, including what is a normal or abnormal period, which symptoms to be aware of, how to reach a diagnosis, possible treatments available to them and where to seek advice.

For instance, given that the majority of outpatient gynaecology appointments are for menstrual problems and pelvic pain, it is surprising that only 16% of NHSTrusts in England provide women with written information about Heavy Menstrual Bleeding (HMB) and pelvic pain, according to research conducted by the All Party Parliamentary Group (APPG) on Women's Health in 2017.¹⁵

In the case of uterine fibroids, confusing or inaccurate information can result in women making ill-informed choices about their treatment options. Uterine fibroids are the most common benign (non-cancerous) tumours of the female pelvis, occurring in 25-50% of all women over the age of 30 and account for one in five gynaecology clinic visits. For these women, the negative impact on their quality of life can be severe and many women will require some form of medical, surgical or minimally invasive treatment for their fibroids.

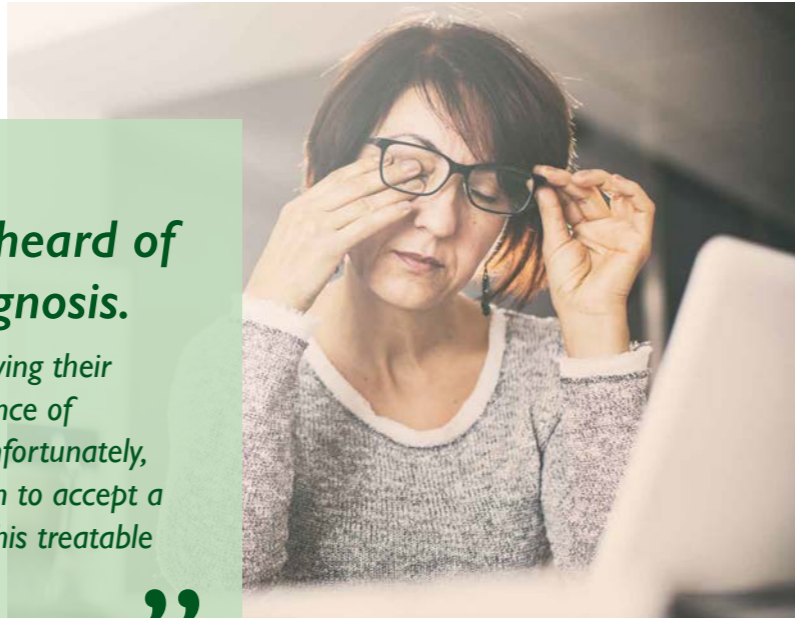


However, as the Fibroids Network UK aptly notes:

“
most women have never heard of fibroids prior to their diagnosis.

For a woman, the idea of a tumour occupying their womb is frightening especially in the absence of information about this benign problem. Unfortunately, the lack of information leads some women to accept a hysterectomy (removal of the womb) for this treatable condition.¹⁶

”



In addition, some older women who have completed their families may be reluctant to accept curative treatments to alleviate their symptoms because they have been subjected to myths that they will become overweight, grow excessive facial hair, suffer depression or develop difficulties having sex if they take hormones or undergo surgery for their fibroids, none of which are evidenced-based.

Endometriosis affects over 1.5 million women in the UK and the negative impact it can have on all aspects of a woman's physical and mental health can be life altering. With the average time to diagnosis being a shocking 7-8 years, many women are left unable

to put a name to their symptoms whilst trying to manage chronic and sometimes debilitating pain. Prior to diagnosis some are told their pain is “normal” or even “in their head”. The socioeconomic burden of endometriosis in the UK is in excess of £8.2 billion per year, with average costs amounting to around £8,500 per woman per year.¹⁷

It is therefore vitally important that information about the symptoms of endometriosis is readily available for women and their healthcare practitioners, as well as timely access to the medical and surgical treatment options available to manage their disease.

The NHS UK website is the go-to place for most women seeking advice about health concerns, but it has its limitations.

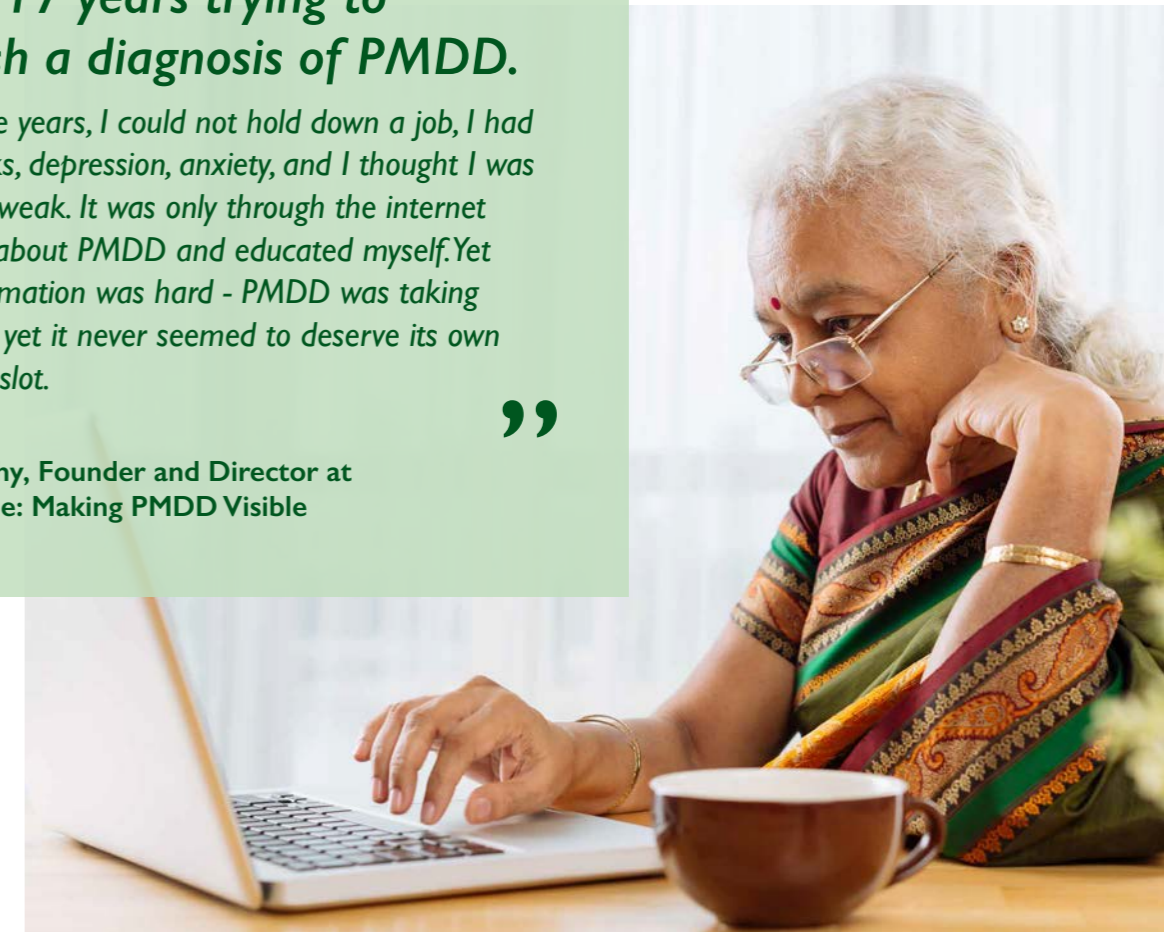
For example, there is no dedicated page on premenstrual dysphoric disorder (PMDD), despite the condition affecting 5-10% of women.¹⁸ Nor does the NHS UK website link to many of the other support networks and tools available on the many dedicated and accredited websites available.

“
I spent 17 years trying to establish a diagnosis of PMDD.

During those years, I could not hold down a job, I had panic attacks, depression, anxiety, and I thought I was broken and weak. It was only through the internet I found out about PMDD and educated myself. Yet finding information was hard - PMDD was taking over my life, yet it never seemed to deserve its own information slot.

”

Laura Murphy, Founder and Director at Vicious Cycle: Making PMDD Visible



Information about fertility

Fertility education will be included in the new RSE school curriculum including teaching on the potential impact of lifestyle behaviours on fertility for both men and women. This is important as difficulties conceiving are experienced by at least 15% of the population, but the success of treatment declines with the woman's age. This often comes as a surprise to those attending fertility clinics, who frequently regret that they were not better informed at a younger age.

Research conducted by Censuwide for the RCOG earlier this year of 1,002 UK women¹⁹ found that women are concerned about the reliability of the fertility information available to them. The survey found that four out of five (86%)

women felt that information from different sources seemed to be contradictory, while three quarters (76%) were unsure as to whether fertility information is impartial and unbiased. The survey findings also revealed that three out of five UK women (62%) reported feeling overwhelmed by the sheer volume of advice on offer.

Almost half of the women surveyed reported that they have worried about their own fertility (49%), and a quarter (25%) of 18-24 year-olds were currently concerned. The RCOG considers that women need to be able to trust the quality and effectiveness of the fertility advice they receive.

Example of good practice - Fertility Education Initiative

The Fertility Education Initiative (a partnership of experts from health, education and government) has developed a website containing clear information and a series of educational film animations to increase awareness.²⁰

Information to help prepare for pregnancy

Prioritising the pre-conception health for all women of childbearing age in the UK is an educational aim that needs to be addressed urgently.

Currently, the lack of cohesion between family planning services and maternity care means that everything between prevention of pregnancy and antenatal care is frequently overlooked. As a result, we are seeing high levels of obesity, smoking, poor nutrition and drug and alcohol misuse among pregnant women in the UK (see chapter four).

This is despite the fact that every day, millions of women of reproductive age in the UK have contact with healthcare professionals. Each one of these contacts is an educational opportunity to engage women in thinking about their health, preparing for pregnancy and understanding how their current lifestyle choices will influence the outcome of their pregnancy and their baby's future health. Although women seldom volunteer to health professionals that they are planning to become pregnant, they frequently come into contact with services for related

reasons, for example attending their GP practice or gynaecology clinic for the insertion or removal of a contraceptive implant or intrauterine device, or visiting their GP or local early pregnancy unit after a miscarriage or ectopic pregnancy. Baby checks and vaccination visits for young children, when many mothers are likely to be planning another pregnancy, are another missed opportunity.

All of these encounters present an ideal opportunity to provide written information about healthy lifestyles, advice on how to lose weight, quit smoking, avoid recreational drugs and ensure that women understand the importance of taking folic acid supplements and vitamin preparations.



Information for marginalised women and communities

It is vitally important that information is available in a variety of formats, to suit women of all ages and living in different situations.



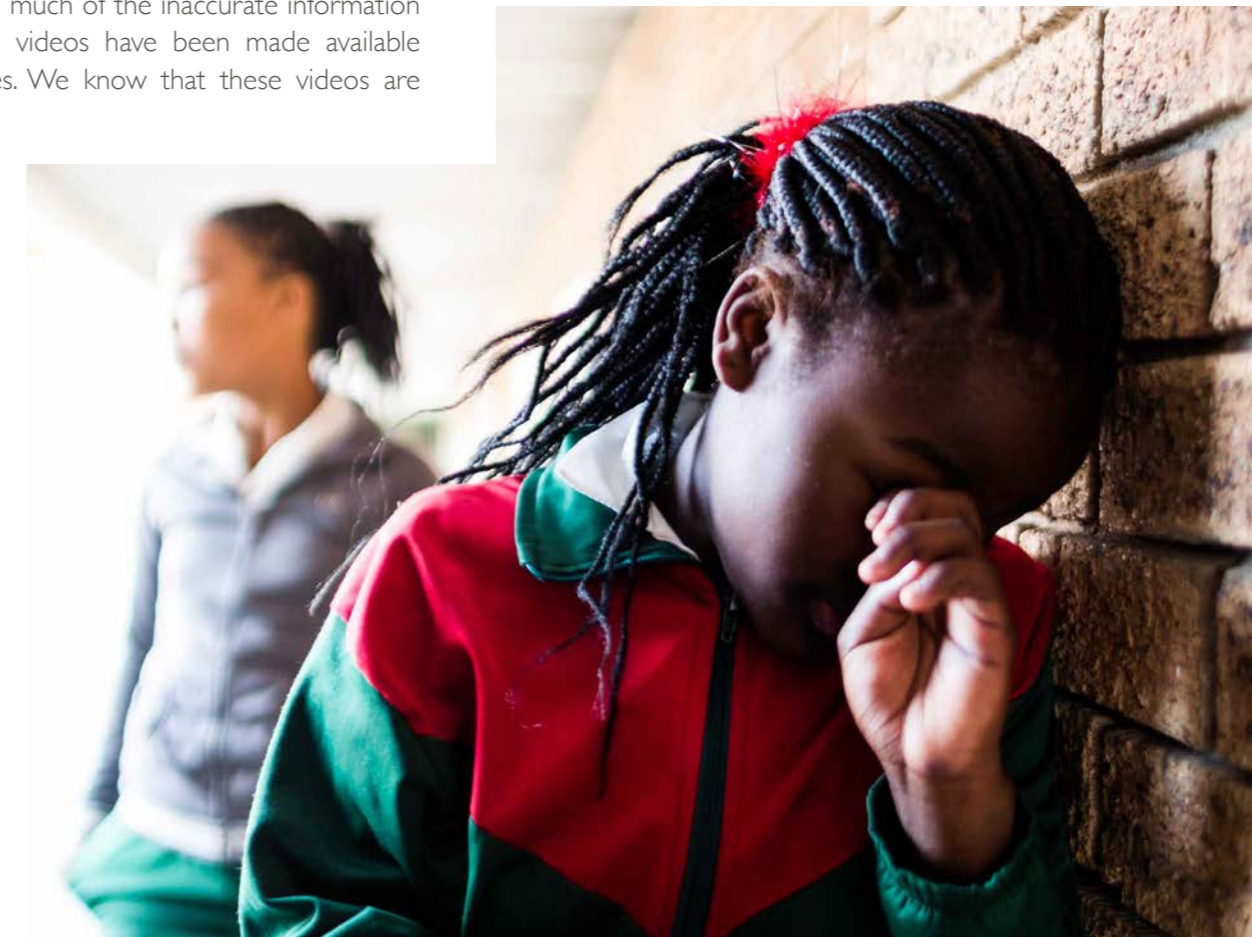
This is for a variety of reasons. For example, women who reside in institutionalised settings are often less able to access the internet and may rely on more traditional information sources and formats. Indeed, the College has recently been contacted by a woman in prison who requested to be provided with hard copy information leaflets about the menopause so that she, and other women in similar situations, can access the information that they need. Some women live in rural or isolated areas or simply prefer written information. Others face language barriers or suffer from visual impairments or mental health issues. If these barriers are not recognised and addressed, important public health messages will fail to reach many girls and women who may need them.

The RCOG supports efforts across the UK to tackle inequalities including the Welsh Government's 'HealthierWales' action plan, the Scottish Government's health improvement initiatives, and Public Health England's (PHE) 2018 report 'Local action on health inequalities amongst ethnic minorities'.²¹ A continued, joined-up approach is needed from all relevant public health bodies to ensure all women are armed with the knowledge that they need. Information must be age-appropriate and delivered in a variety of formats to make it as accessible as possible. Information should also be targeted to reach the girls and women who need it most. Achieving these goals will mean that more women ask the relevant questions and receive the information they need to make informed choices to stay healthy.

Good practice example – animated films on FGM

A series of short animated films on Female Genital Mutilation (FGM) were developed by the Royal College of Midwives (RCM) in collaboration with the RCOG, Royal College of General Practitioners (RCGP), survivors of FGM, non-governmental organisations (NGO) and a variety of local community partners. They aim to create awareness of the health and physiological consequences of FGM and cut through much of the inaccurate information and myths. The videos have been made available in five languages. We know that these videos are

helping to influence men and women who would not necessarily engage with campaigns led by PHE or the Home Office on this issue. This innovative approach to providing information should be considered for other issues and groups. NHS staff are a trusted source of information by many communities and this fact should be capitalized upon.



Information for clinicians and healthcare providers

There is a wide range of information available for clinicians to help them advise and support women. However, due to rising workloads many clinicians in primary and secondary care settings feel that they do not have enough time to stay as well-informed as they would like about some aspects of women's health and feel they have insufficient time allocated to spend with women.

Research conducted by the APPG on Women's Health in 2017 highlighted the need for greater awareness of menstrual health among all healthcare professionals. The APPG's survey of over 2600 women with endometriosis and fibroids²² identified that 62% of women were not satisfied with the information that they received from healthcare professionals about treatment options for endometriosis and fibroids and nearly 50% of women with endometriosis and fibroids were not told about the short or long term complications from the treatment options provided to them.

In the context of increasing demand for, and complexity of, consultations, healthcare professionals need to feel confident in providing advice and support about women's health. They also need to be able to signpost appropriately, easily and efficiently to other services and provide women with the full range of evidence-based information so they can make informed choices.



“

I regularly see women who have struggled to access individualised, evidence based menopause care.

When women finally see a practitioner who listens and who explains what is happening they describe it as 'a lightbulb moment'. Women should not have to fight for this, as many currently say they do.

”

Kathy Abernethy, British Menopause Society menopause specialist



Example of good practice - Menstrual Wellbeing Toolkit for GPs

The RCGP, in partnership with Endometriosis UK, has developed a Menstrual Wellbeing Toolkit for GPs and healthcare professionals that is available on the RCGP's website. The toolkit includes evidence-based resources for GPs and other primary care clinicians to

help diagnose, support and manage problems caused by menstrual dysfunction. It comprises information for commissioners and support for patients and carers as well as top tips for managing Heavy Menstrual Bleeding and endometriosis in primary care.

Overcoming stigmas

Silence, stigma and shame around girl's and women's health are apparent throughout the life course, from the time of a girl's first menstrual period through to her menopausal years. These historical and ongoing taboos mean that many girls and women are suffering unnecessarily from manageable or treatable conditions.²³

Attitudes to periods are a good example. Research conducted by Plan International UK²⁴ found that:



School nurses, teachers and health professionals also need to be alert to spotting and supporting girls suffering from period poverty. Plan International UK found that one in 10 girls between the ages of 14 and 21 in the UK have been unable to afford sanitary products. Furthermore, almost half of all girls in the UK have missed at least one full day of school due to their period, 14% have had to borrow menstrual products from a friend and 12% have had to improvise or use makeshift menstrual products.²⁵ The RCOG supports the new Government Equalities Office's (GEO) Period Poverty Taskforce and its focus on tackling the issue of period poverty and wider stigma around menstruation in the UK.²⁶

An understanding of what is, and is not, normal when it comes to the menstrual cycle is key to breaking down taboos around menstruation, and in equipping girls and women with the confidence to seek medical help when it is needed.

Educating girls and boys at school about 'normal' bodies and menstrual health, fertility, contraception, pregnancy, menopause and everything in between is a crucial first step to prepare them for the future. It is vitally important that RSE is developed in such a way to break down the stigmas and taboos that still exist about women's menstrual and reproductive health at an early age.



It is also important to note that feelings of embarrassment and shame when talking about menstrual health are not confined to girls and young women. Indeed, many studies have shown that women at all ages suffer significant and unnecessary distress caused by the stigmas surrounding menstrual health.²⁷ Research has also shown that silence, shame, discrimination and stigma relating to ageing and the menopause are highly prevalent and can have a huge impact on a woman's quality of life.²⁸ In a survey of 1,000 adults in the UK, the British Menopause Society found that 45% of women felt that menopausal symptoms had a negative impact on their work and over 33% of women felt less self-confident in social situations.²⁹

symptoms that are out of the ordinary. This increases the risks of developing more serious and potentially avoidable ill-health. It also means that girls and women will continue living with conditions that can be successfully treated or managed simply because they are too embarrassed to talk about them.

These findings should be of concern to everyone. If girls and women are too embarrassed to discuss their periods, or other aspects of their health, it is highly likely that they will also be too embarrassed to seek clinical help if they start to experience

It is worth noting that in recent years the media has helped to tackle taboos. There are now many female celebrities opening up conversations about periods.³⁰ Broadcaster Emma Barnett's book 'Period. It's about bloody time' examines attitudes to menstruation and debunks common myths. The creation of a period emoji in 2019 was another breakthrough for girls and women that could help to normalise menstrual health.³¹ In addition to more focus on menstrual

health, BBC Breakfast held a week dedicated to the subject of menopause in May 2019.³² The RCOG was inundated by positive responses from the public.

However, common taboos and embarrassment are still persistent across society and need to be broken down before women can fully take control of their own health.



RCOG recommendations

1. All young people should be educated from an early age about women's health.

- Age-appropriate sex education should be mandatory in all schools for all girls and boys.
- Government education departments across the UK must provide consistent Relationships and Sex Education (RSE) training for teachers. This needs to include giving teachers the tools needed to feel confident using anatomically correct terms for female bodies. Government education departments must collaborate with medical colleges to collate and disseminate accurate, accredited sources of information on girls' and women's health to teachers across the country.
- The Office for Standards in Education, Children's Services and Skills (Ofsted) should evaluate the quality of the content and delivery of Relationships Education and RSE in primary and secondary schools. This should be regularly evaluated, to enable consistent improvement. Ofsted also need to publish data on the number of children currently being withdrawn from this education. This should include analysis of the reasons behind the withdrawals and plans for increasing the numbers of children taking part.
- Relationships and sex education must be open and inclusive, recognising that Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ+) people are at a higher risk of experiencing mental health problems.
- There should be greater investment in school nurses to enable them to provide vital education and support to young people.

2. NHS UK website should become the world's best source of information for women, girls and clinicians.

- NHS Digital needs to work with Royal Colleges and charities specialising in women's health to ensure that the NHS UK website link to all of the relevant support networks and tools available for girls and women. This information is accredited, trusted and co-produced with girls and women and developed in line with National Institute for Health and Care Excellence (NICE) guidelines. Hence, it would come at no added cost to stretched NHS budgets.
- NHS UK needs to consolidate information on women's health for clinicians. This will provide evidence-based guidance to enable easier diagnosis or referral, and direct clinicians to NICE and other guidelines and appropriate support networks for patients. All healthcare professionals should be sign-posted to this resource.

3. To reduce health inequalities, all women should have access to and be provided with the information that they need to stay healthy.

- The Government Equalities Office should work with public health bodies across the UK and charities specialising in women's health to create a strategy to improve the dissemination of information to all girls and women with one or more protected characteristics, or from disadvantaged backgrounds, marginalised communities, those with disabilities, visual impairments or language barriers or those living in institutionalised settings.
- The UK Governments should collect and monitor data on patients' sexual orientation and gender identity to identify inequalities in LGBTQ+ patient experience and outcomes and develop targeted services and initiatives to address these.³³
- The RCOG's Gynaecology and Maternity Standards, which set out frameworks for commissioners and service providers of high-level service standards that aim to improve outcomes and reduce variation in care, should be enacted in all settings to ensure that women receive the best possible care wherever they are.

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A photograph of two women laughing together, overlaid with a semi-transparent red filter. The woman on the left is wearing a denim jacket and has her mouth wide open in a joyful laugh. The woman on the right is wearing a dark top and has her eyes closed and a smile. They appear to be sitting on a wooden bench outdoors. The text 'Prevention and empowerment' is written in white, bold, sans-serif font on the right side of the image.

**Prevention and
empowerment**

Introduction

As we have already seen, supporting girls and women to make good health choices needs to start from a young age and should continue throughout their lives. We know that promoting health literacy and healthy behaviours makes an important contribution to preventing avoidable ill-health and encouraging women to take control of their own future health. There is clear evidence that preventative strategies can help to improve health outcomes for women and their families throughout their life course.

However, our health and care services often fail to take a preventative approach to women's health, which results in missed opportunities to support women to access the care they need and make the decisions that are right for themselves and their families.

Preventing unplanned pregnancies

The National Survey of Sexual Attitudes and Lifestyle (NATSAL) has revealed that 45% of all pregnancies and around one third of births are unplanned or associated with feelings of uncertainty.¹

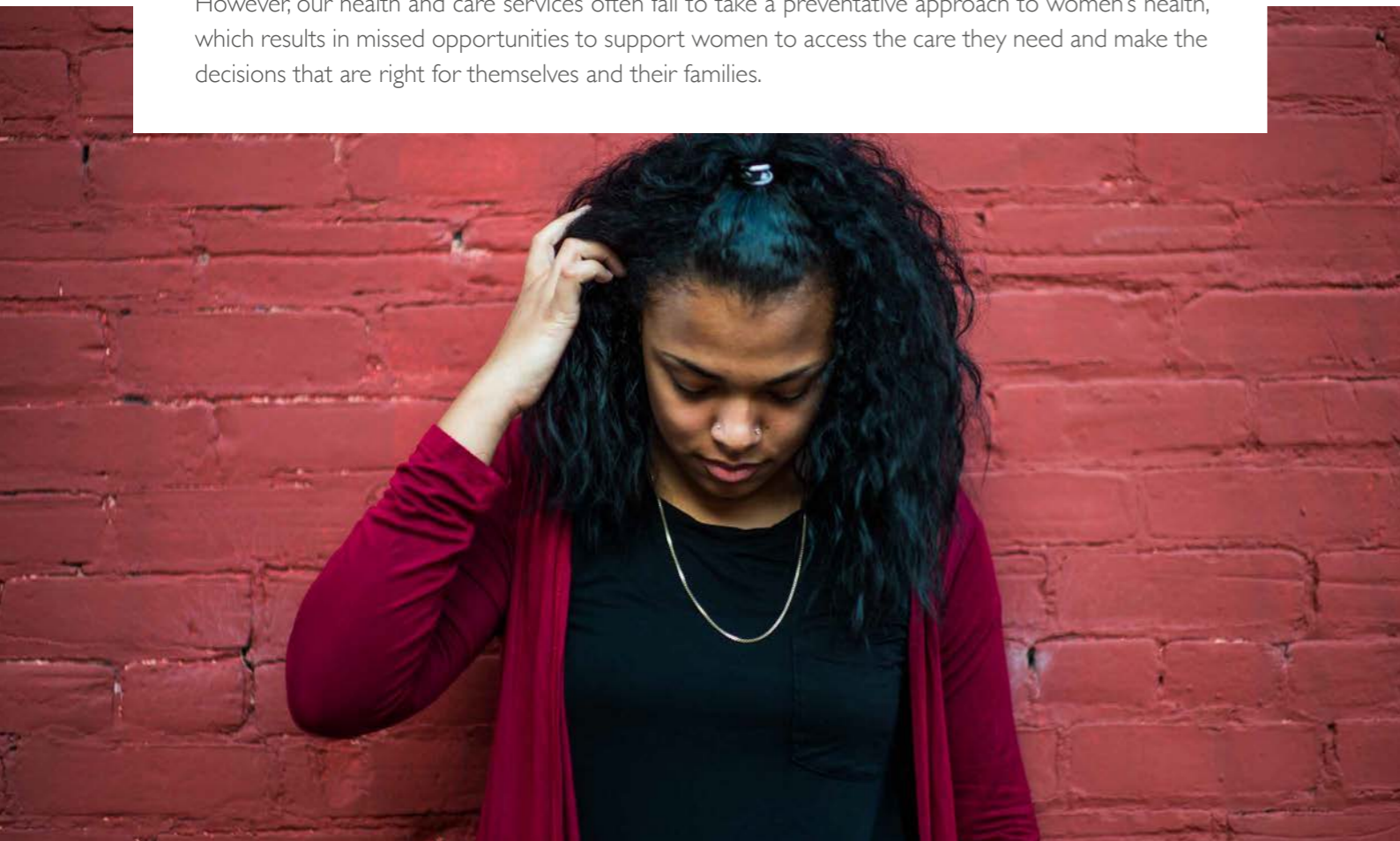
It is important to note that many of these pregnancies which continue to term are not unwanted and have positive outcomes for mothers and their babies. However, there is clear evidence that unplanned pregnancies result in poorer outcomes for women and their babies due to late presentations for antenatal care and a wide range of obstetric complications during the pregnancy, delivery and postnatal period. For some women an unplanned pregnancy can lead to mental health issues including antenatal and postnatal depression.²

Additionally, an unplanned pregnancy can have a negative impact on the child both in-utero and later on in life.

Problems such as low birth-weight, prematurity, mental health issues and lower scores in intelligence quotient (IQ) or cognitive testing at the age of four years are some of the best recognised poor outcomes.

They are more likely to occur in women living in disadvantaged areas with lower educational attainment and poor dietary intake. In turn, these same women are less likely to follow infant feeding advice and hence the cycle of poorer health is passed to the next generation.³

There is also clear evidence that providing girls and women with contraceptive advice and support throughout their reproductive years reduces the number of unplanned pregnancies. Societal changes have resulted in many women choosing to delay childbearing or to have no children. These longer intervals between first sexual intercourse and childbearing mean that an increasing number of women can spend up to 30 years of their lives wanting to prevent an unplanned pregnancy.



There are numerous opportunities for healthcare professionals to provide girls and women with advice about pre-conception care and contraception. These include but are not limited to discussions during the following routine healthcare checks and interactions:

- ✓ School based Human papillomavirus (HPV) vaccination programmes and other immunisations
- ✓ Sexually transmitted infection (STI) checks at all sexual and reproductive healthcare services
- ✓ Cervical cancer screening visits
- ✓ At every consultation with women of reproductive age living with a long-term medical condition
- ✓ During and following a miscarriage, abortion or ectopic pregnancy
- ✓ Before, during and after pregnancy, within and without the maternity unit or hospital setting

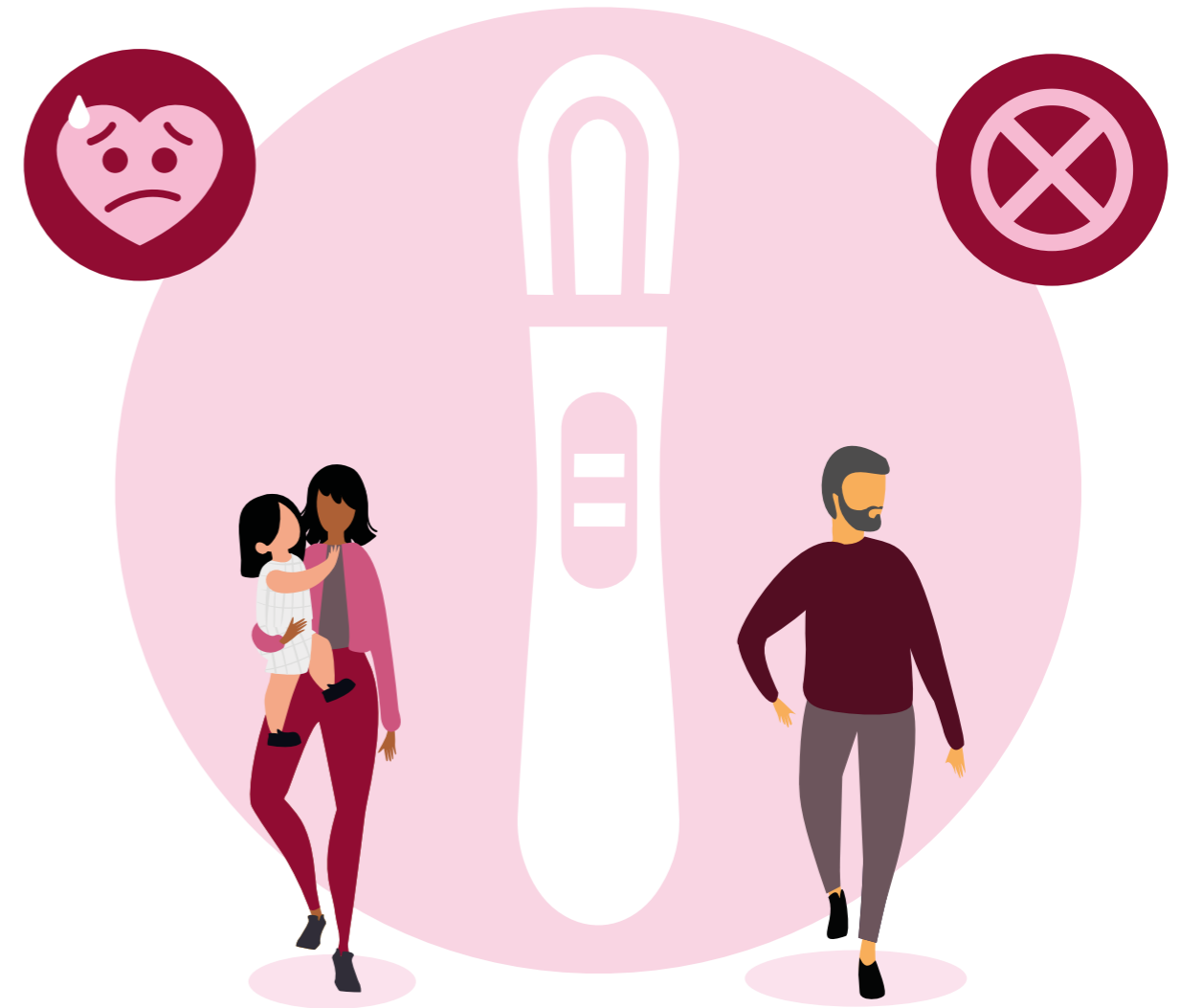
Hospital-based early pregnancy and emergency gynaecology units already offer easily accessible services for large numbers of women on a daily basis. They are extremely well placed to provide reliable, personalised contraceptive advice and treatment but are not currently resourced to routinely do so for all attendees. Similarly, women are ideally placed to receive advice and support about their future contraceptive choices during these visits, during an ongoing pregnancy and following birth.

Planning future contraception should be viewed as an integral part of our maternity care services but all too often this opportunity is missed.



45% of pregnancies and around 33% of births are unplanned or associated with feelings of uncertainty.

Abortion rates for women aged 35 and over have increased over the last 10 years from 6.7 per 1,000 women to 9.2 per 1,000 women.



Providing a full range of contraceptive options after pregnancy is a simple but effective way to avoid short intervals between pregnancies. An interval of less than six months is an independent risk factor for preterm delivery and neonatal death in the next pregnancy. Viewed in a positive context it is well recognised that intervals of more than 18 to 24 months between births lead to improved outcomes for both mother and baby.⁴

Many women still think that their contraceptive options are limited to condoms or the pill. However, long acting reversible contraception (LARC), which includes intrauterine contraceptives, contraceptive implants and injections, are significantly more effective in preventing pregnancy than contraceptive pills or barrier methods. They are also highly cost effective even if the duration of usage is limited to an interval of one year or less.⁵

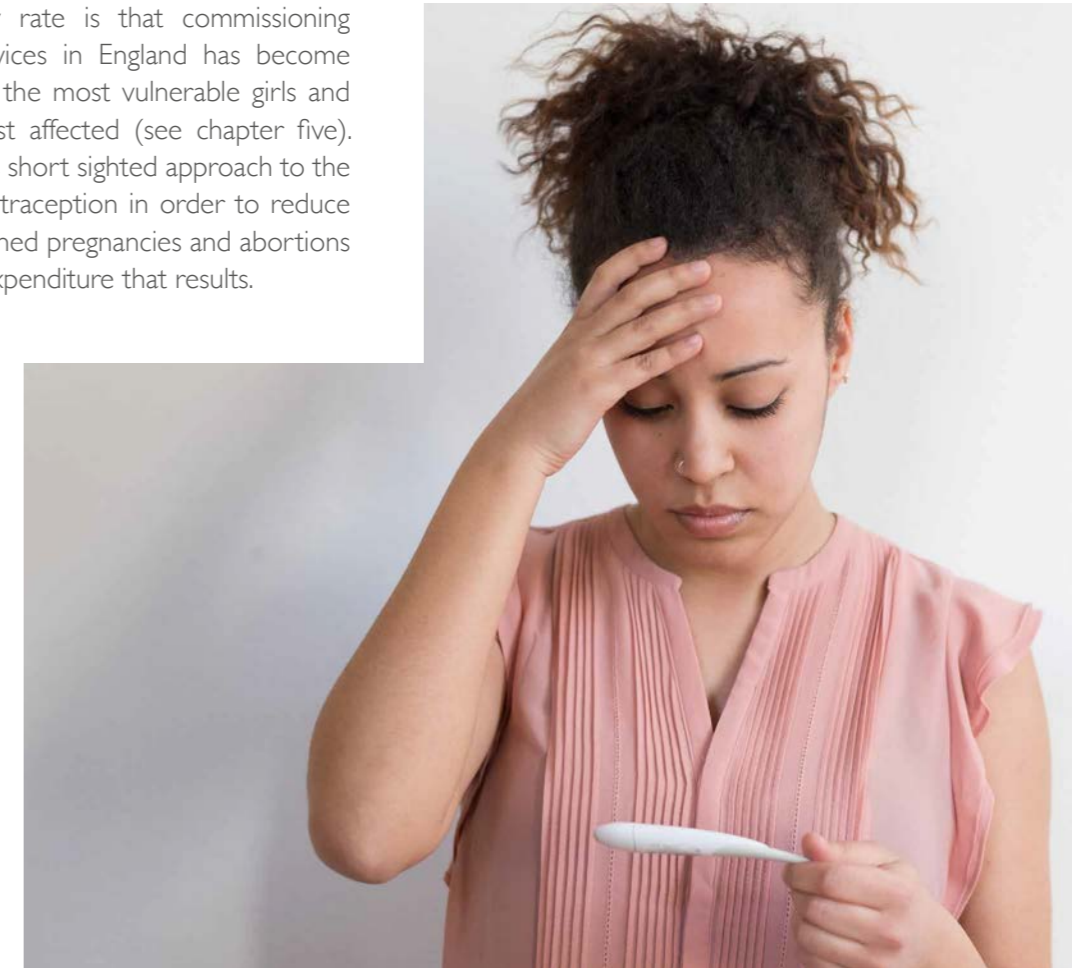
Despite lessons learned from the successful national teenage pregnancy strategy, which achieved a 41% reduction in the under-18 conception rate following a collaborative effort by local government, health partners and individual practitioners, a recent audit of contraception and abortion services in England has shown that in many areas, access to the full range of contraception (including LARC) is declining or completely lacking. It is also frequently restricted to younger women which is making it increasingly difficult for women who have already had a pregnancy to access suitable contraception.



As a result, conception rates are rising among older women, as are the rates of abortion, indicating that women are having unplanned pregnancies at later stages of their reproductive lives. There is an urgent need to reverse this trend and ensure that all women can easily access evidence-based contraception services. Getting this simple and cost-effective intervention right will dramatically improve quality of life for women.

An important factor contributing to the high unplanned pregnancy rate is that commissioning of contraceptive services in England has become very fragmented and the most vulnerable girls and women are the worst affected (see chapter five). We have to tackle this short sighted approach to the commissioning of contraception in order to reduce the number of unplanned pregnancies and abortions and the health care expenditure that results.

Contraception is the single most cost-effective intervention in healthcare.⁶ Public Health England (PHE) estimates that every £1.00 invested in the provision of contraception achieves a £9.00 saving⁷ across the public sector.



Health indicators before, during and after pregnancy

Before pregnancy

Supporting women to be as healthy as possible before pregnancy, in order to increase fertility, have an uncomplicated pregnancy and achieve the best outcomes for both mother and baby, should be a key priority. However, the continuing prevalence of risk factors such as obesity and smoking during pregnancy, as discussed below, indicates that opportunities to optimise women's health in the pre-conception period are being missed.

It also suggests that the information currently offered to girls and women about being healthy before pregnancy is either not effective or is not being delivered in the right way. It is clearly not getting through to many of the women we want to reach. Health services need to find innovative ways of communicating with girls and women at an early stage in their reproductive lives, in order to highlight the importance of eating a healthy diet, having a normal body mass index (BMI), being physically active, stopping smoking, avoiding alcohol and recreational drugs and taking supplements of folic acid in the pre-conception period.

The RCOG supports programmes that promote these healthy behaviours,⁸ which help to achieve the best outcomes for mother and baby and benefit the NHS purse by helping to prevent the onset of costly long-term conditions.



“ I try to support and encourage women to make positive choices about their lifestyle and health.

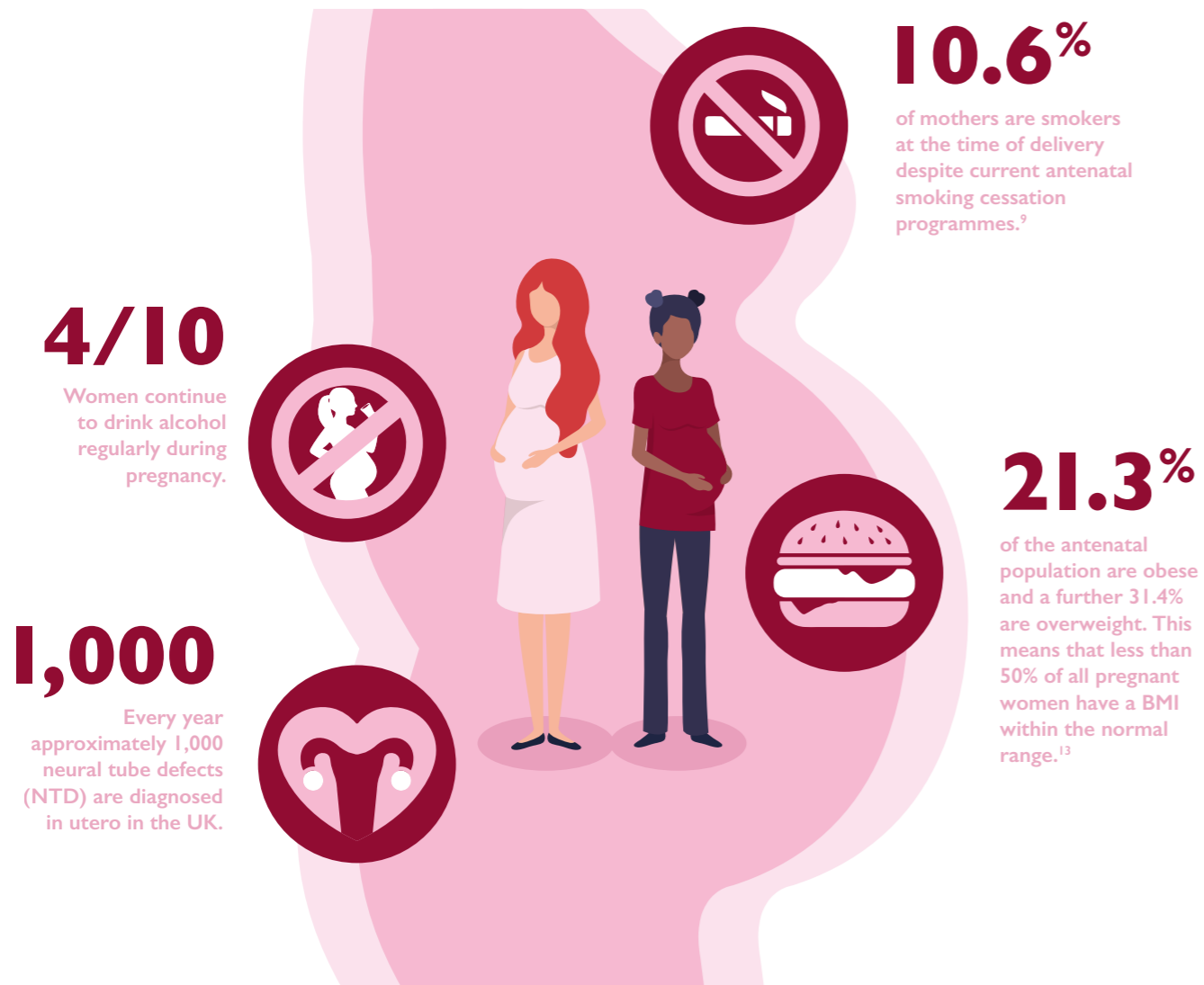
This is as important for all girls and women as it is for a woman and her baby during pregnancy. Throughout a woman's life course it is important that she does as much as she can to improve her health.

”

Professor Janice Rymer, Consultant Gynaecologist at Guy's and St Thomas

During pregnancy

During pregnancy women interact with health professionals on multiple occasions and often feel motivated to make positive changes to their health and health behaviours. However, some pregnant women in the UK are not being adequately supported to optimise their own health and that of their baby's at this critical time of life. This is shown by:

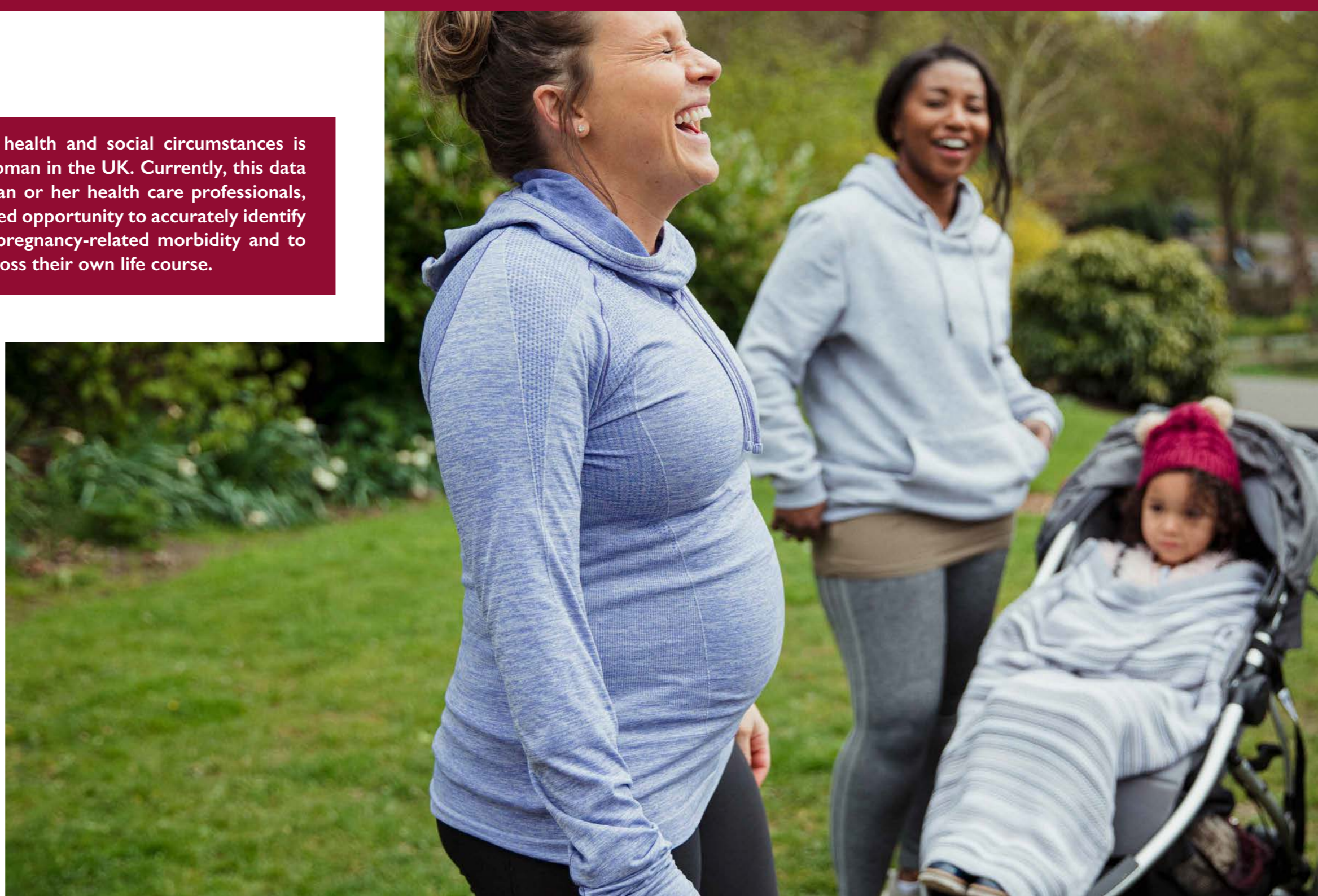


- ✗ **Smoking during pregnancy seriously harms the health of mothers and their babies** and is responsible for an increased rate of stillbirths, miscarriages and birth defects.¹⁰ Smoking is the biggest modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health.
- ✗ **The UK has one of the worst rates in Europe for women drinking during pregnancy** and one of the highest rates of Fetal Alcohol Syndrome in the world.¹¹ Alcohol-specific deaths among females in 2017 reached the highest rate recorded (8.0 deaths per 100,000 females).¹²
- ✗ **Being overweight or obese increases the risk of virtually every complication of pregnancy,** delivery and the postnatal period for both the mother and her baby. This includes miscarriage, stillbirth, gestational diabetes, pre-eclampsia and eclampsia, operative delivery, anaesthetic complications, wound infection, severe blood loss and mental health issues.¹⁴ Women who are overweight are also less likely to start or maintain breast feeding.
- ✗ **In 85% of cases with neural tube defects, the pregnancy ends in an abortion** – more than two procedures per day. Furthermore, two babies are born every week in the UK with a neural tube defects (NTD) that results in a lifetime need of specialist medical care. The simple fortification of flour with folic acid will prevent approximately half of all neural tube defects.¹⁵
- ✗ **Ethnicity, maternal age and social inequalities have a marked effect on pregnancy outcomes in the UK.** Black women are five times more likely to die from pregnancy complications than white women. Asian women are twice as likely to die from pregnancy complications as white women. Mothers aged 40 years or more have a threefold higher risk of dying, as do pregnant women living in the most socially deprived circumstances.¹⁶

Detailed data about physical and mental health and social circumstances is routinely collected from every pregnant woman in the UK. Currently, this data is not easily accessible to either the woman or her health care professionals, during or after her pregnancy. This is a missed opportunity to accurately identify those women who are at greater risk of pregnancy-related morbidity and to empower them to improve their health across their own life course.

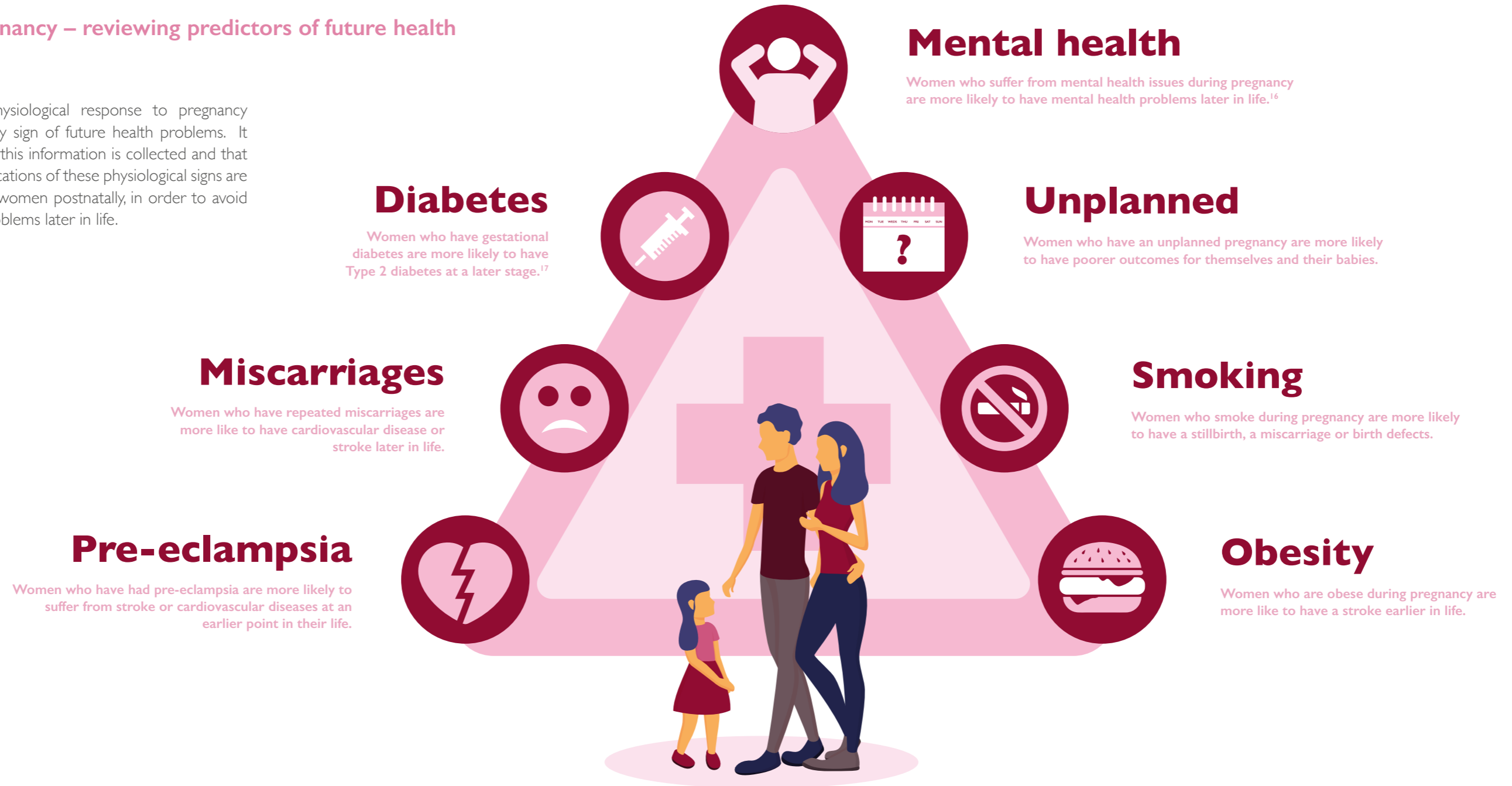
For example, the 2014-16 MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires Across the UK) report identified that the marked increase in mortality among black women could be accounted for by pre-existing medical problems, anaemia during pregnancy, diabetes, previous pregnancy problems, multiple pregnancy, poor antenatal care, substance misuse, maternal age and unemployment.

Since all of these risk factors are recognisable during pregnancy, the NHS needs to develop robust methods to capture and share these data for each individual woman, in ways that ensure that everyone involved in her care can access and utilise them.



After pregnancy – reviewing predictors of future health

A woman's physiological response to pregnancy may be an early sign of future health problems. It is essential that this information is collected and that the future implications of these physiological signs are discussed with women postnatally, in order to avoid preventable problems later in life.



Currently, this does not happen routinely, meaning that opportunities to improve individual women's health in the future are missed. There are four areas where this is particularly important:

Pre-eclampsia

Pre-eclampsia affects up to 6% of pregnancies in the UK and severe pre-eclampsia develops in 1-2% of these pregnancies.¹⁷ Women who become hypertensive during pregnancy or postnatally are nearly twice as likely to suffer cardiovascular disease (frequently developing at an earlier age) than those who have a normal blood pressure during pregnancy.¹⁸

Gestational diabetes

Women with gestational diabetes are seven times more likely to suffer Type 2 diabetes in the future.¹⁹ It is estimated that 50% of gestational diabetics have become Type 2 diabetics within 10 years of their pregnancy. Gestational diabetes affects around 5% of pregnant women.²⁰ It is increasing in prevalence due to demographic changes in the childbearing population – more women are now overweight before, during and after pregnancy, and maternal age is increasing.

Obesity

Maternal obesity places mother and baby at a markedly increased risk of obstetric complications – including maternal death – and can lead to serious health problems for both later in life. In the 2014-16 MBRRACE-UK report, 37% of the women who died were obese and a further 20% were overweight.²¹ There is clear evidence that weight loss between pregnancies reduces the risk of stillbirth, hypertensive complications and large babies and increases the chances of a normal vaginal delivery following previous caesarean section.

Obese women are also at increased risk of suffering a venous thromboembolic event (VTE), heart attack or stroke in later life and of developing some types of cancers, particularly breast and uterine.²²

The children of obese mothers are at greater risk of congenital abnormalities, stillbirth, prematurity, macrosomia and neonatal death. In utero exposure to maternal obesity is associated with a six-fold increased risk of the baby developing Type 2 diabetes and obesity later in life if preventative measures to lose weight are not taken.²³

Mental health

One in four women suffer from mental health problems during pregnancy,²⁴ which increases their risk of suffering a subsequent episode later in life. Mental health problems can have a huge negative impact on all aspects of life, including work, personal and family relationships. They are also detrimental to physical health and serious mental illnesses are estimated to reduce life expectancy by up to 20 years.²⁵

While it is very common for new mothers to have a short-lived period of the 'baby blues', 10–15% of new mothers develop a much deeper and longer-term depression called postnatal depression (PND).²⁶ It can be difficult for busy healthcare professionals to spot the signs of PND and opportunities to support women and prevent their mental health from deteriorating are being missed regularly. Alarming, psychiatric disease is now a leading cause of maternal deaths during pregnancy the first year after birth.



The six week check

The six week postnatal check is equally important for the mother as it is for the baby. It is an ideal time to review all the collected pregnancy health data and provides another opportunity for medical follow-up and planning for future health care.

This can include giving a new mother advice about how to lose any weight she may have gained during pregnancy, directing her to services to help her quit

smoking, informing her about safe alcohol guidelines and ensuring that she is offered effective, reliable contraception to avoid the future obstetric problems associated with short inter-pregnancy intervals.

Used wisely, this is an important means of spotting and treating physical, mental and emotional issues, making a specialist referral where necessary and preventing problems from escalating. Whilst some women are offered the option of an excellent six week check, not all GP practices are funded to include the mother in the check-up. All too often, there is insufficient time for this pivotal appointment and the baby's needs are prioritised over the mother's.

According to a recent National Childbirth Trust (NCT) survey, one in five women say that they were not asked about their emotional or mental wellbeing postnatally.

This means that nearly half of new mothers' mental health problems are missed by health professionals.²⁷ Added to which, the stigma that surrounds mental illness combined with the fear that acknowledging that they are suffering from a mental health problem might result in their baby being taken away from them, may make new mothers reluctant to disclose their mental health problems.²⁸

“ The 6-8 week postnatal check is a golden opportunity for a conversation to take place with all women about their mental health and wellbeing. ”

GPs need to be supported to have an awareness of what they are looking for, what questions they should be asking and when and how to refer to specialist services and/or local support groups if needed.

Maria Viner, CEO Mothers for Mothers Bristol and RCOG Women's Network member



Safeguarding vulnerable girls and women

The many health professionals who are engaged with delivering maternity services are particularly well placed to detect the signs of violence against girls and women and to help safeguard them, both during pregnancy and the postnatal period.

1,370,000

There were an estimated 1,370,000 female victims of domestic abuse in the UK in 2017/18.



£66 billion

The social and economic cost for victims of domestic abuse in England and Wales is estimated at £66 billion annually.

1/4

One woman in four experiences domestic violence in her lifetime.



No boundaries

Domestic violence has no boundaries.

9/100

Four to nine in every 100 pregnant women are abused during their pregnancy or soon after birth.



10

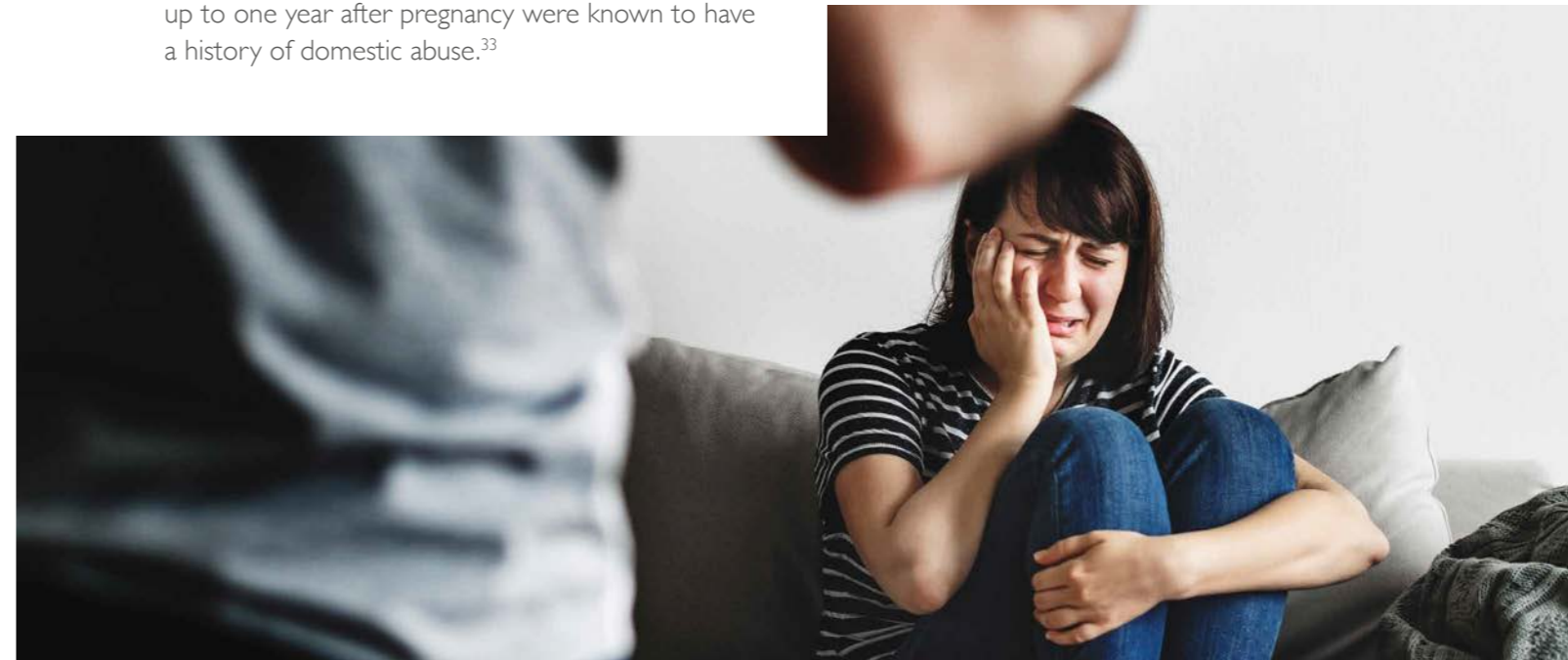
Ten women were murdered during or up to six weeks after pregnancy in the UK in 2014-16.

Around one woman in four will experience domestic violence in her lifetime²⁹ and in 2017 there were over a million female victims of domestic abuse in the UK.³⁰ Domestic violence may be triggered by and frequently accelerates during pregnancy.

As many as 10% of all women are abused during their pregnancy or soon after the birth of their baby.³¹ The latest 2014-16 MBRRACE-UK report found that 10 women were murdered by an intimate partner or former partner during pregnancy and the six week postnatal period.³² Furthermore, 17 of the women who died by taking their own life during pregnancy or up to one year after pregnancy were known to have a history of domestic abuse.³³

Training healthcare professionals to recognise the signs of domestic violence, adopting techniques to encourage disclosure and ensuring that all maternity staff are aware of the local support networks available for women and how to refer them for help are vitally important. Hospital staff used to have mandatory training in gender based violence but this is sadly on the decline due to the competing pressures of staff shortages and multiple additional training needs.

However, finding ways to encourage a pregnant woman to disclose what she is experiencing without fear of the consequences can literally be life saving. For example, some hospitals place small stickers in clinic toilets for women to place on the bottom of their urine sample pot, so they can disclose that they are at risk without fear of being found out.



In January 2019, the UK Government published its draft Domestic Abuse Bill.³⁴ The RCOG is very supportive of this legislation and believes that it is an opportunity to help safeguard women by making real and substantial improvements in the support offered to the survivors of domestic abuse and their families.

A case of Female Genital Mutilation (FGM) is reported in England roughly every 100 minutes.³⁵

Those girls at greatest risk often live in marginalised communities and do not necessarily come to the attention of local social services. They may be subjected to FGM before they start school, during school holidays or before their family moves to the UK.³⁶

Depending on the grade and severity of the procedure performed, the consequences of FGM later in life can be highly significant and include painful sexual intercourse, inability to have sex at all, vaginal cyst formation, difficulties passing urine, painful periods, infertility, recurrent urinary and pelvic infections, complications during labour and delivery, significant psychological sequelae and mental health problems.

The physical signs of FGM may become evident for the first time in pregnancy during an antenatal visit. However, opportunities to safeguard victims and minimise delivery complications will be missed unless appropriate examinations are performed and the findings carefully recorded. However, the outdated IT systems used to record information about victims of FGM are not user friendly, which results in further cases being lost to follow up or the data sets remaining incomplete. The announcement of a new network of community FGM support clinics – in Birmingham, Bristol, London and Leeds – in September 2019 is warmly welcomed.³⁷



In England and Wales, mandatory reporting to the police of all cases of FGM in girls under 18 years of age by healthcare professionals and teachers was introduced in October 2015.³⁸ However, there is no legal requirement for healthcare professionals to report cases of FGM in adult women in England, Wales or Northern Ireland and Scotland's Female Genital Mutilation (Protection and Guidance) Bill introduced in May 2019 does not include mandatory reporting of FGM to the police.

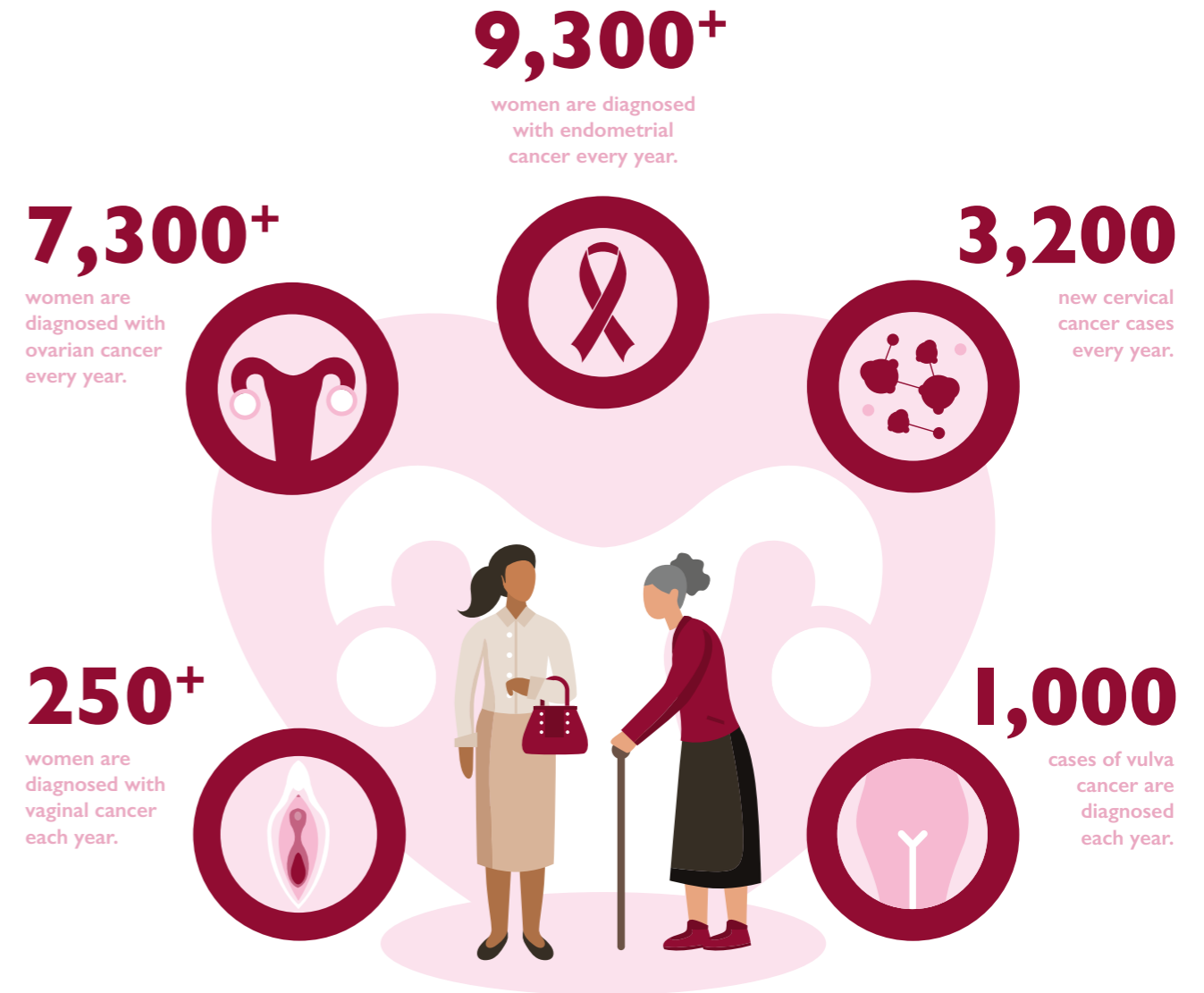
The prevalence of all forms of violence against women has largely remained unchanged since before the UK Government's strategy on ending violence against girls and women was published in 2016. We all need to work together to ensure that violence against girls and women is eradicated.



Gynaecological cancers – prevention and early diagnosis

A worryingly high number of women are diagnosed with late-stage gynaecological cancers in the UK. Every day, 58 women are diagnosed with one of the five gynaecological cancers and 21 women die of their disease.³⁹

- **More than 7,300 women are diagnosed with ovarian cancer and 4,200 women lose their lives each year, or 11 women every day.**⁴⁰ Ovarian cancer is the second most common gynaecological cancer and is often referred to as the 'silent killer', since around 70% of patients present with advanced disease due to delayed diagnosis because of non-specific symptoms. The UK has the worst survival rates in Europe. Only 34% of women survive for five years compared to a European average of 41%.⁴¹
- **More than 9,300 women are diagnosed with uterine cancer every year.**⁴² In the UK, uterine or endometrial (womb) cancer results in some 2,200 deaths each year - 6 women per day.⁴³ Incidence increases with age and peaks in women aged between 70 and 74 years. It is predicted that obesity will further increase the number of cases of uterine cancers to 11,000 per year by 2030 – an increase of 18%.
- **There are around 3,200 new cervical cancer cases every year.** Around 870 women lose their lives to cervical cancer deaths annually, which is more than two every day.⁴⁴ The introduction of the HPV vaccination programme for all school children in 2019 should reduce the incidence of cervical cancers significantly.
- **Just over 250 women are diagnosed with vaginal cancer each year.**⁴⁵ There are around 100 women that die of vaginal cancer deaths in the UK every year - around two deaths every week.⁴⁶
- **Around 1,000 cases of vulvar cancer are diagnosed each year.**⁴⁷ The risk of vulvar cancer goes up as women age and more than half of cases occur in women over age 70.⁴⁸ There are around 440 vulvar cancer deaths in the UK every year. This means that one woman loses her life to this cancer every day.⁴⁹





The UK lags behind its European counterparts in terms of gynaecological cancer survival rates due to the combination of a lack of knowledge of symptoms among women, low uptake of screening, which is an essential part of the prevention and early diagnosis of these cancers, and a lack of funded research. Less than 4% of overall medical research funding is focused on research into cancer prevention and less than 3% is focused on women's specific diseases.⁵⁰

Supporting women to maintain healthy lifestyles is also central to preventing many gynaecological cancers.

Women who lead a healthy lifestyle and are not overweight are less likely to develop some gynaecological cancers.⁵¹ For example, Cancer Research UK has argued that being overweight or obese is responsible for 490 cases of ovarian cancer per year.⁵² Similarly, Ovarian Cancer Action has noted that although treatment options are limited, and prevention via screening for the BRCA gene mutation is vital, maintaining healthy lifestyles is one of the strongest weapons to protect against cancer.⁵³

Currently, 70% of uterine cancers are associated with obesity and oestrogen hormone excess. This figure is predicted to increase by 18% - another 1700 cases per year by 2030, unless the obesity epidemic can be halted. Women who present early with uterine or endometrial (womb) cancer have a good prognosis

if they undergo curative treatment. However, being obese compromises the quality of the surgery and anaesthesia required to achieve the best treatment outcomes. Obesity also shortens the disease free follow up interval and reduces long term survival rates.

Most of these women with uterine or endometrial (womb) cancer present early with postmenopausal bleeding (PMB) and have a good prognosis if they undergo curative surgery with or without radiotherapy.

Hence, reducing obesity will have a marked improvement on the incidence of and mortality rates from uterine cancer. It is predicted that the number of new cases will exceed 11,000 per year in the UK by 2030 if we are unsuccessful in tackling the obesity epidemic. Encouraging women to present swiftly if they experience an episode of PMB will also lead to earlier referrals for treatment and improved outcomes.

Laparoscopic and, more recently, robotically assisted surgery techniques are associated with lower levels of post-operative complications and decreased length of hospital stay. These advantages should allow more women to receive definitive surgery in cases where age, obesity and other co-morbidities mean that their operative risks of major open surgery are high.

Cervical screening

Cervical screening programmes are highly effective and have the potential to prevent 70% of cervical cancer deaths but uptake of the UK's cervical screening programme has declined for four consecutive years and is now at a 20 year low.⁵⁴ In short, one in three women invited for a cervical smear test do not attend.

The number of deaths from cervical cancer is predicted to grow by 143% - from 183 in 2015 to 449 in 2040.⁵⁵

Hence it is of vital importance that we maintain efforts to ensure maximal uptake of cervical screening and HPV vaccination. Women outside of the screening programme because of their age (under 25 or over 65 years of age) who develop symptoms of cervical cancer such as vaginal bleeding after sex, bleeding in between periods or post menopausal bleeding need to be encouraged to seek help and referral for colposcopy if necessary.



Some groups of women are significantly less likely to attend cervical screening than others. NHS England recently highlighted that survivors of sexual abuse and 19% of lesbian, gay and bisexual (LGB) women who are eligible for cervical screening have never been to an appointment. This is partly due to the commonly held but false belief that LGB women are not at risk of HPV.⁵⁶

Black, Asian and Minority Ethnic (BAME) women and women with lower incomes are also less likely to attend screening than other women.⁵⁷

The reasons for this include language barriers, religious beliefs and the belief that screening is unnecessary in the absence of symptoms.⁵⁸

There are additional difficulties for women with physical disabilities, visual impairments and those who are living with mental health problems and learning disabilities. These women will likely need additional support and information to encourage them to attend cervical screening.⁵⁹ Other groups of women for whom the cervical screening programme fails are those in detention centres, refugees, asylum seekers, prisoners, homeless women and travellers.



Around 80% of women would prefer to have an alternative, non-speculum test in the comfort of their own home.⁶⁰

The move to HPV primary testing should therefore help to increase uptake among many women.

This could be particularly important for those groups who are less represented at screening, giving them the opportunity to take part without needing to attend an appointment. HPV primary screening was introduced in Wales in September 2018 and the test is expected to be available in Scotland, Northern Ireland and England by late 2019/2020.⁶¹



General health during and after the menopause

The menopause affects all women at some stage in their life but many women do not know what to expect during the menopause nor do they feel empowered to seek help when needed or able to manage their symptoms. This is particularly challenging for the 25% of menopausal women who experience severe symptoms and can lead to the onset of potentially avoidable health problems in the future.

Supporting women to stay working

Women represent nearly half of the working population and many of them remain in employment through their menopausal years. There are over 3.5 million female workers aged over 50 in the UK and if the workforce trend continues, this figure is set to rise.⁶² The menopause should be seen as a 'health and work' issue in the workplace.⁶³

Women with severe symptoms have found that they are not well equipped or supported to manage at work.⁶⁴ A survey conducted by Wellbeing of Women in conjunction with ITV found that half of the women they interviewed considered that menopausal symptoms had made their working life worse and one quarter agreed that they had considered leaving their jobs altogether because of the menopause.⁶⁵ The intention to stop working due to problematic hot flushes has been cited as an issue in numerous studies.⁶⁶

The menopause remains a taboo subject which prevents women from discussing their experiences with their managers and colleagues and asking for support and appropriate medications. This adds to feelings of stress and anxiety. This is usually due to reasons of privacy, difficulty in discussing the menopause with male managers and embarrassment.⁶⁷ This is borne out by a poll of 1,009 women aged 50 to 60 undertaken for BBC Radio Sheffield and Radio 4's Woman's Hour, which found that 70% of respondents did not make their employer aware they were experiencing symptoms.⁶⁸

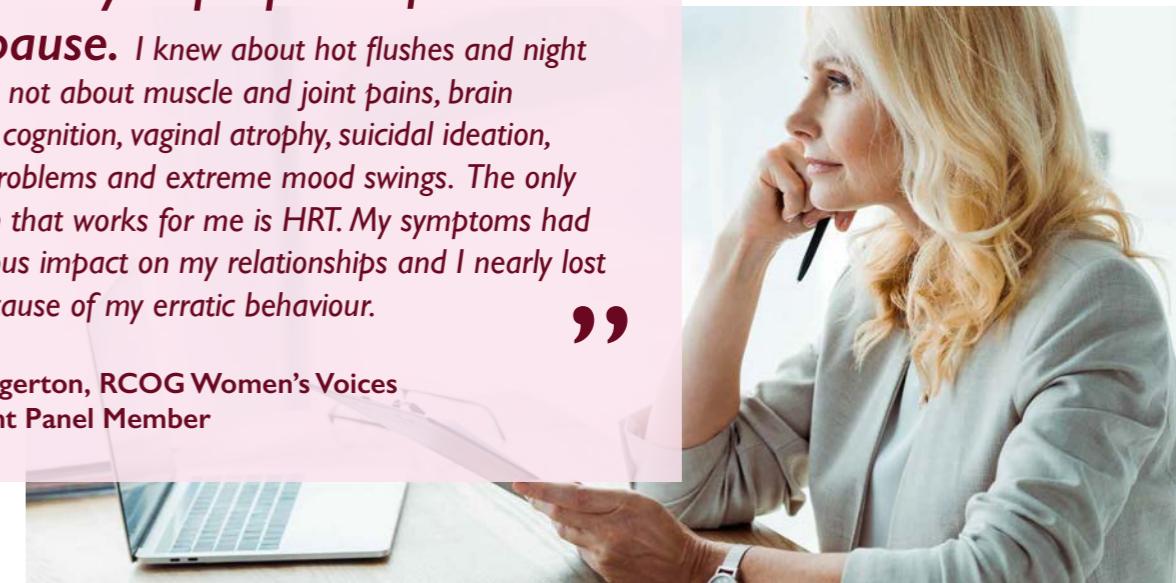
Key to enabling women to manage their own health, stay at work and prevent future health problems is access to appropriate medication and support. However, a generation of women have lost the opportunity of improved quality of life during their menopausal years due to reports about the safety of hormone replacement therapy (HRT).⁶⁹ The number of women taking HRT more than halved between 2002 and 2015 after the Million Women Study linked the hormone treatment to an increased risk of breast cancer.⁷⁰ To put the risk into context, the extra risk of breast cancer associated with being overweight or obese is six times higher than the extra risk associated with combined HRT, according to NICE.⁷¹ As such, it is critical that women and clinicians have access to accurate information so they can make informed decisions about relative risks and treatment.

The Government Equalities Office has estimated a total of £7,276,334 absence-related costs annually for UK women with severe symptoms of menopause.⁷²

If we reverse this trend and get this right for women, the personal and economic benefits could be substantial. A study undertaken for the Department of Work and Pensions, for instance, estimated that if 0.6 million more post-menopausal women worked full-time, **£20 billion** could be added to GDP.⁷³ Action needs to be taken now, to prepare for the inevitability of the ageing workforce and to improve the day to day lives of all women going through their menopausal years.

“ I was totally unprepared for the menopause. I knew about hot flushes and night sweats but not about muscle and joint pains, brain fog, loss of cognition, vaginal atrophy, suicidal ideation, digestive problems and extreme mood swings. The only medication that works for me is HRT. My symptoms had an enormous impact on my relationships and I nearly lost my job because of my erratic behaviour. ”

Rachael Edgerton, RCOG Women's Voices Involvement Panel Member



Maintaining healthy bones

Osteoporosis is a major cause of ill-health and death and affects around three million people in the UK. Post-menopausal women are the most common sufferers and it is estimated that women can lose up to 20% of their bone density during the five to seven years after the menopause.⁷⁴

Around one in three adults over 65 who live at home will have at least one fall a year, and about half of these will have more frequent falls.⁷⁵ One in five women who have broken a bone break three or more before being diagnosed with osteoporosis.⁷⁶

In addition, more than 500,000 people receive hospital treatment for fragility fractures - a fracture that has been caused by a fall from a standing height or less - annually as a result of osteoporosis.⁷⁷

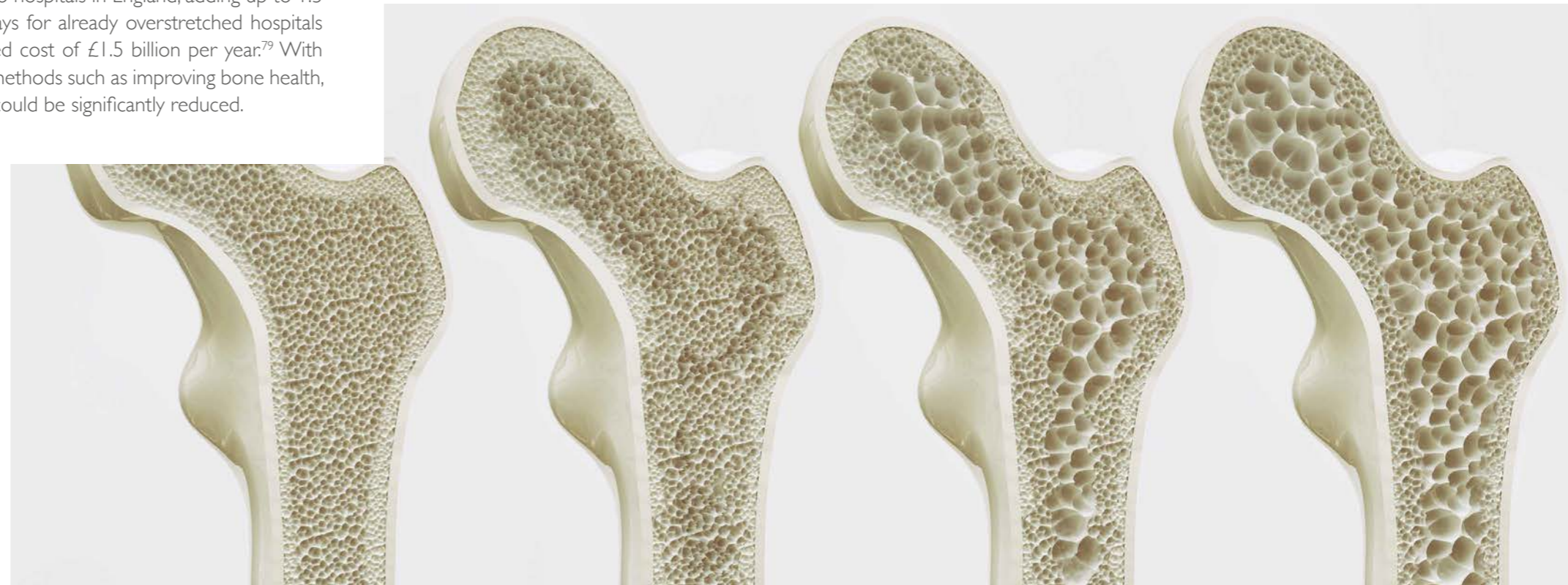
For women with brittle bones, falls can be a major threat to their quality of life, leading to prolonged stays in hospital which are associated with loss of independence, isolation, depression and in the case of a fractured femur significantly increased rates of both general morbidity and mortality.⁷⁸

Falls also have significant economic consequences due to the cost of inpatient care, loss of independence and residential care. Fragility fractures are estimated to cost the UK around £4.4 billion each year. Hip fractures alone account for 69,000 emergency admissions into hospitals in England, adding up to 1.3 million bed days for already overstretched hospitals at an estimated cost of £1.5 billion per year.⁷⁹ With preventative methods such as improving bone health, these figures could be significantly reduced.

As the population is ageing, it is of vital importance for the NHS to aim to prevent osteoporosis and consequential fragility fractures.

To help achieve this, women going through the menopause must be informed about the lifestyle choices they can make to help prevent osteoporosis and improve their overall health as they age.

This includes regular weight bearing exercise, good nutrition and calcium and vitamin D supplements, all of which help to maintain bone density. It is crucial to empower women with this knowledge before and during the menopause as the effects of not doing so can be significant. Furthermore, HRT can help to maintain bone density and reduce the risk of osteoporosis for the duration of the treatment, but long-term use is required.⁸⁰



Pelvic floor health

Pelvic floor health is another important area where greater preventative care is needed.

The organs within a woman's pelvis (uterus, bladder and rectum) are normally held in place by ligaments and muscles known as the pelvic floor. These muscles come under strain during pregnancy and childbirth. This can lead to stress incontinence – leaking urine when coughing, sneezing or straining, and faecal incontinence. It can also lead to pelvic organ prolapse, whereby the pelvic organs can bulge (prolapse) from their natural position into the vagina. It is important to note that pelvic floor problems are age related and can therefore affect women who have not been pregnant or given birth.

The risk of developing incontinence and pelvic floor prolapse is significantly reduced with pelvic floor exercise. Women should be informed about the benefits of maintaining a healthy pelvic floor from an early age, with particular emphasis on preventing the onset of problems following pregnancy and childbirth.

Pre- and postnatal appointments need to have a stronger emphasis on pelvic floor exercises and information about the importance of a healthy pelvic floor. It should also be discussed at ongoing interactions with the health service, for example, at the NHS Health Check or at cervical screening appointments, regardless of whether a woman has been pregnant or given birth.

Furthermore, at all interactions with the NHS, women should be encouraged to make healthy lifestyle choices that can reduce the risk of getting a prolapse or could stop mild symptoms from getting worse. As the NHS UK website notes, they include maintaining a healthy weight or losing weight, eating a high fibre diet, avoiding lifting heavy objects and stopping smoking.

While prolapse is not considered a life-threatening condition, it causes significant discomfort and distress, decreasing quality of life for many women, and may necessitate surgery.

By the age of 80, it is estimated that more than one in ten women will have undergone some form of surgery for prolapse.⁸¹

Urinary and faecal incontinence affects the lives of over five million women in the UK. After pregnancy 33% and 10% of women report urinary and faecal incontinence respectively. Ten years later 20% of all women who have been pregnant continue to suffer a degree of urinary and 3% report faecal incontinence.

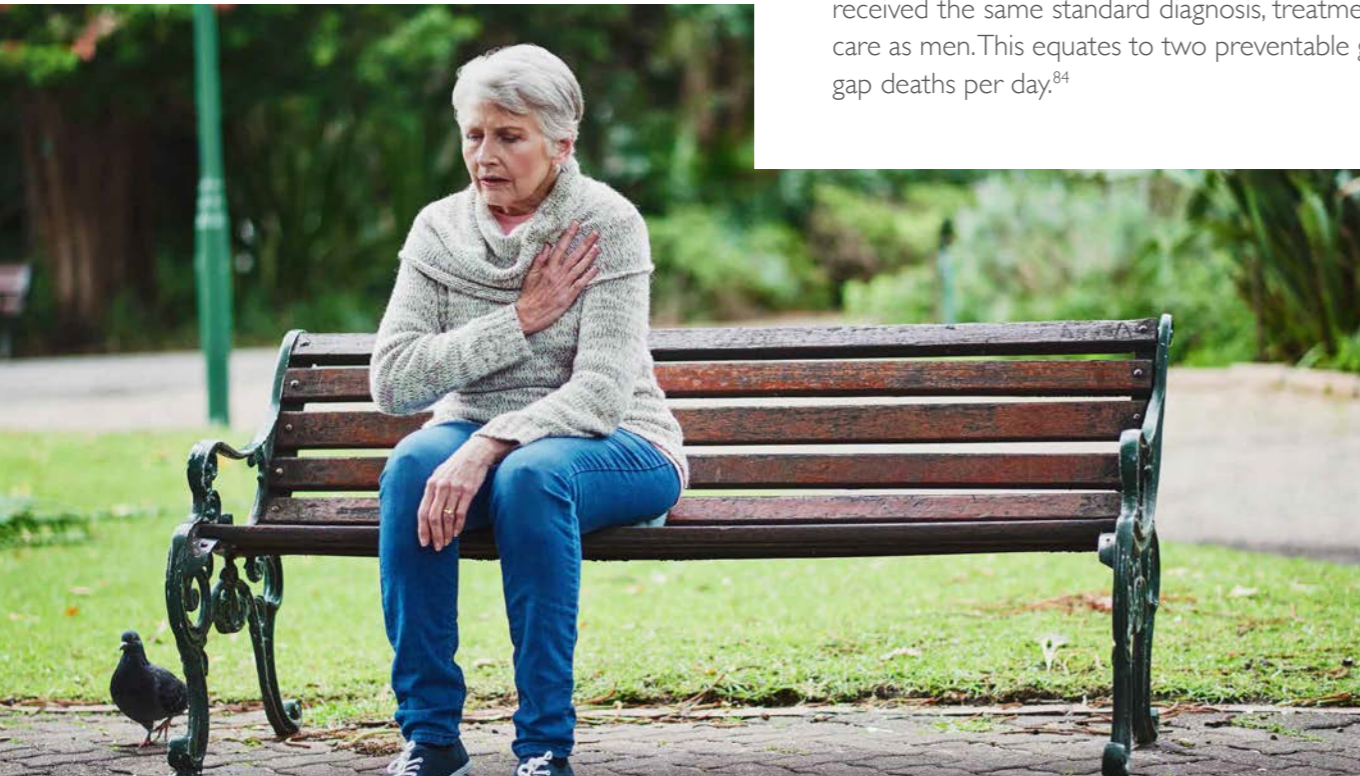


Cardiovascular disease

Coronary heart disease and heart attacks are often considered to be more of a problem for men than for women. However, cardiovascular disease (CVD) is the leading cause of morbidity and mortality in postmenopausal women.⁸²

Furthermore, 35,000 women are admitted to hospital following a heart attack in the UK each year - an average of four women per hour – and coronary heart disease kills twice as many women as breast cancer in the UK.⁸³

Despite these startling facts, a recent report has found that there is a 'heart attack gender gap' that is needlessly costing women their lives. A study funded by The British Heart Foundation (BHF) reported that over a ten-year period, more than 8,200 deaths from health attack among women in England and Wales could have been prevented if these women had received the same standard diagnosis, treatment and care as men. This equates to two preventable gender gap deaths per day.⁸⁴



Factors contributing to this disparity, which need to be tackled, include:

- X Delays in seeking medical help:** The average delay between the onset of symptoms and arrival at hospital for men is usually significantly lower than for women, who are less well-informed about the signs and symptoms.⁸⁵
- X Misdiagnosis:** Women are twice as likely to have an initial misdiagnosis than men, which increases their risk of dying by 70%.⁸⁶
- X Inferior treatment:** Women are 34% less likely than men to receive standard treatments including bypass surgery and stents.⁸⁷
- X Risk factors for women:** The risk of CVD greatly increases after the menopause when estrogen levels reduce.⁸⁸ Pre-eclampsia or gestational diabetes can increase the mother's long-term risk of high blood pressure and diabetes which increases her risk of heart disease.⁸⁹ In addition, smoking, high blood pressure and Type 2 diabetes increase women's risk of heart attack significantly more than they do for men.⁹⁰

- X Poorer aftercare:** Women are 24% less likely to be prescribed statins, which help to prevent another heart attack, and 16% less likely to be given aspirin, which help to prevent blood clots.⁹¹
- X Gender bias in medical research:** Women are less likely to be invited to, or participate in, medical trials and research.⁹² Diagnostic techniques and treatments for cardiovascular diseases have been based upon research conducted predominantly on men meaning that there is a possibility that treatments could be less effective in women than men.⁹³

Caroline Criado Perez, in her book *Invisible Women*, discusses the gender data gap, which, in a world built on data, has very real consequences for women. The example of cardiovascular disease is only one way that women are disadvantaged by research and data built and modelled primarily around men. This is despite that fact that women make up 51% of the population. It is important that clinical research properly reflects society, and that we begin to reverse the gender gap that currently persists.

Preventing the early onset of dementia

Dementia is a broad term used to describe a range of conditions affecting the brain. There are over 200 subtypes of dementia. The most common are:⁹⁴

Alzheimer's disease: this is the most common form of dementia accounting for around 60% of diagnoses in the UK.

Vascular dementia: this is the second most common form of dementia in the over 65 age group, accounting for 17% of diagnoses in the UK.

Dementia with Lewy bodies: this accounts for 10-15% of all cases of dementia in the UK.

Frontotemporal dementia: for people under the age of 65, this is the second most commonly diagnosed dementia. It is less common in people over the age of 65.

Mixed dementia: 10% of people with dementia have 'mixed dementia' – a condition where a person has more than one type of dementia. The most common is a combination of Alzheimer's disease and vascular dementia. Mixed dementia is more common in those over 75 years.

Dementia is the leading cause of death for women in the UK.⁹⁵ The biggest risk factor for dementia is age.⁹⁶ Women are therefore more likely than men to develop dementia in their lifetimes, due to their longer life expectancy. Indeed, 65% of people living with dementia are women.⁹⁷

At the same time women are more likely to take on the role of caring for someone with dementia. It has been estimated that the number of people with dementia will rise to over one million by 2025, assuming that there are no major new public health interventions.⁹⁸

Although the exact causes of dementia are unclear, research has concluded that exercise, mental stimulation and maintaining a healthy weight may

help to protect people from dementia whilst smoking and drinking can increase the risk.⁹⁹ It is essential that women are aware of the importance of maintaining healthy lifestyles as a preventative measure against the early onset of debilitating conditions such as dementia. Furthermore, the importance of clinical trials researching women and dementia cannot be underestimated.

Economic impact of dementia

A report on the economic impact of dementia in the UK, published by the Alzheimer's Society, found that it costs the NHS an estimated £26 billion a year, with an additional £5.8 billion in social care costs being covered by people living with dementia and their carers.¹⁰⁰



RCOG recommendations

1. Post-pregnancy contraception should be a key part of the maternity pathway.

- NHS England, NHS Scotland, NHS Wales and Health and Social Care Northern Ireland must embed immediate post-pregnancy contraception maternity pathways and support for all women. Until 100% implementation has been achieved, clear referral pathways into general practice or sexual and reproductive healthcare clinics should be provided. All midwives and allied health professionals should be trained to provide this important aspect of this holistic maternity pathway and reproductive care.

2. Accessing the full range of contraception methods should be as easy as possible for all women.

- Missed opportunities and barriers to women accessing contraception, in particular long-acting reversible contraception (LARC), and contraceptive advice and counselling need to be addressed. The RCOG supports Public Health England's (PHE) planned efforts to increase uptake of LARC in general practice as part of its action plan on women's reproductive health (due to be published in 2020). Furthermore, we support calls from the Faculty of Sexual and Reproductive Healthcare (FSRH) for funded training courses on contraception and the introduction of incentives to provide LARC in general practice.¹⁰¹ The inclusion of a LARC indicator within the Primary Care Quality Outcomes Framework (QOF) would act as a significant step in counteracting the challenges threatening the training of primary care clinicians to deliver LARC.

3. Introduce a life course approach to preventing non-communicable disease in women and their children supported by data collection before, during and after pregnancy.

- The data collected during pregnancy should be used more effectively to help identify indicators for future health. Data regarding women's general health and life-style habits including whether they smoke, how much they drink, their BMI and mental health concerns should be collected and monitored throughout the pregnancy and beyond. All health data collected should be made accessible for the woman as well as clinicians and should be updated by both parties regularly.
- Maternity and SRH data can be integrated by the inclusion of outcomes such as the London Measure of Unplanned Pregnancy in the antenatal booking history which can be used to monitor the effectiveness of preconception and family planning services and identify areas for action.
- The RCOG supports the work of the Maternity Transformation Programme towards interoperable, digitised maternity records, accessible by healthcare professionals and women alike. This programme of digitisation will help realise our ambition for more effective use of data collected during pregnancy, to help identify and prevent the future onset of disease. For example, GPs would be able to access maternity records at the time of the six-week maternal health check and beyond, to enable discussion with women about the potential future impact of any health problems they experienced during pregnancy. Women would be much more aware of their own health risks and therefore better able to manage their own health and raise any concerns with healthcare professionals in the future.

4. UK Governments should take strong action to improve the health of pregnant women and their babies.

- The introduction of mandatory fortification of all flour and gluten-free products with folic acid would reach women most at risk in our society who have poor diet and low socioeconomic status, as well as those women who may not have planned their pregnancy.

- We support the UK Government's Green Paper's smoke-free by 2030 ambition – This can be achieved by following the recommendations of the Smoking in Pregnancy Challenge Group led by Action on Smoking and Health (2018 Report).¹⁰²
- Pre-conception public health should be prioritised to improve the health of women planning pregnancy. Women should be offered advice on body weight and lifestyle in primary care, such as during pre-conception counselling and appointments about contraception. A structured weight-loss programme and a referral to a dietician or an appropriately trained healthcare professional may be recommended where appropriate. This should be delivered by Primary Care Networks in England, included in Scotland's Health Promoting Health Services, placed into the Welsh Government's 'Healthier Wales' plans and considered by Northern Ireland's Transformation Advisory Board. Attention to pre-conception optimisation of pre-existing medical conditions is essential to complement this approach and will help to reduce the number of maternal deaths.

5. Improve identification of women at risk from mental and physical health issues at the six week postnatal check.

- The RCOG welcomed the UK Government's recent focus on perinatal mental health. We must ensure that opportunities are not missed to prevent physical and mental problems in preparation for future pregnancies or to improve women's health for later life. The RCOG supports the NCT's Hidden Half campaign that calls for better six week postnatal check-ups that focus on mothers as well as babies. We support the campaign's ask for improved guidance, tools and education for healthcare professionals in primary care on best practice around maternal mental health.¹⁰³ There also needs to be a more joined-up approach to data sharing about known vulnerable patients between primary and secondary care services. All clinicians should be made aware of local support groups for these patients to make redirection as seamless as possible.

6. End violence against girls and women via an improved collaborative approach, better IT systems and mandatory training.

- NHS Trusts and Health Boards must implement mandatory training in gender based violence. This training should be undertaken every three years and apply to all hospital staff.
- The RCOG encourages NHS Trusts and Health Boards to adopt innovative and sensitive ways to ensure that women can indicate in confidence that they are a victim or at risk of violence and can get support easily. This is particularly important in maternity services, since 30% of domestic violence starts or escalates in pregnancy.
- NHS Digital and NHS Wales Informatics Service should work with clinicians to improve IT systems used to record and submit cases of female genital mutilation (FGM) in England and Wales. It must be as easy as possible for healthcare professionals to use, so that all cases and girls at risk are documented and safeguarded. Mandatory reporting of FGM must extend to Northern Ireland and Scotland's Female Genital Mutilation (Protection and Guidance) Bill (introduced in May 2019) must be revised to include mandatory reporting of FGM to the police as is the case in England and Wales.

7. Increase uptake in cervical screening amongst disadvantaged and marginalised women.

- Every person with a cervix needs to be screened. Health care professionals should use every opportunity to encourage women to undergo cervical screening and reassure them about the benefits of screening and the realities of the procedure. In turn, this will help to increase rates of attendance.
- PHE, Health Protection Scotland, Public Health Wales and the Public Health Agency (Northern Ireland) must improve the uptake of cervical screening among LGBTQ+ people. This could include raising awareness around the causes of cervical cancer.
- Human papillomavirus (HPV) primary home-test screening should be implemented by the respective UK Government administrations without delay.

8. Improve early diagnosis of gynaecological cancers.

- The UK Government must fund an ongoing ovarian cancer audit to continue to build understanding and substantially improve survival rates. Healthcare Quality Improvement Partnership (HQIP) could lead this UK-wide project, building on the expertise and knowledge of the Ovarian Cancer Audit Feasibility Pilot.
- PHE, Health Protection Scotland, Public Health Wales and The Public Health Agency (Northern Ireland) must prioritise campaigns targeting the public and healthcare professionals in primary care to increase awareness of gynaecological cancer symptoms including postmenopausal bleeding (PMB). All women who present with PMB must be referred for further investigation.

9. Women's health issues should be embedded in workplace policies.

- The challenges of common debilitating women's health issues – heavy menstrual bleeding, pelvic pain due to fibroids or endometriosis and the menopause – should be recognised in workplace policy and processes.
- For example, the UK Government administrations should introduce a requirement for mandatory menopause workplace policies to help keep women in work and to break the stigma associated with menopause.¹⁰⁴ These policies should detail the reasonable measures that should be available for women experiencing symptoms, including flexible working patterns and workplace adjustments to make the physical office environment more comfortable. HR departments should offer training and support to line managers. All workplaces should have guidance about the menopause readily available if women request it – the signs and symptoms, self-help advice, and where to seek professional help. As one of the world's largest employers, the NHS should create robust policies and set an example for all employers to follow.
- There have already been several cases where women have been successful at employment tribunals related to the menopause, arguing discrimination under the Equality Act 2010.¹⁰⁵ By implementing comprehensive menopause policies employers can both enhance the working lives of women and reduce their risk of legal challenges.

- Once menopause policies have been put in place, employers should develop policies covering other women's health issues, such as heavy menstrual bleeding and PMDD. This will further help to break down the stigmas associated with women's health and provide extra support for women in the workplace.

10. Increase awareness of pelvic floor dysfunction.

- Public Health England, and respective devolved nation bodies, should create a Taskforce to consider ways of raising awareness of urinary and faecal incontinence and prolapse in women, and improving signposting to resources, self-help information and treatment pathways which alleviate these conditions.

11. End the data gender gap.

- There must be renewed effort to tackle the gender data gap by funding more studies which focus on women's health and responses to treatment to eliminate the gender bias evident in diagnosis, treatment and medical research.

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Fragmentation and access to services

Introduction

All women need to have access to routine healthcare services easily and efficiently. As described in the previous chapter, these healthcare needs are simple to predict. However, we know that many women are struggling to access basic services including contraception, abortion care and cancer screening, due to fragmentation in the way our services are designed and delivered.

The consequences of this include an increase in the number of unplanned pregnancies (resulting in poorer outcomes for women and their babies), a rise in requests for abortion especially among women in older age groups and later diagnosis of cervical cancer.



Commissioning

The current fragmentation of governance and commissioning responsibilities in England has created confusion and barriers for women when trying to access healthcare.

Sexual and reproductive health (SRH) services have been particularly hard hit due to significant financial cuts in public health budgets - a 40% reduction in funding over five years.¹ Commissioning of women's SRH services is currently split between the following organisations:²

CCGs	NHS England	Local authorities
<ul style="list-style-type: none"> ✓ Contraception for gynaecological purposes (e.g. heavy menstrual bleeding) ✓ Abortion services ✓ Sterilisation ✓ Non-sexual health aspects of psychosexual health services ✓ HIV testing when clinically indicated in CCG-commissioned services 	<ul style="list-style-type: none"> ✓ Contraception under the GP contract (e.g. oral contraceptive to prevent unplanned pregnancies) ✓ Cervical screening ✓ HPV Immunisation ✓ STI and HIV testing and STI treatment ✓ Specialist fetal medicine services (e.g. later abortions of pregnancy for fetal anomaly) ✓ Sexual assault referral centres ✓ Sexual health in secure and detained settings ✓ NHS Infectious Diseases in Pregnancy Screening 	<ul style="list-style-type: none"> ✓ Contraception and advice on unplanned pregnancies in SRH services ✓ LARCs in primary care ✓ STI testing and treatment in SRH services and primary care ✓ HIV testing ✓ Sexual health specialist services (e.g. young people's services, outreach and promotion) ✓ Service in schools ✓ Support for teenage parents ✓ Chlamydia screening ✓ Sexual health aspects of psychosexual counselling

This means there is no single body invested in providing women's basic healthcare needs. This lack of accountability and ownership has led to variations in access to services and quality of care.

It has also created a system where there are few incentives to prevent problems developing, since the sequelae of providing no care or poor care transfer to someone else's budget or balance sheet. The irony is that these poor outcomes are invariably more expensive to resolve than preventing the problem in the first place.

For example, potential improvements made by Clinical Commissioning Groups (CCGs) in primary care might actually be realised further down the line in local authority budgets, leaving little reason to change the status quo. For a joined-up approach to commissioning to be achieved, we need to ensure strong leadership and clear lines of accountability across the system.

Meanwhile women have become the casualties of fragmented services and inflexible funding streams. For example, women cannot get their smear test, STI screening and repeat contraception prescription at the same visit. Instead, they have to book multiple appointments, or be referred to another service to receive part of their care. This is wasteful of both resources and time. It also has significant consequences

for women if they cannot access the care that they need, including more unplanned pregnancies, more abortions, later diagnoses, and a rise in their need to use urgent and emergency care pathways.

One of the most important shortfalls is that none of the commissioners assume responsibility for the complete range of contraception which should be available for all women routinely. For example, specialist gynaecology clinics can prescribe the Mirena device long-acting reversible contraception (LARC) for heavy menstrual bleeding but not for contraception, whereas a woman attending a GP appointment for contraceptive advice who also complains of heavy bleeding cannot be offered a Mirena, which would resolve both issues. The provision of LARC in primary care is split between local authorities and CCGs and few GPs receive the fees to perform insertions in their surgeries.

In the devolved nations, different pathways for the commissioning of SRH services have been tried in an attempt to avoid the fragmentation seen in England. In Scotland and Wales SRH services are delivered by NHS Scotland and NHS Wales respectively, but challenges remain. Despite leading the way in the integration of services, Scotland has seen recent pressures on local budgets and negative impacts on patients as demand for primary care and specialist SRH services increases. In Wales, there is no overall set structure to SRH service design, leading to unclear service pathways for patients.³ It is clear that improvements can be made to the organisation and delivery of women's SRH services across the UK, even in those countries that have less fragmented commissioning arrangements than England.

Example of good practice : Northern Ireland's Integrated Contraceptive and Sexual Health Hub

Recognising that the fractured approach to delivering SRH services in Northern Ireland was hindering women receiving basic care, a new nurse-led Contraceptive and Sexual Health Hub was opened in December 2016 at Braid Valley Hospital, Ballymena. The Hub has helped to improve access to contraception and sexual health services by integrating them within the same building and offering contraceptive services and STI screening at a single appointment.⁴



“

I see a woman in my contraception clinic who requires a difficult fitting of the coil. She is also due her cervical smear test. This is the perfect opportunity to provide both services, however my clinic is not commissioned to provide smears so I am unable to do so. That's two appointments and two vaginal examinations for something that could be done straight away.

It is expensive, frustrating for me as a doctor and unfair for the woman. Something has to change.

”

Dr Asha Kasliwal, President of FSRH

Access to contraception

Contraception needs to become everyone's business but is currently the Cinderella service of women's health. It is the single most effective intervention in healthcare and yet in the current commissioning structure, no one has overall responsibility for it. This needs to change.

The only contraceptive methods available without prescription in the UK (apart from emergency contraception) are male and female condoms, diaphragms and caps, spermicides and digital tools to support the use of natural family planning. All are considerably less effective than hormonal methods, because they rely on the individual taking action with each episode of sexual intercourse.

The most effective hormonal methods are LARCs in all forms - implants, injections or intrauterine devices. Even when used for a short interval their reliability in preventing pregnancy is far greater than contraceptive pills or barrier methods, meaning they are also highly cost effective.

The recent availability of a monthly injectable LARC preparation that can be prescribed for a 12 month period and self-administered by the woman herself after watching a short teaching video, has proven very popular and saves resources.



The oral contraceptive pill (OCP) is the most commonly used form of contraception. Despite being one of the most studied drugs in the world for more than 60 years, the OCP is still only available on prescription in the UK from a medical practitioner. This prescription requirement serves as a barrier to both starting and continuing to use the OCP.⁵

However, the need for contraception does not require a diagnosis to be made; women using contraception are not ill and do not have a disease that requires regular monitoring. They simply want to use effective contraception in order to prevent or postpone becoming pregnant.

Making oral contraceptives available without prescription can be easily achieved by reclassifying the progestogen-only pill (POP). The POP does not contain oestrogen and therefore has fewer contraindications and fewer associated serious health risks than combined oral contraception (COC). It is simple to take – one pill every day for as many years as contraception is required – and those POPs that inhibit ovulation are as effective as the COC. As such, the POP meets all the requirements for an over-the-counter (OTC) medicine.

As detailed in chapter four, postnatal contraception has been particularly difficult for women to access, as the maternity services budget held by NHS England (NHSE) does not include contraception. After delivery of their baby, very few women are provided with more than a single packet of pills or condoms.

Many women would benefit from having a LARC inserted into the uterine cavity at the time of caesarean section, if they choose to do so. However, hospital maternity units are not funded to provide contraception and therefore cannot order the LARC devices. Similarly, for many new mothers the six week postnatal check is focussed on their baby and another opportunity to provide her with reliable contraception is missed.

As noted earlier, the current tripartite commissioning arrangements in England cause significant barriers for many girls and women trying to access contraception. Access is made more difficult for a number of additional reasons.

1. Stringent cuts to public health budgets

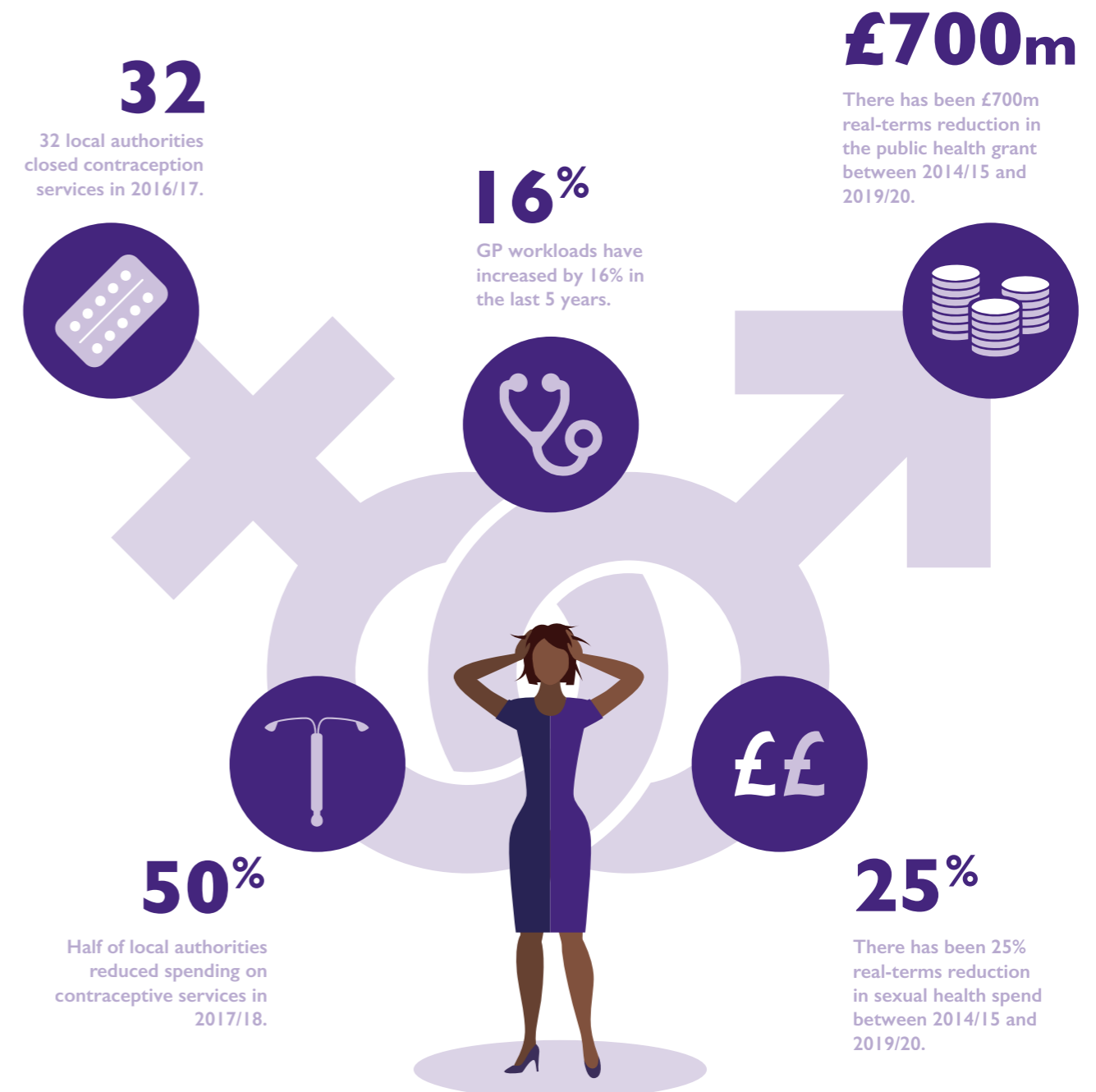
The reduced funding to local authority public health budgets has had a huge impact on women throughout the UK. In England for example, half of all local authorities have reduced their spending on contraceptive services. The Advisory Group on Contraception reported that **61% of local authorities with the highest quartile of social deprivation, were forced to either freeze or cut their SRH budgets between 2016/17 and 2017/18. As a consequence, there has been a 53% increase in the number of abortions performed in these same areas.**⁶

2. Difficulty getting a convenient appointment

For many women who are trying to juggle work, childcare and other family commitments, access to sexual health and GP services to obtain routine contraception can be challenging. Opening hours vary between local areas and from provider to provider. In many health centres inflexible booking systems and the lack of readily available out-of-hours appointments (including at the weekend), mean that a simple straightforward need for contraception becomes a complex, frustrating and lengthy exercise.

3. Pressures on GP surgeries

Women using the contraceptive pill are regularly required to make an appointment to renew their prescription, despite extensive research showing the extremely safe 60 year track record of the oral contraceptive.⁷ Indeed, **half of all appointments made for contraception are for repeat prescriptions.**⁸ This imposes unnecessary pressure on hard-pressed GP services and makes it difficult for women to access their contraception in a timely manner. These are further good reasons to increase the availability of LARCs.



4. Lack of funding for LARC insertion training and fees for provision

There are many missed opportunities for GPs, midwives and specialist nurses in primary and secondary care settings to provide women with LARCs, because funding to provide protected time for training and fees for the provision of injectables, implant and IUD insertions are not prioritised. This is despite clear evidence that **LARCs are the most reliable and cost-effective methods of contraception and do not require renewal for 3-5 years.** The Faculty of Sexual and Reproductive Healthcare (FSRH) offers excellent e-learning tools which together with two practical sessions secure a Diploma qualification for LARC insertion.

These barriers to accessing contraception are considerable for many women,⁹ but for those who are socioeconomically disadvantaged or have difficulties accessing the health system, the barriers can become insurmountable.

Women who are not registered with a GP or are unable to get an appointment for contraceptive advice or access a prescription may be unaware of alternative services in their area. As a result, they are forced to resort to less reliable or more expensive methods of contraception. This includes condoms, cycle tracker apps, the withdrawal method and the emergency contraceptive pill.

The Chief Medical Officer's annual report on women's health (published in 2015) highlighted the fact that geographical areas with restricted access to the full range of contraception – including LARC – have relatively higher abortion rates and rising conception rates in older age groups, indicating unplanned pregnancies. The report recommended that commissioners should “ensure provision for a full range of contraception services to all women, that is person centric and at all reproductive ages”.¹⁰ Since contraception is such a cheap, simple and cost-effective intervention, it is difficult to understand why this has not been implemented.

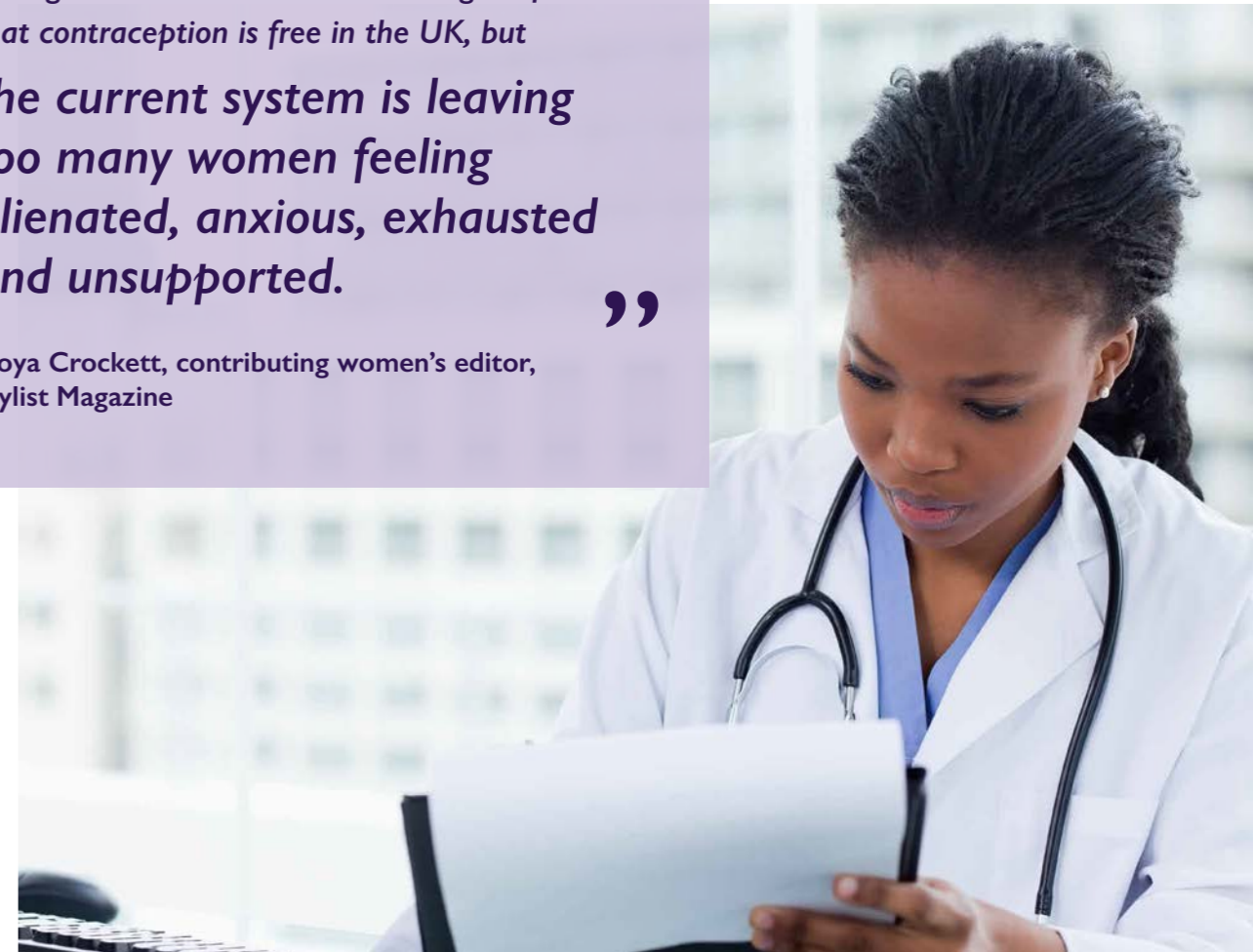


“

Despite getting on well with my pill, I was rarely allowed a prescription for longer than three months, meaning I frequently had to take time off work for check-ups and repeat prescriptions. And when I tweeted about my experiences in July 2019,¹¹ I received hundreds of messages from women saying they'd been through the same or similar. I'm so grateful that contraception is free in the UK, but the current system is leaving too many women feeling alienated, anxious, exhausted and unsupported.

”

Moya Crockett, contributing women's editor,
Stylist Magazine



“

Time to perform enhanced services, such as intrauterine device or contraceptive implant fitting, is hard to find when there is such a pressure on the front-line in general practice.

So GPs and primary care nurses are having to make difficult decisions about whether they are able to continue to offer provision of the most reliable methods of contraception at a time when they know that access to specialist services is also reducing.

”

Dr Anne Connolly, Clinical Champion for Menstrual Wellbeing, RCGP



Against this backdrop of obstacles, it is not surprising that some girls and women are forced to turn to emergency contraception (EC) in order to prevent a pregnancy.

In the UK, two single dose oral emergency hormonal contraceptives (EHC) are available. The most effective form of EC is to have an intrauterine device inserted within five days of having unprotected sex.¹² However, the time delay many women face when trying to access an appointment at their GP or local sexual health clinic frequently makes this option impractical.



EHC is available without prescription from all pharmacies free of charge in Scotland and Wales. In England, EHC is commissioned and should be free for all women attending sexual health clinics and general practices. The reality is that many girls and women in England have to pay up to £35¹³ to access EHC, because it is not available free of charge in 50% of services in England.¹⁴ This sum of money is unaffordable for many girls and women, reinforcing the many existing sexual and reproductive health care inequalities.

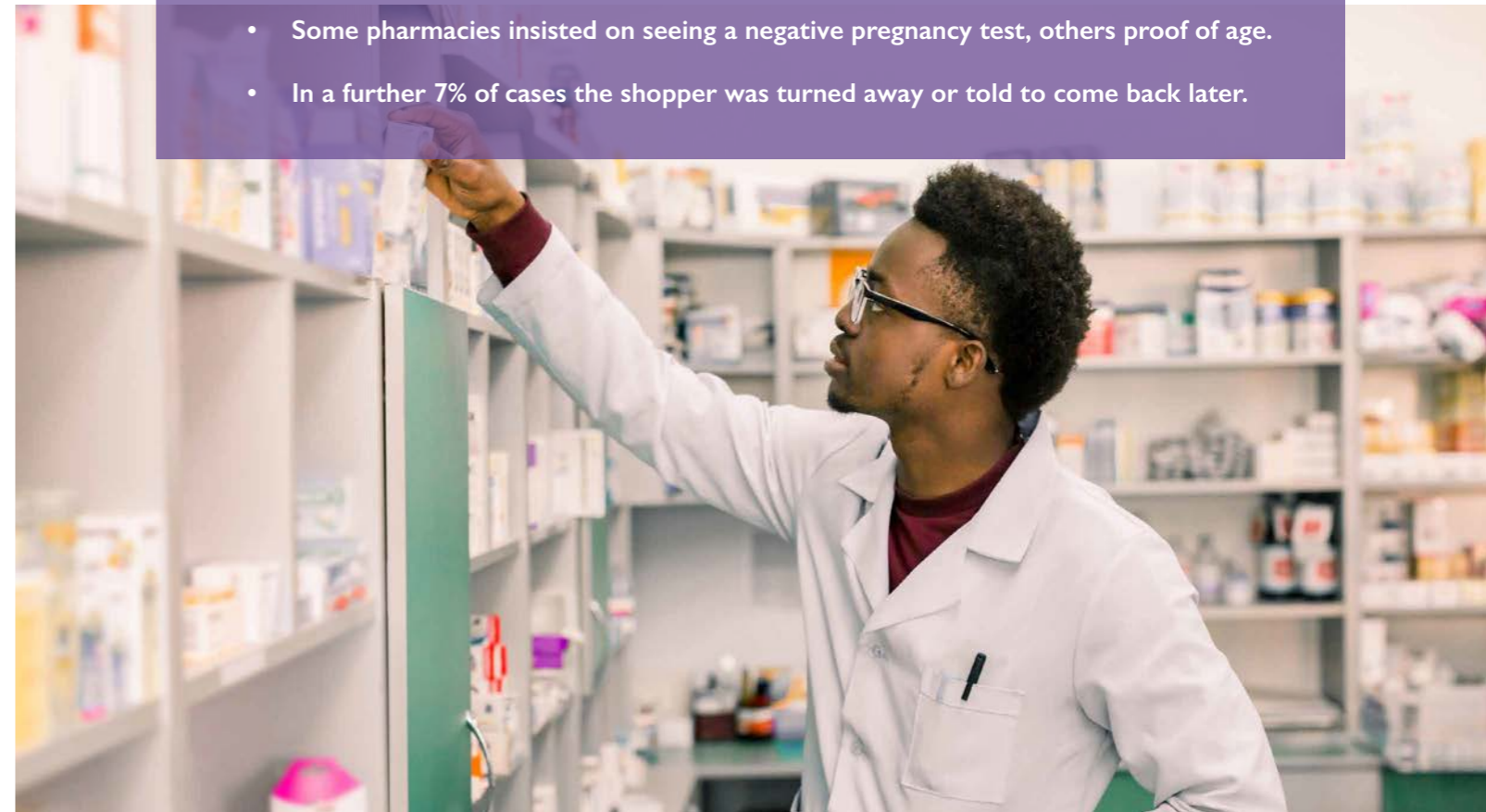
Even in geographical locations where EHC is available free of charge, a mandatory consultation with the pharmacist is required. This adds a further barrier to access since many girls and women report that this consultation leaves them feeling uncomfortable, embarrassed or judged.¹⁵ Many pharmacies display no information about EHC and do not have any dummy packets on their shelves, yet they do display pregnancy tests, a wide range of condoms and even information about Viagra.

EHC has been available over the counter in the UK for almost 20 years with no evidence that it is being “misused” or over used. Oral EC is available ‘in front of the counter’ in pharmacies in Canada and Scandinavia where it is recognised that it can safely be used without supervision, and that the behind the counter framework inhibits women’s access. The UK must follow this example of good practice.

A mystery shopper study

A study of 30 pharmacies in England conducted by British Pregnancy Advisory Service in 2018¹⁶ reported that:

- Pharmacists generally provided a non-judgemental service, once they were dealing directly with the client.
- However, in more than half of the cases the shopper needed to ask at least two people before help was provided.
- In 10% of visits the consultation was poor and unprofessional.
- Some pharmacies insisted on seeing a negative pregnancy test, others proof of age.
- In a further 7% of cases the shopper was turned away or told to come back later.



Access to cervical screening

The national cervical screening programme is offered to women aged from 25 to 49 years every three years and women aged 50 to 64 every five years. The vast majority of women who attend screening are found to have no abnormality, but those with abnormal test results require further investigation (e.g. repeat test or colposcopy) and may need treatment. The UK cervical screening programme is estimated to save around 5000 lives per year. Started as a smear test in 1988, progressed to liquid based cytology (cells examined under the microscope), and is now moving to primary human papillomavirus (HPV) testing, which will further reduce the incidence of cervical cancer when the impact of school HPV vaccination is realised.

The current commissioning arrangements for cervical cancer screening and the split responsibility for quality assurance and governance between Public Health England (PHE) and NHSE have been highlighted in Professor Sir Mike Richard's independent review of national cancer screening programmes in England.¹⁷

This fragmentation means that cross system leadership is missing and accountability is unclear leading to confusion, delays and risks to patient safety.



A recent study found that 37 local authorities and 76 CCGs do not consider they have a role in increasing cervical screening coverage, some viewing it as the responsibility of PHE or NHS England.¹⁸ This creates confusion, delays and risks to patient safety.¹⁹ Cervical screening is not a mandated requirement for local authority commissioning, and hence is not always included in service specifications for SRH services. This is despite the fact that 12% (1 in 8) of abnormal cervical screening test results are identified at SRH services compared to 5% (1 in 20) via general practices.²⁰

Fragmentation of commissioning also creates barriers for healthcare professionals who may be prevented from providing cervical screening for a woman attending their clinic for another problem because they are not commissioned to do so. Instead, women have to book another appointment, usually in a different location, instead of having their needs managed at a single visit. This is not just inconvenient, it acts as a disincentive for many women who are not prepared to undergo multiple examinations.

Added to which, the majority of cervical samples are taken in primary care by nurses and GPs whose workload often results in women experiencing difficulties accessing an appointment.

Exacerbating this situation is the fact that the NHS IT systems used to communicate with women are outdated and unreliable.²¹ A report published by the National Audit Office (NAO) in 2019²² found antiquated IT systems and registration databases at GP services mean that eligible patients are not always identified and invited for screening. Nor are they receiving results when they should. NHSX (a cross-governmental unit to drive digital transformation of the NHS and social care in England) is now giving high priority to the development of new IT systems for screening programmes and cervical cancer is recognised as having the greatest need.

As a result of these many barriers, uptake of the screening programme reached a 20-year low of 71.4% in 2017/18²³ and there are huge variations in the number of women attending cervical screening appointments across regions of England.²⁴

As discussed in the previous chapter, uptake is particularly low in deprived populations and those with a high proportion of ethnic minorities. A recent population study reported that some 50% of non-attenders for cervical screening had intended to be screened and would have attended if the screening process had been more convenient.²⁵ It is clear that more needs to be done to ensure that health services are maximising opportunities to increase rates of cervical screening, particularly among marginalised groups. HPV self-sampling at home may prove to be more acceptable for some women than attending their GPs surgery. Results from pilot studies in Australia look promising.²⁶

One of the key standards for the cervical screening programme is that at least 98% of women should receive their test result within two weeks of the cervical sample being taken. This is the 14-day Turnaround Time (TAT) target which was set in 2010. However, this standard has not been achieved since October 2015 and the Richards review has reported that by February 2019 only 46% of women received their results within 14 days.²⁷

Further problems have occurred as a result of the transition to primary HPV testing. The current cytology testing means that highly skilled cytologists are required to analyse smears from every woman who is screened. In the future, only women who have persistently positive HPV results will need cytology testing which is expected to decrease by 85%. In order to maintain expertise among cervical cytologists it is proposed that the number of laboratories undertaking this screening will reduce from 46 to eight.

However, the predictable fall in demand for their services has prompted many cytoscreeners to move into other specialist areas, to secure long term employment.²⁸

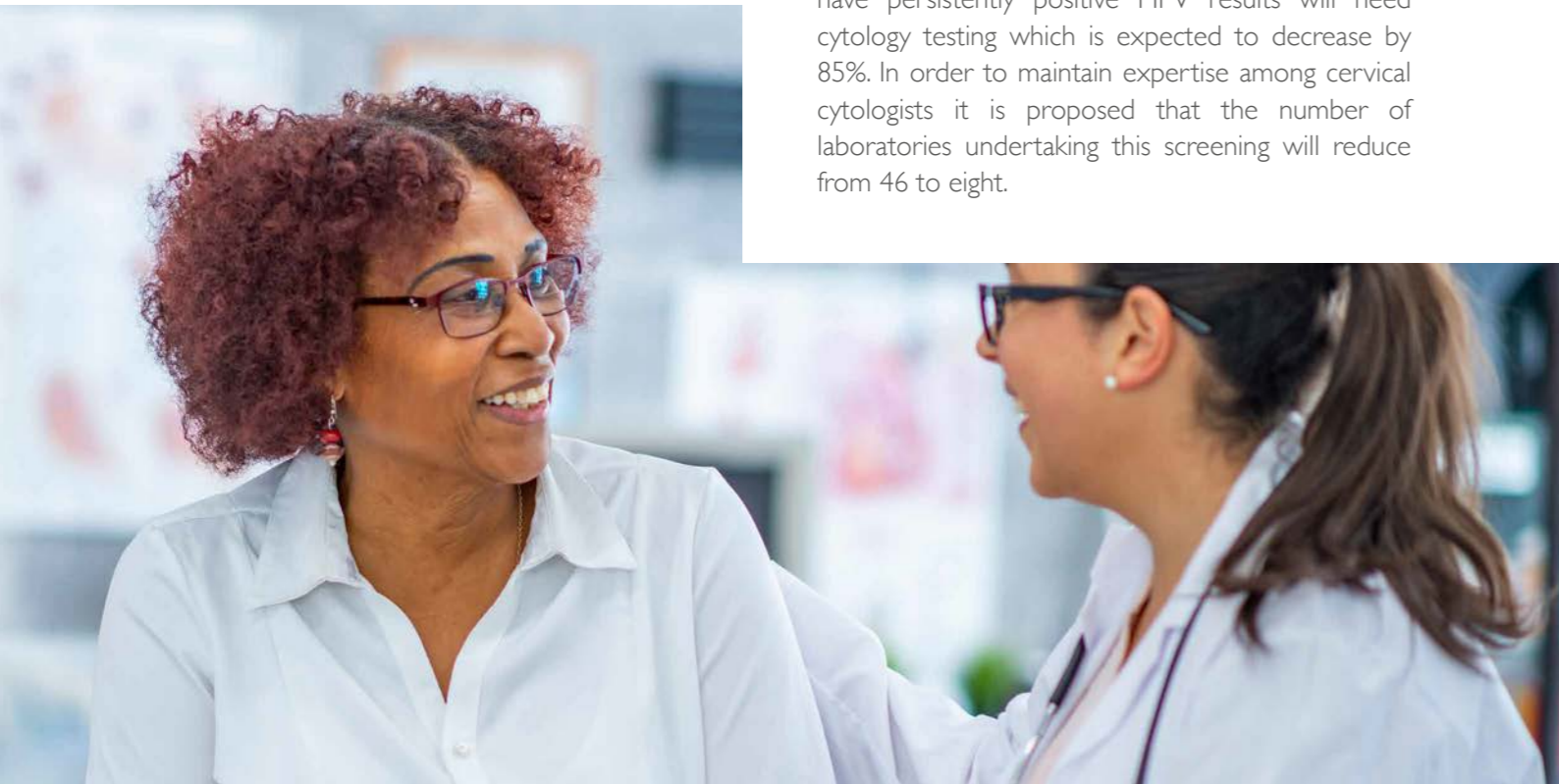
As a result, in October 2018 there was a backlog of 97,628 samples awaiting analysis which needs to be addressed.²⁹ In addition, referrals for colposcopy are predicted to rise by 25% in the next few years but should then drop back to current or even lower levels in time. However, in the long term, HPV testing system will be less prone to human error; will allow centralisation and reduce the need for resources.

It is clear that collaborative efforts need to be made to improve rates of cervical screening to ensure that women do not miss out on the opportunity to prevent a potentially serious disease. We welcome Professor Mike Richard's review of national screening programmes and are encouraged to see many of our concerns about cervical screening highlighted. It is vital that the NHS acts urgently to implement Professor Richard's recommendation that all aspects of screening become the responsibility of a single organisation – NHS England - to benefit all women across society.

“ The cervical smear test has fallen off the commissioning list at my clinic so I currently cannot provide this service. We used to train clinicians how to take a smear test. Now that has suffered too.

My clinic used to take 5,000 smears annually. That figure is now zero which means that women in hard to reach groups are now even less likely to get their smear. ”

Dr Asha Kasliwal, President of FSRH



Access to abortion care

Abortion care is a core service underpinning women's health and wellbeing.

3,269

In 2018, 3,269 abortions were carried out for fetal abnormalities in England and Wales.

Core service

Abortion is the most common gynaecological procedure provided by the NHS.

NHS



205,295

In 2018, there were 205,295 abortions performed in England and Wales.³¹



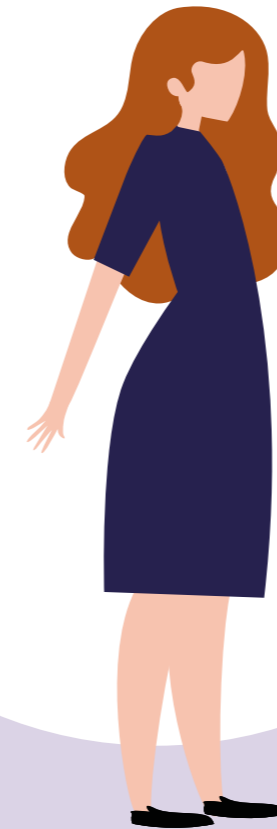
1 in 3

An estimated one in three women will have an abortion in their lifetime.³²



1 in 5

One in five pregnancies lead to a woman having an abortion in England and Wales.³³



Abortion care has been simplified considerably over the last thirty years in the UK, with the introduction of a medical management option. Women no longer have to be admitted to a hospital setting and undergo a surgical operation under anaesthesia. Instead, if the pregnancy is less than 10 weeks of gestation they can be offered a medical abortion – a combination of two drugs, mifepristone followed by misoprostol, in the outpatient clinic. Over the last decade the percentage of early medical abortions has almost doubled, from 37% in 2008 to 71% in 2018. This has significantly reduced the need for hospital admission and the risk of women suffering complications associated with surgical procedures.

Further progress was achieved in 2018, when the Secretary of State for Health agreed that misoprostol could be dispensed by the clinic doctor, but taken by the woman at a later time in the comfort of her own home. This avoids distress and embarrassment for women experiencing pain and bleeding on their journey home from the abortion clinic.

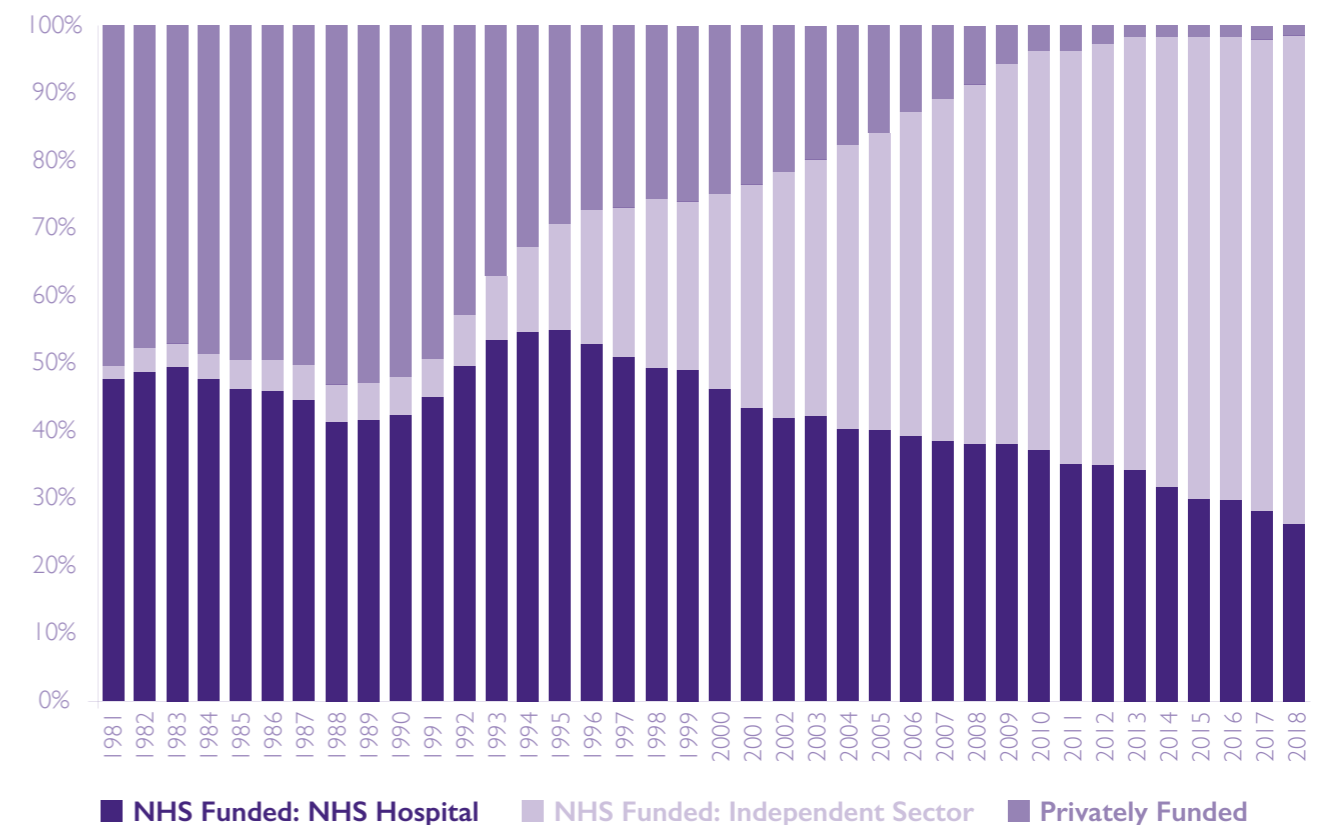
This simple adjustment to service delivery also means that precious NHS resources are saved by reducing the number of visits that a woman has to make to a clinic to obtain her medication.

However, women continue to face many barriers when trying to access abortion care in the UK. These include the dwindling numbers of NHS healthcare professionals taking part in abortion care, very few units with experience of caring for women requiring late gestation abortions or women with complex medical co-morbidities, and service tariffs that do not always reflect the costs of care in difficult cases. Furthermore, women and staff face intimidation outside abortion facilities and the care offered to women remains constrained by a legal framework which criminalises abortion.

Recognising the need to address the many factors contributing to these barriers, the RCOG set up an Abortion Taskforce in 2016, in partnership with Independent Sector Providers (ISP), the The Department of Health and Social Care (DHSC) and NHSE. The first priority identified was the critically low number of NHS medical providers undertaking abortion care and the need to build a sustainable workforce for the future.

In the 1980s, approximately 50% of abortions were performed in NHS facilities and 50% in the private sector, but most doctors performed abortions in both sectors and had developed valuable experience. Since the mid-1990s, the NHS has commissioned the independent sector to deliver abortion services on its behalf under NHS contracts. The proportion of cases undertaken by ISPs has increased steadily since then and in 2018 only 26% of abortions were performed in NHS hospitals, with 72% provided by the independent sector, and 2% performed privately.³⁴

DHSC: Percentage of abortions by purchaser/provider, England and Wales, 1981 to 2018³⁵



One of the consequences of this shift in abortion provision has been the reduced ability for trainees in the NHS to gain experience in the skills required to deliver abortion care and recognise complications when they arise.

There is an urgent need to teach our undergraduate and postgraduate doctors about the importance of this service and to encourage more of our senior colleagues to contribute to abortion care.

Currently, only five NHS Trusts in England provide surgical termination of pregnancy at later gestations and in Scotland there is no provision for surgical abortions at later gestations. Predictably, this has resulted in limited training opportunities for late abortion and less choice offered to women. Given that

many late gestation abortions follow the detection of a fetal abnormality, women who choose not to proceed with their pregnancy may have to travel long distances to access help. Alternatively they are forced to undergo a medical abortion, involving induction of labour and vaginal delivery, which for some women is deeply distressing.

In 2014 a study by Antenatal Results and Choices identified that only 14% of women seeking an abortion after a diagnosis of fetal abnormality were offered a choice of procedure and 74% of women were only given the option of medical abortion.³⁶ This further emphasises the disconnect between services, with fetal medicine services being located in NHS hospitals, while the majority of abortions are provided by ISPs in the community.



The introduction of first trimester screening allows the diagnosis of fetal abnormality to be confirmed by 16 weeks of gestation in 50% of cases. The learning curve to acquire the clinical skills needed to offer surgical abortions for women up to this gestation is less steep than at later gestations. It is hoped that

by encouraging specialist fetal medicine services that undertake invasive testing to provide a surgical option for the women they diagnose with anomalies, women will receive more timely and compassionate care closer to home.

The RCOG welcomes the comprehensive NICE guidance on abortion care published in September 2019.

The key recommendations for commissioners and providers of abortion services are:

- **Women must be offered a choice of medical or surgical procedures.**
- **Commissioners and providers should allow women to self-refer to abortion care services.**
- **Women should be offered assessment within one week of request, and undergo the abortion within one week of the assessment.**
- **Women should also be able to access assessment using telemedicine (telephone or video calls).**
- **Provision of post abortion contraception should be routine including the option of LARC methods.**

These excellent guidelines provide a real opportunity to achieve a step-change in the quality of abortion care services. We must ensure that they are implemented successfully.

Decriminalisation of abortion

Abortion remains a criminal offence in the UK.

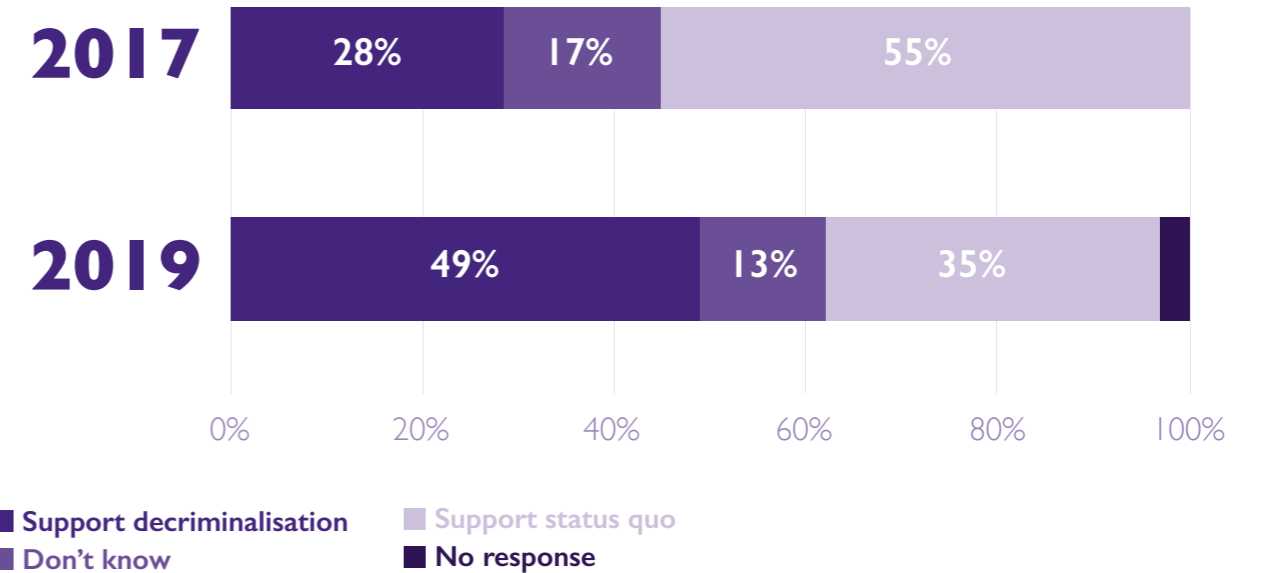
However, the introduction of the 1967 Abortion Act provided five clauses under which an abortion may be carried out legally. The Act aimed to bring an end to the common practice of backstreet abortion which cost the lives of many girls and women. In 1955, when the first Confidential Enquiry into Maternal Death was published in the UK, 14% of deaths in pregnant women were due to unsafe abortion. The Abortion Act was effective in reducing this loss of life but medical advances have progressed significantly since 1967. Women no longer need to be admitted to hospital for an operation and can have a medically induced abortion in a clinic setting. However, abortion remains the only medical procedure which requires two doctors' signatures on the patient consent form. It is time to seek to introduce legislation which places the woman at the centre of her care and ensures abortion care is guided by clinical priorities rather than fear of criminal sanctions.

In 2017 the Royal College of Obstetricians and Gynaecologists became the first medical royal college to support the decriminalisation of abortion up to 24 weeks. We consider that all abortion procedures should be

subject to rigorous regulatory and professional standards, in line with other medical procedures, rather than subject to criminal sanctions. Abortion - for women, doctors and other healthcare professionals - should be treated as a medical, rather than a criminal issue.



Support for the decriminalisation of abortion in Parliament has risen.³⁷ A ComRes poll conducted by the RCOG in 2019 found that support for decriminalisation among MPs in Westminster has increased rapidly - from 28% in 2017 to 49% in 2019. Only 35% of MPs now support the status quo.



There is also a need to tackle the increasing number of campaigns outside abortion clinics aimed at harassing both women and healthcare professionals. In 2018, at least 30 providers were affected by protests, at both NHS and independent facilities.³⁸ A number of councils in England have opted to introduce Public Space Protection Orders (PSPOs)³⁹ to create access zones around clinics in order to protect women and clinic staff. However, since they depend on local councils' decisions to introduce and

maintain them, PSPOs for abortion clinics are not widespread. Scottish councils do not have the power to introduce access zones, despite recent protests at clinics in Glasgow and Edinburgh.⁴⁰ The right to reproductive choice should be balanced with the right to protest. Introducing access zones does not prevent those who wish to protest from doing so, but it does ensure that women are not prevented from accessing healthcare services, and that they can do so without the threat of harassment.

Access to appropriate fertility care

Infertility can have a devastating effect on people's lives, causing distress, depression, and the breakdown of relationships. It affects around one in seven couples in the UK.⁴¹

GPs are the first port of call for many women and their partners experiencing delays in conceiving a pregnancy. After initial investigation, these couples are referred to their local fertility clinic. However, many experience long delays in gaining access to appropriate secondary care and this is often when they are at an age when their fertility is declining rapidly.

While many hospital gynaecology departments have a consultant with an interest in reproductive medicine, this is not always the case. Hospital facilities are also variable and not all services have an assisted conception unit providing in vitro fertilisation (IVF) and associated treatments. IVF treatment is poorly funded by the NHS and as a result 60% of IVF treatments nationwide are provided by the private sector, often in stand-alone IVF clinics.

The National Institute for Health and Care Excellence (NICE) Fertility Guidelines recommend that all eligible couples should have access to three full cycles of IVF where the woman is aged under 40.

For eligible women aged 40-42 one full cycle should be available.⁴² However, a survey by Fertility Fairness showed that 91% of CCGs in England do not follow NICE guidelines and restrict IVF treatment to couples where both partners have no living children.⁴³ NHS Scotland on the other hand offers three cycles of IVF for all couples even when one already has children from a previous relationship.⁴⁴

These restrictions in England are partly a result of inadequate funding, with many women receiving only one free cycle, and some not being offered any cycles at all. This means that some women and their partners turn to costly private clinics for treatment or have to travel abroad to countries where services may be cheaper but less well-regulated.

The Human Fertilisation & Embryology Authority's Commissioning Guidance for Fertility Treatment (published in 2019) notes that "infertility is a recognised medical condition which can have a real impact on individuals' mental health. Failure to address infertility and commission appropriate treatments can lead to a significant economic burden on the health sector".⁴⁵

Commissioning fertility treatment can have positive impacts on patient experiences and can also have positive economic benefits including:⁴⁶

- **Reducing mental health problems related to infertility.**
- **Reducing the incidence of multiple births, which can be very costly to neonatal services and long term health and social care services.**
- **Reducing reproductive tourism, where people travel abroad for fertility treatment, which can lead to health complications or multiple births that are later managed by the NHS.**



RCOG recommendations

1. Introduce mandated co-commissioning of SRH services across the UK.

- NHS England (NHSE), Clinical Commissioning Groups (CCGs) and local authorities must deliver a joined up approach to commissioning to end the fragmentation of services and to ensure that women can get their sexual and reproductive health care needs met in one place, as acknowledged in the Government's response to the Health and Social Care Committee's report on sexual health (published October 2019). This includes the whole range of SRH services, such as contraception, cervical cancer screening, and treatment and advice about the menopause. This would be cost-effective for the NHS in the long-term whilst providing girls and women with high-quality and efficient health care. The RCOG is committed to working with local authorities in England, NHS England and CCGs to make joined up commissioning a reality. Integrated, holistic commissioning of SRH services is supported by FSRH, the the Royal College of General Practitioners, the Royal College of Pathologists and the Academy of Medical Royal Colleges.

2. Establish women's health one-stop clinics in local community hubs.

- NHSE must implement and fund one-stop women's health clinics into Integrated Care Systems (ICS) in England. Where possible, clinics should be made available at weekends and out-of-hours. This will ensure a more joined-up approach to women's health, diminish unnecessarily long referral times and ensure that women receive the best possible care by providing all of their healthcare needs in one location and at one time. This approach will require NHSE to work with Health Education England (HEE) and local providers to ensure

that the right workforce is available at the right time in the right place. A similar approach should be adopted in Wales, Scotland and Northern Ireland as part of their integration plans.

3. Increase public health and sexual health budgets.

- The UK Government must ensure that there is a real terms increase in public health budgets and each of the devolved Governments must ring-fence funding for SRH services. Resources need to be prioritised to the locations and services that require the most investment. This includes services which provide contraception and gynaecological cancer screening services.

4. Make access to progestogen-only oral contraceptives easier for women.

- Given the long safety track-record for the progestogen-only oral contraceptive pill (POP), the Medicines and Healthcare Products Regulatory Agency (MHRA) should reclassify POP from 'prescription-only' to 'pharmacy product'. Girls and women should also be able to order them online.

5. Provide easier access to emergency hormonal contraception.

- The MHRA should ensure that oral emergency hormonal contraception (EHC) is reclassified to the General Sales List to enable it to be sold straight off the shelf without consultation. It should be made available, free of charge, over the counter throughout the UK. The RCOG supports FSRH calls for individuals, including under-18s, to have full access to free emergency contraception at time and place of need.⁴⁷

6. Increase uptake in cervical screening by ending fragmentation and harnessing technologies.

- The UK Government should implement the recommendations of Sir Mike Richard's report on screening programmes in England without delay. The devolved Governments must also take note of the recommendations in the report.
- This includes the proposal to make NHS England responsible for oversight of cancer screening programmes, removing the existing fragmented governance arrangements, and creating a new national director for screening. In addition to this, it will be vital that the new director for screening works closely with the national clinical director for maternity and women's health to ensure a joined-up approach to women's health.
- Given the current backlog of cytology samples awaiting analysis, the director for screening must work with HEE to closely monitor the recruitment and retention of the cytology workforce and ensure a system-wide response to workforce demand issues within screening services.
- The ongoing work of NHSX (a cross-governmental unit to drive digital transformation of the NHS and social care) on developing a new IT system for the cervical screening programme must be given the highest priority. This will mean that patient data can be shared quickly and efficiently between services across the country and will help to mitigate health inequalities and increase uptake amongst all women. Systems should also be able to communicate with women quickly and easily via texts, internet and emails to further increase uptake.
- The UK Government, alongside the future director of screening, must prioritise securing extra funding for screening programmes. It is clear that the screening service needs greater investment to ensure it can manage any welcome increase in demand, provide results within agreed timescales and utilise the best possible technology.

7. All women should be able to access abortion care easily and without fear of penalties or harassment.

- Undergraduate medical schools must teach the importance of abortion care to students.
- The RCOG must teach abortion skills as a part of its core curriculum and assess those skills through examination.
- The DHSC must review and expand the definition of "home" under the Abortion Act 1967. The DHSC should also consider allowing women to take mifepristone, the first drug used to effect early medical abortion, at home.
- Independent Sector Providers and NHS England, NHS Scotland, NHS Wales and the Health and Social Care Board must work together to secure indemnity cover for healthcare professionals across sectors. This will allow an open door between the independent sector and the NHS, allowing greater opportunities for training in these essential skills.
- CCGs must commission abortion care services which implement, or are seeking to implement, the recommendations of the 2019 NICE guidance on abortion care.⁴⁸ This will ensure women have a choice of procedure and guarantee quick access to services.
- NHS England specialised services must continue their work to introduce regional centres where access to abortion care for women with complex co-morbidities is available.
- The UK and devolved governments must legislate to introduce access zones around abortion care providers.
- The RCOG must continue to work with partner organisations to advocate for the decriminalisation of abortion up to 24 weeks across the UK.

8. End postcode lotteries in IVF treatment and offer all eligible women three full cycles of IVF.

- CCGs must follow the NICE Guidelines on Fertility that cover diagnosing and treating fertility problems. This will lead to a reduction in variation in practice and improve the way fertility problems are investigated and managed. This will help to remove the current variation in IVF funding around the country and end postcode lotteries.
- England, Wales and Northern Ireland must offer women the same opportunities for IVF treatment as in Scotland and follow the NICE fertility guideline which recommends that women under 40, who have been trying to get pregnant for two years, should be offered three full cycles of IVF. CCGs, NHS Wales and Northern Ireland's Health and Social Care Board must commission fertility services in order to ensure that all women have access to appropriate fertility treatment and care.

9. Appointment times at GP services should increase to 15 minutes.

- The College supports RCGP's calls for 15-minute appointments as standard in general practice, with longer for those patients with complex health needs.⁴⁹ Too many women are spending years in pain and discomfort because appointment times are too short and demands on the time of doctors and other healthcare professionals are too great. This makes women less likely to talk about their issues. It is also not cost-effective as women often require multiple appointments before diagnosis and treatment.



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Conclusion

This report highlights some of the important unmet health needs of women in the UK.

Too many women are struggling to access basic health care. Health services too often miss opportunities to ask the right questions, optimise the resources available to prevent illness and ensure the best outcomes. There are too many variations in the quality and availability of services across the country.

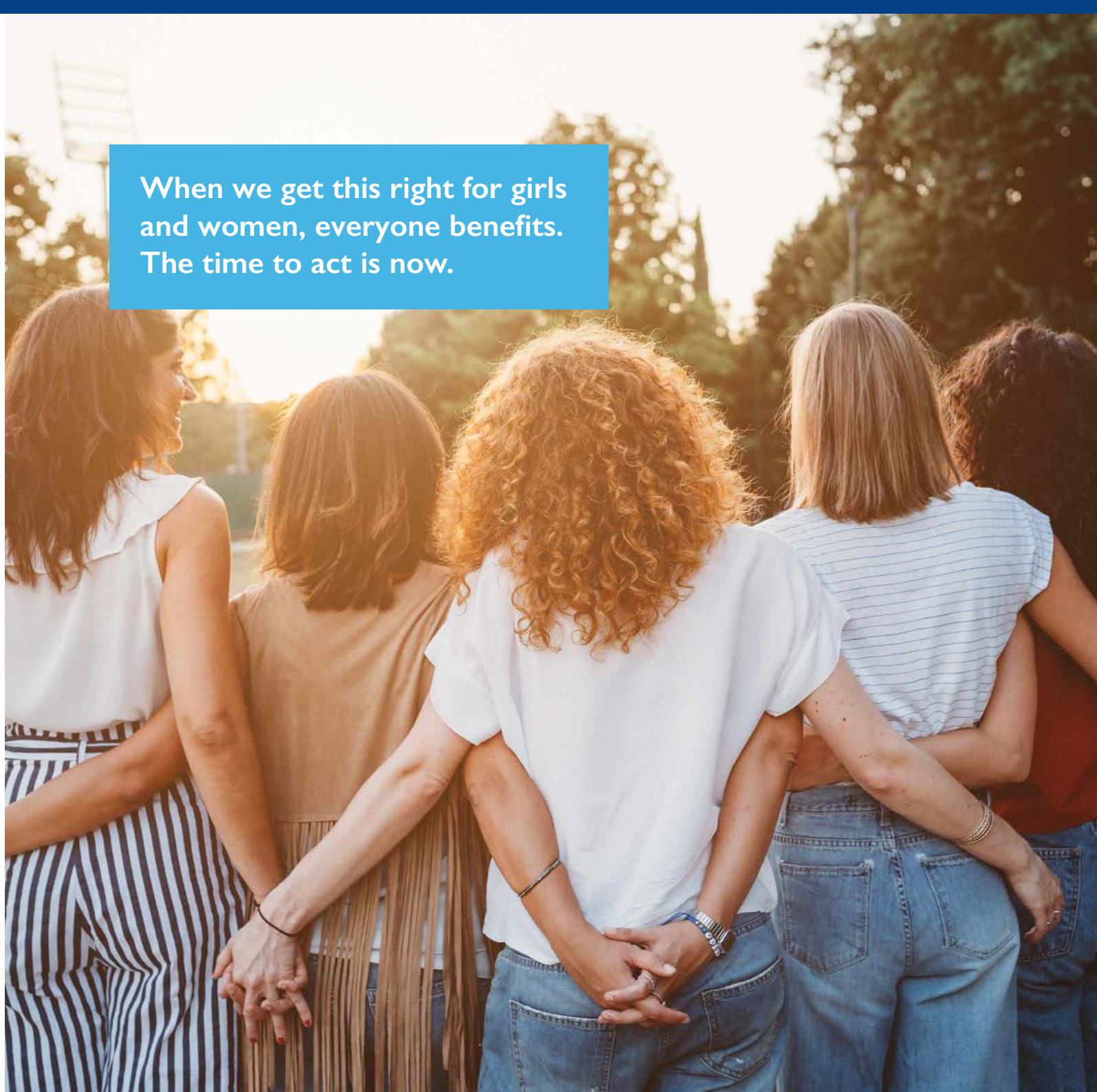
Our primary recommendation - the creation of national Women's Health Strategies that adopts a life course approach to women's health – is the first important step towards ensuring better health for girls and women, now and in the future.

We have identified simple and cost-effective solutions to prevent girls and women falling through the cracks of our health systems to reach those who are stuck in a vicious cycle of poor outcomes. This includes making access to contraception as easy as possible, reversing the declining cervical cancer screening rates and ending the fragmentation of healthcare services

to ensure that all women have access to the care they need, when they need it. We need to listen to what women want and work with them in order to better respond to their predictable needs and eradicate the taboos that persist in too many areas of women's health.

By empowering women to help themselves we will improve their health and save precious NHS resources. By improving access to accurate education and information throughout their life course we can support them to make positive choices and prevent avoidable illness. By designing care around the needs of women, we can streamline services. By shifting focus away from episodic care towards prevention, women will live healthier lives and our NHS will be placed on a more sustainable footing.

This report is not aiming to solve every health issue facing girls and women and we recognise that there is plenty more to be achieved. However, it lays the foundation for the creation of Women's Health Strategies across the UK. We call on the UK Governments to work closely with women, the NHS, professional bodies and key stakeholders to develop and realise its ambitions.



When we get this right for girls and women, everyone benefits. The time to act is now.

Join the conversation #BetterForWomen

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