



Results of the 'Women's Health – Let's talk about it' survey

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Executive summary

The Department for Health and Social Care (DHSC) launched a Call for Evidence in March 2021 to inform the first-ever government-led Women's Health Strategy for England. This report focuses on the survey component of the consultation.

Nearly 100,000 people in England got in touch to share their personal views and experiences as a woman, the experiences of a female family member, friend or partner, or their reflections as a self-identified health or care professional.

The results highlight priority areas for action and further research and underpin DHSC's [vision statement for England's Women's Health Strategy](#) (published in December 2021). The full Strategy will be published in spring 2022.

Priority topics

The top 5 topics respondents want DHSC to prioritise for inclusion are:

- gynaecological conditions (63%)
- fertility, pregnancy, pregnancy loss and post-natal support (55%)
- the menopause (48%)
- menstrual health (47%)
- mental health (39%)

This selection varies most notably by age, with topics rising in importance as they correspond with each stage of a woman's life course.

Other popular topics include research into health issues or medical conditions that affect women (34%), gynaecological cancers (30%), and the health impacts of violence against women and girls (30%).

Women's voices

Over 4 in 5 women (85%) feel, or are perceived to feel, comfortable talking to healthcare professionals about general physical health concerns. This falls to less than 3 in 5 women when discussing mental health conditions (59%).

When asked about specific women's health topics, the proportion of women who felt (or were perceived to) feel comfortable talking to professionals was:

- 77% for menstrual wellbeing
- 72% for gynaecological cancers
- 71% for gynaecological conditions
- 64% for the menopause

More than 4 in 5 (84%) went on to tell us there have been times when they (or the woman they had in mind) were not listened to by healthcare professionals.

Tens of thousands of examples were submitted. Based on our thematic analysis of this data, 'not being listened to' appears to manifest at all stages of the healthcare pathway. Specifically, many women told us:

- their symptoms were not taken seriously and/or dismissed upon first contact with GPs and other health professionals
- they had to persistently advocate for themselves to secure a diagnosis, often over multiple visits, months and years
- if they did secure a diagnosis, there were limited opportunities to discuss or ask questions about treatment options and their preferences were often ignored

Information and education

The top 5 sources respondents rely on for health information are:

- family or friends (74%)
- Google search (71%)
- other online search engines and blogs (69%)
- GPs or other healthcare professionals (59%)
- the NHS, including their non-emergency helpline and the NHS website (54%)

These results varied most notably by age and by ethnicity. For example: social media platforms (such as Facebook, Instagram and Twitter) featured in the top 5 sources of

health information listed by 16 to 17 year olds, and Black respondents were much less likely to rely on GPs/healthcare professionals than all other ethnic groups.

The topics at least 1 in 2 respondents said they have enough information on are:

- how to prepare for or prevent a pregnancy (59%)
- general physical health concerns (56%)
- how to prevent ill-health or maintain their health (51%)

Access to information falls substantially for topics specific to women's health:

- less than 1 in 5 have enough information on menstrual wellbeing (17%)
- around 1 in 7 have enough information on gynaecological cancers (14%)
- less than 1 in 10 have enough information on the menopause (9%), female genital mutilation and sexual assault centres (9%), and gynaecological conditions (8%).

Solutions put forward by respondents included: improving the quality and dissemination of information available to the public; improving and expanding the education of healthcare professionals and joining up services through the use of women's health hubs and drop-in centres; and diversifying the current Relationships, Sex and Health Education curriculum to ensure children and young adults are better informed about women's health issues.

Access to services

Just 2 in 5 respondents said they, or the woman in mind, can conveniently access the services they need in terms of location (40%), and around 1 in 4 said the same in terms of timing (24%).

To improve women's access to services, respondents put forward a range of suggestions that centred around:

- system level changes, such as geographical diversity in, and joined up provision of, women's health services, hubs and drop-in clinics
- better education and training of GPs and other healthcare professionals as treatment gatekeepers
- an increase in specialists and services to treat women's health conditions, such as the menopause and endometriosis

Nearly 3 in 4 respondents (74%) thought that the COVID-19 pandemic had a negative effect on women's access to healthcare services. Alongside general barriers experienced, such as a lack of GP appointments and limited access to mental health services, some women also reported delays to female cancer screening services and inadequate support during and post pregnancy.

Health in the workplace

Around 1 in 3 respondents said women feel comfortable talking about health issues in their workplace (35%), and 1 in 2 said their current or previous workplace had been supportive with regards to health issues (53%).

Of those who said a health condition or disability had impacted their experience in the workplace (62%) more than 3 in 4 said it had increased their stress levels (76%), and 2 in 3 said it had impacted their mental health (67%). We also found that:

- 26% said it impacted their earnings
- 25% said it affected their opportunities for promotion
- 22% said it meant they stopped work earlier than they had planned

To raise awareness of and destigmatise women's health conditions and their impact in the workplace, many respondents called on employers to do more to encourage and facilitate open discussions with line managers and colleagues.

Women also suggested that the government and employers should:

- continue to promote flexible working arrangements and facilitate access to occupational health services to enable women to better manage their health needs and communicate this to their managers
- create new policies to better support women in work, such as paid leave and counselling for miscarriage and baby loss, and reasonable adjustments for women who are going through the menopause, or living with painful gynaecological conditions
- provide better support for women seeking to re-enter the workplace and/or progress their careers after maternity leave, and while living with or recovering from female health conditions

Research and data gaps

There was a consensus among respondents that more must be done to improve research, evidence and data on women's health. Their main suggestions, which would be enhanced by ensuring diversity and support for women in research career pathways, were:

- to ensure women, and women with different protected characteristics, are represented in clinical trials and studies
- to initiate further research into health issues specific to women, such as endometriosis and the menopause, and health issues that may impact women differently, such as autism and cardiovascular disease
- to better translate research data and evidence into practice, policy, and the public domain

Other research opportunities, following on from the insights generated through this survey, include:

- evaluating models of health service delivery that better listen to and serve women's health needs
- optimising the provision of information and education to women and professionals on women's health issues to improve health outcomes
- developing interventions to improve health in the workplace, including access to appropriate occupational health services and policies
- understanding other determinants of women's experiences in the healthcare system, such as their socio-economic background (which was not captured through this survey), or the characteristics of healthcare professionals themselves

Introduction

Trigger warning: This report contains content that some readers may find upsetting, including anonymised, personal testimonies of not being listened to by healthcare professionals, and experiences of baby loss.

In March 2021, the Secretary of State for Health and Social Care and the Minister of State for Patient Safety, Suicide Prevention and Mental Health launched a [Call for Evidence](#) seeking views on the first-ever government-led Women's Health Strategy for England.

There were 3 parts to this Call for Evidence:

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

This report focuses on the results of the public survey, which received 110,123 responses in total - of which 97,307 were from individuals in England who wanted to share their own experiences, the experiences of a female partner, family member or friend, or their observations as a healthcare professional.

Our approach to analysing these responses is summarised in the 'Methodology' section, while the 'Respondent demographics' section considers the demographic characteristics of respondents and how representative they are likely to be of the wider population. We then explore respondents' experiences, reflections and suggestions under the following headings:

- health topics for the strategy
- women's voices
- information and education
- access to services
- health in the workplace

- research and data gaps

A separate report on the written evidence submitted by organisations and individuals with expertise in this field will be published in early 2022. The findings of the focus group study can be found on the [University of York's website](#).

Methodology

In this section we provide an overview of the ways in which individuals could respond to the 'Women's Health – Let's talk about it' survey, how we processed and analysed the data, and points to consider when interpreting the results.

Format

The survey was launched on 8 March and remained open for 14 weeks, closing on 13 June 2021. 2 versions were hosted on GOV.UK: the 'standard' version, which was completed by 108,813 individuals, and an 'easy-read' version, which contained a smaller sub-set of questions and was completed by 1,298 individuals. The easy-read version was also available in paper format and was returned by 12 people.

We then created a single dataset for our analysis, which incorporated the easy-read responses where the question text and response options were the same as, or substantially similar to, the standard version. The aggregated results from this dataset have been published on GOV.UK as accompanying data tables ([Annex A](#)), and these tables explicitly reference where and how the easy-read responses have been incorporated.

Data cleaning

In the UK, the National Health Service (NHS) is the umbrella term for the 4 health systems of England, Scotland, Wales and Northern Ireland. Because healthcare is devolved, the survey was therefore only open to individuals aged 16 and over, who live in England.

We included a mandatory question on place of residence at the start of the survey, and from this we were able to filter out 12,677 responses from individual who told us they live in Scotland, Wales, Northern Ireland, or elsewhere. This left us with a total sample size of 97,307 for our analysis.

Respondent type

Individuals were able to share their personal experiences, the experiences of a female family member, partner, or friend, or their reflections as a self-reported healthcare professional. The overall results in this report therefore contain a mix of primary and secondary accounts of women's experiences.

As shown in Table 1, the vast majority (97%) did share their own experiences. For the minority answering as a family member, partner, friend, or self-identified health or care professional, the question wording of subsequent questions in the survey was changed slightly to ask them about the experiences of the woman/women they had in mind. Similarly, family members, friends, and partners were asked to share the demographic characteristics of the woman they had in mind, rather than their own.

Table 1. In which capacity are you responding to this survey?

Response	Frequency	Percentage
Sharing my own experiences	93,093	96.9%
Health or Care professional	1,589	1.7%
Family member (excluding partners) to a woman	542	0.6%
Partner to a woman	417	0.4%
Friend to a woman	321	0.3%
Other	76	0.1%

Generalisability

While we received a very large volume of responses, the results are still only representative of those who completed the survey. Where we refer to the views of women, and how these vary by age, ethnicity, and other characteristics, this cannot be taken to represent all women in England. For this reason, statistical significance testing has not been used to analyse the results; instead, differences between demographic groups have been highlighted using judgement, focusing on gaps of 5 percentage points (pp) or more, based on rounded values.

It is also worth noting that many of the questions in the survey were negatively phrased, to test and quantify the assumption that women do not feel listened to within our healthcare system. While many of the narratives in this report do therefore focus on negative interactions with healthcare professionals, this should not be interpreted as a criticism of all healthcare professionals in England.

Analysis

The survey included closed, tick-box style questions, as well as open-ended questions where individuals could write detailed comments. Responses to the open-ended questions were analysed using a topic modelling and tagging system. This identified and labelled emerging themes and topics in the responses for every question and allowed responses to be tagged with multiple themes.

Throughout this report, we quote a selection of anonymised comments left by respondents. These comments have been selected manually to best represent, and give further insight into, the themes that emerged from the topic modelling. Where comments have been shortened for inclusion in this report, the omitted text is represented by an ellipsis in square brackets “[...]”; care was taken to ensure this did not misrepresent what the individual was telling us, or their tone of voice. Spelling errors have also been corrected where the intended word or words in question were obvious. No other changes have been made.

A glossary of the health conditions and other key terms referred to in our analysis is included at the end of this report.

Respondent demographics

To understand the extent to which our survey sample is likely to be representative of the wider population in England, we looked at the most recent [mid-year population estimates](#) published by the Office for National Statistics (ONS).

As of June 2020, there were an estimated 45.7 million individuals aged 16 or over in England, of which approximately 23.3 million were female (Table 2). Our sample of respondents therefore represents around 0.2% of the total population and 0.4% of the female population in England.

Table 2. Estimated number of individuals and females aged 16+ in England, compared to number responding to our survey

Population	Number of survey respondents	ONS mid-year estimates (June 2020)	Estimated % of population represented in survey
Individuals aged 16 or over in England	97,307	45,697,898	0.2%
Females aged 16 or over in England	95,051	23,280,733	0.4%

Nearly all respondents (99%) said they, or the woman they had in mind, are cisgender – meaning that their gender identity matches their sex registered at birth. In comparison, 1% said they identify with a gender different to their sex at birth (for example, they were registered female at birth, but identify as a man). The ONS mid-year estimates do not capture this level of information, so a comparison is not possible.

By region, 21% of survey respondents said they live in South East England, 18% in London, and 13% in South West England (Table 3). This means that respondents from all other regions in England were slightly underrepresented in our sample.

Table 3. Location in England

Response	Number of respondents	Percentage of respondents	Percentage of population with characteristic (ONS mid-year estimates, 2020)
South East England	20,152	21%	16%
London	17,542	18%	16%
South West England	12,780	13%	10%
North West England	10,720	11%	13%
Yorkshire & the Humber	8,129	8%	10%
West Midlands	8,023	8%	10%
East Midlands	7,488	8%	11%
East of England	7,472	8%	9%
North East England	3,689	4%	5%
South	499	0.5%	N/A
North	318	0.3%	N/A
Midlands	237	0.2%	N/A

Note: 'London' includes respondents who completed the 'easy-read' version of the survey. The options South, North and Midlands were only seen by 'easy-read' survey respondents and could not be incorporated into the standard survey results.

By age, 80% of respondents were 25 to 59 years old (Table 4). Those falling outside of this age bracket were underrepresented in our sample, relative to the wider. This was particularly true for individuals aged 60 and above, who represent approximately 30% of the population in England, but just 9.2% of respondents to our survey.

Table 4. Age band

Response	Number of respondents	Percentage of respondents	Percentage of population with characteristic (ONS mid-year estimates, 2020)
16 to 17 years old	655	1%	3%
18 to 19 years old	1,364	1%	3%
20 to 24 years old	7,961	8%	8%
25 to 29 years old	13,195	14%	8%
30 to 39 years old	25,951	27%	17%
40 to 49 years old	21,384	22%	16%
50 to 59 years old	17,498	18%	17%
60 to 69 years old	7,280	7%	13%
70 to 79 years old	1,746	2%	11%
Above 80 years old	167	0.2%	6%

By ethnicity, 91% identified as White, while the remaining 9% identified with a Black, Asian, Mixed, or minority ethnic group (Table 5). The Asian ethnic group (2%) was the only group to be underrepresented relative to the estimated population overall (7%).

Table 5. Ethnic group

Response	Number of respondents	Percentage of respondents	Percentage of population with characteristic (ONS mid-year estimates, 2020)
White	87,328	91%	87%
Asian	2,334	2%	7%
Black	3,255	3%	3%
Mixed	2,720	3%	2%
Other (includes Gypsy, Roma, Traveller)	785	1%	1%

We then looked at [NHS England's GP Patient Survey](#) (2021) to estimate how representative our sample was of people who live with a health condition or disability, and found that we had a higher proportion of respondents with an existing health condition or disability (67%) than we would expect to see in the population at large (52.5%, Table 6).

This was not entirely unexpected given that our Call for Evidence emphasised the need to hear from women with a broader range of health conditions including, for example, endometriosis and the menopause.

Table 6. Health status

Response	Percentage of respondents	Percentage of population with characteristic (GP Patient Survey, 2021)
Has an existing/ long-term health condition or disability	67%	52.5%
Does not have an existing/long-term health condition or disability	30%	44.5%
Prefer not to say	2%	3%

Due to a constraint on the number of questions we could include in our survey, we did not collect data on other protected and personal characteristics such as sexual orientation, religion or belief, and socio-economic background. We therefore do not know how representative the findings in this report are for women with these characteristics.

The population comparisons in this section can be found in a supplementary spreadsheet published on GOV.UK ([Annex B](#)). A full breakdown of all demographic results from the survey can be found in the survey data tables spreadsheet, Tables 1_1 to 1_9b, also on GOV.UK ([Annex A](#)).

Health topics for the strategy

To ensure the Women's Health Strategy is directly informed by the views and experiences of women, we asked respondents to pick up to 5 topics they would most like us to prioritise for inclusion, from a list of 23 options.

Summary

Overall, the topic respondents most wanted to be included in the Women's Health Strategy was gynaecological conditions (63%). This was followed by fertility, pregnancy, pregnancy loss and post-natal support (55%), the menopause (48%), menstrual health (47%), and mental health (39%).

This list of priority topics did vary by age (broadly aligning with each stage of a woman's life course), as well as ethnicity and gender identity. For example, the health impacts of violence against women and girls featured in the top 5 topics selected by younger respondents, aged 16 to 29, the Mixed/Multiple ethnic group, and those who identify with a gender different to their sex registered at birth.

Priority topics

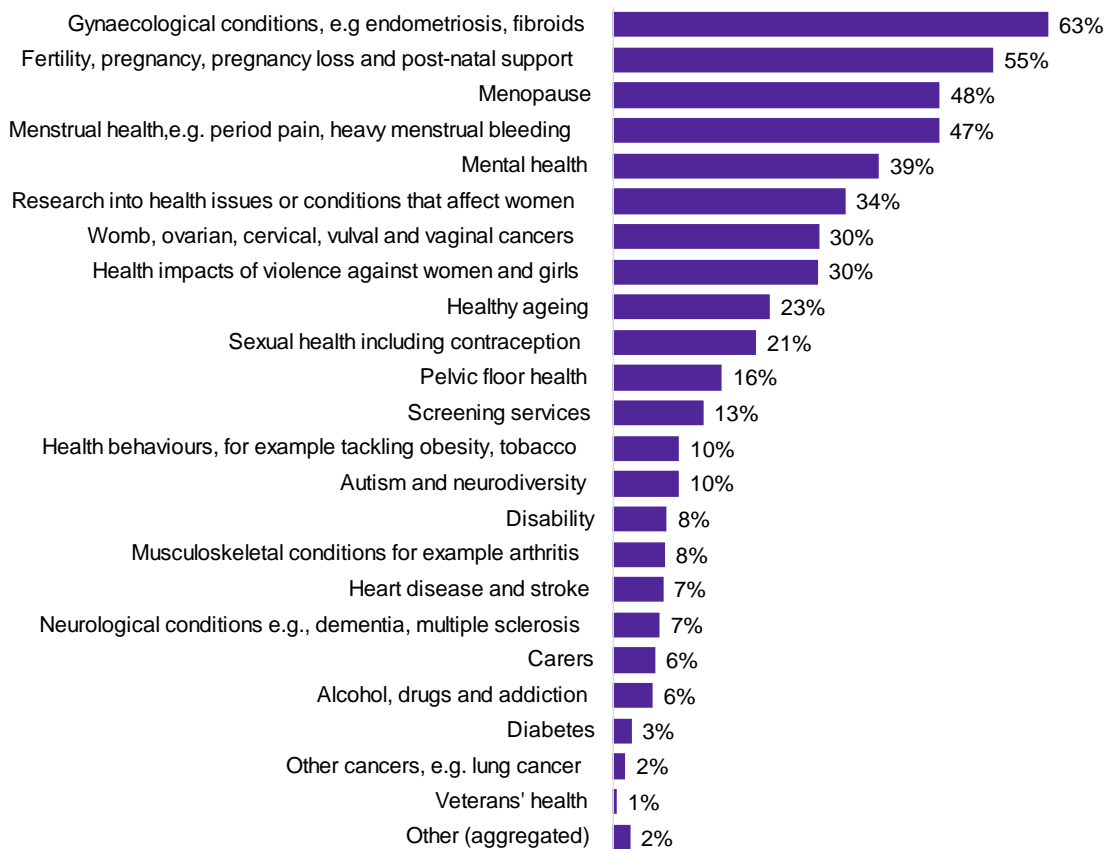
The top 5 topics selected by respondents overall were:

- gynaecological conditions (63%),
- fertility, pregnancy, pregnancy loss and post-natal support (55%)
- the menopause (48%)
- menstrual health (47%)
- mental health (39%)

Other popular topics, selected by more than 1 in 4 respondents, were: research into health issues that affect women (34%), gynaecological cancers (e.g., womb, ovarian, cervical) (30%), and the health impacts of violence against women and girls (30%) (Figure 1).

The topics that were selected less frequently tended to centre around health conditions that are not exclusive to women (e.g., alcohol, drugs and addiction, diabetes, non-gynaecological cancers), and topics that affect a minority of the population (e.g., veterans).

Figure 1: Which women's health topics do you think the Women's Health Strategy should cover? Select your top 5.



Space was provided for respondents to suggest 'Other' topics not already listed in the survey. These suggestions, put forward by 2% of respondents, included: breastfeeding, breast cancer, fatigue, fitness and weight, gastrointestinal conditions, gender disparities, immunosuppression, lipoedema, pain, poverty, racism, urinary tract infections (UTIs), and vitamin deficiencies (in particular vitamin B12).

Demographic variations

The level of interest in each health topic did vary by demographic. The most notable differences are summarised below.

Age

The number 1 topic selected by respondents varied by age and, by association, the key stages in a woman's life course.

For those aged 16-17, it was menstrual health; for those aged 18-19, 20-24 and 25-29 it was gynaecological conditions; for those aged 30-39 it was fertility, pregnancy, pregnancy

loss and post-natal support; for those aged 40-49 and 50-59 it was the menopause; and for those aged 60-69, 70-79 and 80+ it was healthy ageing.

We also found that the menopause dropped out of the top 5 topics selected by younger respondents (aged 16-17, 18-19, 20-24 and 25-29), and was replaced with the health impacts of violence against women and girls.

Furthermore, musculoskeletal conditions, such as arthritis, only featured in the top 5 topics for our 2 oldest age groups (70-79 and 80+). For those aged 80 and above, the topics of carers and heart disease and stroke, also appeared in their top 5.

Ethnicity

The same top 5 topics were selected by respondents who described their ethnicity as White, Asian, or Black, while Mixed/Multiple ethnic respondents selected the health impacts of violence against women and girls instead of the menopause.

Outside of the top 5 topics selected by each ethnic group overall, we found that Black respondents were 5 times more likely than White and Mixed/Multiple ethnic respondents, and twice as likely as Asian respondents, to select diabetes for inclusion in the strategy.

Gender identity

For those who identify with a gender different to their sex registered at birth, the health impacts of violence against women and girls featured in their top 5 rather than the menopause.

Compared to cisgender respondents, we also found that they were 4 times more likely to select autism and neurodiversity for inclusion in the strategy, and 3 times more likely to select disability.

Health status

There were no differences in the top 5 topics selected by respondents with and without an existing health condition or disability.

However, outside of the top 5 selected, respondents with an existing health condition were 3 times as likely to want disability to feature in the strategy, and twice as likely to want autism and neurodiversity to be included, compared to those with no existing conditions or disabilities.

A full breakdown of the results summarised in this section can be found in Tables 2_1a and 2_1b of the survey data tables spreadsheet (Annex A).

Women's voices

We wanted to understand whether women feel comfortable discussing different health topics with friends, family members, and healthcare professionals. We also wanted to know if there have been instances where they felt they have not been listened to by healthcare professionals, and the nature of these discussions.

Summary

The overall proportion of women who felt (or were perceived to feel) comfortable talking to healthcare professionals varied by topic: 85% for general physical health concerns, 78% for pregnancy and contraception, 77% for menstrual wellbeing 72% for gynaecological cancers, 71% for gynaecological conditions, 64% for the menopause, 63% for disability, autism and neurodiversity, and 59% for mental health. Except for gynaecological cancers, women felt more comfortable talking to friends about these issues than healthcare professionals.

More than 4 in 5 respondents (84%) went on to tell us that there have been instances when they (or the woman they had in mind) felt they were not listened to by healthcare professionals. Based on our thematic analysis of the personal testimonies provided, 'not being listened to' appears to be prevalent across all stages of the healthcare pathway. Many women recalled their symptoms being dismissed upon first contact with GPs and other professionals; women felt they had to persistently advocate for themselves to secure a diagnosis, often over multiple visits, months and years; and post-diagnosis, discussions about treatment options were often limited, and some said their preferences were ignored.

Comfort discussing health topics

The extent to which women felt (or were perceived to feel) comfortable talking about their health varied by topic and tended to be higher when discussing general physical health concerns, and lower when discussing mental health conditions (Figure 2).

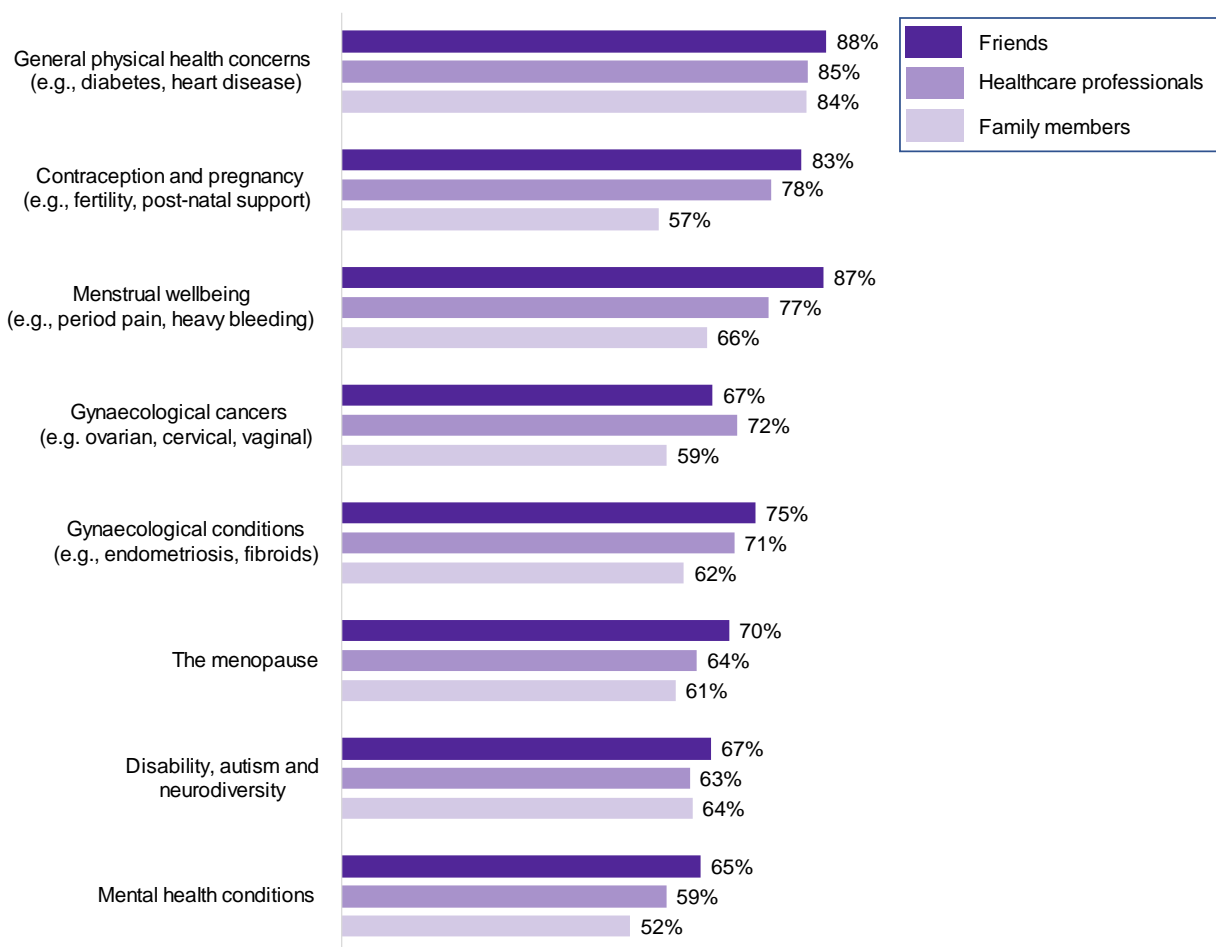
Comfort levels also varied depending on whether the discussion was with friends, family members, or healthcare professionals. This was most apparent when discussing contraception and pregnancy, and menstrual wellbeing.

Specifically:

- General physical health concerns: 88% are comfortable talking to friends, 85% healthcare professionals, and 84% family members (a range of 4 percentage points (pp))

- Contraception and pregnancy: 83% are comfortable talking to friends, 78% healthcare professionals, and 57% family members (a range of 26pp)
- Menstrual wellbeing: 87% are comfortable talking to friends, 77% healthcare professionals, and 66% family members (a range of 21 pp)
- Gynaecological cancers: 72% are comfortable talking to healthcare professionals, 67% friends, and 59% family members (a range of 13 pp)
- Gynaecological conditions: 75% are comfortable talking to friends, 71% healthcare professionals, and 62% family members (a range of 13 pp)
- The menopause: 70% are comfortable talking to friends, 64% healthcare professionals, and 61% family members (a range of 9pp)
- Disability, autism, neurodiversity: 67% are comfortable talking to friends, 64% family members, and 63% healthcare professionals (a range of 4pp)
- Mental health conditions: 65% are comfortable talking to friends, 59% healthcare professionals, and 52% family members (a range of 13 pp)

Figure 2. How comfortable do you / the woman you have in mind feel talking about health issues with friends / healthcare professionals / family members?



Demographic variations

Given that it is part of a healthcare professional's role to discuss health-related issues with their patients, we were interested to explore whether comfort levels with this group varied according to other protected characteristics held by respondents. The most notable differences are summarised below.

General physical health concerns

Older respondents tended to feel more comfortable talking to healthcare professionals about general physical health concerns than younger respondents; the biggest gap was 15 percentage points between those aged 18-19 (78%) and those aged 80 or above (93%).

Cisgender respondents were 9 percentage points more likely to feel comfortable talking to healthcare professionals about general physical health concerns, compared to those who identify with a gender different to their sex registered at birth (85% vs 76%).

Contraception and pregnancy

Older respondents generally felt more comfortable talking to healthcare professionals about contraception and pregnancy than younger respondents; the biggest gap was 22 percentage points between those aged 16-17 (61%) and those aged 50-59 and 70-79 (83%).

Cisgender respondents were 14 percentage points more likely to feel comfortable talking to healthcare professionals about contraception and pregnancy than those who identify with a gender different to their sex registered at birth (78% vs 64%).

Respondents with no existing health condition or disability were 5 percentage points more likely to feel comfortable talking to healthcare professionals about contraception and pregnancy, compared to respondents with a disability (82% vs 77%).

Menstrual wellbeing

Older respondents generally felt more comfortable talking to healthcare professionals about their menstrual wellbeing than younger respondents; the biggest gap was 13 percentage points between those aged 16-17 (71%) and those aged 70–79 (84%).

Across ethnicities, Asian respondents felt the most comfortable talking to healthcare professionals about menstrual wellbeing (81%), while respondents from the Mixed/Multiple ethnic group felt the least comfortable (76%, a gap of 5 percentage points).

Cisgender respondents were 15 percentage points more likely to feel comfortable talking to healthcare professionals about menstrual wellbeing than those who identify with a gender different to their sex registered at birth (78% vs 63%)

Gynaecological cancers

Older respondents tended to feel more comfortable talking to healthcare professionals about gynaecological cancers than younger respondents; the biggest gap was 22 percentage points between those aged 16-17 (61%) and those aged 80 or above (83%).

Cisgender respondents were 10 percentage points more likely to feel comfortable talking to healthcare professionals about gynaecological cancers than those who identify with a gender different to their sex registered at birth (72% vs 62%).

Gynaecological conditions

Older respondents tended to feel more comfortable talking to healthcare professionals about gynaecological conditions than younger respondents; the largest gap was 21 percentage points between those aged 16-17 (60%) and those aged 80 or above (81%).

Cisgender respondents were 12 percentage points more likely to feel comfortable talking to healthcare professionals about gynaecological conditions than those who identify with a gender different to their sex registered at birth (71% vs 59%).

Menopause

Older respondents tended to feel more comfortable than younger respondents in talking to healthcare professionals about the menopause; the largest gap was 31 percentage points between those aged 18-19 (54%) and those aged 70-79 (85%).

Cisgender respondents were 13 percentage points more likely to feel comfortable talking to healthcare professionals about the menopause than those who identify with a gender different to their sex registered at birth (65% vs 52%).

Disability, autism, and neurodiversity

Older respondents tended to feel more comfortable than younger respondents in talking to healthcare professionals about disabilities, autism and neurodiversity; the biggest gap was 16 percentage points between those aged 18-19 (54%) and those aged 80 or above (70%).

Cisgender respondents were 15 percentage points more likely to feel comfortable talking to healthcare professionals about disabilities, autism and neurodiversity than those who identify with a gender different to their sex registered at birth (63% vs 48%).

Respondents with no existing health condition or disability were 6 percentage points more likely to feel comfortable talking to healthcare professionals about disabilities, autism and neurodiversity, than those with a health condition or disability (68% vs 62%).

Mental health

Older respondents tended to feel more comfortable than younger respondents in talking to healthcare professionals about their mental health; the largest gap was 31 percentage points between those aged 16-17 and 18-19 (41%), and those aged 80 or above (72%).

Across ethnicities, Black respondents felt the most comfortable talking to healthcare professionals about their mental health (61%), and the Mixed/Multiple ethnic group felt the least comfortable (56%, a gap of 5 percentage points).

Cisgender respondents felt 12 percentage points more comfortable talking to healthcare professionals about their mental health than those who identify with a gender different to their sex registered at birth (59% vs 47%).

A full breakdown of all results in this section can be found in Tables 3_1a to 3_2h of the survey data tables spreadsheet (Annex A).

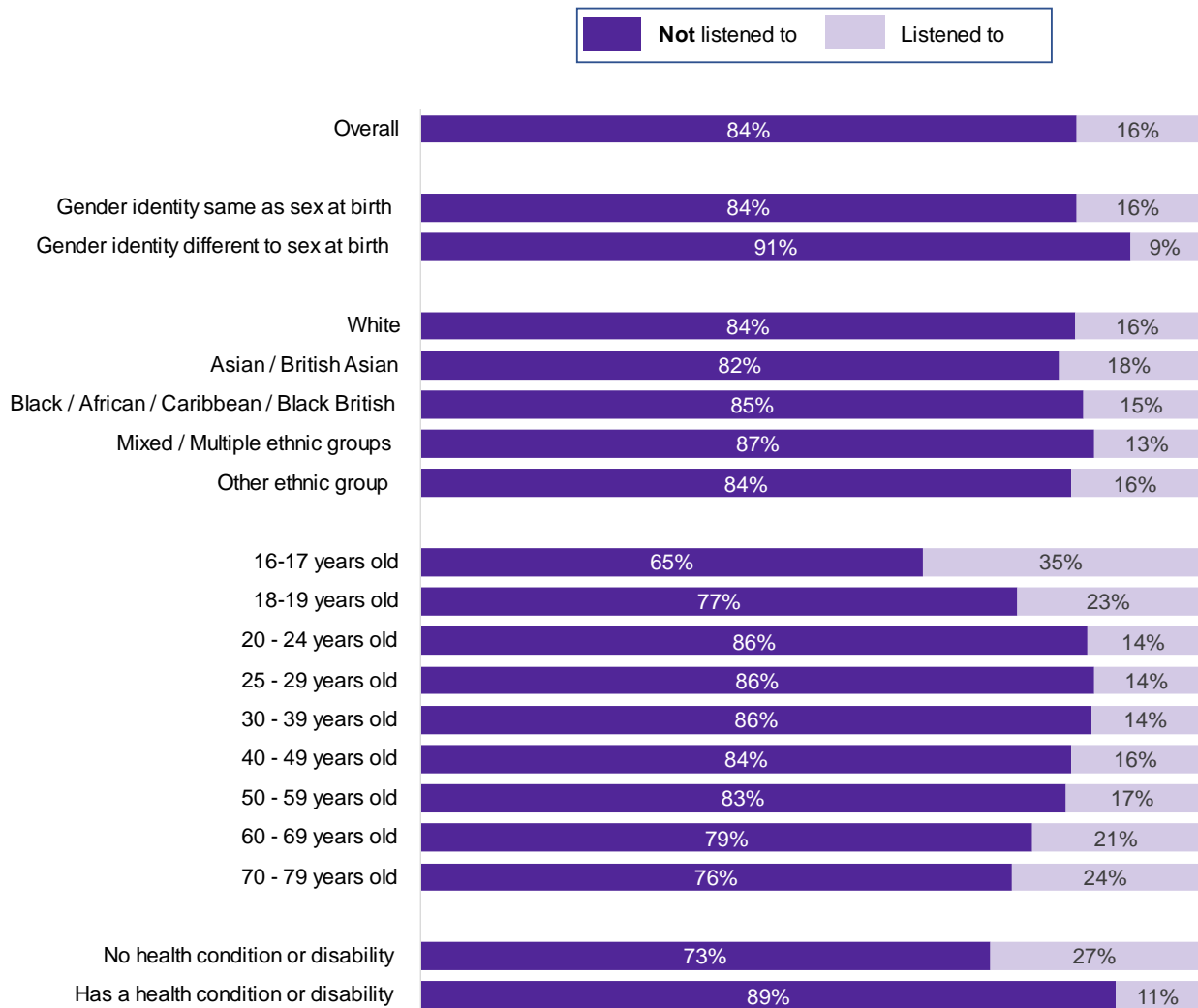
Feeling listened to by healthcare professionals

Overall, 84% of respondents told us that there have been instances where they, or the woman they have in mind, felt they were not listened to by healthcare professionals.

As shown in Figure 3, the likelihood of not being listened to did vary by demographic, ranging from:

- 91% of respondents who identify with a gender different to their sex registered at birth, compared to 84% of cisgender respondents
- 87% of the Mixed/Multiple ethnic group, compared to 82% of Asian respondents
- 86% of respondents aged 20-24, 25-29, and 30-39, compared to less than 80% of those aged 16-17, 18-19, 60-69, and 70-79
- 89% of those with an existing health condition or disability, compared to 73% of those without

Figure 3. Have there been any instances where you / the woman you have in mind were not listened to by health or care professionals?



Of those who told us that there have been instances where they were not listened to, 72% said this was in relation to discussing symptoms, 56% when seeking referral to a specialist, and 54% when discussing treatment options (Table 7). There were also issues around follow-up care and informed consent.

Table 7. Please select the nature of the discussion selecting all that apply:

Nature of discussion when not listened to by healthcare professional	Percentage
Discussing symptoms	72%
Seeking referral to a specialist	56%
Discussing treatment options	54%
Asking for more information about an issue or condition	50%
Discussing diagnosis of a condition or disability	41%
Follow-up care	40%
Raising concerns or a complaint	25%
Being asked for consent to a procedure or course of action	10%
Seeking informed consent	8%

A full breakdown of all results in this section can be found in Tables 3_1a to 4_2 of the 'Survey Data Tables' spreadsheet.

Personal testimonies

To explore women's experiences in more detail, respondents were asked to provide up to 2 examples of times when they felt they had not been listened to by healthcare professionals in relation to specific health issues or conditions. Space was also provided to enable respondents to reflect on how the healthcare system listens to women more broadly. Because the themes that emerged from both questions were similar, we have combined the results in this section of our report.

A large proportion of the personal testimonies focused on issues and conditions that are specific to women, such as heavy and painful periods, the menopause, and childbirth. Others reflected on how they have not been listened to when discussing health conditions common to both men and women, including mental ill health and musculoskeletal pain. The most common conditions mentioned by respondents are listed in Table 8 (please refer to our Glossary for a brief definition of terms).

Table 8. Summary of health topics and conditions where respondents feel they have not been listened to by healthcare professionals

Topics centred around women’s health conditions	Topics centred around more general conditions common to both men and women
<ul style="list-style-type: none"> • Heavy periods and endometriosis • Pain related to menstruation and other gynaecological conditions • The oral contraceptive pill and side effects • Menopause • Female fertility and sterilisation • Labour and childbirth • Post-natal care for mothers • Fibroids • Intrauterine devices • Lumps and breast cancer • Pelvic prolapse • Smear tests and cervical cancer • Female sterilisation • Weight management and polycystic ovary syndrome 	<ul style="list-style-type: none"> • Mental health • Pain (e.g., back, knees, joints) • Autism • B12 deficiency • Chronic conditions (e.g., fatigue) • Diabetes • Eating disorders • Gastrointestinal problems • Respiratory problems • Skin and eye conditions • Stress, headaches and migraines • Thrush • Thyroid function • Urinary tract infections

While the pathway from initial contact through to follow-up care is not always linear, many respondents have experienced not being listened to at every stage of their journey. The ways in which not being listened to manifested itself is summarised in Table 9 and discussed in more detail below.

Table 9. Summary of how respondents described not being listened to by, by stage of healthcare journey

Stage of healthcare journey	How not being listened to often manifested
Initial contact with healthcare professionals	<ul style="list-style-type: none"> • Symptoms not taken seriously and viewed as exaggerated • Symptoms dismissed as a natural part of being a woman • Symptoms dismissed as not falling within the ‘typical’ profile of a woman with that condition • No treatment or wrong treatment
Further contact with healthcare professionals	<ul style="list-style-type: none"> • Multiple visits over an extended period often required • Speaking to a specialist often crucial to a correct diagnosis, but difficult to get referred • Reliance on private healthcare services
Treatment options	<ul style="list-style-type: none"> • Limited discussion of treatment options / risks • Treatment preferences ignored • Fragmented service provision
Follow-up care	<ul style="list-style-type: none"> • Poor post-natal care for the mother • Lack of support and poor communication after miscarriage • Dismissal of medication side effects
Across all stages	<ul style="list-style-type: none"> • Feeling dismissed by some male healthcare professionals / Feeling judged by some female healthcare professionals

Initial contact with healthcare professionals

Most women who responded to this survey said that their symptoms were immediately dismissed upon first contact with healthcare professionals. Often, this was in reference to GPs, though respondents did also reflect on negative experiences with doctors, nurses, and medical professionals more broadly.

Dismissal was often grounded in women not being believed or being told there is nothing wrong with them. For example:

Respondent (aged 25-39):

"My doctor didn't listen or ask for further information when I expressed concerns about my irregular periods, I was told it was normal and not to worry despite the NHS website saying I should speak to my GP [...]"

Respondent (aged 25-39):

"I have a chronic pain condition. The doctor told me pain relief was not for "people like me". When I asked what he meant he said that young women do not need pain relief, pain relief is only for people in "proper pain"

Respondent (aged 25-39):

"[...] no one would believe me that I was miscarrying I was left to bleed through my clothes in A&E for 3 hours without pain relief. [...] I was eventually sent home, told to take paracetamol and seen by EPU [Early Pregnancy Unit] the day after who confirmed the miscarriage."

Respondent (aged 40-59):

"[...] Last year I experienced heavy and continuous vaginal bleeding for 5 months and, despite repeatedly raising it with my GP, was not listened to. Had I been bleeding heavily and continually for 5 months from any other part of my body I have no doubt that my GP would have taken steps to investigate urgently. As it was, no action was taken until I became so anaemic that my body almost failed."

Dismissal was often coupled with being told that certain symptoms should be accepted as inherent to being a woman and therefore do not require treatment. This was particularly prevalent in relation to menstrual health:

Respondent (aged 25-39):

"[...] I have had my endometriosis over looked and just told it was period pain and to deal with it. "It's part of being a woman". Told I have no right to go into A&E because "my period is normal and I am exaggerating my pain, it's all in my head"

Respondent (aged 25-39):

"[...] told repeatedly my period are just heavy, I'll grow out of it, when I have a baby the pain will go away, by GPs from age 15 till 35. No one investigated further. No scans nothing."

Other women felt that their concerns had been dismissed because there was a lack of acknowledgement and/or understanding about how conditions can present in different ways, for different women. For example:

Respondent (aged 40-59) [spelling errors corrected]:

"trying to discuss possible menopause symptoms including hot flushes, told I was too young so it was just the weather no one cared about the effect on my life"

Respondent (aged 25-39):

"Because my ectopic pregnancy wasn't presenting in the 'textbook' way my concerns were routinely dismissed and as a result I ended up having emergency surgery which led to a lot of emotional trauma. [...]"

Further contact with healthcare professionals

Women said they had to persistently advocate for themselves and push for further investigation to increase their chances of securing a diagnosis, speaking to doctors on multiple occasions over many months or years. These delays often had wider ramifications for their health and quality of life. For example:

Respondent (aged 25-39):

"[...] I was diagnosed with endometriosis in 2014 after eight years of going to doctors with chronic, severe pain [...] I have lost count of the number of GPs I went to for help [...] Those eight years of being ignored or told it was all in my head, as well as living with chronic pain and missing out on lots of 'normal things that a young person should be doing' had a severe impact on my mental health, and this is something I continue to struggle with. [...]"

Respondent (aged 40-59):

"[...] Going back again and again to GP with different symptoms for years and not realising that the symptoms were all indications of being perimenopausal. GP did not join up the dots either. It was 5 years until they suggested doing a blood test for a marker in my blood and then concluded I had early onset menopause."

Respondent (aged 40-59):

"I was always given medication to manage my period pain and no investigations were done. It turns out I had fibroids, endometriosis and adenomyosis. Had I been investigated properly earlier I may have avoided a total hysterectomy"

Contact with specialists was frequently highlighted as crucial to securing an accurate diagnosis. However, women's requests to be referred to a specialist were not always acted upon. This caused further delays and, on occasion, indirectly placed a financial burden on women who felt that paying for private treatment was the only viable alternative. For instance:

Respondent (aged 25-39):

"I had to visit my GP Surgery three times about a single suspect mole. The first two times it was dismissed. They eventually referred me to a specialist. It turned out to be cancerous".

Respondent (aged 16-24):

"[...] I have had to push to get my symptoms checked and to be diagnosed [...] I had multiple doctors visits before being offered a ultrasound scan in which I was diagnosed with PCOS [polycystic ovary syndrome]. It's then taken a further 3 years to be diagnosed with Endometriosis, and I have had to go privately in order to get the diagnosis [...]"

Respondent (aged 16-24):

"I went to the doctors three times across two months with bleeding from my anus, a lot of stomach pain, bloating, nausea etc. [...] I had to bring my mum in with me [...] to get him to refer me [...] When I was finally referred to a specialist, I had a flexible sigmoidoscopy and was barely told what was happening or what anything meant. [...] the results weren't really explained and I had to keep going to the GP to ask for help. After being

told that I should stop calling about these kind of things [...] I finally went private and got a diagnosis and some medication [...]"

Respondent (aged 60 or over) [spelling errors corrected]:

"In my personal experience I've never felt like my health has been taken seriously by the NHS. I have little to no hope left. It's almost impossible to find a decent GP and As I've gotten older its only getting worse! I have trouble with my feet 13....years on I still don't know why. Menopause issues for many years a total uphill battle now Incontinence 15 months on still no answers.... just today I was due to have a telephone appointment and well that didn't happen neither I'll have to chase it up tomorrow. I could go on and on. Everything feels like a battle and I no longer have the mental or physical strength to keep pushing through. Over the years I have been able to pay privately but those days are now gone. It terrifies me!"

Treatment options

Post-diagnosis, discussions about potential treatment options were often limited, and some women felt their preferences were ignored and/or overridden by healthcare professionals:

Respondent (aged 40-59):

"Advised to discontinue HRT [hormone replacement therapy] due to Breast Cancer risk via grandmother. Explained Quality Of Life issues on lowered dose HRT. Advised to have Breast Cancer gene test which would not be available on NHS and discontinue HRT if test indicated. Dr did not appreciate current quality of life more important than future risk."

Respondent (aged 40-59):

"Discussing treatment options for musculoskeletal condition and options for medication. I did not feel it was a discussion in which I was given information to understand why certain options were not offered to me and declined. there wasn't a dialogue as such just a decision made by the health care professional without explaining why/why not"

Respondent (aged 40-59):

"[...] I had numerous appointments with GP who I felt was trying to force me to take antidepressants, which I knew I didn't need. I finally got HRT [hormone replacement therapy] and my symptoms were lessened. I also

saw a gynaecologist who tried to force the Mirena coil on me despite me telling her I'd tried it twice in the past and it wasn't successful. She objected to the HRT I'd been prescribed and later had to write an apology as she'd found out that my prescribed treatment was in fact not "abnormal" [...]"

Sometimes, gendered stereotypes about what women 'should' want (particularly in relation to having children) were reportedly used to deny treatment:

Respondent (aged 25-39):

"I wanted to discuss sterilisation and was told I was too young to know that I didn't want children. The doctor then went on to tell me that I would change my mind when I met a "nice boy" despite being engaged to a man at the time (and still). They did not listen to the concerns I raised."

Respondent (aged 25-39):

"After my first (and only) pregnancy I had a catch up with my GP and I requested to see a specialist for female sterilisation. [...] the GP (a female I might add) kept wanting to change my mind with a variety of (frankly insulting) reasons. From "but what if your husband (I'm not married) decides to have more children" to "you've only just had a baby, you're emotional" and "you can't possibly want to do this, what if you change your mind later". I managed to get a referral [...] where I was again met with a nurse whose whole purpose seemed to be to put me off having the procedure so I never went to get it done because of the way I was treated. In the end my partner went and got a vasectomy and (surprise, surprise) he never once got asked what his partner thinks, or that maybe I'll want to have children later. [...]"

Respondent (aged 25-39):

"Gynaecologist wouldn't listen to my wishes. I have chronic bleeding and want my tubes tied/womb removed completely. I do not want children and know the implications of these surgeries but was told that I would want to have children when I am older and that I might change my mind about being in a lesbian relationship."

Fragmented services were also surfaced as a potential blocker to effective treatment, for example:

Self-reported health or care professional [spelling errors corrected]:

“There is an inequality of access to the right services; in my professional capacity I see women who had a mixture of issues and referred to a few specialisms but because the wait for Gynaecology services is significantly long, they are seen by whichever specialist has the shorter waiting list. A course of treatment/therapy is then started which doesn't always address the additional needs they have and then when they get seen by the gynaecology team, they cannot have the necessary treatment because of the treatment started by the other teams. It does appear that services that are specifically for women only are significantly under resourced than compared to services that are for men as well.”

Follow-up care

Many of the narratives that touched on follow-up care centre around poor experiences following childbirth or baby loss. For example:

Respondent (aged 25-39):

“No follow up from health visitor because my postnatal depression score was fine even though I had reached out for help because my partner was suffering with depression and I felt overwhelmed with that, bereavement and a new baby.”

Respondent (aged 25-39):

“At my 6 weeks postnatal check they rolled this together with baby's 8 week check. There wasn't enough time to discuss my concerns (scar healing, contraception preferences) properly”

Respondent (aged 25-39) [spelling errors corrected]:

“No real support or information re pelvic floor rehabilitation post pregnancy. Suffered diastasis recti but no information given post pregnancy about this or about rehabilitation that might be needed for pelvic floor, which is given automatically in some countries”

A smaller proportion of women talked about a lack of adequate follow-up care when they sought help for medication side effects:

Respondent (aged 16-24):

"When I went to my nurse at my doctor's surgery regarding symptoms I was experiencing whilst on the contraceptive pill, I was dismissed and told it could not possibly be the pill causing this, even though the symptoms are on the sheet inside the pill box [...] I have never gone back as now I am too nervous I will be dismissed again as though I am stupid."

Across all stages

Across all stages of the healthcare pathway, there were women who felt that they had not been listened to because the healthcare professional they saw was male. Here are just a few examples:

Respondent (aged 25-39):

"Typically, I find male doctors less responsive and less likely to run blood tests as mentioned, a male doctor assumed my symptoms were anxiety without running any tests, only to later find after seeing a female doctor and getting blood tests that I had an overactive thyroid and was put on medication immediately. [...]"

Respondent (aged 60 or over):

"Went to GP (male) disabling pains in stomach, frequent urinating, feeling sick, periods unusually irregular. Told nothing wrong with me. Went back after few days saw lady GP referred to hospital & after scans & tests found I had fibroids. Had full hysterectomy. [...]"

Respondent (aged 25-39):

"[...] I once found a lump in my breast, when I booked an appointment, my dr didn't even examine me, he simply said "well I doubt you're going to be comfortable with me having a feel, so I won't, it's not going to be anything anyway, you're too young" a completely wasted appointment, luckily it was just a fatty lump that I got checked out elsewhere. [...]"

However, this must be interpreted carefully, given that not all interactions with female healthcare professionals were viewed as positive. For instance:

Respondent (aged 25-39):

"Last two smears the nurse has been amazing, but the nurse before refused to believe that the procedure would/could hurt me since then

another nurse has identified I need a smaller speculum and it's been ok. All the nurses were female but even some women are not kind or accepting of diverse experiences from other women.”

Respondent (aged 25-39):

“[...] I've also felt judged by female doctors around lack of knowledge about my body or about sexual history (e.g. when professing a lack of knowledge about Menstrual Cycle I've had a female doctor say “Really? Honestly you're (xx years of age)” which makes you feel stupid but it's not something that is taught in schools effectively and online information is really all over the place. [...]”

Information and education

We wanted to understand the main sources of information women rely on for health information, and whether they have access to enough information on different topics, such as menstrual wellbeing and the menopause. We also wanted to collate suggestions for improving access to information and education on women's health.

Summary

Overall, family or friends was the main source of information respondents said they, or the woman they had in mind, rely on for health information (74%). The second most common was Google (71%), followed by other online search engines and blogs (69%), GPs/healthcare professionals (59%) and the NHS (54%). These results did vary by group; for example, reliance on GPs/healthcare professionals and the NHS was much lower among Black respondents relative to all other ethnic groups.

More than half of respondents said they can access enough information on how to prepare for or prevent a pregnancy (59%), general physical health concerns (56%), and how to prevent ill-health or maintain their health (51%). In comparison, fewer than 1 in 5 said they have sufficient information on menstrual wellbeing (17%) and gynaecological cancers (14%), and fewer than 1 in 10 said the same for the menopause (9%), female genital mutilation and sexual assault centres (9%), and gynaecological conditions (8%).

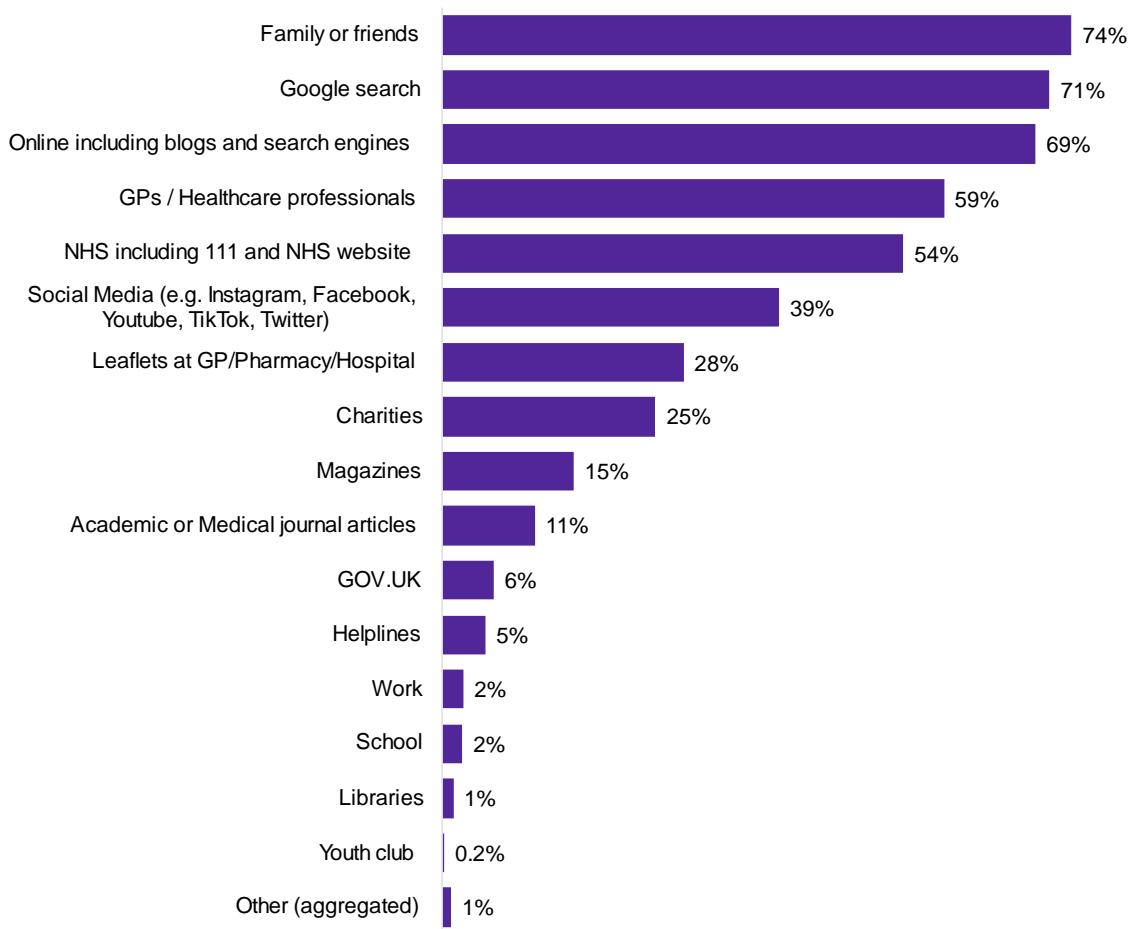
To improve access to information and education on women's health, respondents suggested: improving the quality and dissemination of information available to the public; improving and expanding the education of healthcare professionals and joining up services through the use of women's health hubs and drop-in centres; and diversifying the current Relationships, Sex and Health Education curriculum.

Sources of information

Overall, the most common source of information respondents rely upon for health information is their family or friends (74%) (Figure 4). However, this does not mean that family members and friends are approached with equal enthusiasm; as discussed in the above section 'Women's voices', respondents generally felt, or were perceived to feel, much less comfortable talking to family members about many different health topics, compared to their friends.

The next 2 most common sources of information were Google search results (71%) and other online search engines and blogs (69%). Less common, though still in the top 5, were speaking to a GP or healthcare professional (59%), and seeking guidance from the NHS, including via 111 and the NHS website (54%).

Figure 4. Which of the following sources do you/ the woman you have in mind go to for health information? Please pick up to 5.



The sources of information women rely on, or are reported to rely on, does vary by other personal characteristics.

For example:

- the most common source of information for those aged 70-79 and 80+ was their GP and/or healthcare professionals (37% and 31% respectively)
- half of those aged 16-17 (51%) said they rely on social media for health information; this declined by age, down to 12% of those aged 70-79

- the most common source of information for Asian respondents was Google (57%), rather than family or friends (54%)
- reliance on GPs or healthcare professionals was much lower among Black respondents (39%), compared to those identifying as White (48%), Asian (44%), Mixed (48%), and Other (45%)
- reliance on the NHS (including 111 and the NHS website) was also much lower among Black respondents (30%), compared to those identifying as White (44%), Asian (40%), Mixed (44%), and Other (40%)

A full breakdown of all results in this section can be found in Tables 5_1a and 5_1b of the survey data tables spreadsheet (Annex A).

Level of information

Overall, more than 1 in 2 respondents agreed that they (or the woman in mind) have enough information on:

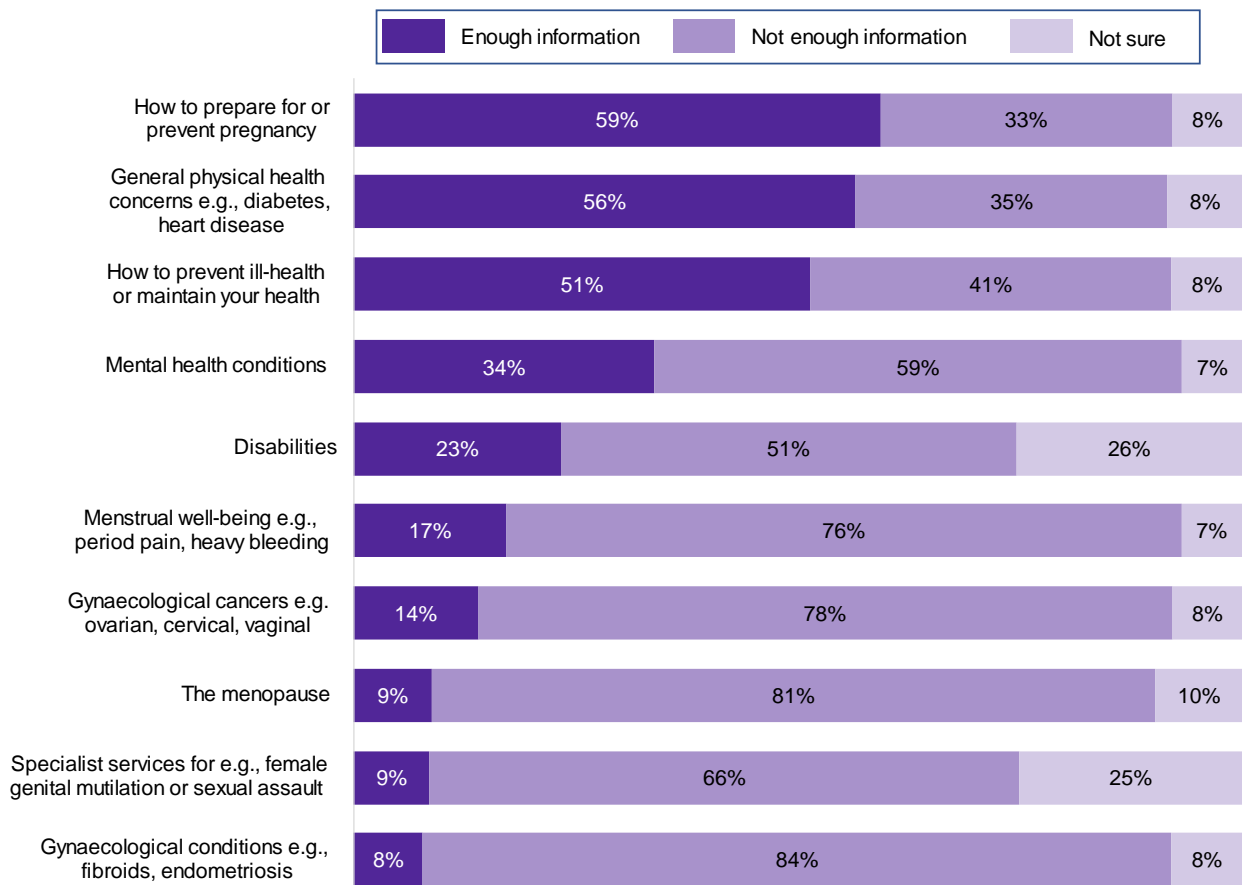
- how to prepare for or prevent pregnancy (59%)
- general physical health concerns (56%)
- how to prevent ill-health or maintain their health (51%)

They were much less likely to agree they have sufficient information on:

- mental health conditions (34%)
- disabilities (23%)
- menstrual wellbeing (17%)
- gynaecological cancers (14%)
- specialist sexual assault referral centres and female genital mutilation (FGM) clinics (9%)
- the menopause (9%)
- gynaecological conditions (8%)

These results are illustrated in Figure 5.

Figure 5. Do you think you / the woman you have in mind have received or have access to enough information on the following topics...



Demographic variations

The extent to which respondents felt they can access enough information on various health topics did vary by demographic. The most notable differences are summarised below.

How to prepare for or prevent pregnancy

Those aged 25-29 were the least likely to agree they have enough information on this topic (50%), while those aged 40-49 were the most likely (70%, a gap of 20 percentage points).

Asian respondents were the least likely to agree they have enough information on how to prepare for and/or prevent pregnancy (47%), while White respondents were the most likely (60%, a gap of 13 percentage points).

General physical health concerns

Respondents aged 50-59 and 60-69 were the least likely to agree they have enough information on general physical health concerns (55%), while those aged 16-17 were the most likely (61%, a gap of 6 percentage points).

Black respondents were the least likely to agree they have enough information on general physical health concerns (49%), while White respondents were the most likely (57%, a gap of 8 percentage points).

Preventing ill-health / maintaining health

Respondents aged 50-59 were the least likely to say they have enough information on how to prevent ill health and maintain their health (50%), while those aged 80 or above were the most likely (56%).

Asian and Black respondents were the least likely to agree they have enough information on how to prevent ill health and maintain their health (42%), while White respondents were the most likely (52%, a gap of 10 percentage points).

48% of respondents with an existing health condition or disability said they have access to enough information on how to prevent ill-health and maintain their health, which was 11 percentage points lower than those with no disability (59%).

Mental health conditions

24% of those aged 80 or above said they have enough information on mental health conditions, compared to 37% of 40-49 year olds (a gap of 13 percentage points).

28% of those identifying with a gender different to their sex at birth said they have enough information on mental health conditions, compared to 34% of cisgender respondents (a gap of 6 percentage points).

32% of respondents with an existing health condition or disability said they have access to enough information on mental health conditions, compared to 39% of those with no disability (a gap of 7 percentage points).

Disabilities

32% of those aged 80 or above said they have enough information on disabilities, which was higher than all other age groups (ranging from 21% to 26%).

17% of respondents in the Mixed/Multiple ethnic group said they have enough information on menstrual wellbeing, rising to 24% of White respondents (a gap of 7 percentage points).

18% of those identifying with a gender different to their sex at birth said they have enough information on disabilities, compared to 23% of cisgender respondents (a gap of 5 percentage points).

It is worth noting that this question had the highest proportion of respondents who said they do not know if they have enough information (26%).

Menstrual wellbeing

14% of respondents aged 25-29 said they have enough information on menstrual wellbeing, rising to 34% of those aged 80 or above (a gap of 20 percentage points).

14% of respondents in the Other ethnic group and 15% in the Mixed/Multiple ethnic group said they have enough information on menstrual wellbeing, rising to 20% of Black respondents (a gap of 5-6 percentage points).

12% of those identifying with a gender different to their sex at birth said they have enough information on menstrual wellbeing, compared to 17% of cisgender respondents (a gap of 5 percentage points).

16% of respondents with an existing health condition or disability said they have access to enough information on menstrual wellbeing, rising to 21% of those with no disability (a gap of 5 percentage points).

Gynaecological cancers

5% of respondents aged 16-17 and 7% of respondents aged 18-19 and 20-25 said they have enough information on gynaecological cancers, rising to 31% of those aged 80 or above.

11% of respondents belonging to the Mixed/Multiple ethnic group said they have enough information on gynaecological cancers, rising to 16% of Black respondents (a gap of 5 percentage points).

Menopause

6% of respondents aged 25-29 and 30-39 and 7% of respondents aged 40-49 said they have enough information on the menopause, rising to 33% of those aged 70-79 and 80 or above.

7% of respondents in the Mixed/Multiple ethnic group said they have enough information on the menopause, rising to 14% of Black respondents (a gap of 7 percentage points).

Specialist services

18% of respondents aged 80 or above said they have enough information on the specific health services available for female genital mutilation and sexual assault, compared to 6% of those aged 16-17 and 18-19.

This question also had a high overall proportion of respondents who said they do not know if they have enough information on these services (25%).

Gynaecological conditions

Respondents aged 16-17 (2%) and 18-19, 20-24, and 25-59 (each 4%) were the least likely to say they have enough information on gynaecological conditions, rising to 25% of those aged 80 or above.

Mixed/Multiple ethnic respondents were the least likely to agree they have enough information on gynaecological conditions such as endometriosis (5%), while Black respondents were the most likely (12%, a gap of 7 percentage points).

A full breakdown of all results in this section can be found in Tables 5_2a and 5_2b of the survey data tables spreadsheet (Annex A).

Improving access to information and education

Respondents were asked to provide up to 2 suggestions for things that could help women better access information and education on women's health. Space was also provided for them to share any other reflections they had regarding information and education on women's health. Because the themes that emerged from both questions were similar, we have combined the results in this section of our report.

Responses fell into 3 overarching categories: information for the public, service improvements, and education for children and young adults. The sub-themes within each category are described briefly in Table 10 and discussed in more detail below.

Table 10. Summary of suggestions and reflections put forward by respondents on access to information and education on women’s health

Overarching theme	Sub-themes
Information for the public	<ul style="list-style-type: none"> • Dedicated women’s health section on official websites, in particular the NHS and GP websites • Improve the quality of information available, including answers to frequently asked questions, and help individuals decide whether to trust sources of information • Make better use of mainstream and social media to raise awareness of women’s health conditions, and to destigmatise and normalise conversations • Improve recognition of gynaecological issues
Improvements to services	<ul style="list-style-type: none"> • Better education and training of GPs and healthcare professionals • More frequent ‘Well Women’ checks and screening (including smear tests) • Improve access to specialist hubs and clinics that bring women’s health services together • Consider promotion of community support groups
Education for children and young people	<ul style="list-style-type: none"> • Better sex and health education in schools, teaching both sexes about women’s health • Continuing sex education throughout the later stages of education • Better training for teachers and access to modern teaching tools e.g. podcasts • Teach about infertility as well as pregnancy prevention

Information for the public

Many women who responded to this consultation felt it would be helpful to have more information on women's health topics online, ideally accessible through official medical platforms such as the NHS website and GP websites.

Respondent (aged 40-59):

"Expand information on NHS website. It is often brief, so you need to look elsewhere, but then don't know whether to trust non NHS sources"

Respondent (aged 25-39):

"The NHS needs to provide more information on its website perhaps links to further reading/research. I often don't find enough out from just the NHS website and it leads me to search the internet, but I would rather learn from UK guidance than international articles/sources were I'm not sure about the integrity of the information."

Women flagged that it is much more difficult to know whether the information they are accessing is trustworthy and accurate if it does not come from an official source such as the NHS website.

Respondent (aged 40-59):

"There is too much information online that's contradictory and doctors don't have time to discuss everything. So trying to find real and correct information is difficult. I usually look at NHS gov site first but it is very brief in descriptions which then leads to more online research and info overload / misinformation. Personally I think if NHS site was better and had more links to corroborated and accurate information that would be really helpful."

Respondent (aged 40-59):

"I didn't grow up in the UK and SRE [sex and relationships education] was nonexistent where /when I grew up. As a result I had to do research mainly from books and online personally and it can be very frightening to search such a topic without help. It also involves a risk that we get inaccurate information. SRE should teach pupils who they can consult/ where they can look up for reliable information."

Without timely and accurate information, respondents felt women may not know whether the symptoms they are experiencing do point to a specific condition, and whether they should speak to a healthcare professional to investigate further.

Respondent (aged 25-39):

“Being a woman who suffers with endometriosis and PCOS [polycystic ovary syndrome], it feels like a constant battle with my symptoms, my last employer had no idea about my conditions and how they affect my day-to-day life. I feel like this should be general knowledge, just like puberty symptoms are. [...] knowing the symptoms and what to look out could lead to early diagnosis and better management of these conditions”

A common suggestion was that social media and mainstream media could be better to more effectively disseminate information from official sources such as the NHS, and to educate the wider population on women’s health topics.

Respondent (aged 25-39):

“Adverts on social media, accounts on social media such as TikTok, Facebook, Twitter and Instagram sharing information in a way that connects with the audience. Short sharp bursts of info with links to more in dept info in NHS pages and other reputable websites”

Respondent (aged 40-59):

“Mainstream TV programs to normalise talking about women's health issues with emphasis that these affect half the population. Not to be ignored or embarrassed about.”

Destigmatising and normalising discussions around women’s health was also felt to be important.

Respondent (aged 40-59):

“There is some progress being made on removing stigma around menstruation I'd like to see similar progress on common gynaecological issues such as fibroids, cysts, PCOS, endometriosis, fertility, perimenopause and menopause”

Respondent (aged 16-24):

“Reducing societal stigma around the topics and making women feel more comfortable talking to their GPs about problems without being brushed aside or just prescribed the pill”

Service improvements

In terms of existing services, some respondents emphasised the need for healthcare professionals to receive better education and training on women’s health conditions. Many of these comments tended to emphasise GP education, as they can be the first port of call for many women, and gatekeepers to other services. For example:

Respondent (aged 25-39):

“Better education of GPs. It's not acceptable that GPs are unaware of conditions such as endometriosis, interstitial cystitis etc. Better treatment of women starts with better awareness and education in healthcare professionals.”

Respondent (aged 40-59):

“I was wrongly diagnosed with anxiety & depression 5 years ago aged 45. I went to many GPs and A&E on several occasions as I was having sudden very strange symptoms, I informed professionals that I was experiencing extremely painful periods and my cycle was getting further apart. I was experiencing sudden extreme anxiety and sleep disturbance, it was very frightening. I was told I am too young for menopause and given multiple Antidepressants which made me unable to function, my brain was like cotton wool could not even read or watch TV and so I lost my job. I came off the Antidepressants myself & slowly as I knew they were not helping and my brain came back. After 5 years of repeatedly going to GP & now aged 50 I have done my own research from [... a] Menopause specialist website who has up to date information on perimenopause and safe HRT [hormone replacement therapy] treatment. I have at last been able to access a GP who is better informed and I have been prescribed body identical HRT. I needed HRT treatment and not Antidepressants. All women and in particular GPs & nurses urgently need up to date training on how to identify perimenopause and be on the same page about HRT as some Drs are still refusing to prescribe it using outdated information.”

A smaller proportion of respondents also suggested that women should be able to access screening services for gynaecological cancers more frequently, and that the age for automatically being invited for smear tests should be lowered.

Respondent (aged 25-39):

"Lower cervical screening age to 21 like in Scotland or like in most countries, to when women are sexually active girls and women die of Cervica Cancer every day and dont live in statistics. Offer yearly exams to all women as opposed to a single Smear Test every 3-5 years which is not a full exam."

Many respondents to the consultation supported the creation and/or expansion of specialist women's health hubs and clinics, because they felt it would provide quicker and direct access to professionals with expert knowledge in women's health conditions.

Respondent (aged 40-59):

"The NHS needs specialist Menopause Clinics that women are able to self-refer to. We also need Women's Health Clinics that women can easily self-refer to and attend, for the whole of their lives, as a one stop place for advice and information."

Respondent (aged 40-59):

"Increase the number of specific women's health and community gynaecology clinics. So many women's health issues can be managed conservatively and holistically by specially trained GPs and community gynaecologists/ Sexual Health healthcare professionals. Cheaper and MUCH better than send all women to hospital outpatients."

Community support groups were also felt to be a good option to help a broader range of women not only access information, but to support and learn from the experiences of others. For example:

Respondent (aged 25-39):

"Organising small community groups of women by age group to discuss health matters, similar to parent and baby groups at local family centres."

Respondent (aged 40-59):

"Children's centres are a great place to help women postnatally. Before ours closed, I was able to access information of pelvic floor support,

breastfeeding help and postnatal weight loss/fitness after my first pregnancy. These had closed when my second child was born and I received no guidance at all.”

Education for children and young adults

Generally, respondents felt that improvements could be made to the Relationships, Sex and Health Education (RSHE) curriculum taught in schools. However, this comes with the caveat that just 55% of respondents were aware that menstruation, contraception, pregnancy and the menopause are now a statutory part of this curriculum.

Examples of topics respondents felt the curriculum needed to cover included diversity in sexual intercourse experiences, abusive relationships, women's health conditions such as endometriosis, infertility and baby loss.

Respondent (aged 16-24):

“The sex and relationships education in schools should absolutely cover female sexual pleasure, not just pregnancy & STD [sexually transmitted diseases]. Young women need to grow up knowing that sex should be pleasurable for them and shouldn't be painful so that they feel empowered to access health care if they do feel pain. Too many young women are conditioned to believe that sex is just inherently painful so they ignore symptoms and then even when they do seek help they also are ignored because the doctors they speak to have also likely been taught that sex is painful for women. It needs to be a systematic change and the young women in schools are where it needs to start”

Respondent (aged 25-39) [spelling errors corrected]:

“Informed Consent should be taught as part of Sex Education at ALL schools, as well as healthy relationships and how to spot early signs of emotional, psychological and physical abuse, including amongst peers. Children should also be taught what to do if they or someone they know is involved in an abusive relationship. [...] it should be mandatory to cover LGBTQIA+ sex and relationships comprehensively and with as much time and respect as heterosexual sex and relationships. The importance of women's pleasure should also be taught in schools.”

Respondent (aged 25-39):

“I only knew I had endometriosis because of a family history but a friend had no idea she was suffering with it for so long until I mentioned it. We need more education in school on endometriosis, fibroids and cysts.”

Respondent (aged 25-39):

“No one prepares you for the difficulties of infertility, where to go and when, what might be the cause, what's possible. No one talks about male factors. All you got taught at school was how men want sex, and it's your job as a woman to limit that, and to prevent pregnancy. No one tells you what to do if you can't get pregnant when you want to. No one tells you what to do if you experience a miscarriage. No one tells you how to manage the emotional aspect of all this.”

Many felt that teaching both boys and girls about women's health issues, such as menstruation, would help to reduce stigma throughout the life course and make women feel more comfortable discussing their health.

Respondent (aged 25-39):

“It is my belief that if there were better education, from a young age, for both girls AND boys on women's health that this would help to increase awareness and perhaps more importantly play a role in decreasing stigma around women specific health concerns and issues.”

Respondent (aged 25-39):

“When I was at school, the girls learned about periods and the boys learned about wet dreams there was no crossover. This is wrong. Girls and boys should be educated about both sexes and both bodies at school otherwise the boys will grow up to be uneducated/unaware men. Periods are not shameful and its only by talking about them openly (with both girls and boys) that the stigma will be removed.”

Finally, respondents, including many who stated that they were teachers, noted that there currently appears to be a lack of useful and modern tools to teach young people about sex and relationships.

Respondent (aged 25-39):

“As a primary school teacher, I found it very difficult to find any modern teaching tools/aids to cover the SRE curriculum. We curated our own that

followed the curriculum but it concerns me that there are many teachers who will feel uncomfortable teaching the curriculum without any supporting materials and will just choose to ignore some parts.”

Access to services

We wanted to understand whether women can conveniently access the services they need in terms of location, timing, and for any specific conditions or disabilities they have. We also wanted to collate ideas for improving women's access to services.

Summary

Overall, 2 in 5 respondents (40%) said they (or the women they had in mind) can access the services they need in a way that is convenient in terms of location; 1 in 4 (24%) said the same in terms of timing; and 1 in 5 (21%) of those with a health condition said they feel supported by the services available for individuals with their condition and/or disability.

Suggestions to improve women's access to services included: system level changes, such as geographical diversity in, and joined up provision of, women's health services, hubs and drop-in clinics; better education and training of GPs and other healthcare professionals as treatment gatekeepers; and an increase in specialists and services to treat women's health conditions, such as the menopause and endometriosis.

Service accessibility was impacted by the coronavirus (COVID-19) pandemic. Alongside general barriers experienced, such as a lack of face-to-face appointments and limited access to mental health services, women also reflected that they suffered from delays to female-specific cancer screening services and received inadequate post-natal support.

Access to women's services

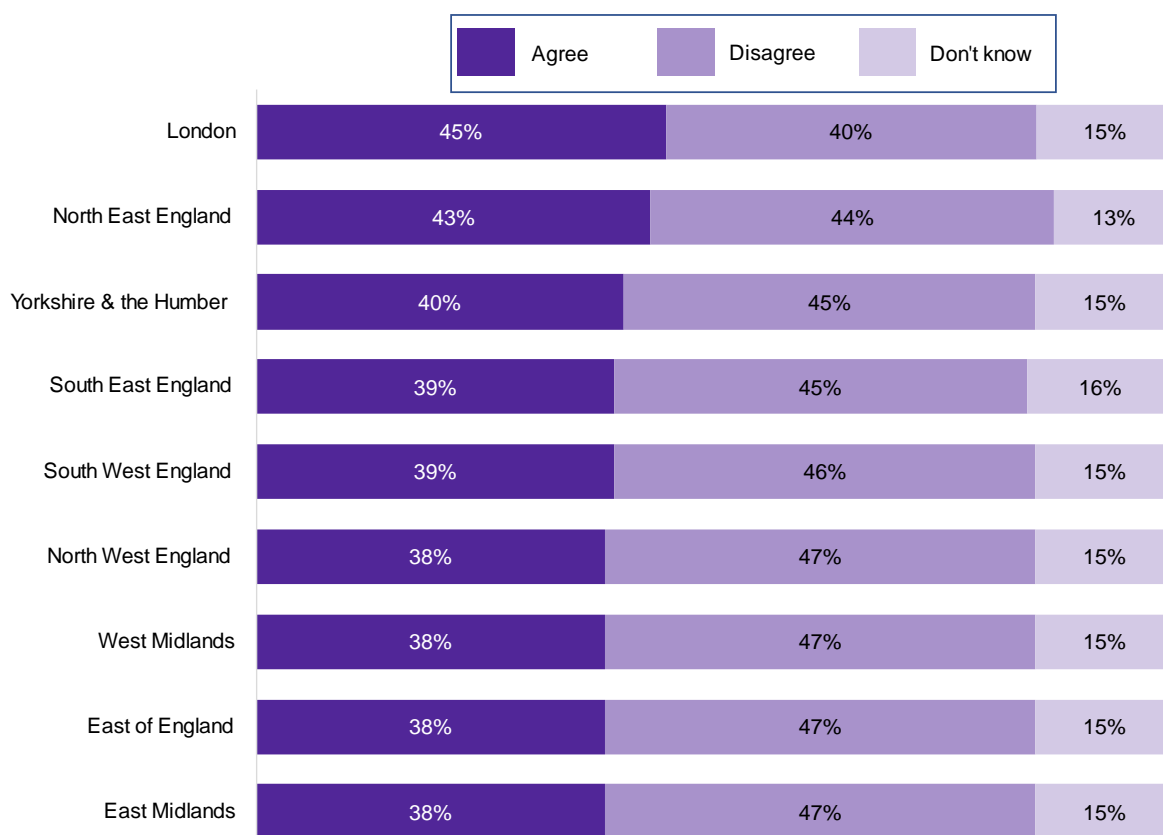
Locality

Overall, respondents were divided as to whether they (or the woman they had in mind), can access services conveniently in terms of location: 40% said they can, 45% said they cannot, and 15% said they do not know.

As shown in Figure 6, London was the only region in England where respondents were more likely to agree (45%) rather than disagree (40%) that services are accessible in terms of location.

Respondents living in the Midlands, East of England, and North West England were 6 percentage points less likely to say services are accessible in terms of location (38%), compared to those in London.

Figure 6. Can you / the woman you have in mind access all the services you / they need in a way that is convenient in terms of location?



These results also varied by other demographic characteristics. Specifically, the following groups were less likely to agree they can access services in a way that is convenient in terms of location:

- respondents aged 40-49 or 50-59 (36%, compared to 41% to 45% of all other age groups)
- individuals with an existing health condition or disability (37%, compared to 47% of those with no disability)
- those with a gender identity different to their sex registered at birth (34%, compared to 40% of cisgender respondents)
- respondents within the Other ethnic group (32%, compared to 40% of White respondents)

Timing

Overall, around 3 in 5 respondents (62%) said they, or the woman they had in mind, cannot access all the services they need in a way that is convenient in terms of timing. In comparison, just 1 in 4 respondents (24%) said they could.

These results were relatively consistent across regions, with only minor variations of between 1 and 2 percentage points. There were, however, more notable variations by other demographics.

Specifically, respondents were less likely to say they/women can access services in a way that is convenient in terms of timing if they:

- were aged 25-29 (24%), 30-39 (23%), 40-49 (22%), and 50-59 (23%) (compared to 28% to 34% of other age groups)
- have an existing health condition or disability (22%, compared to 29% of respondents without a disability)
- fall within the 'Other' ethnic group (19%, compared to 24% of White respondents)

Services for specific conditions

52,677 respondents said they, or the woman they had in mind, have an existing health condition and/or disability. The most common types of condition or disability disclosed by this group were anxiety disorders and stress (33%) and depression (23%).

In terms of women's health conditions, nearly 1 in 4 respondents with a health condition or disability described this as the menopause (23%), and around 1 in 10 (12%) said they have endometriosis.

Table 11. Please select which health condition(s) or disability you/ the woman you have in mind live with:

Response	Frequency	Percentage
Anxiety disorders and stress	17,197	33%
Depression	11,986	23%
Menopause	11,832	23%
Mental Health	11,253	21%

Gastrointestinal conditions and IBS	9,386	18%
Asthma	9,022	17%
Migraine	8,862	17%
Persistent pain	7,740	15%
Endometriosis	6,281	12%
Musculoskeletal condition (including Arthritis)	6,130	12%
Hypothyroidism	4,500	9%
Hypertension	3,464	7%
Fibroids	2,991	6%
Dyslexia	2,695	5%
Fibromyalgia	2,636	5%
Chronic fatigue syndrome/ME	2,395	5%
Eating disorder	2,038	4%
Neurological condition	1,812	3%
Diabetes	1,748	3%
Hearing Impairment (deafness)	1,689	3%
Heart condition	1,585	3%
ADHD	1,379	3%
Adenomyosis	1,378	3%
Cancer	1,254	2%
Autism spectrum disorder	1,171	2%
Dyspraxia	910	2%
Epilepsy	495	1%

Chronic Kidney Disease	436	1%
Atrial Fibrillation	369	1%
Visual impairment (blindness)	341	1%
Chronic Obstructive Pulmonary Disease	299	1%
Stroke or Transient Ischaemic Attacks	296	1%
Multiple sclerosis	290	1%
Learning disability	266	1%
Coronary Heart Disease	187	0.4%
Other (aggregated)	150	0.3%

Nearly 2 in 3 respondents with a health condition or disability, said they do not feel supported by the services available for individuals with their condition or disability (65%). Just 21% said they do feel supported, and 13% said they were not sure.

A full breakdown of all results in this section can be found in Table 1_8b and Tables 6_1a to 6_3 of survey data tables spreadsheet (Annex A).

Suggested improvements

Respondents were invited to share examples of how service accessibility could be improved, both in general, and for specific health conditions or disabilities. Their suggestions broadly fit within 3 overarching themes: system level changes; better education and training of healthcare professionals as service and treatment gatekeepers; and improved services and support for specific health conditions. The sub-themes within each category are summarised in Table 12 and discussed in more detail below.

Table 12. Summary of suggestions put forward by respondents to improve service accessibility, both in general and for specific health conditions and disabilities

Overarching theme	Suggestions to improve accessibility
System level changes	<ul style="list-style-type: none"> • Better information on the different services that are available • Geographical diversity in healthcare services to reduce postcode lottery • Joined-up provision of specialist services and treatment pathways • Reduce waiting list times • Increase GP capacity • Provide flexible appointment times for women in full-time employment
Better education and training of healthcare professionals	<ul style="list-style-type: none"> • Training to improve how healthcare professionals listen to, communicate with, and treat women • Better education on female-centric conditions and treatment options, in particular the menopause and HRT • Improve specialist referral pathways
Services and support for specific health conditions	<ul style="list-style-type: none"> • Better service and support for the menopause, endometriosis, fibromyalgia, chronic fatigue syndrome, irritable bowel syndrome, autism, and ADHD • Improved access to mental health services, including counselling and therapy • Blood testing for thyroid conditions

System level changes

Many women felt that clearer information on which services were available, and how to access them, would be beneficial.

Respondent (aged 16-24) [spelling errors corrected]:

“It needs to be clearer what services are available locally and where. E.g. I do not know where I could go if I was raped. There needs to be more signposting to what is available and this should be resources available to schools to give to students”

Respondent (aged 25-39):

“I don't really know where to look other than my GP, who I would only go to with a specific ailment. In terms of learning I tend to go online. This obviously presents a minefield. I wouldn't know where to look to find a HCP [healthcare professional] who I could trust to learn more from with regards e.g. the menopause.”

And many noted that the location and distance of services had impeded their ability to access them:

Respondent (aged 40-59):

“I am on weekly chemo. I live 5 minutes drive from my large local hospital but receive no treatment, Blood Tests, scans or consultations there as it is all elsewhere in different hospitals across the region. My 3 monthly scans are a 40 min train journey then 20 walk away. My weekly Blood Test & chemo treatment are on 2 different days at another hospital which is a 28 mile round car trip each time. Nuclear bone scans are at another hospital an hours drive away [...] I understand that not all hospitals can offer all services but 5 years ago I used to get my weekly bloods & chemo at my local hospital so the situation is worse than it was. If 1 in 2 people will get cancer then hospitals should offer local basic cancer services.”

Respondent (aged 25-39):

“More specialist services available outside of London. It isn't equitable or fair that I am precluded from accessing specialist services and support because they are not locally available. The use of remote consultations can aid accessibility as it avoids travel.”

Respondent (aged 40-59):

“Infertility services vary across the country meaning that depending on where you live your access to services will differ. This creates inequality in healthcare throughout the country”

Women shared frustration that specialist services and treatment pathways were not joined up, for example:

Respondent (aged 40-59):

“the diagnostic pathways for autism (and other hidden disabilities) are inconsistent across the country and poor, I would say they do not exist in a way which could be considered even adequate. Once diagnosed, you are discharged. No further signposting. Connecting communities, charities, Social Care and health would be a great start to create a seamless pathway and driving consistency across all locations. Quality of training for Health Professionals diagnosing. It is incredibly sad that this followed through to my daughter's diagnosis, a total of c.15hrs to diagnose, spread out over 3 years. (I knew more that the senior practitioner diagnosing her and wasn't listened to as just the parent!)”

And many felt let down by the length of waiting lists for a number of different services:

Respondent (aged 25-39):

“[...] I've been told a minimum of 5 months waiting list just to be initially seen by a specialist, for an issue that certainly requires surgery and could become an urgent surgical requirement before then. Feedback and biweekly updates of the progress of the waiting list would be nice the not knowing and not having access to sort something that is worrying me and causing pain is hard.”

Respondent (aged 25-39):

“Waiting lists are too long. Waiting upwards of 9 months just to see a gynaecologist, then face a wait of 12 months or more for surgery. Feels like wasting my life away waiting for treatment.”

Respondent (aged 25-39):

“I feel that waiting times are a barrier to having a good and consistent relationship with health care professionals”

A large volume of women commented on the fact they were unable to book or access GP appointments, both for face-to-face and online appointments. Particularly, women highlighted that the system of calling on the same day to book an appointment was inconvenient and difficult.

Respondent (aged 25-39):

“It is virtually impossible to get an appointment with my GP. You cannot book appointments in advance of the day when you must call early in the morning and hold for a potentially long time. This is hard for anyone trying to get children to school in the morning. Once you get through to a receptionist you have to justify yourself. This is particularly hard when it's in relation to a stigmatised condition, especially mental health. This system is discriminatory and has serious impacts on access to the wider health service given that GPs are in effect gatekeepers, but they are now so hard to access.”

Respondent (aged 25-39) [spelling errors corrected]:

“Trying to get a GP appointment is almost impossible. Not everyone can call at 8am in the morning and keep ringing trying to get through, and everybody in the surrounding area is calling at the same time trying to get an appointment, and if by the time you get through there's none left you have to do the same the next day. Let us book drs appointments for different days, if I ring on the Monday and there's none that day but there is on the Wednesday let me book it.”

Finally, women felt it was difficult to access services - both GP appointments and more specific health services – outside of usual working hours, which made it very difficult for those who worked full time, especially in jobs where it is difficult to get time off at short notice:

Respondent (aged 40-49):

“Women work so services need to be accessible outside of work hours. For example I've been unable to access domestic abuse Support Groups because they all take place within working hours. If they do operate outside of office hours, it's something like 6pm 8pm which is no good for me as I commute to London and don't get home from work until 7pm.”

Respondent (aged 16-24):

“I have never been able to book a time slot for a doctors appointment. It's always a case of them phoning me throughout the day and keeping my

phone next to me. If I don't answer then I don't get to speak to a doctor. This is inconvenient because I am a teacher and I do not have access to my phone all day and cannot just take time off work to wait for a phone call.”

Better education and training of healthcare professionals

Women felt that, at times, healthcare professionals acted as a barrier which prevented them from accessing the relevant services or treatment.

Many felt that there could be improvements to how healthcare professionals listen to, communicate with, and treat women, and that training could help this:

Respondent (aged 25-39):

“[...] The first urogynaecologist I saw used appalling language when discussing my condition. He said “f*ck” on numerous occasions and said my vagina would be “smashed to bits” if I had a baby post-surgery. My second urogynaecologist always seems rushed. It would help if there were more women urogynaecologists and gynaes a lot of women feel uncomfortable talking to men about these things. There certainly feels like a lack of empathy, especially in my first experience. Maybe some training about how to listen and be opened minded with women patients would help. A recent study showed that women's pain is often dismissed by Health Professionals.”

Respondent (aged 25-39):

“Take reported symptoms seriously I feel women aren't listened to. When I experienced concerns regarding fertility I was repeatedly dismissed. If I hadn't really pushed my symptoms would have been dismissed. I know friends who have had similar experiences”

Respondent (aged 25-39):

“[...] Also, training for all staff on how hospital environments can be highly stressful for people with unseen/invisible illnesses/disabilities and not be dismissive of their needs or any adjustments required. Reducing the stress involved with all these situations would help people suffer psychologically from medical trauma much less.”

Many thought healthcare professionals needed to be better educated and trained on female-centric conditions and treatment options, with a large volume referencing the menopause and HRT in particular:

Respondent (aged 40-59) [spelling errors corrected]:

“All GPs need compulsory training in menopause and prescribing HRT. It is unacceptable that i have to inform my GP re HRT using Dr [name redacted]'s material and turn down Antidepressants and fight for HRT”

Respondent (aged 40-59):

“I am currently attending a private menopause clinic because my GP was unable to address my condition. I was prescribed the lowest dose of HRT and my symptoms did not improve. After a years worth of my own research, I found Dr [name redacted]'s Menopause Clinic and am now on double the dose of HRT as before, Utrogestan and Testosterone. Testosterone (developed for women specifically!) needs to be made available to women who need it and not only to those who can afford it. It has been a life changer for me and I feel I have my life back again but I pay for a private prescription and so many women out there do not have that option. Health Professionals need compulsory intensive menopause training.”

Respondent (aged 25-39):

“I very much do not have access to the health care I need at a convenient time or location. The general knowledge and expertise about women's reproductive health in particular is so poor in average primary care, that I have repeatedly had to be referred to a particular clinic or treatment centre for what should be routine health care. These often require significant waiting times and travel to a particular centre. The standard of knowledge and expertise on women's healthcare should be radically improved. All health care practitioners should be given significant professional development and training to improve this, and more resources should be put into the NHS to provide for basic health care for women.”

Finally, women called for improvements to specialist referral pathways, suggesting that it would be beneficial if they were able to self-refer to specialists:

Respondent (aged 25-39):

“We should be able to request specialist appointments without always requiring a GP referral. Even if this is request is then vetted by another. A lot of women get stuck trying to talk to a GP or nurse about specialist gynaecological conditions when the GP is ignorant of but is unwilling to refer to a specialist. A lots women source information from social media

support groups and end up self-diagnosing due to a lack of support from a GP”

Respondent (age unknown):

“A lot of the time, a women needs referral to a specialist to seek correct diagnosis or/and treatment. But to get this referral, you have to jump through hoops with your GP. There should be some services where women can go directly to a specialist clinic to seek specialist advice. I have yet to see a clinic set up for women who have symptoms for Endometriosis. A lot of the time GPs do not refer women with these symptoms.”

Respondent (aged 40-59):

“I have seen a specialist gynaecologist regarding my fibroids. I have now been discharged and if symptoms recur I need to go back to my GP to start the process again which could mean waiting a long time to see the specialist. This has also occurred regarding my fatty liver diagnosis. Could an easier access system be put in place to access specialists if you have already seen them and want follow up?”

Specific conditions that would benefit from increased service accessibility

Women gave examples of specific conditions or areas of health that they felt were not currently adequately treated through the services available. Many mentioned a lack of help for female-centric conditions:

Respondent (aged 25-39):

“There are not enough specialist gynaecologists in endometriosis and PCOS. Lots of endometriosis sufferers end up with substandard surgeons for something so skilled due to the true lack of [...] accredited endometriosis specialist centres. This causes unbearably long waiting lists for a surgeon who will be guaranteed to perform expert excision surgery, not laser. This can also result in having a surgeon who may incorrectly say you do not have the disease because they are unable to identify it in all its appearances.”

Respondent (aged 16-24):

“Specific services just for women's health, more women's only clinics which main focus is around woman's health (PCOS, Endometriosis, etc). Rather than women having to seek private clinics which specialise in

women's health or having to wait to be referred throughout general hospitals”

A common theme throughout was also a general lack of access to mental health support and services:

Respondent (aged 25-39):

“Mental health services need to be properly funded. Wait times for support are far too long and the bar for accessing support is set too high people should receive help as soon as they are brave enough to seek it and not be told that what they're feeling isn't severe enough to warrant help at that point. It will only deteriorate. Utilise phone and video call appointments more.”

Respondent (aged 40-59):

“Were it not for the private therapy I have access to, I would be struggling a lot more with my mental health. I tried therapy on the NHS, and while it helped in the short term, I felt long term therapy of the type that suits me best is unavailable, or I was not helped to extend the therapy when it reached its conclusion.”

And some respondents highlighted that they had experienced difficulties accessing mental health support specifically for female-centric issues, such as miscarriage and postnatal depression.

Respondent (aged 25-39):

“An increase in support for mental health as this area is extremely underfunded. I have never suffered with mental health issues until being diagnosed with Postnatal Depression and it is clear how little funding and support there is available for mental health compared to physical health complaints. [...]”

Respondent (aged 25-39):

“The offer for mental health is poor unless you are in crisis or very low level (where group support or online CBT is appropriate). Many women in the middle falling down a gap. Provision for domestic abuse survivors and women with PTSD/CPTSD is woeful. More resource to local mental health services for those who cannot pay privately (which may include third sector support or counselling)”

Many flagged that their GP service is not sufficient for their sexual health and contraceptive needs, but that sexual health clinics can also be hard to access:

Respondent (aged 16-24):

“GP Surgeries in my area no longer offer long-acting reversible forms of contraception such as the hormonal coil. After years of suffering with my mental health, which I now know was due to my contraceptive pill, I was unable to be fitted with a coil at my local surgery despite the GP recommending it to me. The only Sexual Health Clinic was the only place to get the coil fitted. It is tricky to get to and there was a waiting list of 4 months. I also had to call up every morning at 9am for over a week to try and get a coil appointment. GPs need funding for all forms of contraception, or there needs to be more Sexual Health Clinics/contraceptive fitters who can travel to women who live rurally.”

Respondent (aged 25-39):

“Recently I tried to get my contraceptive implant removed due to Side Effects that I found debilitating. I called the Sexual Health Clinic in Sheffield who told me I couldn't have it removed there (despite me having it put in there) as my GP was registered in Derbyshire. I called the Sexual Health Clinic in Derbyshire who told me I couldn't have it removed there as I lived outside the county. I have to register at a GP in Sheffield in order to get it removed. I think you should be able to access contraceptive treatment wherever you are and easily.”

Finally, a lack of support for a number of specific conditions that show clear disparities in diagnosis and treatment for women compared to Men, including hypothyroidism, ADHD, autism, and deficiencies, was highlighted.

Respondent (aged 25-39):

“[...] Hypothyroidism is a lifelong endocrinological disorder but there is no psychological support for patients as there are for people with other endocrinological conditions, and it is not given enough consideration about how this condition changes a woman's life. Women with hypothyroidism also do not routinely get checks and reviews with an endocrinologist, leaving it to the GPs to manage, who are rarely experts in management for this condition.”

Respondent (aged 25-39) [spelling errors corrected]:

“Adult ADHD services are shocking. My local clinic has a two year waiting list and triages patients based on the GP and patients own written evidence on the referral form. I personally think this is completely discriminatory and in effect the same as asking someone with a broken leg to walk up to the fourth floor to the broken leg clinic before getting treatment. I have never seen the same GP twice so had a ten minute conversation with the referring GP in which I had to educate him regarding inattentive ADHD and women. I then never filled in my section because I have ADHD and executive dysfunction. I emailed the ADHD clinic to ask for help filling it out, they never answered [...]”

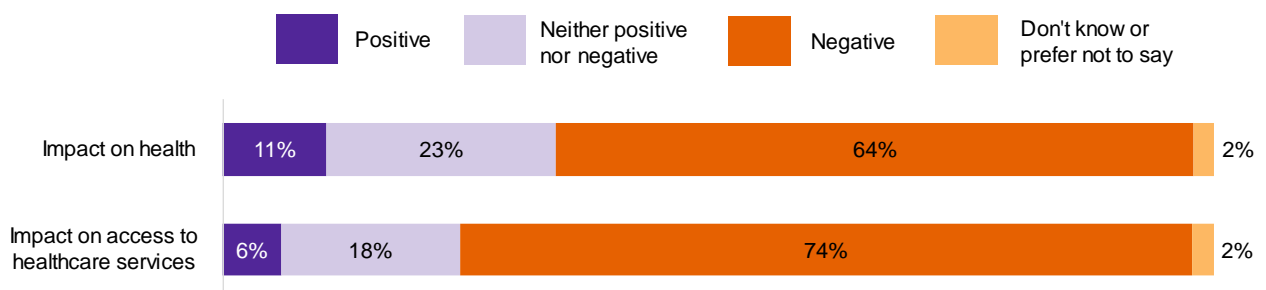
Respondent (aged 60 or over):

“B12 deficiency. I have been diagnosed with pernicious anaemia, so I do not absorb vitamin B12 from food or oral supplements. By the time this was diagnosed I had developed anaemia and various neurological symptoms. My doctor will not accept that I need more frequent B12 injections to live a full life.”

Impact of COVID-19 pandemic

Nearly 2 in 3 respondents (64%) thought that women would say the COVID-19 pandemic has had a negative impact on their health. A further 3 in 4 respondents (74%) thought that women would say the pandemic has had a negative impact on their ability to access healthcare services. (Figure 7)

Figure 7. Do you think women feel that the COVID-19 pandemic has had a positive or negative effect on their health / access to healthcare services?



A full breakdown of all results in this section can be found in Tables 6_4 and 6_5 of the survey data tables spreadsheet (Annex A).

Personal testimonies

Respondents were asked if there were any aspects of healthcare women particularly struggled to access during the COVID-19 pandemic. Some of their feedback centred around general access problems, such as a lack of face-to-face GP appointments and ability to book routine check-ups and blood tests, while others focused on barriers to women's health services, such as screening and smear tests, and elective female reproductive health surgeries. These themes are summarised in Table 13 and discussed in more detail below.

Table 13. Summary of barriers respondents felt women faced in trying to access healthcare services during the COVID-19 pandemic

General access difficulties	Difficulties accessing specific women's health services or treatments
<ul style="list-style-type: none"> • Lack of face-to-face GP appointments and difficulties getting sufficient outcomes through online appointments • Routine check-ups and blood tests • Mental health services • Physiotherapy services • Sexual health services and access to contraception • Dental appointments and non-emergency dental treatments • Outpatient appointments • Support to manage pain 	<ul style="list-style-type: none"> • Maternity services, including attending pregnancy-related appointments alone • Post-natal support • Fertility treatments for women • Screening services for women • Referrals to women's health specialists e.g. gynaecologists • Elective female reproductive health surgeries • Help and advice on menopause symptoms

General access difficulties

Many respondents flagged service accessibility issues that were not specific to women, but none-the-less important to note.

This included, for example:

...not being able to access face-to-face GP appointments:

Respondent (aged 25-39) [spelling errors corrected]:

“My GP has run a reduced service and not face to face, and there have been obstructions and barriers to getting face to face appointments”

Respondent (aged 25-39):

“Knowing how best to contact a GP online when the form is very prescriptive. The online consultation form used categories that didn't cover my issue so had to lie to be able to complete the form to report my issue”

...an inability to book routine blood tests, made even more difficult when needing to time them around their menstrual cycle:

Respondent (aged 25-39):

“Blood Tests must now be booked in advance very difficult to time when a test must be done at a specific time in a woman's cycle when her periods are irregular.”

...struggling to access mental health support:

Respondent (aged 16-24):

“Mental health services throughout COVID19 have been worse than they usually are, with most doctors also suggesting that COVID is the reason for any mental health issue regardless of if it begun before the pandemic”

...cancelled or delayed physiotherapy, outpatient, and pain management appointments:

Respondent (aged 40-59):

“Getting access to hospital-based services such as physiotherapy. This was understandable as many physios were seconded to help on COVID wards, including my Pain Team physio. However, as soon as the 1st wave was over many services at our local hospital got underway again which was brilliant!”

Respondent (aged 16-24):

“I attend the pain clinic at [hospital] in London and am treated with Botox injections there. The clinic was shut for the first 6 months of the pandemic and has been behind ever since causing the treatment to be quite ineffective at best.”

...limited or no access to dental treatments:

Respondent (aged 25-39):

“Had a broken tooth, couldn't get it fixed as dentists were shut, now need to get a root canal and a crown, which could have been avoided if the tooth was filled at the time.”

Difficulties accessing women's health services

The difficulties that were reported to disproportionately affect women during the COVID-19 pandemic included, for example:

...access to screening services for female-specific or female-predominant cancers:

Respondent (aged 16-24):

“My grandmother struggled to access appointments to access her Breast Cancer diagnosis in time, because GPs didn't have appointments. She subsequently died after the cancers spread.”

...access to postnatal care:

Respondent (aged 25-39):

“Postnatal care was horrendous. I had a traumatic C-section and had to travel to clinic 5/10 days post birth for appts. Midwife check was over the phone”

Respondent (aged 40-59):

“Mental health support untreated PND [postnatal disorder] and anxiety. No follow-up following traumatic birth, triggering issues from traumatic first birth and miscarriages.”

Respondent (aged 25-39):

“I was pregnant and then had a young baby, there was no visits from healthcare professionals or midwives. I had very little support for the entire first year after my child was born”

...delays in referrals to women's health specialists and elective female health treatments:

Respondent (aged 25-39):

“Gynaecologist endo treatment seen as elective even though it's a chronic pain condition, surgery being the only treatment, is debilitating, worsened by stress and just gets worse with time, all appointments and surgeries cancelled and now a huge backlog & women going to A&E with ruptured cysts”

Respondent (aged 25 to 39):

“Surgery to treat endo delayed 5 times because it is not considered an urgent case under medical categories. However, I would say irreversible loss of fertility and prolonged (severe) pain should be considered a criterion for what is considered urgent.”

In addition, some of the women who responded to our consultation reflected that even when they could access certain services, such as pregnancy-related check-ups, not being able to have their partner with them had a detrimental impact on their wellbeing. For example:

Respondent (aged 25-39) [spelling errors corrected]:

“Currently pregnant following multiple miscarriages and was made to attend early scans without my husband which was extremely traumatic for me considering my history. Overall pregnancy has been extremely stressful during the pandemic without being able to have the support of my Husband at appointment”

Women respondents also expressed feelings of guilt in adding more pressure to the NHS or GPs during the pandemic:

Respondent (aged 60 or over):

“I have been able to ask for GP appointments but have felt terribly guilty doing so when everything has been so challenging.”

Continuation of service changes after COVID-19

Alongside asking respondents to reflect on the barriers they felt women experienced due to the COVID-19 pandemic, we also asked if there were any service changes that they would like to see continued in the future.

This meant that while a lack of face-to-face appointments were flagged as an accessibility issue, moving forward, many respondents would like GP surgeries and other healthcare practices to take a hybrid approach - giving patients the choice to book a virtual appointment if appropriate. For example:

Respondent (aged 25 to 39):

“My GP Practice has an online form you can complete and then you will receive a call from a GP the next working day. This has been an excellent service and one I would like to see continued”

Respondent (aged 40 to 59):

“Telephone consultations work well to a certain extent and these are particularly useful for me as I work Full-time but there should be the option of also seeing your GP.”

Respondent (aged 60 or over):

“Phone / video consultations where appropriate. Saves us time and money by not driving a long way to consultant But please let me make that choice, not an assumption from the consultant that it is for the best.”

Some respondents also expressed a preference for virtual appointments to include video calls or photo sharing, to enable their doctor to see the more visible symptoms they are describing:

Respondent (aged 25 to 39):

“Video calls. My mum benefited of this when she had sciatica. Could show exactly where the pain starts and ends. I would also rather have a video call reg mental health (but wasn't offered one) as I have hearing impairment and seeing people while they speak helps!”

Respondent (aged 25-39) [spelling errors corrected]:

“Everything being accessible online is great. Being able to text a photo, especially of children's issues, and [have a] GP message back, without having to take time out of school, go into [the] surgery, potentially get other's germs etc. Get [a] quick answer, it's great”

However, respondents also acknowledged that the use and/or expansion of virtual appointments would need to be done carefully and monitored, to avoid unintentionally causing harm:

Respondent (aged 40 to 59):

“Ability to contact GP via an online consult form. Useful for when you don't actually need to be examined. Danger, though, if things being missed when not seen in person.”

Respondent (aged 40 to 59) [spelling errors corrected]:

“Triage worked well in some instances to get the right help. In others triage was a real barrier to accessing the right service. This needs to be monitored and assess from the patient's point of view”

Health in the workplace

We wanted to understand whether women feel comfortable talking about health issues at work, how health issues might have impacted their experience at work, and what the types of support that could help them reach their full potential.

Summary

Overall, just over 1 in 3 women felt, or were perceived to feel, comfortable talking about health issues with their workplace (35%), and around 1 in 2 said their current or previous workplace had been supportive with regards to health issues (53%).

When asked if a health condition or disability had impacted their experience in the workplace, 3 in 5 answered 'yes' (62%). The most common impact was increased stress levels (76%), but 1 in 4 also said that it had impacted their earnings (26%) and/or opportunities for promotion (25%).

Encouraging open discussion of women's health issues was a common suggestion put forward by respondents, to help break taboos, reduce stigma, and raise awareness in the workplace. As well as calling for the continued and increased promotion of existing policies, such as flexible working arrangements, many also called for the creation of new policies and support packages to better support women in work, including paid leave for miscarriage and baby loss.

Employment status and work sectors

85% of respondents (57,890 individuals) reported that they, or the woman they had in mind, are currently in work, while 13% said they are not. A further 2% selected the response option 'other' and described their situation as being on maternity leave, self-employed, retired, furloughed, or a student.

The most common sector respondents said they currently or most recently worked in was the public sector (26%), followed the private sector (19%), the education sector (15%), and human health and social work activities (14%) (Table 14).

Table 14. Which sector do you/did you or the woman you have in mind most recently work in?

Response	Frequency	Percentage
Public sector	17,162	26%
Private sector	12,197	19%
Education	9,925	15%
Human health & social work activities	9,357	14%
Administrative & support services	2,946	5%
Financial & insurance activities	2,879	4%
Information & communication	2,241	3%
Professional scientific & technical activities	1,983	3%
Accommodation & food services	1,596	2%
Manufacturing	1,031	2%
Construction	971	1%
Wholesale retail & repair of motor vehicles	749	1%
Transport & storage	503	0.8%
Public admin & defence; social security	478	0.7%
Real estate activities	385	0.6%
Mining, energy and water supply	335	0.5%
Agriculture, forestry & fishing	250	0.4%

This explains, in part, why some of the personal testimonies captured through our thematic analysis, was able to highlight the experiences of teachers and NHS staff.

Comfort discussing health topics

Overall, 35% of women felt (or were perceived to feel) comfortable talking about health issues with their workplace; 58% said they feel uncomfortable; and 7% said they are not sure how they feel.

The proportion of those feeling comfortable talking about health issues at work varied by ethnicity; White respondents felt the most comfortable (37%), while the Asian and Other ethnic group felt the least (30% and 29% respectively).

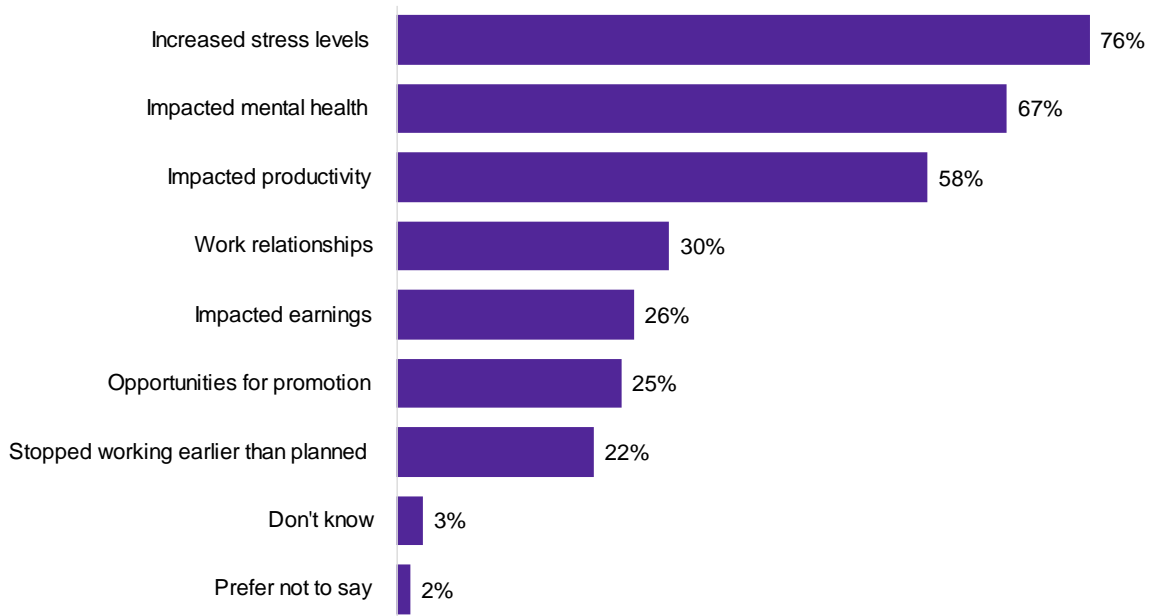
We also found that comfort levels increased with age; for example, 26% of those aged 20-24 said they feel comfortable discussing health issues in the workplace, compared to 45% of those aged 60-69 and 55% of those aged 70-79 (noting that the sample size was much smaller for these older groups).

Workplace support

Overall, 53% of women felt (or were perceived to feel) that their current or previous workplace had been supportive with regards to health issues; 27% said their workplace had been unsupportive; while 20% said they don't know.

When asked if a health condition or disability had impacted their experience in the workplace, 62% said yes, 35% no, and 3% preferred not to answer. The most common impact was increased stress levels (76%), but 1 in 4 also said that it had impacted their earnings (26%) and/or opportunities for promotion (25%) (Figure 8).

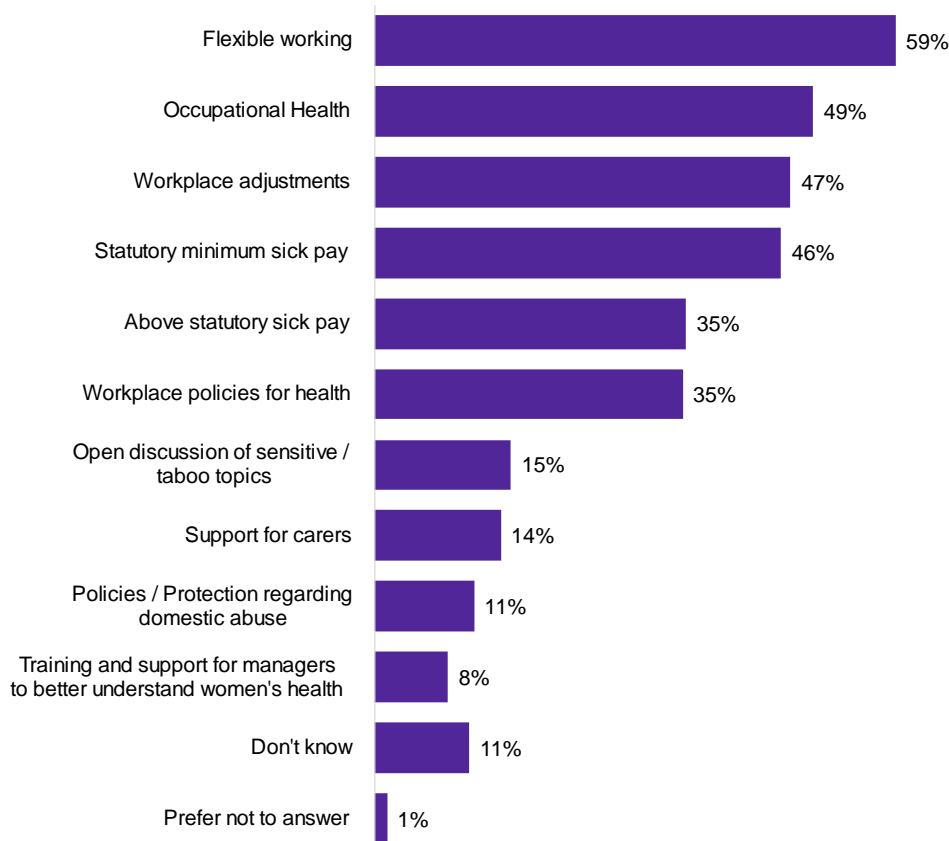
Figure 8. How did you think your health condition or disability / the health condition or disability of the woman you have in mind impact your/ their experience in the workplace? Select all that apply.



Overall, 59% of respondents said their current or previous workplace provides flexible working options (Figure 9). This was more common in the public sector (68%), compared to those in the private sector (55%), and specific professions such as those in education (35%).

Just 15% said their workplace facilitated open discussion of sensitive or taboo topics, and 8% said their workplace had training and support for managers to better understand women's health (Figure 9).

Figure 9. Does your current or previous workplace / the current or previous workplace of the woman you have in mind provide any of the following policies or support that you are aware of? Select all that apply.



A full breakdown of all results in this section can be found in Tables 1_9a, 1_9b and 7_1a to 7_4b of the survey data tables spreadsheet (Annex A).

Personal testimonies

To understand women’s experiences of health issues at work, we asked respondents what support has or would have helped them to reach their full potential. The examples provided fell within 3 core themes: workplace culture; continued and better implementation of existing workplace policies; and the creation of new workplace policies or support packages. These are described briefly in Table 15 and discussed in more detail below.

Table 15. Summary of the types of support respondents felt benefited or would benefit them / women in reaching their full potential in the workplace

Theme	Sub-theme
Workplace culture	<ul style="list-style-type: none"> • Open discussion of women’s health issues to break taboos and improve understanding of symptoms and impacts. • Supportive and caring employers, HR (human resources) professionals, managers, and colleagues. • Reduce stigma of asking for and accepting help.
Continued and better implementation of existing workplace policies	<ul style="list-style-type: none"> • Flexible working arrangements • Access to occupational health services, mental health support, and workplace adjustments • Protection against bullying and discrimination
Creation of new workplace policies / support packages	<ul style="list-style-type: none"> • Paid leave and counselling for miscarriage and baby loss • Paid leave for painful female health conditions such as endometriosis • Paid leave and phased return to work for female reproductive surgery (e.g. hysterectomy) • Improved workplace facilities for women with heavy periods • Workplace adjustments for women through the menopause • Support to return to work and/or progress careers after maternity leave, and while living with or recovering from female health conditions

Workplace culture

Respondents called for open discussion of women's health in the workplace to break taboos, and improve their managers' and colleagues' understanding of the range of symptoms associated with women's health conditions, and the impact they can have on their productivity and experiences at work. This was emphasised in relation to menstrual health, gynaecological conditions, and the menopause.

Respondent (aged 25 to 39):

"Flexible working needs to become the norm. So many days I've felt exhausted due to my period, [...] I should be able to message my boss and say I have really bad cramps, I want to work from home or I'm taking the day off because of my period but periods are still taboo in society, so we make up other excuses...."

Respondent (aged 16-24) [spelling errors corrected]:

"Training & support for managers to better understand women's health and an open discussion would have massively helped me work to my full potential. Even if I just got one chance to be able to talk about it candidly with my manager it would have helped me feel more at ease, made it less taboo and reduced the mental toll of not ever being asked about my health/condition or if anything could be done to help. I had previously tried to bring it up with my manager after I had been off for a month for endometriosis surgery and I got a simple, well we all have periods and have to get on with it which doesn't help the taboo in women talking openly about their health."

Respondent (aged 40 to 59):

"The ability to seek empathetic support from my employers would have made a major difference to my experience of the menopause. Because it was a taboo subject I felt unable to approach my line manager for support and approaches to HR were rebuffed as menopause was interpreted as simply the end of my ability to have children!"

A sub-set of women reflected on their experiences of going through miscarriages and not being able to talk about it at work.

Respondent (aged 40 to 59):

“When I miscarried at work, I didn't think I could tell anyone so had to carry on working as normal, still in meetings and carrying on my working day, while losing a baby with nobody knowing.”

Respondent (aged 25 to 39):

“Working in a more understanding and caring environment, I'm lucky to work in one now but the position I left recently only cared about trying to push me to the edge and not understand why I wasn't being so unproductive and because they were so cold, I was unable to share that I had recently miscarried and I was struggling to fight back the tears everyday because I have an autistic child at home that needs me to be strong”

Beyond raising awareness and understanding of women's health issues, some respondents felt that normalising these discussions in the workplace would also make it easier to accept help when it is offered.

Respondent (aged 25 to 39):

“Although the support is available at my work (NHS) there is a taboo around accepting or asking for it. [...]”

Respondent (aged 25 to 39):

“When I had a miscarriage, my work were supportive but it feels difficult to talk about this or take time off for it. Making it clear you want to start a family feels like it might harm your career prospects. I was signed off for 2 weeks by the doctor but I only took 2 days. Providing proper leave specifically for baby loss and opening up the conversation around this so it isn't a taboo would help a lot of women.”

Respondent (aged 25 to 39):

“[...]I have not felt comfortable disclosing my infertility to the head of dept or HR for fear it is seen as a condition that is by choice and therefore not understood (I.e. I am choosing to have a child). Flexible working has only been possible since the pandemic. Outside of this, attending so many appointments in work time would have been impossible.”

Implementation of existing workplace policies

Many women who responded to this consultation flagged that employers and managers could be doing more to encourage the take-up and proper implementation of policies that already exist in many workplaces, including the use of occupational health services and reasonable adjustments.

Respondent (aged 25 to 39):

“I am a GP and my previous workplace struggles to provide workplace adjustments. My new workplace has flexible working options and a supportive HR department. Being able to adjust my hours and appointment lengths, and work from home helped the lethargy and eye symptoms associated with the menopause.”

Respondent (aged 40 to 59):

“My current employer is great but my previous one was dire. When I went back after 3 months off with the arthritis, they refused me a desk assessment. I ended up having to go to HR to get it sorted which didn't go down well with my line manager. She just kept saying that I should take 2 weeks annual leave and then I would be properly better. She went on to bully me for taking time off sick, making my life a misery. Even when I telephoned her to say I couldn't come to work as I was in too much pain, she asked me to drive to Birmingham the following day as I was supposed to be giving a presentation and then [got] sick. She couldn't grasp that at that point, I couldn't manage to get out of bed, have a shower and get dressed. Getting pants on was virtually impossible due to the severe inflammation, I couldn't safely drive anywhere, let alone stand and do a presentation! [...]”

Respondent (aged 16 to 24):

“[...] I have access to clinical supervision due to the nature of my work as well as the opportunity to take mental health days. This means that if I am suffering with my mental health, I can feel confident in speaking to my employers about this and not only will they support me in improving my mental wellbeing, they will also give me some time off work should I need it to enable this to happen. I feel for me personally, knowing I have incredible support from my workplace in terms of my health both physical and mental this in itself helps me to reach my full potential as it alleviates stress. [...]”

On top of this, many respondents called for a continued uptake of flexible working arrangements which, for some, were not available pre-pandemic.

Respondent (aged 25 to 39) [spelling errors corrected]:

“Working from home has helped me hugely, as it gives me flexibility to work in ways that are more comfortable for my body. I can work from my bed on a bad day, or have a hot water bottle on my stomach when I have cramps. I have really struggled to manage my symptoms in jobs that are full time in the office. [...] I would also like for Endometriosis to be recognised as a disability or long-term condition that requires workplace adjustments. I'm currently too embarrassed to ask for any adaptations because I feel I'd have to really argue my case, and Endometriosis is currently still quite embarrassing and taboo to talk about.”

Respondent (aged 25 to 39):

“[...] Better flexible working also helps I had bad morning sickness through my first trimester when I was pregnant pre-pandemic and had to travel 1 hour per day on crowded transport to get to work. I couldn't easily explain why I was finding it so tough without disclosing the pregnancy, and as I had almost miscarried 6 weeks in, I really wasn't keen to tell colleagues in case I did end up losing the baby.”

Many women flagged that their experiences in the workplace, particularly resulting from women's health issues such as infertility, menopause and miscarriage, had had a severe impact on their mental health, often increasing instances of stress and anxiety. They felt that this impact on their mental health was not fully considered, and they didn't feel supported to manage this.

Respondent (aged 16 to 24):

“I felt in all my workplaces that I could not discuss with anyone about what I was struggling with. Obviously everyone tries to separate personal and work lives but these do affect each other. When I was having a hard personal life my work place loaded more on me without any support and/or anyone to talk to. This created even more stress and Mental Health Problems which resulted in a few panic attacks. It is extremely hard to privately ask for a personal chat with a manager and it felt like they were turning a blind eye to the issue as my colleague had noticed and tried to speak out for/help me. The right support at work (someone to discuss, services to talk to, flexible working while I was struggling, education on how to deal with it, support on workload etc) would have enabled me to work more productively and would have helped improve my health.”

Instead I was made to feel I did not have a voice and could not speak about such issues. When I did, I felt like I may be fired/let go, and ignored”

Respondent (aged 25 to 39):

“Making it easier and more accepted to talk about mental health. It's still a bit of a stigma and people can be judged against their jobs. I think that alongside sickness there should be mental health days. Someone may not be able to get out of bed or be struggling and going into work then leads to further anxiety and stress, sometimes just a day is needed to practice self-care. It would also help people to know that their job isn't at risk or people will be talking about them if they do experience mental health concerns.”

Respondent (aged 25 to 39):

“I was signed off with work related stress during a high-risk pregnancy. When I tried to explain my stress was not just work related but pregnancy related they struggled to understand why I had an issue.”

Respondents who stated that they are teachers appeared to face a unique set of challenges in taking advantages of policies that are standard in many other sectors, including a lack of funding for workplace adaptations and cover for sick leave.

Respondent (aged 25 to 39) [spelling errors corrected]:

“Workplace adjustments for migraine I was previously a teacher, but there was no funding available for covering fluorescent lighting and I wasn't allowed to wear special glasses for migraines while teaching. I left the sector, because there was no space for accommodating long term Chronic Conditions. My repeated single days of absence also made work for other colleagues and bad feeling began to grown. Workplace policies for sickness also didn't account for frequent day absences (necessary for migraines) and I have been on probation for sick leave for every job I've had for the last ten years. Doctors couldn't provide a long-term sickness note for single day absences either. More support is needed for teaching to help them work around staff members with disabilities and illnesses.”

Respondent (aged 25 to 39) [spelling errors corrected]:

“[...] In teaching, having a sick day is frowned upon due to limited budget of state schools to pay for cover teachers. Women including myself often have issues with urinary tract infections due to limited time for bathroom breaks (can't leave students unattended and no one to cover your lesson) which exacerbates the problem. Taking a day off also results in stress

because teachers are very aware they are then adding additional workload and burden to another teacher's day as another member of staff often covers lessons for the ill teacher (schools save money this way because they then don't need to have an external cover teacher come in). Female teachers including myself rarely take a day off for something like "menstrual cramps" because this would be considered minor illness and also working from home is never an option with teaching (unless there is a global pandemic!!!)"

Creation of new policies

Baby loss

For respondents who have lived through miscarriage and baby loss, having a supportive employer who used their discretion to grant them paid leave made a significant difference to their mental health.

Respondent (aged 25 to 39) [spelling errors corrected]:

"My company has been supportive with my miscarriages and allowing me to have paid time off for many hospital appointments and checks. They also paid for me whilst I had a few days off following a miscarriage which they technically didn't need to do. Its horrendous that a woman can lose a baby at 20 weeks and only be entitled to statutory leave. [...]"

Respondent (aged 25 to 39):

Work were fantastic when I miscarried they offered me as much time off as I needed, phased return, and time off to see a counsellor for a full year afterwards"

Respondent (aged 40 to 59):

"When I lost my baby at 32 weeks pregnant I was allowed to take up to a year off work to grieve and recover. This enabled me to go back to work. I think all women who suffer any type of baby loss should be given the opportunity to have time off to grieve."

However, this did not appear to be common practice, and the consequences were often wide ranging – including loss of income, worsened mental health, and reduced career prospects.

Respondent (aged 25 to 39) [spelling errors corrected]:

“I had a miscarriage at 12 weeks pregnant, and I was docked pay for having to be at home delivering the dead foetus”

Respondent (aged 25 to 39):

“I suffered a miscarriage and had no support from my company, they gave me one week unpaid [...] leave and that was it. I then suffered with stress and depression due to it, but I couldn't have had more time off due to not being paid.”

Respondent (aged 25 to 39):

“I asked for flexible working during a very difficult pregnancy and was refused. I had HR contact me during Maternity Leave after my baby had died and they never once asked how I was. They referred me to occupational health and he kept asking me when I was returning from being sick. I was made redundant whilst still on maternity leave eight months after my loss and I was offered no support with gaining employment/CV/career advice. And this was an NHS hospital. [...]”

Again, these barriers appeared to be heightened for respondents in the teaching profession.

Respondent (aged 25 to 39):

“[...] When I suffered a miscarriage halfway through my pregnancy I was pressured to return to work 2 weeks later so that my class didn't suffer from my absence. Being unable to grieve for my child affected me deeply. I was not offered counselling at the time or any support from health services after the miscarriage. No one seemed to care about me and how I was coping.”

Respondent (aged 25 to 39):

“Just some support when I came back from miscarriages instead of being in my head teacher's office 2 weeks later having my children's school books scrutinised. Another teacher who is off with stress will have a

phased return but I was straight back in to work (which is fine) but with no regard to how difficult this may have been.”

Menstrual health

Many respondents advocated for an extra day of paid leave per month for women who suffer from painful, heavy periods. Some also called for better bathroom facilities and access to sanitary products.

“[...] Women should get one period day per month extra sick leave. We have to endure and suffer so much more than men and there is no support for this. Most offices don't even stock tampons or pads in the toilets, which should be a default legal requirement. [...]” – respondent aged 25-39

Respondent (aged 25 to 39):

“Better bathroom facilities to allow women cubicles with sinks inside so that we can handle menstruation easily. I must have spent hours of my life waiting for the one disabled bathroom to be available so that I could deal with my heavy, messy periods privately. Even if period blood was less of a taboo, it's not easy to reclathe oneself and unlock a locked stall to wash one's hands halfway through changing tampons, menstrual cups or pads. Just having a sink right there is honestly so much easier. [...]”

Leave for women's health appointments and treatment

Some also called for paid leave categories to be expanded to properly recognise the time needed to attend certain appointments for female-health conditions, and to recover from female reproductive surgery.

Respondent (aged 40-59):

“I had a planned hysterectomy paid for by my company at the time. They had a strict sickness policy managed by an external company. They wanted HR to interview me because my recovery time after my operation triggered an alert for too much time off. I was lucky and my manager stopped it from happening but it caused me stress I could have done without. occupational health also said I only needed 4 to 6 weeks to recover without fully understanding the extent of my procedure. Women's health needs to be taken seriously and more understanding is needed. I also had to have a CVS [chorionic villus sampling] performed while I was pregnant and again the sickness absence line I rang only wanted to know when I would return to work even though I could have miscarried after the procedure.”

Respondent (aged 25 to 39):

“[...] Women need support from organisations if they need IVF [in vitro fertilisation] treatment or need to go to appointments for fertility, smears etc. It should be encouraged to have these tests and checks done and also understand that sometimes a hospital appointment takes half a day with travel and waiting and the appointment itself. Also more women need support during pregnancy, to see how they are doing physically and mentally.”

Career support

Finally, some women reflected that they would like to see a better package of support put in place for women who want to return to work and/or progress their careers after maternity leave, and while living with or recovering from female health conditions.

Respondent (aged 25 to 39):

“Miscarriage and pregnancy have impacted my work. My workplace is very flexible and understanding if day to day work is impacted by health conditions. However, specific roles that were potential opportunities for me to progress, had application and interview dates that fell around the time of childbirth. I was not blocked from applying, but I was at a significant disadvantage when applying due to recovering from birth, breastfeeding a newborn and caring responsibilities I do not feel this significant disadvantage was accounted for when making hiring decisions and there were no accommodations made to support me in the application process.”

Respondent (aged 25 to 39):

“[...] There needs to be reassurance from companies that if a woman raises a health issue especially if it's a long-term condition which requires support and can impact on productivity, the chances of progression and pay increases are not affected. Because either work becomes untenable or if you seek support there is a perception that it will have an impact on promotion, pay and progression even if not officially, especially if there is competition for pay and promotion and the other candidate does not have a health condition. [...]”

Research and data gaps

We wanted to understand whether respondents feel there are specific aspects of health or medical research that overlooks or neglects women's perspectives or experiences, as well as the perspectives of healthcare professionals in this area.

Summary

Overall, respondents reflected that much more can, and needs, to be done to improve research, evidence and data on women's health. Their main suggestions were: to ensure women, and women with different protected characteristics, are represented in clinical trials and studies; to initiate new research into health issues specific to women, such as the menopause; and to better translate research data and evidence into practice and the public domain. We also heard from a small number of respondents, who self-reported as health or care professionals, and echoed these reflections. They called for more diversity in the research profession and career support for women researchers.

Based on the results discussed across other sections of this report, future research could also seek to identify and test initiatives to improve how healthcare professionals listen to and treat women, develop and evaluate interventions to improve health in the workplace, and to explore whether other characteristics not collected through this survey, such as socio-economic background, might reveal further variations in women's experiences.

Respondents' reflections on research and data gaps

Women's participation in research

Historically, men have been disproportionately represented in clinical trials and studies in many countries, including the UK. This is problematic because it reduces the chances of identifying how symptoms may manifest differently due to biological differences between men and women, and whether treatments are likely to be as effective and associated with the same side effects.

This imbalance was highlighted by respondents, who felt that more needs to be done to recruit women, with different characteristics, into research studies. For example:

Respondent (aged 16 to 24) [spelling errors corrected]:

“More research is necessary that considers female bodies as separate, not just a deviation from a male body. Symptoms can look different from a male body and a female body and means the male body symptoms are

seen as the standard. We need more public information on female symptoms, this is also true in mental health conditions such as autism and ADHD.”

Respondent (aged 25 to 39):

“[...] Create more opportunities to collect data and carry out research, engage with women in a variety of ways and make the effort to have women from marginalised groups design research and help to collect data so it's not a top-down approach which does not reach them.”

Respondent (aged 25 to 39):

“How are research participants recruited? I would always be willing to participate and have never been approached. Look at broadening recruitment, seek participants via their employers/places of worship/education institutes etc. to encourage a diverse pool.”

This was echoed by the small group of (mainly female) healthcare professionals who responded to our survey:

Health or care professional:

"There are lots of aspects / areas of health in which the knowledge and understanding of disease, treatment, rehabilitation is informed by studies that are largely using male subjects. Women's inclusion in sample groups is difficult due to the many hormonal and physiological changes throughout the life span, but it is lazy on the part of researchers and those who commission the research not to try to seek to understand this more, rather than just sticking with the male-dominated data and applying to the "small men" (aka women)."

Health or care professional:

"As a highly specialist clinical pharmacist who works with a lot of early-phase trials, the lack of women included in research as a huge knock-on impact on how that translates through to clinical practice. Our understanding of drug metabolism, bioavailability, effectiveness & toxicity/side effects is biased towards men. So when that research gets published we have to fit diagnosis and conversations around that male profile, which sometimes excludes women all together for access to treatment."

A small number of healthcare professionals suggested that this is unlikely to change unless we also increase the diversity of those involved in designing research studies, and better support women in research roles. For example:

"Research is still driven (at least in my experience) by older, male, consultants and professors, many of whom simply are not interested in women's health in the wider sense (leaving it to the gynaecologists and breast surgeons) but women's health is fundamentally broader than our genitals!"

"[...] Minority women are in medical and healthcare research, but you will often find their research findings are not taken seriously especially if it is not addressing preferred subject or highlighting the inequalities that exists. [...] So, it is no wonder their perspectives in healthcare are under-represented [...]"

"As a fledgling researcher becoming part of the research movement is a difficult and exclusionary process. Research itself is set up to exclude women; the level of commitment required means that men are more able to thrive, and the playing field is anything but level. Accepting that women have different requirements than men, different demands, different resources and different experiences is vital."

"My experience as a Health and Nursing researcher has demonstrated [...] There is [...] a lack of funding for such research, where the research can be done, more women professors from BAME backgrounds are required to establish trust and visibility in the work undertaken and published. [...] The structure in universities must alter to stop barriers at Pro Vice Chancellor level in acting as gatekeepers to research and research funding."

Research into specific health conditions

Respondents identified that there needs to be greater investment in research to understand health issues and conditions that are specific to, or disproportionately affect, women. This suggestion was most commonly made in reference to:

- the menopause
- pregnancy, childbirth, and post-natal care
- gynaecological conditions, such as endometriosis
- menstruation

- female contraception

Respondents also called for research into:

- the perceptions and experiences of Black, Asian and Minority Ethnic women
- how healthcare professionals can better listen to women
- women's experiences of mental ill health
- women's experiences of cardiovascular disease and heart-related health issues
- women's experiences and treatment of pain

Dissemination of research findings

Respondents said that more needs to be done to effectively share and explain information on women's symptoms, health conditions, and the results of medical research, to ensure healthcare providers are aware of the latest evidence available, and to enable women to educate themselves and make informed decisions.

Respondent (aged 40-59):

“Evidence based practice is great in theory, but where it falls down is with practitioners saying in an appointment “there is evidence for this but it's your decision if you want to proceed or not”. Patients need the information presented to them in an accessible way, in sufficient detail and with sufficient time to assimilate it in order to make an informed decision.”

This was echoed by some of our health or care professional respondents:

Self-reported health or care professional:

"There are many research findings that we know about in relation to women's health and their choices but often these are not put into practice in guidance, policies and clinical practice. Often the reason for this is financial which is an indictment. [...]"

Self-reported health or care professional:

" [...] where both men and women are included in research the results are not necessarily split by gender which may invalidate the results. So ALL future research needs to separate out the impact on men and women, and

by different racial backgrounds, to accurately identify the impacts on the different groups."

Our reflections on areas for future research

This report contains a wealth of insights, underpinned by the views and experiences of the 97,307 people in England who completed our survey. However, because this reflects a small fraction of the wider population (as discussed in the Section 'Respondent demographics'), further research to build on this evidence base is required. Such research opportunities would be enhanced by ensuring diversity, and support for women, in research career pathways.

For example, the following areas could be prioritised:

- health issues specific to women, such as gynaecological conditions, fertility, pregnancy, pregnancy loss and post-natal support, the menopause, menstrual health, and gynaecological cancers
- health issues that may impact women differently, such as disability, autism, and neurodiversity, mental health conditions, and cardiovascular disease, and symptoms that may be treated differently by health professionals, such as physical pain
- health impacts of violence against women and girls, and the specific services available for those who have experienced this
- ensuring that women, and women with different protected characteristics, are represented in clinical trials and studies
- evaluating models of health service delivery that better listen to and serve women's health needs
- optimising provision of information and education to women and professionals on women's health issues to improve health outcomes, from initial discussions about symptoms, through to treatment and after-care
- optimising provision of information and education to children, young adults, and the public, to raise awareness of and destigmatise women's health issues
- developing interventions to improve health in the workplace, and across sectors, including access to appropriate occupational health services and policies, and considering support for those who are self-employed

- better translating research data and evidence into practice and policy, and the public domain

Glossary

This glossary contains a brief definition of key terms referenced in this report, including medical conditions and treatments, which some readers may be less familiar with. The definitions are correct at time of publication and should not be used for the purpose of self-diagnosing any symptoms you or others may be experiencing.

Term	Definition	Source
Adenomyosis	Adenomyosis is a condition where the endometrium (lining of the womb) is found deep in the myometrium (muscle of the uterus). It is not known exactly why adenomyosis happens, but it is likely that women with adenomyosis have a predisposition due to their genes, immune system and hormones. It can commonly cause painful and heavy periods.	NHS NORTH BRISTOL TRUST
Anxiety	Anxiety is a feeling of unease, such as worry or fear, that can be mild or severe. There are multiple types of anxiety disorder, including generalised anxiety disorder (GAD) and social anxiety disorder (social phobia).	NHS
Asthma	Asthma is a common lung condition that causes occasional breathing difficulties. It affects people of all ages and often starts in childhood, although it can also develop for the first time in adults.	NHS
Atrial Fibrillation	Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate.	NHS
Attention deficit hyperactivity disorder (ADHD)	Attention deficit hyperactivity disorder (ADHD) is a condition that affects people's behaviour. People with ADHD can seem restless, may have trouble concentrating and may act on impulse. People with ADHD may also have additional problems, such as sleep and anxiety disorders.	NHS
Autism	Autism is a lifelong developmental disability which affects how people	NATIONAL AUTISTIC SOCIETY

	communicate and interact with the world. Autism is a spectrum condition and affects people in different ways.	
B12 deficiency	Vitamin B12 or folate deficiency anaemia occurs when a lack of vitamin B12 or folate causes the body to produce abnormally large red blood cells that cannot function properly. General symptoms of anaemia may include extreme tiredness, lack of energy, breathlessness, feeling faint, headaches, pale skin, noticeable heartbeats, tinnitus, loss of appetite and weight loss.	NHS
Chronic conditions	Chronic conditions are those which in most cases cannot be cured, only controlled, and are often life-long and limiting in terms of quality of life.	NHS WALES
Chronic kidney disease (CKD)	Chronic kidney disease (CKD) is a long-term condition where the kidneys don't work as well as they should. It's a common condition often associated with getting older.	NHS
Cisgender	Relating to or being a person whose gender identity corresponds with the sex the person had or was identified as having at birth. For example, a person who was registered female at birth, and who identifies as a woman.	MERRIAM-WEBSTER
Combined oral contraceptive pill	The combined oral contraceptive pill is often just called "the pill" or "birth pill". It contains artificial versions of female hormones oestrogen and progesterone, which are produced naturally in the ovaries. When taken correctly, the pill is over 99% effective at preventing pregnancy.	NHS
Coronary Heart disease (CHD)	Coronary heart disease (CHD) is the term that describes what happens when the heart's blood supply is blocked or interrupted by a build-up of fatty substances in the coronary arteries. It is a major cause of death in the UK and worldwide. CHD is sometimes called ischaemic heart	NHS

	disease or coronary artery disease.	
Depression	Depression is a common mental disorder. When someone is depressed, they feel persistently sad for weeks or months, rather than just a few days. Depression affects people in different ways and can cause a wide variety of symptoms.	NHS
Diabetes	Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are 2 main types of diabetes: type 1 diabetes – where the body's immune system attacks and destroys the cells that produce insulin, and type 2 diabetes – where the body does not produce enough insulin, or the body's cells do not react to insulin.	NHS
Domestic abuse	Domestic abuse is an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-partner, but also by a family member or carer.	WOMEN'S AID
Dyspraxia	Dyspraxia, also known as developmental co-ordination disorder (DCD), is a common disorder that affects movement and co-ordination. It affects both children and adults.	NHS
Eating disorders	An eating disorder is a mental health condition where one uses the control of food to cope with feelings and other situations. The most common eating disorders are: anorexia nervosa, bulimia, and binge eating disorder (BED).	NHS
Ectopic pregnancy	An ectopic pregnancy is when a fertilised egg implants itself outside of the womb, usually in one of the fallopian tubes. The fallopian tubes are the tubes connecting the ovaries to the womb. If a fertilised egg or embryo gets stuck in them, it won't develop into a baby and the woman's health may be at risk from rupture of	NHS

	the tube if the pregnancy continues to increase in size. It usually has to be removed using medicine or an operation.	
Endometriosis	Endometriosis is a condition where tissue similar to the lining of the womb starts to grow in other places, such as the ovaries, fallopian tubes and outside the reproductive tract, commonly the pelvis. Endometriosis can affect women of any age. For some women, endometriosis can have a big impact on their life and may sometimes lead to feelings of depression.	NHS
Epilepsy	Epilepsy is a common condition that affects the brain and causes frequent seizures. Seizures are bursts of electrical activity in the brain that temporarily affect how it works. They can cause a wide range of symptoms. Epilepsy can start at any age, but usually starts either in childhood or in people over 60.	NHS
Fallopian Tubes	The fallopian tubes are muscular tubes that sit in the lower abdomen/pelvis, alongside the other reproductive organs. There are two tubes, one on each side, that extend from near the top of the uterus, run laterally and then curve over and around the ovaries. The primary function of the fallopian tubes is to transport eggs from the ovary to the uterus.	VERYWELL HEALTH
Female sterilisation	Female sterilisation is an operation to permanently prevent pregnancy. The fallopian tubes are blocked or sealed to prevent the eggs reaching the sperm and becoming fertilised. Female sterilisation is more than 99% effective at preventing pregnancy.	NHS
Fibroids	Fibroids are non-cancerous growths that develop in or around the womb (uterus). The growths are made up of muscle and fibrous tissue and vary in	NHS

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

	<p>treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.</p>	
Gynaecologist	<p>A doctor skilled in the treatment of women's diseases, especially those of the reproductive organs (see gynaecology below).</p>	<p>CAMBRIDGE DICTIONARY</p>
Gynaecology	<p>Gynaecology is concerned with the well-being and health of the female reproductive organs and the ability to reproduce. It includes endocrinology, female urology and pelvic malignancy. The specialty spans paediatric and adolescent gynaecological problems through to later years.</p>	<p>NHS HEALTH CAREERS</p>
Hormone replacement therapy (HRT)	<p>Hormone replacement therapy (HRT) is a treatment to relieve symptoms of the menopause. It typically contains the hormones oestrogen and progesterone which are two of the main hormones that control reproduction. The amount of natural reproductive hormones changes around the time of the menopause. The main benefit of HRT is that it can help relieve most of the menopausal symptoms. It can also help prevent weakening of the bones (osteoporosis), which is more common after the menopause.</p>	<p>NHS</p>
Hypertension	<p>Hypertension is a term used to describe high blood pressure. Hypertension rarely has noticeable symptoms. But if untreated, it increases the risk of serious problems such as heart attacks and strokes.</p>	<p>NHS</p>
Hypothyroidism	<p>An underactive thyroid gland (hypothyroidism) is where one's thyroid gland does not produce enough hormones. There's no way of preventing an underactive thyroid. Most cases are caused either by the immune system attacking the thyroid gland and damaging it, or by damage to the thyroid that occurs</p>	<p>NHS</p>

	during some treatments for an overactive thyroid or thyroid cancer.	
Hysterectomy	A hysterectomy is a surgical procedure to remove the womb (uterus). Women are not able to get pregnant after this operation. Many women have a hysterectomy. It's more common for women aged 40 to 50. Hysterectomies are carried out to treat health problems that affect the female reproductive system, including heavy periods, long-term pelvic pain, fibroids and certain cancers.	NHS
Intrauterine device (IUD)	The intrauterine device (IUD), also known as the copper coil, is a method of non-hormonal contraception. It is a small T-shaped device made from plastic and copper that is fitted into the womb (uterus) to prevent pregnancy. This lasts from 5-10 years.	NHS
Intrauterine system (IUS)	The intrauterine system (IUS), also known as the hormonal coil, is a hormonal contraceptive inserted into the womb (uterus). It prevents an egg implanting and may prevent fertilisation. It tends to make periods much lighter and can be used to treat heavy periods. It is also sometimes used as part of HRT. It lasts for 3-5 years, depending on the brand.	NHS
In Vitro fertilisation (IVF)	In vitro fertilisation (IVF) is one of several techniques available to help people with fertility problems have a baby. During IVF, an egg is removed from the woman's ovaries and fertilised with sperm in a laboratory. The fertilised egg, called an embryo, is then returned to the woman's womb to grow and develop.	NHS
Irritable bowel syndrome (IBS)	Irritable bowel syndrome (IBS) is a common condition that affects the digestive system. It causes symptoms like stomach cramps, bloating, diarrhoea and constipation. These tend to come and go over time, and can last for days, weeks or months at a time.	NHS

Learning disability	A learning disability affects the way a person understands information and how they communicate. This means they can have difficulty: understanding new or complex information; learning new skills; and/or coping independently. A learning disability can be mild, moderate or severe.	NHS
Menopause	The menopause is when a woman stops having periods and is no longer able to get pregnant naturally. The menopause is a natural part of ageing that usually occurs between 45 and 55 years of age, as a woman's ovaries stop releasing eggs and then the woman's oestrogen levels decline. In the UK, the average age for a woman to reach the menopause is 51.	NHS
Menstruation	See definition for periods.	
Migraine	A migraine is usually a moderate or severe headache felt as a throbbing pain on one side of the head.	NHS
Miscarriage	A miscarriage is the loss of a pregnancy during the first 23 weeks.	NHS
Multiple sclerosis (MS)	Multiple sclerosis (MS) is a condition that can affect the brain and spinal cord, causing a wide range of potential symptoms, including problems with vision, arm or leg movement, sensation or balance. It's a lifelong condition that can sometimes cause serious disability, although it can occasionally be mild.	NHS
Musculoskeletal (MSK) conditions	Musculoskeletal (MSK) conditions affect the joints, bones and muscles, and also include rarer autoimmune diseases and back pain. More years are lived with musculoskeletal disability than any other long-term condition. There are more than 200 musculoskeletal conditions.	NHS ENGLAND
Myalgic encephalomyelitis or chronic fatigue syndrome (ME/CFS)	Myalgic encephalomyelitis, also called chronic fatigue syndrome or ME/CFS, is a long-term condition with a wide	NHS

	range of symptoms. The most common symptom is extreme tiredness.	
Neurological conditions	Neurological conditions such as Parkinson's disease, motor neurone disease, and epilepsy result from damage to the brain, spinal column or peripheral nerves. Some neurological conditions are life threatening, with many severely affecting an individual's quality of life.	NHS ENGLAND
Pelvic floor	The pelvic floor is made up of layers of muscles which support the bladder, bowel and uterus.	ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS
Pelvic organ prolapse	Pelvic organ prolapse is when one or more of the organs in the pelvis slip down from their normal position and bulge into the vagina. It can be the womb (uterus), bowel, bladder or top of the vagina. This occurs most usually sometime after childbirth. A prolapse is not life threatening, but it can cause pain and discomfort. Symptoms can usually be improved with pelvic floor exercises and lifestyle changes, but sometimes medical treatment is needed.	NHS
Perimenopause	Perimenopause means "around menopause" and refers to the time during which a woman's body makes the natural transition to menopause, marking the end of the reproductive years. This can be a time where women experience symptoms of the menopause or their periods can become less frequent, before stopping. Perimenopause is also called the menopausal transition.	MAYO CLINIC
Periods	A period is the part of the menstrual cycle when a woman bleeds from her vagina for a few days. For most women this happens every 28 days or so, but it's common for periods to be more or less frequent than this, ranging from day 21 to day 40 of their	NHS

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

health education (RSHE)	schools in England to teach Relationships/ Relationships and Sex Education (RSE) and Health Education — sometimes abbreviated as 'RSHE'.	ASSOCIATION AND GOV.UK
Sexual health	Sexual health is an integral part of overall health, well-being and quality of life. It is a state of physical, emotional, mental and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity.	WORLD HEALTH ORGANISATION
Smear test	Cervical screening (a smear test) checks the health of a woman's cervix. The cervix is the neck of the womb with an opening into the vagina. It's not a test for cancer, it's a test to help prevent cancer. All women and people with a cervix aged 25 to 64 should be invited by letter.	NHS
Stroke	A stroke is a serious life-threatening medical condition that happens when the blood supply to part of the brain is cut off. Strokes are a medical emergency and urgent treatment is essential.	NHS
Thrush	Thrush is a common yeast infection that affects men and women. It's usually harmless but it can be uncomfortable and keep coming back. It is not classed as a sexually transmitted infection (STI)	NHS
Triage	Triaging in healthcare settings is when patients are sorted based on their needs and involves the assignment of degrees of urgency to wounds or illnesses to decide the order of treatment of a large number of patients or casualties.	DENTAL REFFERALS.ORG
Urogynaecologist	A health professional who works in the field of urogynaecology. Urogynaecology is a subspecialty of Gynaecology. It covers services that provide assessment, investigations and treatment for women with urinary incontinence, vaginal prolapse,	ROYAL COLLEGE OF NURSING

	<p>recurrent urinary tract infections, bladder pain and pelvic floor injury after childbirth including faecal incontinence. It links with obstetrics, urology and colorectal services.</p>	
<p>Urinary tract infections (UTIs)</p>	<p>Urinary tract infections (UTIs) affect the urinary tract, including the bladder (cystitis), urethra (urethritis) or kidneys (kidney infection). UTIs can be treated with antibiotics, but these are not always needed.</p>	<p>NHS</p>

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