Royal College of Obstetricians & Gynaecologists

Department of Health and Social Care Women's Health Strategy: Call for evidence

June 2021

About the College

The Royal College of Obstetricians and Gynaecologists (RCOG) is a professional membership organisation made up of over 16,000 members worldwide. We work to improve the health of women, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's health care.

Introduction

The development of a Women's Health Strategy for England, the overarching call of RCOG's Better for Women: Improving the health and wellbeing of girls and women, is a huge opportunity for the Government to set out an ambitious and comprehensive plan to make real, sustained improvements in women's health throughout their lives. The RCOG looks forward to continuing to work closely with Government, the NHS, and the wider health and care system to achieve this.

The first theme of this consultation must be central to the Women's Health Strategy: placing women's voices at the centre of their health and care. This isn't a call for a re-design of the whole system, but a shift in the way that organisations, policy makers, and healthcare professionals think about, develop and deliver interventions to improve women's health. The ambition to improve women's health is bold and requires an equally bold strategy. The levers for real change are multi-faceted and complex and span far beyond the confines of what is traditionally defined as 'women's health' in the NHS. It is about how women live every part of their lives: their work, their family lives and relationships, their communities and how they socialise, and so much more. It is therefore essential that the actions in this strategy are not developed in isolation in one government department, but are made up of cross-government commitments and aligned with other key strategies that also have the power to improve women's health. In particular this must include close alignment with the Violence against Women and Girls (VAWG) strategy within the Home Office, the upcoming national sexual health strategy, and the NHS Covid-19 recovery plan.

The Covid-19 pandemic has changed so much for women and for the services they use in such a short period of time, and a meaningful strategy must reflect on the pandemic and learn from it. Ending the stark inequalities in women's health that were further exposed and exacerbated by the pandemic must be at the heart of the strategy.
To develop our response to this consultation, we have worked closely with women, with the clinicians who support them, and with stakeholders across the women's health sector. This has included sustained engagement with our Women's Network, a group of women with lived expertise in women's health, and a series of small-scale surveys through our wider communications channels. We also gathered the views of RCOG Council members to ensure we included the expertise and experience of our clinicians.

There are organisations whose specialist knowledge and expertise in particular areas of women's health, or for particular groups of women, will be essential for the development of the strategy. In particular, RCOG supports the recommendations made in the submissions

from the Maternal Mental Health Alliance (MMHA) of which we are a member, The Faculty of Sexual and Reproductive Healthcare, The Primary Care Women's Health Forum, Birth Companions, and from the Inter-Collegiate & Agency National DVA (INCADVA).

What should the future look like?

The RCOG has developed vision statements for the future of women's health, based on the themes outlined by the Women's Health Strategy consultation. These form the backbone of a comprehensive strategy.

Placing women's voices at the centre of their health and care

- Professionals listen to and empower women
- Women's health is represented at every level across the health and care system
- There is no stigma preventing women from accessing the right care and support

Improving the quality and accessibility of information and education on women's health

- All women, whatever their background, can access trusted and comprehensive information
- All young people are educated from an early age about women's health
- Professionals and services are equipped with the right information to provide high-quality advice and care around women's health

Ensuring the health and care systems understands and is responsive to women's health and care needs across the life course

- Women can easily access care to meet all their sexual and reproductive healthcare needs, at every stage of their life
- Prevention, early intervention and public health are at the centre of our approach to women's health
- Healthcare and wider public services are systematically geared to reduce and eliminate inequalities in access, experience and outcomes for women

Maximising women's health in the workplace

- Women's health is never a barrier to their participation in work

Ensuring research, evidence and data support improvements in women's health

- Across the health and care system, there is consistent collection of data on women's health outcomes and experiences
- Research into diagnostics and treatment in healthcare gives equal weight to women's experiences and health, and we reach a point where the gender data gap no longer exists

Understanding and responding to the impacts of Covid-19 on women's health

- The impact of Covid-19 on women's services, including any backlog in care, is fully addressed
- All women have equitable access to a Covid-19 vaccination, with the right information and support to ensure they feel confident to take up the offer of a vaccine
- The positive ways of working that have been developed or accelerated because of the pandemic are built into long-term service delivery

Placing women's voices at the centre of their health and care

Professionals listen to and empower women

Without professionals listening to and empowering women, a barrier between women and good health will always exist. They will not be able to access the care and support they need, and they will not trust professionals to support them to make decisions about their future health, leading to worse health outcomes through their lives. Professionals are a key enabler to ensuring women are at the centre, and feel in control of, their own health.

We asked women about their confidence in healthcare professionals, and there was a real range of responses. Some felt very positive, most others had neutral or middling experiences, either because their experiences had been mixed or because there were caveats to their trust and confidence. There were a number of respondents who felt they had little or no confidence in healthcare professionals. Women spoke about healthcare professionals having a lack of knowledge and experience in women's health issues, and not feeling listened to or acknowledged, as contributing factors to a lack of trust and confidence. This chimes with the findings of the APPG on Endometriosis 2020 Inquiry, where the most common themes for a better experience were being 'listened to', 'believed' and 'taken seriously'.

Not listening to women or acting on their experiences can have devastating consequences. The First Do No Harm report set out how dismissal of patients' experiences by clinicians can have a profound impact. The report is also clear that for women there is an 'added dimension – the widespread and wholly unacceptable labelling of so many symptoms as 'normal' and attributable to 'women's problems''.

The Strategy should outline an approach to ensuring all women are listened to and empowered by the healthcare professionals who support them. This should include: mandatory training for all NHS staff on bias (including on race, gender, sexuality and disability) and listening; monitoring of patient reported outcomes on perceived bias; and the inclusion of patient representatives in all women's services and in training and medical curriculum development.

Women's health is represented at every level across the health and care system

In order to ensure women's voices are at the centre of their health and care, their voices must be at the centre of the systems and services that are there to support them. Women's health must be represented wherever decisions are made that will impact their health and care. Members of RCOG Council are clear that patient experience could be used much more to improve services. They highlighted the current variability of patient involvement from trust to trust and between different services, and the need for clear minimum standards and best practice examples.

The Strategy must outline an approach to ensuring voices for women's health are built into governance and leadership structures at every level in the health service. This should look both at ensuring credible and effective direct patient involvement, and representation from appropriate services and professionals in women's health. It should include: outlining requirements for the representation of women's health in Integrated Care System Boards and Partnership Boards, and within the governance and leadership of Primary Care Networks; highlighting best practice for lived experience involvement and co-production in women's health services, including actions to further embed and standardise the role of Maternity Voices Partnerships. **All trusts should also appoint a Director of Midwifery with direct access to the Board, to advocate for safe, high-quality maternity care.**

There is no stigma preventing women from accessing the right care and support

Silence, stigma and shame around girls' and women's health are apparent throughout the life course. In recent years, public conversations about issues including the menopause and period poverty have contributed to reducing stigma somewhat. In a recent RCOG survey most respondents felt stigma around menstruation had reduced in recent years (59% said they felt it had improved 'slightly' and 24% said they felt it had improved 'a lot').

However, there is much more to do. Women we spoke to felt there remained stigma and bias associated with women's health, that it was less spoken about in public, and that internalised biases also prevented them from accessing information and care. In a recent small-scale survey undertaken by RCOG, over 40% of respondents reported shame or stigma about women's health issues (like menopause or menstruation), which stopped them from accessing care. This echoes existing findings on stigma and taboos around women's health, such as research on attitudes to periods by Plan International UK, which found that nearly half (48%) of girls in the UK are embarrassed by their periods. Research has also shown that silence, shame,

discrimination and stigma relating to ageing and the menopause are highly prevalent and can have a huge impact on a woman's quality of life. [1]

If girls and women are too embarrassed to discuss their menstrual, menopausal or sexual health symptoms, it is likely they could be too embarrassed to seek clinical help when they require it, increasing the risk of more serious and potentially avoidable ill-health and unnecessary impacts on their health and lifestyle because of embarrassment.

The Strategy should commit to funding evidence-led campaigns and projects that aim to reduce stigma around women's health.

Improving the quality and accessibility of information and education on women's health

All women, whatever their background, are able to access trusted and comprehensive information

All women need easily accessible, accurate information they can trust, to give them the best possible support to become, and remain, healthy.

The Strategy must identify and address gaps in high-quality information on women's health conditions. Where current information around women's health is inadequate, the Strategy should outline what information is required and commission expert organisations, including Royal Colleges and charities, to support its development.

We asked women about what barriers (if any) they faced when accessing information and support in relation to their health. The most common answers were time, discerning the quality and trustworthiness of information and access to healthcare professionals to gather information. When asked what would make it easier to access good quality information women talked about how beneficial a 'central hub' or 'one stop shop' for women's health information would be. **The Strategy should commit to creating a comprehensive, centralised resource for information on women's health that sits on the NHS website. It is vitally important that information is available in a variety of formats and is accessible to all regardless of background, education, disability or socioeconomic status, to meet the needs of all women.**

The Strategy should include a plan to improve the availability and dissemination of information to all girls and women with one or more protected characteristics, or from disadvantaged backgrounds and marginalised communities, including those in institutionalised settings.

All young people are educated from an early age about women's health

Education about women's health must start from a young age so that all girls and women better understand their bodies, are informed of where and when to get help and feel

confident to talk about any health issues.

The introduction of compulsory relationship and sex education (RSE)[2] in schools is a big step towards ensuring age-appropriate education on women's health is an integral part of every young person's education from an early age. It is essential that its introduction is seen as a first step towards this ambition, however, and not the final.

The quality of the content and delivery of RSE in primary and secondary schools should be evaluated regularly, to enable consistent improvement.

Education has been significantly disrupted as a result of the Covid-19 pandemic, including the teaching of RSE. **It is therefore important that the Government uses the strategy to reinforce the requirement for the introduction of RSE in schools and to set out how disruption and delays to learning will be caught up.**

Professionals and services are equipped with the right information to provide high-quality advice and care around women's health

RCOG Council members told us that there is variation in the quality and accessibility of information they are able to signpost their patients to, and they provided examples of where gaps in information exist. **NHSEI should consolidate information on women's health into one comprehensive resource for clinicians and services.** This would provide evidence-based guidance to enable easier diagnosis and referral, and direct clinicians to NICE and other guidelines and appropriate support networks for patients. All healthcare professionals, service providers and commissioners should then be signposted to this resource.

Ensuring the health and care systems understands and is responsive to women's health and care needs across the life course

Women can easily access care to meet all their sexual and reproductive healthcare (SRH) needs, at every stage of their life

In a system that is responsive to women's health and care needs, easy access to routine healthcare must be a basic guarantee. To make this a reality, the Strategy must ensure that services are designed, delivered and funded with women at the centre, removing any current barriers to accessing care.

A previous RCOG survey painted a picture of poor access to basic women's health services.[3] This leads to an increase in the number of unplanned pregnancies (resulting in poorer outcomes for women and their babies), a rise in requests for abortion, especially among women in older age groups, later diagnosis of cervical cancer, which can adversely impact on survival rate, and increases in damaging postcode lotteries for care.

One of the reasons that women are unable to access basic routine healthcare is the fragmentation in the way services are designed and delivered. A detailed explanation of the

challenges can be seen here. The new system architecture, in the form of Integrated Care Systems (ICSs) provides an opportunity to improve access to, and reduce fragmentation of, services. It is disappointing that the current proposals do not go as far as the RCOG has recommended and move the commissioning of all women's health services into ICSs. However, there is still an opportunity for co-commissioning of SRH services between the NHS and local authorities through Integrated Care System Partnerships, but this currently relies on local decisions and relationships. **To ensure the new architecture improves care for women, the Strategy should mandate co-commissioning of SRH services.**

Post-partum contraception is another area where fragmented commissioning fails women. Providing a full range of contraceptive options after pregnancy is a simple but effective way to avoid short intervals between pregnancies and planning future contraception should be viewed as an integral part of maternity care services. However, commissioning structures do not allow for the provision of contraception by maternity services. At the start of the pandemic, the RCOG and the Faculty for Sexual and Reproductive Healthcare issued guidance on the provision of post-partum contraception during Covid-19, evidencing the benefits of doing so. [4] Temporary funding was put in place to allow women to access contraception within maternity services and evaluation on the ground showed overwhelming support from women, midwives and obstetricians. [5] Despite clear benefits this has not yet been made permanent. **The Women's Health Strategy should mandate the availability of post-partum contraception as part of the maternity pathway.** [6]

Access is also made more difficult because funding for SRH services has been reduced significantly in recent years, forcing women to travel further and to less convenient locations to access contraception.

The RCOG has consistently called for increased public health and sexual health budgets in real terms, and for these to be ring-fenced within local authority budgets. Analysis shows that the public health grant was cut by 22% in real terms between 2015/16 and 2020/21 and that there has been an 18% decrease in contraceptive spend in real terms since 2015. [7] [8] **There must be action across the Women's Health Strategy and the forthcoming Sexual Health Strategy to commit to a real terms increase in the public health budget, and ring-fenced funding for sexual and reproductive healthcare.**

We recognise that access to contraception will be a focus of the Sexual Health Strategy, but it is essential that this is also acknowledged in the Women's Health Strategy. The two strategies must be coordinated and focus first and foremost on the needs of women, ensuring there are no barriers to contraception.

The RCOG has been calling for the reclassification of progestogen-only contraception (POP) from 'prescription only' to 'pharmacy product' since 2019 and so we welcome the advice from the MHRA to the Government that this should be the case. **The Government should use the Strategy to accept the recommendation from the MHRA to make POP a pharmacy product. The Government must also work with pharmacies to ensure the POP is affordable for all women, including those on low incomes, to avoid creating even greater inequality in women's healthcare.**

Difficulties for women juggling work, childcare and other family commitments to get a convenient appointment, and pressures on GP surgeries, also serve as barriers to accessing routine healthcare. These barriers are considerable for many women, but for those who are socioeconomically disadvantaged or have difficulties accessing the health system, the barriers can become insurmountable. **The Strategy should direct NHSEI to create a mechanism wherein primary care networks can act as women's health hubs, facilitated by the above mandated co-commissioning.** Women's health hubs are ideally placed to meet the full range of women's routine healthcare needs, including contraception, cervical cancer screening and treatment and advice about the menopause, and should aim to offer weekend and out-of-hours appointments.

Prevention, early intervention and public health is at the centre of our approach to women's health

There are many missed opportunities where prevention, early intervention, and a more effective and better funded public health system could have a huge impact on women's health. Enabling prevention and early intervention to make a real difference to women's health requires a commitment to cross-government working. To truly put women at the centre, this Strategy must not only ensure that services are designed around their needs, but that wider policies that can have an impact on their health and wellbeing are too. This will ensure that in every part and at every stage of their lives, women are supported to make decisions that prevent ill-health and help them to stay healthy.

One of these missed opportunities is improving pre-conception health by putting more emphasis on the role of prevention. Supporting women to be as healthy as possible before pregnancy, in order to increase fertility, have an uncomplicated pregnancy and achieve the best outcomes for mother and baby, is vitally important. **The Strategy must outline an approach to improve access to information and support on pre-conception health. This should include urgent action to implement mandatory fortification of all flour and gluten-free products with folic acid to improve the health of pregnant women and their babies, following the 2019 consultation on this topic.** The consensus statement supported by RCOG on the mandatory fortification of flour can be seen here.

Another important opportunity arises at the time of the menopause to engage with women and promote a healthy lifestyle and potential interventions that will keep them well going forward, as RCOG has previously outlined. [9] This should include information and advice on pelvic floor health, preventing the early onset of dementia, and maintaining healthy bones. There is an important role for public health campaigns and interventions designed to increase awareness and support women to remain as healthy as possible throughout their lives. **The Strategy should outline how the DHSC and the new Office for Health Promotion will work together to set priorities and develop and support initiatives to improve women's health. It should also detail how the two departments will influence wider government policy to ensure a 'health in all policies' approach.**

The evidence for the potential effectiveness of cervical screening programmes is clear, but there remain challenges with uptake in England. [10] **There must be targeted campaigns to increase screening uptake, developed in partnership with groups with statistically lower levels of uptake, including the continued focus on the introduction and evaluation of human papillomavirus primary home-test screening.**

Healthcare and wider public services are systematically geared to reduce and eliminate inequalities in access, experience and outcomes for women

The Covid-19 pandemic has both exacerbated and further exposed the stark inequalities in health in this country, for example pregnant women hospitalised with symptomatic coronavirus infection are more likely to be from a Black, Asian or other minority ethnic background, even when controlling for factors such as obesity, age and location. [11]

Significant racial disparities in women's healthcare exist, and ending these inequalities must be a central objective of the Women's Health Strategy. A detailed discussion of these issues is available here. **The Strategy should set a target of a 50% reduction in the disparity in maternal mortality rates for Black, Asian and minority ethnic women in the next five years.** This should act as a driver for a much broader analysis of, and improvement in, how maternity services care for pregnant women from Black, Asian and minority ethnic communities.

The racial disparity in maternal mortality is the most devastating consequence of a wider trend towards poorer outcomes that permeates through all aspects of Black, Asian and minority ethnic women's health care, with research showing disparities in stillbirth, cancer diagnosis times and outcomes, endometriosis diagnosis, and access to and outcomes of fertility treatment[12].

There is clear evidence too that LGBTQ+ women experience inequalities across a range of areas including cancer outcomes, teenage conception and higher rates of health risk behaviours such as smoking, stress and inactivity. [13] There are also disparities in the experiences of disabled women in women's healthcare settings. For example there is evidence[14] showing that disabled women are at higher risk of adverse pregnancy outcomes[15], that healthcare professionals may lack knowledge and experience in planning and providing care for pregnant disabled women, and that women with hearing impairment receive fewer antenatal visits and have limited access to maternity information[16].

The Strategy should explicitly outline plans to understand, reduce and eliminate inequalities in access, experience and outcomes for women's services. This should include an approach to data collection and monitoring of patient experience and outcomes, and an action framework to develop targeted services and initiatives to address inequalities in and between different groups of women.

Maximising women's health in the workplace

Women's health is never a barrier to their participation in work

Women are vital to the UK's workforce and productivity and the recognition of this as part of a Women's Health Strategy is welcome.

There is a body of evidence that demonstrates links between 'good work' and health, and that working conditions contribute to this. [17] Working conditions includes the policies and practices that employers and workplaces have to keep employees safe and well. Being in good health can equally support more women to stay in the workforce.

Symptoms relating to women's health, including menopause, heavy menstrual bleeding and period pains, and other long-term gynaecological conditions including endometriosis, and issues with continence and pelvic health, can have a significant impact on women and their ability to work.

We asked women about their experiences of health and the workplace. 72% of respondents said they had experienced struggling to focus or perform during their period or menopause, 45% had taken time off to manage pain or symptoms, and a few even spoke about having to leave employment altogether because of their health. One woman told us she had experienced 'wanting to quit because [she] felt physically and emotionally unable to continue'. Menopausal symptoms can have a significant impact on women's ability to work. Many women do not know what to expect during the menopause nor do they feel empowered to seek help when needed or able to manage their symptoms. This challenge is most acute for the 25% of women who experience severe symptoms. In a recent survey, half of the women interviewed considered menopausal symptoms had made their working life worse, and one quarter agreed they had considered leaving their jobs altogether because of the menopause. [18]

The intention to stop working due to problematic hot flushes has been cited as an issue in numerous studies.

The Strategy should introduce a requirement for mandatory menopause workplace policies to better support women in work and to break the stigma associated with menopause. Once [19] menopause policies are in place, the Strategy should outline how it will encourage and incentivise employers to develop further policies covering other women's health issues such as miscarriage, heavy menstrual bleeding and other gynaecological conditions.

As the largest employer in the UK, the NHS should lead the way in introducing a comprehensive suite of policies supporting women's health.

The coronavirus pandemic has had a disproportionate impact on women's employment, with a higher number of job losses among women. [20] Figures show women have also been furloughed at consistently greater numbers throughout the pandemic, and analysis showed that women were more likely to be furloughed for longer periods, had worse perceptions of

their job security during furlough, and had worse projected financial security than furloughed men. [21]

Data from the Office for National Statistics also showed that women's wellbeing was more negatively affected than men's during the first year of the pandemic, and women were more likely to spend significantly less time working from home, and more time on unpaid household work and childcare. [22] The Fawcett Society found that 35% of working mothers lost work hours due to a lack of childcare support during the pandemic. [23]

The Strategy must work in coordination with the Government's Plan for Jobs to support women to stay working or return to work, and ensure women's employment does not continue to be disproportionately impacted by the pandemic. This should include consideration of the recommendations made in the Women and Equalities select committee inquiry on the unequal impact of coronavirus. [24]

Ensuring research, evidence and data support improvements in women's health

Across the health and care system, there is consistent collection of data on women's health outcomes and experiences

Good quality data on the outcomes and experiences of women is essential to high-quality care, allowing health systems both locally and nationally to understand and improve care. Data should be used to support a life course approach to women's health. This approach provides an insight into the impact of the many biological, behavioural and social determinants of health and wellbeing and takes in to account the fact that events occurring at each stage of a woman's life have an impact on the quality of the next stage, and the clear evidence of a strong intergenerational transmission of both good and bad health behaviours and outcomes. **The Strategy must outline an approach to data across women's health; how it is to be collected, analysed and used to inform service design and delivery and to support individual women to remain healthy throughout their lives. This should include the continued roll-out of interoperable digital maternity records.**

It is essential that data is collected and can be broken down and analysed by ethnicity, age, geography and socioeconomic background in order to identify and respond to inequalities in outcomes and experience.

Research into diagnostics and treatment in healthcare gives equal weight to women's experiences and health, and we reach a point where the gender data gap no longer exists

Women's health outcomes and experiences are held back by an imbalance in research into women's health, both in terms of diagnostics and treatment. Closing the significant data gap in medical research should be a priority of the Strategy. **The Strategy should provide an action**

plan to ensure clinical research properly reflects society and ensures equitable investment in research into women's health, including addressing the ethnicity data gap.

These actions should include commitments from the Government to fund more studies focusing on women's health and responses to treatment, both in female-specific issues which have historically received low levels of research investment, such as endometriosis, as well as in conditions that may affect genders differently, such as cardiovascular disease. The Strategy should set out plans for a ring-fenced programme across relevant Government-funded bodies. This must be led by evidence of where gaps in research exist, and set clear targets for improvement.

Progress in research into gynaecological conditions has also been hampered by a smaller critical mass of gynaecological researchers compared to other specialties. **The Strategy should identify ways to invest in the next generation of women's health researchers.** This could include rolling out specific training fellowships, funding substantive women's health academic posts, and providing resource for women's health academic hubs and/or research centres. NHS trusts and wider health systems should also be incentivised to give clinicians the time and flexibility to undertake research alongside their clinical work, supporting clinicians who want to contribute to research to do so.

An action plan should outline how Government will support wider investment into women's health research, by working in partnership with charitable and private organisations to accelerate funding into women's health outcomes and experiences.

An additional area for attention is increasing levels of participation in research by women themselves and ensuring that a much more diverse group of women take part, to prevent future inequalities in care. **The Strategy should outline how it will influence ease of access into research and studies.** It should consider setting out best practice guidelines for involving women in research and clinical trials that addresses key factors such as compensation, information and communication and approaches to engaging with underrepresented communities. Further structured funding to gather insight into enablers for participation should be a priority.

Understanding and responding to the impacts of Covid-19 on women's health

The impact of Covid-19 on women's health services, including any backlog in care, is fully addressed

The impact of Covid-19 on women's health services has been significant, with all services affected to a greater or lesser degree by redeployment of staff, staff sickness and self-isolating and the implementation of Covid-secure measures for staff and patients. Many services have delivered parts of their pathways in different ways. The pandemic has inevitably created a backlog across the NHS, which includes the diagnosis and treatment of 'benign' gynaecological

conditions and gynaecological cancers, as well as access to primary care, SRH services, fertility services, perinatal mental health services and much more.

The Strategy must outline how women's services will be prioritised as part of the wider NHS recovery plans, ensuring women are not left at the bottom of the pile. This must include not only a plan to address the backlog, but also an approach to supporting women on waiting lists, for example supporting pain management and good communication.

The positive ways of working that have been developed or accelerated because of the pandemic are built into long-term service delivery

The pandemic changed the way women accessed some aspects of their care, with a significant increase in remote appointments across primary and secondary care. This is a huge opportunity to evaluate new ways of accessing care and potentially widen access and improve outcomes for women.

There have been some successes around remote care delivery, for example studies on the impact of temporary approval of the telemedicine pathway for early medical abortion show it was highly acceptable to women and had a positive impact on safety, accessibility and convenience. [25]

As with telemedicine abortion care, where services have been evaluated as being safe and effective, they should continue to be offered to those women who would like to take them up in order to widen access and improve outcomes for women in the longer term.

However, it is vital that new ways of accessing care are rigorously evaluated, and that health services develop flexible approaches to cater for the diverse needs of women. For example, studies of remote antenatal care have so far typically under-sampled groups who experience worse maternity outcomes, the same groups who are also at risk of being socio-economically and digitally excluded from care. This puts them at risk of disproportionately poorer outcomes from remote appointments where there is not clear evidence to the contrary. [26]

The Strategy should set out best practice for remote appointments in women's health, ensuring that it prioritises choice and ensures that all women are able to access a healthcare professional in person if this would be preferable to them. The use of remote appointments must be led by evidence of outcomes and the experience of patients, and adequate research into the experiences of remote appointments for marginalised groups must be undertaken.

The pandemic has also exposed the unsuitability of some parts of the NHS estate. Many pregnant women have had to attend scans and appointments alone because their local service was unable to accommodate visitors as well as operate adequate social distancing, causing a great deal of distress for women and families. **The Strategy should review maternity services, as a first step towards reviewing the whole NHS estate, and commit to upgrading facilities that have been demonstrably unsuitable.**

Key recommendations

The Women's Health Strategy should:

1. Ensure all women are listened to and empowered by the healthcare professionals who support them.

2. Ensure voices for women's health are built into governance and leadership structures at every level in the health service.

3. Commit to funding evidence-led campaigns and projects that aim to reduce stigma around women's health.

4. Identify and address gaps in high-quality information on women's health conditions and commit to creating a comprehensive, centralised resource that sits on the NHS website. This should include resources for clinicians.

5. Create a plan to improve the availability and dissemination of information to all girls and women with one or more protected characteristics, or from disadvantaged backgrounds and marginalised communities, including those in institutionalised settings.

6. Reinforce the requirement for the introduction of RSE in schools.

7. Mandate co-commissioning of SRH services and commit to a real terms increase in the public health budget, and ring-fenced funding for sexual and reproductive healthcare.

8. Accept the recommendation from the MHRA to make POP a pharmacy product.

9. Enable primary care networks to act as women's health hubs.

10. Outline an approach to improve access to information and support on pre-conception health, including implementation of mandatory fortification of all flour and gluten-free products with folic acid.

11. Outline how the DHSC and the Office for Health Promotion will work together to set priorities and develop and support initiatives to improve women's health.

12. Recommend targeted campaigns to increase screening uptake.

13. Set a target of a 50% reduction in the disparity in maternal mortality rates for

Black, Asian and minority ethnic women in the next five years.

14. Explicitly outline plans to understand, reduce and eliminate inequalities in access, experience and outcomes for women's services.

15. Introduce a requirement for mandatory menopause workplace policies.

16. Support women to stay working or return to work.

17. Outline an approach to data across women's health; how it is to be collected, analysed and used to inform service design and delivery and to support individual women.

18. Identify how to close the data gap in medical research and ensure equitable investment in research into women's health.

19. Set out best practice for remote appointments in women's health, ensuring that patient choice is respected.

20. Review the NHS estates used for maternity services.

References

1. Medical Xpress, Menopause discrimination is a real thing – this is how employers can help, 2019; de Salis et al, Experiencing menopause in the UK: The interrelated narratives of normality, distress, and transformation, 2018; British Menopause Society, A woman's relationship with menopause can be complicated (Infographic), 2017

2. Guidance: Relationships and sex education (RSE) and health education, UK Government, 2020 [Webpage, accessed June 2020]

3. Better for Women, RCOG, 2019

4. Guidance on the provision of contraception by maternity services after childbirth during the COVID-19 pandemic: Information for healthcare professionals, RCOG, RCM and FSRH, 2021

5. 'Our COVID-19 cloud silver lining': the initiation and progress of postnatal contraception services during the COVID-19 pandemic in a UK maternity hospital, BMJ Sexual and Reproductive Health journal, December 2020

6. Women's Lives, Women's Rights, Faculty of Sexual and Reproductive Healthcare, 2020

7. Media statement: Health Foundation response to the public health grant allocations, 2020 [Webpage, accessed June 2020]

8. Latest figures reveal government cuts to the public health grant, Advisory Group on Contraception, 2019

9. https://www.rcog.org.uk/globalassets/documents/guidelines/highqualitywomenshealthcareproposalforchange.pdf

10. Cervical Screening Programme in England, NHS Digital, 2019-20

11. Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population based cohort study, M Knight et al, 2020

12. RCOG, Position statement on racial disparities in women's healthcare, 2020

13. Looking at the health needs of LGBT women, Public Health England, 2017

14. Lipson et al, Pregnancy, birth, and disability: women's health care experiences, 2010

15. Redshaw et al, Women with disability: the experience of maternity care duringpregnancy, labour and birth and the postnatal period, 2013

16. Steinberg et al, Deaf mothers and reproductive healthcare: identifying inequalities and documenting experiences, 2006

17. How is work good for our health? The Health Foundation, 2018

18. ITV News, Quarter of women going through menopause 'considered leaving work', 2016

19. Better for Women, RCOG, 2019

20. COVID-19 and gender equality: Countering the regressive effects, McKinsey, 2020

21. Women losing out under furlough scheme, KCL, 2021

22. Coronavirus (COVID-19) and the different effects on men and women in the UK, ONS, March 2020 to February 2021

23. Coronavirus crossroads: Equal Pay Day report, Fawcett Society, 2020

24. Unequal impact? Coronavirus and the gendered economic impact, House of Commons Women and Equalities Select Committee, 2020

25. Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study, Aiken, A et al in BJOG. 2021; Acceptability of no-test medical abortion provided via telemedicine during Covid-19: analysis of patient-reported outcomes, 2021

26. Creating equitable remote antenatal care: the importance of inclusion, BMJ Blogs, 2021

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