Addressing unmet needs in women’s health
Addressing unmet needs in women’s health – foreword from Professor Dame Parveen Kumar

I am delighted to introduce these briefings on women’s health. They are a collection of papers given at the women’s health symposium held by the Board of Science at the BMA in May 2017. They are a timely reminder to focus attention on the health of women. In a period when the NHS is under enormous pressure across the UK, it is essential that we continue to assess whether the requirements of all patients are truly being met. In terms of meeting the healthcare needs of women, despite examples of excellent practice, it is clear from the evidence presented that there is much room for improvement. As this report demonstrates, the specific health needs of women can too often be overlooked. This is despite women spending more years than men in ill-health, and being more likely to come into contact with health services – mainly in their reproductive years.

The BMA’s Board of Science invited renowned experts from a range of specialist areas to speak at the symposium. We were struck by their clear illustrations of unmet needs and we asked whether some of the issues could be explored in more detail. I’m extremely grateful that the authors of the papers below agreed to our request, and have produced forward-thinking and evidenced calls for action that you will find throughout this report.

Taken as a whole, these papers demonstrate an urgent need to ensure that our healthcare system is able to respond to gender differences, can support women throughout their lifetime, is backed up by education, empowerment and the removal of stigma, and sits within the context of a society where the social determinants of health are recognised and addressed. For example, whilst it is vital that there is adequate staffing for cancer screening tests, the underlying risk factors for cancer present throughout society – such as obesity and smoking – also need to be tackled. Furthermore, understanding and addressing the interaction of these risk factors and rates of diagnosis with gender and inequalities is imperative.

I hope that this report is just the start of a conversation, of which the ultimate goal is to provide the best possible care for all – tailored to the needs of individuals, but with no variation in the quality of the care that they receive.

Professor Dame Parveen Kumar
Contents

Introduction.................................................................................................................................................4

Tackling violence against women – meeting unmet needs.........................................................14
Professor Nicole Westmarland and Dr Hannah Bows

Cancer in women – addressing unmet needs........................................................................21
Sarah Woolnough

Reproductive health and wellbeing – addressing unmet needs........................................35
Dr Sue Mann and Professor Judith Stephenson

Addressing unmet needs in women’s mental health.................................................................45
Professor Kathryn M. Abel and Dr Karen Newbigging

Health inequalities and women – addressing unmet needs..........................................................56
Dr Jessica Allen and Dr Flavia Sesti

Addressing unmet needs in global women’s health.................................................................67
Professor Lesley Regan
Addressing unmet needs in women’s health – introduction
Women’s health – introduction

Why focus on unmet needs in women’s health?
The BMA has a key role in advocating for healthcare services that meet the needs of the populations they serve, and in contributing to the development of effective policies that support improvements in population health. This has included work across a wide spectrum of health issues, from highlighting the current pressures being faced by the NHS, to calling for action on the social determinants of health.

Recent work from the BMA has, for example, demonstrated that investment committed to mental health has failed to reach frontline services, and called for the level of mental health funding to match the burden of disease. Similarly, we’ve called for the reversal of public health budget cuts and the establishment of minimum standards for public health provision across England after our analysis of public health funding highlighted that changes to public health spending were not meeting the needs of local areas, and were causing an unacceptable variation in quality and quantity of service provision. In 2016 the BMA Board of Science published a series of briefing papers, Growing older in the UK, which assessed the ability of the NHS to provide sufficient care to an ageing population and set out a number of recommendations, including ensuring the adequate coordination of health and social care, and providing appropriate support for people with long-term conditions.

Many of the healthcare and public health issues that the BMA has an interest in are pertinent to women’s health. For example, with regard to ageing, women are more likely to suffer with depression and dementia later in life and when analysing health inequalities we have previously highlighted the income effects on women’s health and lifespan and the effect of poverty on pregnancy. Some of our work has had more specific relevance to the health of women, for example, on alcohol and pregnancy, and on domestic abuse. This previous work hasn’t, however, had an overall focus on women’s health, and whether healthcare provision meets the specific health needs of women. Although, in general, women and girls have greater health and social care requirements in comparison to men across their lifetime, there are indications that health and social care services are not meeting their specific health needs. A 2017 investigation coordinated by the All Party Parliamentary Group on Women’s Health concluded that there were serious shortcomings in the provision of women’s physical, mental and gynaecological healthcare, finding that attitudes, lack of information and choice, and cost considerations and short-term thinking were the key issue areas. These shortcomings are all the more worrying in a climate of austerity, with cuts to local authority funding impacting on vital services such as women’s refuge centres and sexual health services. With a health and social care system under strain, and resources stretched, it is critical to ensure that the system is able to respond to the health needs of women. By making women’s health the focal point of analysis in the way undertaken by this report, it becomes clearer to understand where specific services are falling short and what can be done to address this.

Women’s health and equality

Sex is one of the nine characteristics protected from discrimination under the Equality Act 2010 in England, Wales and Scotland, and under the Northern Ireland Act 1998. This means that health and social care service providers cannot treat women or men adversely because of their sex. It does not, however, mean that men and women have to be treated the same. The provision of separate services for women (e.g. a family planning clinic) is objectively justified where providing a combined service (in other words one where men and women had exactly the same service) would not be as effective. Additionally, NHS and social care services have a public sector equality duty – to have ‘due regard’ to the need to eliminate unlawful discrimination and harassment, foster good relations and advance equality of opportunity in carrying out their functions. It is also important to acknowledge the vast range of factors which impact on women’s health and health inequalities – particularly ethnicity, religion, disability, sexual orientation.
The justification for ensuring that health services adequately serve women is clear. Women make up 51% of the overall population\textsuperscript{13} and 47% of the working population.\textsuperscript{14} As well as bearing children, women provide the majority of informal, unpaid care for children, sick or frail older relatives, and increasingly both.\textsuperscript{15,16} They are more likely to come into contact with health services than men,\textsuperscript{17} and yet are also more likely to miss appointments due to these caring responsibilities.\textsuperscript{18,19} Furthermore, as the landmark Marmot Review into health inequalities in England found in 2010 “there are also systematic gender differences in health outcomes”.\textsuperscript{20} The examples of these gender differences in outcomes are numerous. Although women live longer than men they spend a greater proportion of their life in poor health.\textsuperscript{21} Young women and girls are more likely than boys to experience sexual abuse, physical abuse or neglect.\textsuperscript{22} Adult women are over twice as likely as men to suffer from depression,\textsuperscript{23} and are more likely than men to suffer from chronic conditions such as arthritis and migraines.\textsuperscript{24,25} These examples indicate that a gender-focussed approach to assessing healthcare provision is highly relevant.
The BMA’s Board of Science hosted a symposium in May 2017 to discuss key issues associated with women’s health. The following papers – each authored by external experts – explore in more detail some of the major unmet needs in women’s health emerging from this meeting. Five out of the six papers have a UK focus, whilst the sixth helps to situate these issues within the global context.

1) **Tackling violence against women – meeting unmet needs** outlines the scale of the problem of gender based violence and some of the particular challenges that exist, and the role of healthcare professionals in identifying abuse and referring cases.

2) **Cancer in women – addressing unmet needs** examines the increase in cancer incidence in women which is responsible for almost 25% of female deaths, outlines preventable risk factors and differences in rates amongst more deprived women, and highlights the role of health professionals in helping women to recognise signs and symptoms of cancer.

3) **Reproductive health and wellbeing – addressing unmet needs** highlights the importance of reproductive health to wellbeing, recognises the variation and differentiation in women’s reproductive healthcare needs over the life-course, and calls for an integrated health system response.

4) **Addressing unmet needs in women’s mental health** explains why policies, services and practice need to be gender informed, co-designed by women and underpinned by clear leadership and accountability.

5) **Health inequalities and women – addressing unmet needs** explores the inequalities in health between women which are related to socio-economic status, ethnicity and geographic region, and calls for greater understanding of the effect of these social and economic factors on women’s lives by the health workforce.

6) **Addressing unmet needs in global women’s health** introduces the key issues in international women’s health in the context of the United Nation’s Sustainable Development Goals and demonstrates the improvements that could be made to women’s health through improved access to, and quality of, healthcare.

Although most of the themes discussed in these briefing papers are relevant across the UK, it is important to recognise the different political, legislative and cultural contexts in which healthcare is provided. Some of the specific detail in these briefings is therefore only relevant to some of the constituent nations across the UK. With regard to reproductive health, for example, abortion is lawful in England, Scotland and Wales provided the criteria in the Abortion Act 1967 are fulfilled, whereas abortion is lawful in much more limited circumstances in Northern Ireland. Devolution is also evident in mental health policy, with each country legislating through national-level laws – such as the Mental Capacity Act 2016 in Northern Ireland and the Mental Health (Care and Treatment) Act 2003 in Scotland – and also establishing their own strategies, such as the Five Year Forward View for Mental Health in England and the Together for Mental Health strategy in Wales.
Addressing unmet needs in women’s health: key areas for action

Each of the briefing papers in this series focuses on a particular aspect of women’s health, and sets out specific recommendations for action. However, emerging from these papers are a number of common themes, indicating the need to take action in the following broad areas to ensure the health needs of women are adequately met.

1) Ensuring the healthcare system is able to respond to gender differences and provide gender-specific services

An effective healthcare system needs to be able to recognise and respond to complex needs arising from biological and societal gender differences. Biologically, for example, there are certain cancers that solely or disproportionately affect women, such as breast cancer or ovarian cancer. Societally, women and girls are far more likely to be the victims of domestic violence. In reality these biological and social determinants rarely operate in isolation from each other, rather there are often sustained interactions between the two. For example, women bear a greater burden of reproductive ill health than men due to biology (such as during pregnancy) and this can be compounded by wider societal disadvantage (such as workplace discrimination around maternity leave). Research shows that recognition of, and response to, sex and gender differences improves healthcare provision, health research and population health policy. Healthcare systems must also be able to respond to the personal, cultural or religious preferences of female patients, such as providing a female doctor or nurse for intimate examinations if requested. Additionally, hospitals should ensure that the basic needs of their patients are met, and the BMA believes that this includes providing free sanitary products to in-patients.

2) Establishing integrated services to respond to complex needs throughout the life-course

Integrated health and social care breaks down the barriers between services so that the health system is better able to respond to the complex and changing needs of individuals throughout their lifetime. This is a development that the BMA has expressed support for, with the aim of improving communication and coordination between organisations so that patients can move around and through the healthcare system more easily. If successfully implemented in nations where it is not already in place, and continually improved in nations where it is, there could be positive outcomes for the health of women. Consistent, people-centred, locally available services that are able to establish networks across regional and organisational boundaries creates a system which can be proactive, rather than simply responding to the effects of poor health. Furthermore, women can be effectively supported throughout the life-course, rather than simply interacting with a fragmented system only when treatment is required. Cervical smear testing programmes have shown successful outcomes in reducing rates of cervical cancer, and coordinated approaches to maternal health and diabetes have led to better outcomes in pregnancy and birth. Multi-agency working and information sharing has the potential to prevent, and provide better response to, violence against women through improved service coordination between those responding to physical injuries, family doctors and social care providers. Similarly a system-wide, life-course approach with greater integration of primary care, gynaecology and sexual and reproductive healthcare could help to guarantee women’s reproductive wellbeing.

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The biological and societal notions of sex and gender are inherently complex, and changing. Whilst this report is ostensibly focussed on the healthcare needs of women, the BMA is at the forefront of ensuring that the health system is able to respond to issues affecting transgender people, including gender identity healthcare and services. For examples of this work, see our page on gender incongruence in primary care here, and our response to a government consultation on gender identity services here.
3) Enabling and promoting better health outcomes through improved education

Formal education can have a profound impact on health in two distinct ways. The first is through specific health education programmes. In the UK, this is primarily delivered through Personal, Social, Health and Economic (PSHE) education syllabuses, which includes topics on alcohol, tobacco, drugs and sex education among others. A 2015 Government review of PSHE suggested that it could have positive outcomes on physical and psychosocial wellbeing of pupils, which in turn can lead to better academic performance. School curricula could be improved through the compulsory inclusion of emotional and mental health education and high-quality, early, age-appropriate reproductive health education.

The second way education can improve health is through raising the general quality of education and amount of time spent in education, with global evidence demonstrating that the number of years spent in schooling is causally linked to better health outcomes. This is particularly pertinent to the health of women and girls, as globally females face more barriers to education and are more likely to be out of school and/or fail to complete their education. Research has demonstrated that increased levels of female education leads to reduced fertility rates and higher age of marriage and bearing a first child. In the Indian state of Kerala studies have shown how high levels of female education compared to the rest of the country have led to lower child and maternal mortality, improvement of children’s health and an increased domestic, political and workforce role for women.

This relationship is also closely linked to the broader social determinants of health, in particular the fact that education increases the skills, opportunities and earning potential of individuals and helps tackle intergenerational poverty. Furthermore, higher levels of education can have positive impacts at the societal public health level, through equipping people with the tools to change the environment in which they live to the benefit of all others who live around them. Global health could be improved through enhanced educational opportunity of women and girls across the world, in order for them to be able to make their own informed healthy choices, and as part of a wider programme to provide equal opportunities and end gender-based discrimination.

4) Removing stigma around women’s health issues, and empowering women and girls

Many issues related to women’s health are stigmatised, and this stigma can create barriers to women receiving appropriate care. Commonly, stigma can exist around sexual and reproductive health and mental health, and there can be particularly negative consequences where these two intersect. A 2015 investigation found that nearly half of surveyed expectant mothers with symptoms of antenatal depression did not speak to their nurse or midwife about it due to the stigma attached to reporting such conditions. Strategies for overcoming this include reframing stigmatised areas of discussion, such as those around reproductive health, through positive conversations. Similarly, women’s global health can be improved through the empowerment of women and girls so that they are able to make healthy choices and take control of their own healthcare.

5) Tackling the social determinants of health

The social determinants of health underpin many of the health inequalities present in the UK, and across the globe. Research on women’s cancer shows that women from lower socio-economic strata are less likely to take up offers of cancer screenings, thereby increasing their potential for the disease to go undetected. Income can also have a damaging effect on mental health. Women are overrepresented in lower paid, lower skilled jobs which leaves them earning less than men and this can have negative health and social impact: women in the lowest bracket of earnings are 2-3 times more likely to experience mental ill-health than men in the top income bracket. Additionally, women’s greater share of domestic labour and unpaid care for children and older or disabled relatives has a negative effect on their mental and emotional well-being.
For **reproductive health**, the notion of ‘period poverty’ (when females are unable to afford basic sanitary supplies during their period, to the detriment of their health, hygiene and wellbeing)\(^{50}\) exists at the intersection of the social determinants of health and gender. The [Scottish government committed in 2018](#) to providing free sanitary products to women from low-income homes, and in schools, colleges and universities, in a bid to end period poverty, and a similar initiative is to [be piloted in Wales](#). However, the same cannot be said for England and Northern Ireland, and the BMA is one of a number of organisations [calling for the](#) universal provision of sanitary products across the UK.

As the Marmot Review found, gender differences in health arise from “particular exposures and discriminatory practices that compound existing socioeconomic disadvantage”\(^{51}\) – tackling these underlying inequalities will be the key to beginning to meet the healthcare needs of women.
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Tackling violence against women – meeting unmet needs

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Tackling violence against women – meeting unmet needs

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Key Messages:

- Responding to the scale of the problem is the largest challenge facing healthcare – further improvements are needed in terms of multi-agency working and information sharing.
- Particular challenges exist around responding to non-recent violence and abuse, non-physical forms of abuse, and working with an ageing population.
- The healthcare system is used by those perpetrating violence and abuse as well as those experiencing it. GPs are particularly likely to come into contact with perpetrators and need training and resources to make appropriate referrals.

Introduction

‘Violence Against Women’ is an umbrella term used to describe ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life’. As well as domestic violence and abuse, it also includes (but is not limited to) rape and sexual abuse, crimes against women and girls based on notions of ‘honour’, forced marriage, forced prostitution and trafficking, female genital mutilation (FGM), and sexual harassment.

Historically, healthcare responses to violence against women have focused predominantly on domestic violence and abuse. Twenty years ago, in 1998, the Board of Science and Education of the British Medical Association led in the development of healthcare responses to domestic violence in their influential report ‘Domestic violence: a health care issue?’. This report was crucial in elevating the status of domestic violence amongst healthcare practitioners as well as managers. Today, it is recognised that there are a broad range of forms of violence and abuse against women and that these represent serious, global, public health issues. It is therefore an appropriate time to take stock of unmet needs in tackling violence against women.

Understanding the scale of the problem

Knowing the exact scale of violence against women is difficult due to systemic underreporting and definitional issues. There are many reason why women and girls may not report experiences of violence, including: fear of retaliation, feeling their experience is not serious enough, an ongoing relationship with the perpetrator, not recognizing their experiences as abusive, and/or (misplaced) feelings of embarrassment. Women who do not speak English as their first language, women with disabilities, women from minority ethnic communities, and women with insecure immigration status face additional barriers.

In light of the high levels of underreporting of violence against women, victimization surveys are generally viewed as a more reliable source of data. The most accurate data available comes from a European-wide survey, which found that an estimated 13 million women in the EU have experienced physical violence in the course of the previous 12 months (approx. 7% of women aged 18-74). Furthermore, 3.7 million women have experienced sexual violence and 9 million women have experienced stalking in the previous 12 months. In the UK, 8% of women had experienced physical and/or sexual violence and 5% of women had been stalked in the previous 12 months. Data from the Femicide Census reveals that violence against women is one of the leading causes of premature death of women.
Data on the extent of forced marriage is even more difficult to gather with accuracy, but The Forced Marriage Unit reported giving advice or support in relation to 1,428 cases of possible forced marriage in 2016 alone.\(^5\) There is similarly little available data on the extent of Female Genital Mutilation, however the NHS reports 1,971 women attending NHS trusts or GP practices between July and September 2016 where FGM was identified or a procedure for FGM was undertaken.\(^6\) These figures should all be understood as underestimates.

Research has linked violence against women to a range of physical and mental health problems including depression, emotional distress, and suicidality, as well as injuries, pain and long-term health conditions.\(^7\) Sexual violence increases risk for a range of physical health problems, including sexually transmitted infections or diseases, vaginal bleeding, urinary tract infection, miscarriage and neonatal death.\(^8\) Mental health impacts of rape include suicidality, flashbacks, anxiety, depression and panic attacks.\(^9\) The health impacts of intimate partner violence (IPV) have been most researched and therefore has the strongest evidence base, showing a complex relationship whereby IPV can: a) lead to adverse health effects, b) worsen pre-existing health conditions, or c) lengthen the duration of IPV exposure for women who are depending on partners due to illness or disability.\(^10\) It is important to remember that not all women have equal access to safety and freedom or the resources or ability to leave.

**Responding to the scale of the problem is the largest challenge facing health care**

The scale of the problem raises different problems depending on the recency of the violence and abuse. Different healthcare responses are needed for someone who is at immediate risk of serious harm or homicide or who has just sustained life threatening physical injuries compared to someone who has experienced years of sexual abuse as a child, has been living in a forced marriage for ten years, or is experiencing long-term post-traumatic stress.

To date, there has been more attention placed on acute needs than chronic conditions, however the healthcare burden needs to be recognised as falling heavily across each of these areas. Failing to do so is leaving a huge level of unmet need which weighs heavily on mental health provision and voluntary sector organisations.

**Responding to acute needs through multi-agency working**

Responding to acute needs includes treating immediate physical injuries, an active involvement in managing risk through liaison with partner organisations and supporting the collection of any forensic medical evidence. It also means dealing with situations that change from being chronic to acute or become acute because of a previous lack of knowledge, for example if a woman who has experienced Type III FGM (narrowing of the vaginal orifice with a covering seal created from the labia minora or majora) goes into labour without previous knowledge of her condition or if a person who has experienced child sexual abuse or exploitation becomes suicidal.

While acute needs have arguably been better responded to than chronic needs, there are still a number of improvements that can be made, particularly around multi-agency working and information sharing. Where there is an ‘instinct’ that something is wrong but no disclosure or direct evidence, it is the piecing together of the multi-agency picture that becomes crucial.

An extreme example of this is the case of Mr X (anonymised in order to protect the identity of his daughters) who was given 25 life sentences in 2008 for the repeated rapes of his two daughters over a 27-year period. The abuse continued into adulthood and the rapes began to result in pregnancies. Between them, they had nineteen pregnancies and nine children (two of which died at birth). A serious case review showed that a number of organisations had information, including the family doctor and medical staff involved in their maternity care, and that there had been missed opportunities to intervene. In total, the family had received input from 28 different agencies over a 35-year period. Some of the family had long term health problems and therefore had a number of healthcare practitioners involved in their lives. The sisters were specifically asked about the paternity of their children on 23
separate occasions, and 7 allegations of incest/sexual abuse were reported to professionals during this time by family members and other professionals. Some of the babies died at birth because of genetic disorders that could only occur when both parents carry a particular genetic abnormality, and two of the seven that lived have severe physical disabilities. The review summarised:

‘The Serious Case Review identified that there existed a culture of ‘having a quiet word’ where informal unwritten information was passed between services sometimes because the professional did not have the understanding or knowledge to escalate the concern, particularly as the belief was that the evidence was either not there to investigate (genetic, DNA) or that the situation had been investigated by the police with no further action required or possible.’

Domestic Homicide Reviews (DHRs) have also pointed to healthcare, particularly GP surgery staff, as stakeholders that are consistently and actively engaged with victims and perpetrators. Sharp-Jeffs and Kelly argue that those in primary health are in a unique position to identify and respond to people at risk, but that in over half of the cases in their analysis of 32 DHRs GPs had failed to ask victims about domestic violence.

One way in which healthcare practitioners can engage in multi-agency working around acute needs is through the Multi Agency Risk Assessment Conference (MARAC) process. However, research shows that while healthcare practitioners do engage in the conferences, they very rarely refer cases into the MARAC process. Data obtained for this paper (personal communication with SafeLives) shows that little progress has been made in terms of MARAC referrals from health over the last decade: in 2008 just one in fifty referrals was from primary (1.6%) or secondary healthcare (0.4%) and this has now risen to one in twenty-five (2.5% from primary and 1.5% secondary healthcare). Greater awareness and proactive engagement (including referrals) from healthcare with existing MARAC processes is a place where some immediate leaps forward could be made.

Responding to non-recent violence and abuse

The last five years has seen a steep rise in the number of disclosures of non-recent violence and abuse (previously called ‘historic’ abuse). Cases that have received particular attention, such as the sexual abuse perpetrated over many decades by Jimmy Savile and the related Operation Yewtree investigation, have all led to a greater acknowledgment that abuse is not always reported at the time it happens, and that survivors can live with the effects of abuse for many years or even decades before telling anyone. Sometimes attempts were made at the time to speak out, but those attempts were silenced. This represents a new ‘breaking of the silence’ on a colossal scale and brings with it both opportunities and challenges.

In terms of opportunities, a new openness, willingness to hear, and reduced stigma associated with being a survivor of non-recent violence or abuse – particularly sexual abuse – can lead to better identification and management of symptoms. The need to respond to the ‘root cause’ of the problem has been an objective since the cross Government ‘Victims of Violence and Abuse Prevention Programme’ 2004-2007, but one that is now closer to being realized as it becomes more possible to speak out and be believed.

Armed with the knowledge of the widespread nature of non-recent abuse, there is also the opportunity to think laterally and create changes in key areas of routine and/or women’s health. For example: forced penile penetration of the mouth (legally classed as rape since 2005) might make survivors reluctant to engage in dental check-ups; female genital mutilation or forced vaginal penetration by a penis or other object (legally classed as rape since 2005) may make survivors reluctant to engage in sexual health screening such as smear tests, seek help where diagnosis or treatment may involve trans-vaginal scans (e.g. Early Pregnancy Unit scans or IVF); a fear of childbirth linked to a lack of control following sexual abuse may result in a higher level of requests for caesarean sections; a jealous and controlling partner may prevent a woman being able to commence or continue
breastfeeding an infant. For women from ethnic minority groups, there may be additional difficulties for disclosing abuse including a fear or distrust of healthcare providers, language barriers and cultural norms and attitudes.  

In terms of challenges, the scale of the problem means that many of those who are now disclosing non-recent sexual abuse are being placed on waiting lists that can be very long. There is not the provision to meet the need within the healthcare system, and the passing on to the historically under-resourced voluntary sector is creating a bottleneck. Therefore, without additional service provision to deal with the scale of the problem, the opportunities to think laterally and to reduce the long-term effects cannot be fully realized.

**Dealing with non-physical forms of abuse**

In 2013 the Government definition of domestic violence and abuse changed to include coercive control, and in 2015 a new criminal offence was introduced of ‘Controlling or Coercive Behaviour in an Intimate or Family Relationship’, punishable by up to five years imprisonment. Coercive control refers to the micro-regulation of the way a woman lives her life – from what she wears, where she can go, what she eats, whether she can work, how she parents, and who she sees. People who are experiencing coercive control describe doubting their own judgement, feeling worthless, having low self-esteem, high levels of stress and anxiety caused by a constant feeling that they are ‘walking on eggshells’.

There is a need for health professionals to be more aware of the seriousness of coercive control. Spanish researchers have shown that if health professionals were able to identify this form of violence at an early stage, the long term negative effects on women’s health could be minimized but note that research on psychological victimization has tended to receive less attention and be under-researched. They suggest that healthcare professionals should be encouraged to ask about domestic violence where there is no physical or sexual violence, but women report symptoms such as mood swings, crying without reason, irritability, insomnia or permanent fatigue.

**Working with an aging population**

Older women have been absent from the majority of research, policy and practice developments around violence against women. One of the reasons violence against older women has been invisible is because the problem of violence is not recognized until it becomes ‘subsumed under the category of elder abuse’.

Violence against older women may be perpetrated inside or outside the family. Some older people may be socially isolated which can increase their risk of abuse whilst at the same time reducing their opportunities for disclosure. Both primary and secondary healthcare practitioners may be the only agencies older people have contact with. In particular, those in community-based healthcare positions who may visit older people in their homes are uniquely placed to be able to identify the signs of abuse and may receive disclosures from older survivors.

It is important that healthcare practitioners are aware of the additional problems age can create for older survivors. It may be more difficult to identify abuse because of health issues associated with aging. For example, physical injuries, bruising or cuts may be associated with trips or falls rather than abuse. Moreover, older people with dementia may find it more difficult to disclose abuse or articulate their experiences and may be more likely to be dismissed or not believed when they do. Generational norms and attitudes may also create difficulties for older women disclosing abuse.
Putting perpetrators into the (healthcare) frame
There has been a tendency to focus on victims/survivors rather than perpetrators of violence against women across all professional and practice sectors, including healthcare. This has long-term implications in terms of the continuation of violence against women— for example one woman may be supported to leave an abusive relationship but if there is no response to the perpetrator then the violence may start again against a new partner. While criminal justice responses to perpetrators are improving, it is still the case that criminal convictions are rare for all forms of violence against women. For example, there have been very few convictions for forced marriage, the rape conviction rate is notoriously low, and there has never been a successful conviction for female genital mutilation (despite a number of UK clinics openly advertising these procedures). Although there is limited research on responding to perpetrators, what does exist suggests healthcare practitioners are ideally situated. For example, research by Hester et al. found that 83% of the convicted domestic violence perpetrators they interviewed had contacted their GP for help. However, GPs often did not know how to respond or made inappropriate referrals. Appropriate referrals for domestic abuse perpetrators are referred to in the NICE quality standard [QS116]: ‘referral to specialist services for people perpetrating domestic violence or abuse’ (Quality statement 4) and research on accredited domestic violence perpetrator programmes in the UK shows encouraging findings. However, there is more work to be done on the awareness and availability of such services, and responses to perpetrators of other forms of violence against women is currently even more lacking.

Actions for healthcare professionals
— All healthcare practitioners need to be alert to the impact that violence against women might have on their area of practice.
— Practitioners should be aware of the negative health effects non-physical violence and abuse — particularly ‘coercive and controlling behaviour’, which is now a criminal offence.
— It is important to remember that not all women have the same access to safety and freedom, or the resources or ability to leave.
— Violence against older women may be more difficult to identify because of health issues associated with ageing, and healthcare practitioners should be alert to the signs of violence against women across the lifespan.
— GPs are particularly likely to come into contact with perpetrators and need to be given the training and resources needed to respond appropriately.

Actions for policy makers
— Focus should continue to be expanded to all forms of violence against women and not solely on domestic violence and abuse.
— Funding arrangements should recognise the resources required for responding to chronic health care needs.
— There is a particular challenge around responding to the scale of non-recent sexual abuse.
— Increased confidence is needed around multi-agency working and information sharing - including referrals into the MARAC process.
— Awareness of violence against older women needs to be increased and ageist assumptions should be challenged through training. General training on violence against women should include older women as case examples.
— More focused attention on perpetrators of violence and abuse is needed.
References

8. Ibid
Cancer in women – addressing unmet needs

Sarah Woolnough
Executive Director, Policy and Information, Cancer Research UK
Cancer in women – addressing unmet needs

Sarah Woolnough, Executive Director, Policy and Information, Cancer Research UK

Key Messages:

On average in the UK, a woman is diagnosed with cancer every three minutes, and every seven minutes a woman dies from cancer.

This paper highlights the increase in cancer incidence in women and the projected rise in cancer cases over the next 20 years. It outlines preventable risk factors and differences in rates amongst more deprived women, including specific gynaecological cancers. Cancer is the most common cause of death in women but cancer treatment is more successful and survival higher when the disease is diagnosed at the earliest stage. We therefore highlight that:

– More focus is required to prevent cancers in women, especially through smoking cessation programmes and tackling rising obesity.
– It is imperative to have the right diagnostic capacity and resources for the projected rise in need for services to make sure this is not a cause of avoidable delays in their diagnosis and treatment.
– Health professionals have a crucial role to play in helping women to recognise signs and symptoms of cancer, to be aware of the benefits of the national screening programmes and encourage awareness and adoption of NICE guidelines amongst fellow professionals.

We must keep striving to reduce the impact of the disease; preventing cancer and diagnosing earlier to give the best chance of securing a curative treatment, long term survival and improved quality of life.

Cancer in Women 

Incidence

In 2015, around 177,000 new cases of cancer were diagnosed in women in the UK. Breast, lung and bowel cancers together accounted for 54% of cases. Gynaecological cancers (cervix, uterus, ovary, vagina and vulva) accounted for 12% of cases.

Age-standardised rates have increased over the last decade in the UK for the two most common cancers in women; by 6% for breast and 18% for lung.

Figure 1. Ten most common causes of cancer in women, UK, 2015

This chart excludes non-melanoma skin cancer because of known under-reporting. Data in this chart do not sum to the all cancers combined total provided elsewhere, because ‘Brain, other CNS & Intracranial’ includes tumours that are malignant, benign and of uncertain or unknown behaviour but only the malignant tumours are included in ‘all cancers combined’ total.
Cancers of the uterus and ovary are the 4th and 6th most common cancers in women respectively. Whilst ovarian cancer incidence rates have fallen slightly (5%) over the last 10 years, uterine (womb) cancer incidence is rising rapidly; rates increased by 56% over the last 20 years and 21% over the last decade. Along with the increase in obesity, increased use of tamoxifen and a decline in the rates of hysterectomies for sterilisation or treatment of heavy menstrual bleeding are also contributors to this rise.

Figure 2. Womb cancer incidence rates and obesity prevalence, women, England, 1995 – 2015

**THE RISING LEVELS OF OBESITY AND WOMB CANCER**

- **Number of womb cancer cases per 100,000 women in England (Blue bars)**
- **% of overweight and obese women aged 16 and over in England (Red line)**

17% increase in the proportion of overweight and obese women (over 20 years)

55% increase in womb cancer rates (over 20 years)

Mortality

Cancer is the most common cause of death for women, causing 26.2% of deaths in 2016 in England and Wales. It is the biggest cause of avoidable deaths in women, accounting for 40% of all deaths classified as avoidable and over 50% in women aged 15 and over in 2015. There were around 77,900 cancer deaths in women in 2016 in the UK. Lung cancer was the most common cause of cancer death, followed by breast and bowel.
Figure 3. Ten most common causes of cancer death in women, UK, 2016

Gynaecological cancers accounted for 10% of cancer deaths (around 8,000). Reflecting the rise in incidence rates from the early 1990’s, mortality rates from cancer of the uterus have increased by around 21% over the last 20 years. This is expected to continue to increase over the coming years and is projected to be the 6th most common cause of cancer mortality in women by 2035.5

Deprivation
Cancer incidence and mortality rates are higher amongst more deprived communities compared to the least deprived for many cancers in women. Risk factors contribute to differences by deprivation. The three cancer sites showing the largest difference between least and most deprived for both incidence and mortality all have smoking as a risk factor.6

Figure 4. Percentage Deprivation Gap in European Age-Standardised Incidence Rates, Statistically Significant Cancers, Women, England, 2006-2010
Incidence is lower for the more deprived for cancers of the brain, breast and skin. For breast cancer, age-standardised cancer incidence rates are 14% lower amongst the more deprived compared to the least deprived. Breast screening uptake plays a role in this difference with more deprived women less likely to attend breast screening. Screening uptake is also likely to contribute to the difference in the mortality rate for breast cancer by deprivation, with higher mortality observed for women who are more deprived, indicating a later stage disease diagnosed.

**Survival**

Trends in cancer survival can help to identify progress in diagnosis and treatment, and provide an indication of those cancer types where more work is urgently needed.

The latest survival figures show that just over half (54%) of women diagnosed with cancer survive their disease for ten years or more. This is a huge improvement since the 1970s when 10-year survival was only 28%. However, this overall figure hides the enormous variation in survival between cancer types. For many sites, survival at five years, and even at one year, can be very poor, for example survival of pancreatic cancer in women is estimated at 25% for one year and only 7% at five years.

There have been substantial improvements for some cancer sites. Ten-year survival estimates for women with breast cancer in the 1970s was 40%, whereas today that figure stands at 81%. For women with bowel cancer, ten-year survival has increased from 22% to 57%. Whilst over the last 40 years lung cancer survival has doubled, it has increased from just under 3% to 7% highlighting the need to improve earlier diagnosis and treatment.

Survival estimates for gynaecological cancers differ by site. Around 78% of women diagnosed with uterine cancer survive their disease for 10 years or more compared to only 35% of women diagnosed with ovarian cancer. Differences are also evident at one year with survival estimates at 90% and 69% respectively.

**Figure 5.** Age standardised 10-year survival for all cancers combined and the three most common cancers in women in England and Wales, 2010 – 2011

Future burden

Projections show that by 2035, nearly 244,000 new cases of cancer will be diagnosed each year in women, an increase of 36%. Our growing and ageing population is behind much of the predicted increase in the number of cancer cases.
The proportions of different cancers in women are projected to remain fairly consistent with today. With increasing cancer incidence trends in breast, lung and bowel cancers over the last decade, these are expected to remain as the most common cancers. Uterine and ovarian cancers are projected to still be amongst the more common cancers in women.

The rates of cancers which can be linked to infection with certain forms of the human papillomavirus (HPV) are also increasing, making them among the fastest growing challenges. It is hoped that progress in prevention measures mean that the figures are an overestimate, for example, the full benefits of the HPV vaccine programme for girls are yet to be realised which is likely to affect the current projected increase in cervical cancer incidence.
A spotlight on the evidence and key opportunities for improvement

Prevention

Around 4 in 10 cancer cases in the UK could be prevented, largely attributed to potentially modifiable risk factors. A radically upgraded prevention effort will therefore be critical in reducing the impact of the disease in the coming decades.

Figure 7. Risk factors for preventable cancers, UK
Tobacco smoking
Tobacco smoking is the biggest preventable cause of cancer in the UK. Around 22,000 cancer cases in UK women each year are linked to smoking. In 2017, 13.3% of UK female adults smoked cigarettes.\textsuperscript{10}

Over the last decade, lung cancer incidence rates have increased by 18% but are now expected to have reached their peak. This follows the trend in smoking prevalence in females which was highest in the late 1960’s.

Smoking contributes to at least fourteen cancer types other than lung cancer. To reduce the future burden of smoking-related cancers it is vital to prevent uptake of smoking and help female smokers quit through properly resourced smoking cessation services.\textsuperscript{11}

Obesity
Overweight and obesity is the second-biggest preventable cause of cancer in the UK. Being overweight or obese causes thirteen different types of cancer in women with around 13,200 cancer cases in UK women each year linked to excess bodyweight. In 2015, around 6 in 10 UK women were overweight or obese\textsuperscript{12} and this is projected to rise.\textsuperscript{13}

Breast, ovarian and uterine (womb) cancers are associated with excess bodyweight. To prevent the future burden of overweight-related cancers, it is of paramount importance to reduce the proportion of women who are overweight and obese. Obese children are more likely to be obese adults so early intervention through a comprehensive plan to tackle childhood obesity should be a priority for government.

Early Diagnosis
Patients diagnosed at an early stage have the greatest chance of receiving potentially curative treatment and improved quality of life.

Over 90% of women recognise one of the main signs or symptoms of cancer.\textsuperscript{14} These include an unexplained lump, change in bowel habit, mole changing appearance, unexplained bleeding and unexplained weight loss. Previous surveys show that the majority of women report that they would seek medical help within two weeks.\textsuperscript{15} There are, however, barriers that are cited in seeking medical help. The most commonly reported barriers for women were difficulty in getting an appointment (45%), difficulty getting an appointment at a convenient time (46%), and not wanting to talk to the doctor’s receptionist about symptoms (46%). Additionally, lower awareness of cancer symptoms and reporting more potential barriers were associated with longer intended delays in visiting a doctor, suggesting that increasing awareness and reducing perceived barriers could help improve earlier presentation.

Stage at diagnosis and survival
Stage at diagnosis has a significant impact on one-year survival. The figures are especially stark for bowel and lung cancer.
For those cancers where stage of disease is recorded, just over half of patients (54%) in England are diagnosed at an early stage (1 and 2) each year, however, there is substantial variation in the stage distribution between cancer types.

**Figure 8.** Stage-specific survival for women in England, 2014

**Figure 9.** Stage at diagnosis for women in England, 2012-14
Variation between sites reflects differences in symptomatology, rate of progression, and over diagnosis as well as the availability of effective diagnostic tests and screening programmes.

More diagnosis of early stage cancers is only positive when it translates into fewer cancers diagnosed at a late stage and fewer women dying from cancer. Striving to pick up lots of early stage cancers comes with the risk of increasing over diagnosis – identifying (and usually treating) women whose cancer may never have gone on to cause them any harm. Over diagnosis also has broader implications for health service resource. Evaluation of early diagnosis efforts such as the advances in imaging techniques must take over-diagnosis into account.

**Bowel screening**
Randomised controlled trials of the bowel screening programme have shown a mortality reduction of 25% in those who participated in the faecal occult blood test (gFOBT).17

The uptake for bowel cancer screening remains lower than the UK’s other national screening programmes. In 2013-2015 overall uptake of gFOBT amongst women varied across Great Britain from 55 to 61%.18 This was higher for women compared to men but much lower than other screening programmes, for example breast screening uptake in the UK varied from 70 to 74%.19,20

Improving participation in the bowel screening programme represents a huge opportunity to increase the number lives saved from bowel cancer through earlier diagnosis. Around six in ten women are aware of the bowel screening programme, this is higher in the screening age range.21 The introduction of Faecal Immunochemical Testing (FIT), as a more straightforward test, should help improve and reduce inequalities in uptake but other efforts are also required.

Bowel screening relies on endoscopy services, as patients with an abnormal screening result require a colonoscopy for diagnosis. Planning for the future colonoscopy capacity is paramount to gain the most from the screening programme.

**Cervical screening**
Since the introduction of the NHS cervical screening programme in 1988 cervical cancer mortality rates have decreased by 69%. Women diagnosed through the cervical screening programme have a higher 3-year relative survival than those diagnosed via any other route22 and it is estimated that at least 2,000 cervical cancer deaths are prevented in the UK each year through screening23.

Despite the overall success of the programme, cervical screening coverage has been declining across England and Scotland for several years and has not reached its 80% target in England since 200924; comparable data for Wales and Northern Ireland are not publicly available. There are also disparities in coverage, with geographical variation in participation25 and ethnic minority groups less likely to take part.26

Evidence suggests that using HPV as the first line test followed by a cytology test in HPV-positive women will be a more effective way of screening (unlike the current programme configuration). Scotland, England and Wales have committed to introducing this test in 2019.

**Breast screening**
The latest figures show that over 2 million women were screened by the NHS Breast Screening Programme (BSP) in 2016-17, an increase of 1.8% on the previous year. Of those, around 18,400 women were diagnosed with breast cancer.27

Women who present through the breast screening programme are more likely than those diagnosed following a 2-week wait referral appointment from their GP to be diagnosed at stage 1: 62% compared to 27%.28 It has also been estimated that there is a 20% reduction in breast cancer mortality in women who participate in screening.29
Although the BSP’s acceptable standards of uptake of ≥70% have been achieved nationally, overall screening uptake has fallen over a 10-year period from 73.6% to 71.1% in England. In particular, uptake for women receiving their first invitation to breast screening fell from 69.1% to 62.6%.27,30

The breast screening programme has attracted controversy about the balance of harms and benefits. In 2012, the Department of Health and CRUK jointly convened the Independent Review of Breast Screening which found that for every life saved through the UK breast screening programme, three women are over diagnosed.31

Across all programmes, a commitment to informed choice with respect to participation is essential and to communicate appropriately that screening has both benefits and harms.

**Recognition, management and referral of patients**

Most cancers are diagnosed symptomatically, however, it is estimated that on average a GP sees less than ten new cases of cancer per year in the UK. Primary care needs the relevant support and resources to be able to respond to and refer patients appropriately.

NICE’s updated cancer recognition and referral guidelines in 2015 advocate for a lower referral threshold (3%) than in previous guidelines (5-10%). Although there has been a positive shift in GP culture on this topic and acknowledgement of the need and value of swift and appropriate management of patients, variations in practice remain and evidence suggests that a significant proportion of practices are not yet meeting these updated guidelines.

In secondary care, ensuring the timely diagnosis of a patient subsequent to their first presentation to the health service is key to achieving earlier diagnosis. Evidence suggests that within this diagnostic interval there is room for significant improvement.

**Actions required**

The UK can do better now to diagnose cancer earlier and radically upgrade our prevention effort. Action from the government and national decision makers is crucial to addressing this.

**Policy**

Recommendations for top priorities for government and national decision makers are:

- Diagnostic services are already struggling to keep up with growing demand and demand for tests is only going to increase. Ensure there are enough staff to carry out diagnostic tests, through a more strategic approach to workforce planning in the longer term, as well as actions to address immediate shortages in specific groups, especially radiology, radiography, endoscopy and pathology.
Halt cuts to the Public Health Grant. Local authorities in England are facing a reduction of £531 million to their budgets until 2020/2021 when the Public Health Grant will be cut entirely. Almost 60% of local authorities have cut their smoking cessation budgets. Stop Smoking Services offer smokers the best chance of quitting, and are around 3 times more effective than quitting with no support.\textsuperscript{32}

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**TOBACCO COSTS SOCIETY OVER £11BN A YEAR**

- Smoking related illnesses
- NHS hospital admissions
- Sick days from work
- Social care burden

**HALT CUTS TO THE PUBLIC HEALTH GRANT TO SAVE STOP SMOKING SERVICES NOW**

Source: Tobacco Control Plan for England

**LET’S BEAT CANCER SOONER**
cruk.org/dontquitonus

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Take steps on obesity: with the Soft Drinks Industry Levy achieved, we must evaluate impact. Cancer Research UK’s research shows introducing a tax of 20% on sugary drinks could prevent 3.7 million cases of obesity by 2025\textsuperscript{33}. Implementation of the reformulation programme and rebalancing price promotions away from unhealthy foods to healthier choices are important steps.

Health professionals

Alongside recommendations for policymakers, health professionals play a crucial role and recommendations include:

- The role for primary care endorsement and involvement in supporting informed uptake of bowel screening. This includes practices giving permission for their details to be included on bowel screening letters and projects to proactively contact those who have not responded to their screening invitation, but could also include proactively raising the topic of bowel screening during the course of routine health care.
- Continued focus on raising awareness and adoption of the revised NICE guidelines.
- Health professionals play a key role in encouraging smokers to think about stopping and organising appropriate referrals.
- Similarly, having discussions with patients about how to eat more healthily and incorporate more activity into their daily lives will become increasingly critical to tackle obesity.
References

1. Unless otherwise stated, figures provided throughout the paper are for UK from Cancer Research UK. Cancer incidence refer to 2015 and mortality figures refer to 2016 unless specified. [https://www.cancerresearchuk.org/health-professional/cancer-statistics-for-the-uk](https://www.cancerresearchuk.org/health-professional/cancer-statistics-for-the-uk)


4. Number of avoidable deaths by broad cause group, sex and 5-year age group, England and Wales, Office for National Statistics [https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/thenumberofavoidabledeathsbybroadcausegroupsexand5yearagegroupenglandandwales](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/thenumberofavoidabledeathsbybroadcausegroupsexand5yearagegroupenglandandwales)


13. Cancer Research UK, projected from trends on obesity using data from Health Survey for England

14. Cancer Research UK’s Cancer Awareness Measure


23 Calculated by the Statistical Information Team at Cancer Research UK, by extrapolating to UK data the number of cervical cancer deaths within 5 years of diagnosis in England, from Landy et al. (2016)


   http://digital.nhs.uk/catalogue/PUB22414


31 http://www.cancerresearchuk.org/about-cancer/breast-cancer/screening/screening-2012-review


Reproductive health and wellbeing – addressing unmet needs

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Reproductive health and wellbeing – addressing unmet needs

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Key Messages:

– Reproductive health is vital for wellbeing, to prevent morbidity and maintain economic productivity. It encompasses pregnancy-related health, some aspects of sexual health and health unrelated to pregnancy.
– Age-appropriate education for reproductive health should start as soon as understanding develops and be continued into adulthood.
– Universal care in reproductive health is important in meeting women’s contraceptive, preconception, screening and menopause care needs.
– Provision of socially or medically complex reproductive health care, such as fertility treatment, later abortion and menopause care, should be distributed in a way that prioritises those with the greatest need to help reduce inequalities in access and outcomes.
– Current indicators of reproductive health are not adequate for measuring reproductive wellbeing at population level. New measures are being developed but further work is needed to evaluate and implement them.

Introduction

Reproductive health affects both men and women but women bear the brunt of reproductive ill health, not only as a result of their biological status but also because of a wider social, economic and political disadvantage. There are public health, human rights and economic reasons for investment in reproductive health. In the UK, women make up 51% of the population and 47% of the working population.1 Whilst the Maternity Review2 has focused efforts on improving healthcare for women and their babies during the crucial period of pregnancy and childbirth, the greater proportion of women’s lives exists outside these events. Reproductive wellbeing for the non-pregnant woman is vital both for the woman herself and for the protection of future generations through the whole life course.3 The non-pregnancy related aspects of reproductive health are often overlooked compared with the short and intense healthcare needs of a pregnancy.

The World Health Organization (WHO) define reproductive health and healthcare as:

“A state of physical, mental, and social well-being in all matters relating to the reproductive system. It addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Reproductive healthcare is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.”
Reproductive health is framed here as a positive state associated with well-being although the reproductive health of a population is typically measured by pregnancy-related “morbidity” outcomes such as rates of abortion or repeat abortion and teenage pregnancy. This problem-based approach leaves less room for a positive and rights based approach to care that could be directed towards reduction in gender inequalities, violence, discrimination and stigma - the often-hidden issues that determine reproductive wellbeing.

In stark contrast with the global context, poor reproductive health in the UK is not a significant contributor to national mortality figures and is therefore often seen through the important but narrow lens of contraception and as a component of sexual health. Commissioning structures separate contraception care from other related aspects of reproductive care such as abortion, maternity, cancer screening and menopause care which further compound this single-issue approach. Thus, contraceptive needs in the immediate postnatal period or menopause advice with perimenopausal contraception are likely to be separated from usual arrangements for contraceptive provision.

“...I would have been a bit happier...for my midwife to discuss it (contraception) during my pregnancy...because...at no point in my life was I more scared of getting pregnant than when I just had a baby. I just couldn’t think of anything more traumatic...” (Focus group participant)

Other aspects of reproductive care such as heavy menstrual bleeding, infertility and menopause are often overlooked. This pattern in the delivery of care is at odds with the reality and needs of women’s lives.

“...I look back and I think how much of my life I've lost to my periods... It's only when you step back and think other women don't go through this every month...” (Focus group participant)

“...it’s been an atrocious, ferocious and frightful experience (menopause)...” (Focus group participant)

Comprehensive reproductive health is linked with perceptions of individual well-being and the rights agenda. It also impacts on population health across three distinct but related categories of health – pregnancy related, sex related and non-pregnancy non-sex related.

**Figure 1. Three-pronged approach to reproductive health**
Each of these categories is intrinsically linked with important population outcomes and the different areas of the Public Health Outcomes Framework (Figure 2).

Figure 2: Links of poor reproductive health with outcomes measured at national and local level contained within the Public Health Outcomes Framework (PHOF)4

<table>
<thead>
<tr>
<th>Sex related</th>
<th>Pregnancy related</th>
<th>Non-pregnancy non-sex related</th>
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<tbody>
<tr>
<td>Domestic abuse</td>
<td>Percentage of live births with low birth weight</td>
<td>Sickness absence (e.g. for menstrual pain and bleeding, endometriosis)</td>
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<tr>
<td>Violent crime (including sexual violence)</td>
<td>Infant mortality</td>
<td>Hip fractures in people 65 or over (linked to post-menopausal health)</td>
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<tr>
<td>Cervical screening coverage</td>
<td>Breastfeeding initiation and continuation</td>
<td>Health related quality of life for older people (menopausal symptoms, incontinence)</td>
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<td>Chlamydia detection rates in 15-24-year-olds</td>
<td>Under 18 conceptions</td>
<td>Self-reported well being</td>
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<td>Population vaccination coverage (HPV)</td>
<td>Child excess weight</td>
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<td>Excess weight in adults</td>
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<td>Drug and alcohol misuse</td>
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A new model to define the scope and meaning of ‘reproductive wellbeing’ for women, linked to outcomes that matter to women, is needed to provide a framework for promotion, prevention and delivery of care across all domains throughout the life-course.

**Defining the scope of reproductive health**

Debate continues about definitions of reproductive health – what it is and is not, and how it interfaces with other aspects of health. WHO definitions may be important at policy levels, but they need to be operationalised in order to relate more closely to people’s lived experiences. A modified Delphi exercise (consensus process) was therefore conducted alongside a mixed methods study (Women’s Voices) to clarify the scope of reproductive health and the implications for population healthcare, exposing hidden needs and gaps in the delivery of care. Capturing the essence of reproductive health in this way ensured that a shared meaning between women themselves and those who make policy or deliver care was reached.

**Consensus process**

Conducting a consensus process was a way of obtaining commitment from relevant stakeholders and organisations to work together for a common goal and providing a platform on which to base future organisational action. Application of a modified Delphi process enabled this shared understanding to be formed across the wide range of stakeholders within different disciplines, at different levels of the system and geographically spread to be reached. Involvement of purposefully selected stakeholders representing all key groups, including commissioners, providers from all related disciplines, voluntary sector representatives, users and policy makers was essential to achieving the aims.
Women’s Voices
Mixed methods were used to collect data from women about their views. Focus groups across the country with women from teenage to post-menopausal years were conducted. In addition, a national survey of more than 7500 women through social media was run which provided useful insights on many of the experiences that were significantly affecting women’s lives.

Pillars of reproductive health
A distillation of themes emerging from both the consensus process and views of women resulted in “six pillars of reproductive health” (figure 3). These pillars offer a longer-term vision and a new framework for assessing unmet need, mapping provision and identifying appropriate outcome measures and/or information gaps.

Figure 3: Six pillars of reproductive health, from A consensus statement: reproductive health is a public health issue. (Public Health England, 2018)

- **Positive approach:** The opportunity for reproductive health and access to reproductive healthcare, to be free from stigma and embarrassment.
- **Knowledge and resilience:** The ability to make informed choices and exercise freedom of expression in all aspects of reproductive health.
- **Free from violence and coercion:** The ability to form enjoyable relationships whilst not fearing or experiencing any form of power imbalance or intimidation.
- **Proportionate universalism:** The ability to optimize reproductive health, and social and psychological well-being through support and care that is proportionate to need.
- **User-centred:** The ability to participate effectively and at every level in decisions that affect reproductive lives.
- **Wider determinants:** The opportunity to experience good reproductive health free from the wider factors (such as education and social deprivation) that directly and indirectly impact on reproductive well-being and the ability to access reproductive healthcare when needed.

Each of the pillars is illustrated with examples of hidden needs that surfaced through both “Women’s Voices” and the emergent themes from the consensus forming process.

Positive approach and freedom from stigma
Women experience stigma and “reproductive shame” throughout their lives, both through their reproductive experiences and their interactions with healthcare. Societal constructions about womanhood as motherhood induce stigma surrounding both voluntary and involuntary childlessness and fear of social judgment when having an abortion. Negative stereotypes associated with teenage motherhood affect how well young people engage with services and the responses of potential support networks.

“...I never had the urge for a child and it’s hard to say that.” (Focus group participant)

Reproductive symptoms are also a source of embarrassment and shame. Menstrual taboo means that although one third of women take at least four days off work due to period related symptoms per year, almost half would not feel able to report the reason. Around the menopause women also report hot flushes and cognitive difficulties at a time that they are likely to be at the peak of their work life.
"I never did say to work, that I was off because of period pain because I worked for years in a very male dominated banking environment...I felt there was an issue of stigma with saying I was off...I would have to invent reasons month after month and soldier on and dose myself up..." (Focus group participant)

Stigma constructs and shapes all perceptions and must be acknowledged as a central determinant of the degree to which a vision for reproductive well-being can be achieved.

**Knowledge and resilience for informed choice**

Learning about relationships, puberty, fertility and the reproductive life course, how to remain healthy and how to access care when needed provides a solid bedrock for making future decisions about health, although many women report large knowledge gaps.

"...she (my mother) gave me a pad and I didn’t know what to do with it. I thought...that the sticky side went up." (Focus group participant)

An individual who has had good quality school Relationships and Sex Education (RSE) is more likely to make behavioural choices that minimize risk. Following an amendment to the Children and Social Work Bill (2017) statutory RSE will be implemented in 2019, which is a real opportunity for incorporating the comprehensive reproductive health education that is needed.

Multiple knowledge sources are needed including online, intergenerational and lifelong learning. Consistent and comprehensive messaging in reproductive health should become an integral part of wider public health messaging. Society, employers and healthcare professionals also need education and encouragement to positively support women with reproductive needs.

"My GP just said, 'well you should have had your children earlier...you're going to find it very difficult now. You're just about to hit 30. The optimal time is about 22.'" (Focus group participant)

Developments in the workplace are needed to ensure that women can function effectively, free from discrimination and able to access non-judgmental help when needed e.g. to facilitate breastfeeding or take time for antenatal or gynaecology appointments.

**Enjoyable relationships free from violence**

Having positive and pleasurable sex and relationships free from violence and coercion is not only considered as a human right but is also an important factor in maintaining wellbeing and reducing sexual morbidity. In stark contrast, adults with the most severe history of physical and sexual violence are the most likely to describe their health as poor or fair. 14% of women in the UK have experienced sexual violence in comparison with 11% across the EU. Despite these important influences on public health, less than half of women who have experienced sexual violence report it. Support for these women is patchy and there are no routine outcome measures that relate to either pleasure or violence in assessing reproductive health.
Universal care delivered proportionately to need

Services should be available in adequate number, physically and economically accessible and of good quality to maintain basic sexual and reproductive rights.

Basic reproductive healthcare — contraception, preconception advice, screening for reproductive disease and care around the menopause — is needed by virtually all women and often their male partners for a large proportion of their adult lives. The majority of women require contraception for around 30 years, interspersed (for about 4 out of 5 women) with shorter periods of wanting to become pregnant. All women intending to conceive have a need for preconception care — at least for folic supplementation - that mostly goes unrecognized.17 At this time they should also receive screening for the early detection and prevention of reproductive tract morbidity such as cervical dysplasia and sexually transmitted infection. As women age, many will still require sexual health care, but their needs for contraceptive and preconception care are gradually overtaken with symptoms of the menopause with its associated impacts on wellbeing and need for care.

“...the whole of the symptoms of the menopause, depression, anxiety, hot flushes, sleepless nights, you feel yourself worthless...it’s a horrible state. And you come back to your GP and she’s telling you ‘no, it’s normal. Just get on with your life.’” (Focus group participant)

Contraceptive, preconception, menopause and screening care are universal and overlapping requirements throughout life that require a population-based and integrated approach to delivery that recognizes, informs and normalizes but that is responsive to need. Historical patterns of delivery and current commissioning structures and service models have not intuitively generated this kind of system wide approach. Both universal (and light touch) coverage of care is needed but with provision of care proportionate to the scale and intensity of need, defined as proportionate universalism.18

Pathways into care

Successful universal provision maximizes access, information and choice for women, through innovative and potentially cost-saving pathways in a wider range of medical and non-medical settings. Nevertheless, this is offset by consequent identification of greater numbers needing equitable and timely access to more complex care such as complex contraception, colposcopy, fertility services, specialised menopause care, gynaecology or abortion.

“You spend years not trying to get pregnant, and then when you’re trying to get pregnant, you think it’s just going to happen.” (Focus group participant)

For example, whilst in the last decade there has been a strong drive to enable women to have full range of choice over contraception including the most cost-effective user-independent methods such as the implant or intrauterine device (IUD), this is not always matched by expansion of the specialized skills required to meet the resulting increased numbers requiring more complex care. Similarly, fertility services for preconception care or specialist menopause care for women debilitated by symptoms in spite of supported self-management can be hard to access. Access to these specialized services is guided by historical models of service provision and funding inconsistencies rather than need, with a potential for widening inequalities and limiting access.

Information gaps

Returning to the definition of reproductive health, meaningful measures of reproductive wellbeing can only truly be user defined. Nationally, reproductive wellbeing is measured according to rates of teenage pregnancy, rates of unplanned pregnancy as evidenced by abortion, access to contraception services and uptake of longer acting methods. Access to information about choice, uptake and satisfaction with contraception method is limited, particularly from General Practice where 70-80% of women attend, and none of the measures capture reproductive well-being per se.
The London Measure of Unplanned Pregnancy is a validated measure for use in pregnant populations which gives a more robust measure of reproductive choices. Implemented at population-level, it would enable the incidence of unplanned pregnancy to be estimated (using a score from 0-12) thereby providing a public health monitoring / surveillance system, just as antenatal HIV testing provides valuable estimates of HIV incidence in the population. New measures of pregnancy intention for non-pregnant women are in development, offering the promise of identifying and responding to a need for effective contraception to prevent unintended pregnancy or pre-conception care to improve maternal and infant health. Since much of reproductive health is about well-being, which is harder to measure than absence of disease such as cervical cancer, there is a great need for better quality of life measures specific to different aspects of reproductive health.

Moving forwards
The government is tasked with delivering cross-departmental plans for the attainment of the UN’s sustainable development goal 5, gender equality. This is an opportunity for improving the health of women throughout the lifecourse. A framework that is meaningful to professionals and women and that advances the WHO definition for a UK context is a significant step to inform this process. This can form the basis of action acknowledging that reproductive health means more than contraception and the prevention of abortion (Figure 4) and calls for a widened set of accountability measures that truly reflect whether needs are being met. User-centred outcomes are essential for a comprehensive assessment of achievements in advancing women’s reproductive health and rights.

Figure 4: Proposed actions for policy makers to advance reproductive health

- Reframe reproductive health in the context of choice and autonomy to promote wellbeing across the life-course rather than merely the absence of disease.
- Initiate campaigns that seek to reduce the stigma around reproductive health conditions and the barriers to seeking help.
- Raise awareness of prevalence of non-volitional sex and work to de-stigmatise and support reporting.
- Inform and encourage wider society, including employers, to recognise and support women with debilitating reproductive health symptoms enabling them to function effectively and free from discrimination.
- Ensure that an understanding of the reproductive life-cycle and awareness of fertility as well as teaching about healthy relationships is incorporated into the RSE curriculum and beyond through lifelong learning.
- Promote a system wide approach with leadership and accountability mechanisms that foster cross sectoral collaboration integrating maternity, primary care, gynaecology and sexual health.
- Support commissioning of reproductive healthcare in settings where risk of poor reproductive outcomes are enhanced e.g. substance misuse, mental health, weight management services.
- Implement self-reported and validated measures, such as the London Measure of Unplanned Pregnancy, into routine datasets.
- Develop new, user-reported measures that capture quality of reproductive wellbeing and can be incorporated into routine datasets.
**Figure 5:** Proposed actions for healthcare professionals to advance reproductive health

<table>
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<tr>
<th>Action</th>
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<tr>
<td>Develop a universal standard of care for healthcare services that supports the maintenance of sexual and reproductive health and rights that addresses stigma associated with provision and use of reproductive healthcare.</td>
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<tr>
<td>Support users in lifelong learning about reproductive health including how to remain healthy, the importance of positive relationships and how to access care when needed.</td>
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<tr>
<td>Provide a safe space in healthcare settings and train providers so that they can develop confidence in identifying and managing disclosures of violence and in providing holistic care to vulnerable women such as asylum seekers or sex workers.</td>
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<tr>
<td>Take a lifecourse approach to reproductive health, integrating different aspects of care such as contraception and preconception and enabling individuals to optimize health before pregnancy.</td>
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<tr>
<td>Develop a strategy to reach those who do not access services that they are likely to need such as contraception, preconception care, cervical cytology and menopause care. Capitalise on the “gateway” contact opportunities such as pregnancy, emergency contraception consultations, abortion and menopause.</td>
</tr>
<tr>
<td>Link specialized and routine care through integrated care pathways that mirror the user journey and provide equitable access to specialized care when needed.</td>
</tr>
<tr>
<td>Target prevention at the marginalized who are at greater risk of poor outcomes and/or for whom the consequences of poor sexual and reproductive health are magnified, ensuring a renewed focus on proportionate universalism.</td>
</tr>
<tr>
<td>Acknowledge and address as routine practice the influences of wider lifestyle factors on reproductive health outcomes such as smoking, substance misuse and obesity, social factors and environmental factors.</td>
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Addressing unmet needs in women’s mental health

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Addressing unmet needs in women’s mental health

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**Key messages**

1. Women and girls have distinct and specific needs and, therefore, policies, services and practice need to be gender-informed.
2. Clear leadership and accountability is required to ensure gender sensitive policy and provision.
3. Data collection and reporting should take account of differences between women and men and include gender as a standard variable.
4. Policies, services and therapeutic options should be co-designed with women with experience of poor mental health.

**Introduction**

For several decades it has been apparent that there are differences between women and men in how they express mental distress. This is seen in the prevalence of mental illness (particularly common mental disorder such as anxiety and depression, self-harm, substance misuse and suicide); pathways into treatment and support and in therapeutic preferences. There are well established links between the risks of mental illness and the social realities of women’s lives. These include women’s relatively lower incomes and access to household resources and responsibility for childcare and other caring responsibilities, as well as sexual abuse and domestic violence. Gender neutral approaches to service provision fail to recognise the specific needs of women. If health and social care truly is to be personalised, it must recognise the social context for women’s lives and respond appropriately to gendered differences in mental health. This briefing paper provides an overview of the mental health of women in the UK today and some recommendations for actions towards gender-sensitive practice.

**Background**

In 2002 and 2003, two landmark policies published a clear rationale for change in thinking about women’s NHS services, stressing the need for gendered responses to mental health. Unlike most psychiatric practice at the time, it asked mental health professionals and services to recognise elements of the (now well respected) feminist purview which locates the origins of women’s distress and mental illness both within social inequalities and the social construction of their difficulties. Therefore, the solutions to such distress were not simply better treatments but better solutions to that inequality and to the discrimination that women face.

Although the need for, and the design of, gender specific and gender sensitive mental health provision for women had been clearly articulated, the challenge for services was the lack of an evidence-base for what service to deliver or how to deliver gendered services. Practice development, feminist scholarship and activism and the exposure of abuse by mental health professionals, including rape and abuse of women in inpatient settings, led to ‘Into the Mainstream’: an evidence-based guide for service development and practice which remains relevant today. Consultation with women for the development of ‘Into the Mainstream’ enabled components of women-friendly services to be identified, as summarised and updated from Barnes et al (2002) in Figure 1.
Figure 1: Characteristics of gender sensitive services (adapted Barnes et al., 2002)

Women-friendly services:
- Prioritise understanding mental distress in the context of women's lives
- Are co-designed with women with lived experience
- Enable all dimensions of problems experienced to be addressed
- Address sexual abuse, domestic violence, body image concerns, reproductive and life stage elements of health and wellbeing
- Are sensitive to the diversity of women's needs, experiences and backgrounds including race, sexuality and disability
- Enable women to make choices about their care and treatment
- Provide women-only spaces, particularly in-patient settings, which enable women to feel secure, safe and respected
- Empower women to develop skills for addressing their difficulties
- Promote self-advocacy and advocacy for women who need support to voice their views
- Value women's strengths and potential for recovery

'Into the Mainstream' (Department of Health, 2002) called for a reappraisal of women's mental health presentations in the context of their complex and often traumatic lives. Specifically, it advocated that women of working age should be considered differently from men of working age. Women were far more likely to have experienced or be experiencing violence and sexual trauma; to be poor; to be undertaking multiple roles as mothers, partners and carers to elderly and disabled relatives and because the way they accessed support and what they valued was frankly different in many ways from men.

The creativity of ‘Into the Mainstream’ was accompanied by a detailed implementation guide clearly outlining ways in which services could be modified and care delivered at little or no extra cost in a gender-sensitive and often gender-specific way. It provided a series of models of good practice and, in particular, was one of the first policies on NHS care pathways to acknowledge the major role of the third sector in care provision to women e.g. crisis housing and Women’s Centres (Mainstreaming Women 2003). A pivotal element of the implementation plan was the appointment of national and regional leads for gender equality and a women’s mental health lead by the National Institute for Mental Health in England (NIMHE). Some NHS Trusts followed suit and appointed a lead to support implementation. This implementation programme included:

- Support to implement the gender equality duty in mental health (incorporated into the Equality Act in 2010).
- Improving access to perinatal mental health services.
- Addressing violence and abuse through routine inquiry.
- The roll out of single gender provision in acute in-patient settings.
- Provision for women from black, Asian and minority ethnic communities.

The closure of NIMHE in 2010 meant these measures were short-lived leaving a long way still to go. Since then, mental health policy has paid scant attention to the differentiated needs of women, with the recent Five Year Forward View focusing almost exclusively on perinatal mental health. This previous work, therefore, provides a useful resource for making progress on gender today.
Mental health in women in the UK today

It is in this context that the household adult psychiatric morbidity survey (APMS) reports that rates of common mental disorder in women have been increasing steadily between 1993 and 2014, compared to stable rates in men since 2000.¹²

Figure 2: Current Trends in Women’s Mental Health in UK (APMS 2016)

- 1:6 adults (17.0%) had a common mental disorder.
- 1:5 women (20.7%) compared with 1:8 men (13.2%).
- Overall the rate is largely stable in men compared with a steady increase in women.
- Young women are at especially high risk.
- 1:5 16-25yr women report recent self-harm.
- Suicide rates in women are at their highest for a decade.

More women than ever are now presenting with common mental disorder: 25% of young women between the ages of 16-25 (APMS 2016) report symptoms of common mental disorder (mainly anxiety and depression); rates of self-harm in women are higher than ever, again especially in young women.

Figure 3. Adult Psychiatric Morbidity Survey showing rates of common mental disorder (CMD) for women and men aged 16-64. Clinical Symptom or CIS-R scores 12 or 18+ denotes severity of clinical symptoms i.e. 12 mild and 18 equate to either moderate or severe symptoms (Source: NHS Digital, 2016).
And, in spite of significant funding for suicide prevention and the National Confidential Inquiry into Suicide, rates of suicide in women are at their highest for a decade (ONS 2017).13 Alarmingly, the number of suicides in women is dwarfed by the very large numbers of women reporting suicidal ideation, especially young women.

Figure 5: Suicidal thoughts by age and sex

Rates of self-harm and suicidal behaviour are higher for women in minority ethnic communities than for women in the majority community, although most studies report rates for South Asian women.14 The role of family-based problems, including domestic violence, community pressures, acculturative stress, discrimination and barriers to help-seeking are important precipitating factors.15 They point to the necessity of considering the intersection between gender, race, sexual orientation, age, disability and other factors when developing accessible and appropriate services.

Recent global trends of increasing mental illness and lack of wellbeing, especially in girls and young women, beg many questions about causal mechanisms; sex and gender effects. We cannot blame the internet or media pressures, as many commentators searching for simplistic answers are keen to do.16 A range of explanatory mechanisms is likely to be in play, not least of which is inequality. The World Health Organization (WHO) identifies the power differential between women and men and their access to resources in society and in the home, alongside sexual and domestic violence, as profoundly shaping women’s mental health and the global disparities in their wellbeing.17
Thus, the gender differences in mental health are underpinned by socio-economic realities which can disadvantage women and restrict their ability to access the support and resources they need to cope in the face of adversity. In turn, this continues to be heavily influenced by the social construction of gender roles and expectations; and by women’s seemingly immovable tenure in part-time, low skilled, high strain jobs and low paid work.\textsuperscript{18,19} This phenomenon has increased with the ‘marketisation’ of care and the growth of zero hours contracts. The results of the 2014 Household Survey illustrate the link between gender, household income and mental ill-health: women in the lowest quintile for income are 2-3 times more likely to be diagnosed with a mental illness than men in the top income quintile.

Figure 6: Diagnosis of mental illness by ‘equivalised’ household income and gender (Source: NHS Digital, 2015)\textsuperscript{20}

Gender inequalities have become systematised through policy which is shaped by the dominant social norms (‘malestreaming’) and may adversely affect women’s mental health. For example, accumulating evidence suggests women have been disproportionately disadvantaged by the welfare policy agenda and austerity measures.\textsuperscript{21} These have led to reductions in welfare benefits and reductions in services, with the voluntary sector and carers increasingly expected to fill gaps in public provision. In spite of this, the last seven years has seen drastic cuts in local authority funding for a wide range of third sector services designed to support women dealing with adversity, e.g. domestic violence, and to provide support with caring responsibilities. Ageing also disadvantages poor women and their mental health disproportionately. At older ages, women are increasingly involved in long term caring roles and make up 60\% of informal carers and 80\% of the low paid care workforce.\textsuperscript{22} So, as women grow older, they are more likely to experience financial hardship as a result of gender inequality in pay and to become unable to afford good quality care for themselves.

**Service implications of increasing mental ill health**

As the more recent survey data (APMS, 2016) are suggesting, the great majority of mental health presentations by women will be anxiety or mood related; including the significantly increased rates of post-traumatic stress disorder (PTSD) symptoms in young women. However, in spite of longstanding calls for women to have control of their own health\textsuperscript{23} and, thus, to access talking therapies rather than medications for mood and anxiety-related conditions, recent studies from the UK and Canada report that young people, and particularly young girls, are increasingly being treated with psychotropic drugs.\textsuperscript{24} Researchers from the University of Manchester report that antidepressant prescribing for depression and other indications has been rising most rapidly in 15 to 17-year-old girls.\textsuperscript{25} Antidepressant prescribing in children increased between 2006 and 2015 and, at
least in part, this is because these medications have been strongly marketed for use in a much broader range of presenting symptoms than depression, including anxiety, chronic pain, sexual disorders and migraine. The use of psychotropic medications, including antipsychotics, has special significance for women in psychiatric services of whom the majority are within the reproductive age range. Women show more severe side effects from psychotropic medication, including greater weight gain, cardiovascular and metabolic side effects per dose of medication than men but mental health clinicians are largely unaware that side effects are gendered.

**Figure 7: Gendered effects of psychotropic medication**

- Women exposed to prolactin-raising psychotropic drugs produce more than twice as much prolactin (PRL) as men
- This effect is dose-dependent
- Young women with severe mental illness have 10-fold increased risk of osteoporosis and fracture
- Prolonged hypo-oestrogenaemia associated with high PRL causes a syndrome akin to premature ageing and menopause
- Premature aging appears unacknowledged by clinicians
- Most focus on metabolic syndrome
- Many mental health professionals are unaware that women have more severe metabolic syndrome for lower dose of drug than men

This illustrates how existing practice needs to be adapted to become gender-informed. New initiatives will also need to consider the particular challenges for women in services. Thus, routine inquiry about abuse and domestic violence, supported by appropriate therapeutic and support services, is an example of gendered practice currently being implemented in Scotland (NHS Scotland, 2018). Trauma-informed care and trauma-specific services need to be more widely available because they recognise the pervasive impact of trauma and abuse and the potential for services settings and practices to be retraumatising. They are tailored to enabling women and girls to build their resilience, ensure their safety and negotiate the impact of trauma on their lives, with recovery from the trauma as the primary goal. Progress on initiatives developed through “Into the Mainstream” must also be maintained and most notable of these is the provision of gender-specific inpatient care and other measures to ensure the security, safety and dignity of women using mental health services.

This needs to be underpinned by well-developed partnership working with the voluntary sector. Women’s Centres in particular (see for example WomenCentre in Calderdale and Kirklees), have been at the forefront of innovations in women’s mental health. However, recent cuts to local authority budgets have meant this sector is struggling to provide sustainable support to women; notably domestic violence provision. Such services are vital for a systemic approach to women’s mental health and for GPs and mental health professionals to be advocating for their role.

**Future solutions**

The Five Year Forward View for Mental Health makes little reference to gender inequalities or, indeed, to women’s mental health or consideration of women-specific treatment needs. With the exception of perinatal services, the needs of women for gender sensitive and gender specific services are largely ignored. Whilst the shortfall in mental health provision for new mothers should remain a priority, the needs of women are far broader than this and yet remain overshadowed by the dominant narratives of perinatal depression or suicide reduction.

Similarly, the search for causal explanations of the rising rates of common mental disorder in young women compared to young men is important, but should not be prioritised over a stakeholder-led search for sustainable ways to support young people using gender-informed approaches. This is critical as the implications of these findings for the health and wellbeing of future generations are clear. Children and young people’s wellbeing must be at the centre
of our future mental health strategies. These approaches should begin as early as possible with schools playing a critical role. This means emotional and mental health is embedded within education alongside physical health through a concerted, joined-up public mental health strategy. Two easily identifiable at-risk groups are the increasing number of children and young people living with parental mental illness and young people in the care system.

The Equality Act (2010) provides a framework for policy makers and practitioners to assess and identify priorities for action and ensure equalities for a range of population groups with protected characteristics. For women, this means developing policies and services with an eye firmly on gender sensitivity, and trauma-informed approaches, which will also benefit men. For example, a better understanding of treatment preferences in terms of gender (and other dimensions) could influence the disproportionate numbers of African Caribbean men currently being detained under the Mental Health Act. There is much that can be done within existing practice: routine enquiry about interpersonal violence and recording of responses in the clinical digital dataset is crucial for future service provision. The same is true for routine inquiry about women's sexual and reproductive health which can already be supported by available provision within primary care. Whilst digital innovations may offer new solutions for genuinely personalised psychiatry, and may benefit women in particular, approaching data from a gendered perspective is also an important future requirement if we are to understand the causes and mechanisms of women's mental health inequalities. Thus, surveys must ask about individuals' access to household resources, as these are often unequally distributed rather than simply recording household or area level socioeconomic data. And future commissioned service evaluations and research should specify gender as a key variable.

Future service provision also means co-producing collaborative care models which encourage service users and clinicians to engage in a shared understanding of care needs, treatment and support preferences. Such approaches chime well with an agenda promoting greater public mental health and preventive self-management and include current initiatives that seek to personalise care and make it more collaborative, including decision-making about medication.

For now, slow progress and scarce acknowledgment of women's needs in current mental health policy requires local champions and radical action so that the needs of women are put back at the centre of new service design and modern professional practice. This requires national and local leadership in partnership with women. The recent Department of Health Women's Mental Health Taskforce is encouraging; it must be underpinned by clinical and managerial leadership supported by governance arrangements that have the diverse needs of women in their sights.

Implications for policy makers and practitioners

Policy

- Needs a gender-informed approach so that service design takes account of the differential needs of women and men.
- Recognition of the need to collect gender-informed health and social care data and to report data in a gendered format.
- Welfare policy should be scrutinised, in line with the Equality Act, to identify whether it is disproportionately affecting women and their mental health.
- A national women's mental health strategy needs implementation, supported by both infrastructure and accountability at a local level.
- Reversing cuts and ensuring sustainable investment in third sector organisations that provide support to women, particularly domestic violence services; and ensuring access to a Women's Centre in every local area.
- A focus on the sexual, reproductive as well as perinatal health of women.
- Violence and abuse safe spaces for women should be a priority.
- Successful implementation requires a workforce trained in gendered differences in mental health including trauma-informed approaches to care and services.
Actions for practitioners
- Routine enquiry about reproductive health, body image, domestic violence and sexual health including abuse.
- Become informed about the role of gender and complexity in mental health presentations and response to treatment.
- Develop and provide trauma-informed care.
- Develop collaborative approaches/shared decision-making with women under your care including medical and social prescribing.

Conclusions
Services and research which is gender-informed and actively addresses gender and sex differences is beneficial to men as well as women, informing greater understanding at a societal and individual level of what protects and sustains mental health and wellbeing. It must take account of their diversity in terms of age, ethnicity, sexual orientation and disability if support is to genuinely be person-centred. This must go hand in hand with service provision that has women at the heart of decision-making and a stakeholder-led search for sustainable ways to support gender-informed approaches. We have recommended low cost, immediately implementable actions that all services and practitioners can consider, as well as recommending the urgent development of policy to promote women’s mental health.
References


Health inequalities and women – addressing unmet needs

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Health inequalities and women – addressing unmet needs

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Key messages:

– There are clear and stark inequalities in health between women, which are related to socio-economic status, ethnicity and geographic region.
– Across different stages of women’s lives there are different social and economic factors which drive health and associated health inequalities; including experiences during early childhood, education, family building and working life and through retirement and into older age.
– The broad health workforce must take full account of the social and economic factors which shape women’s lives and health at different stages of life.

Introduction

There are marked and persistent health inequalities across the United Kingdom (UK) in both length of life and in length of healthy life, for both men and women. These inequalities are closely related to socio-economic position.1 Figures 1 and 2 show life expectancy and disability-free life expectancy related to level of neighbourhood deprivation. Each dot on the graphs is a neighbourhood in England. It is clear that inequalities in life expectancy and healthy life expectancy impact on everyone below the highest socio-economic status, not just the most deprived. The social gradient in health is shown for men in figure 1 and women in figure 2, both of which clearly show gradients in disability free life expectancy and life expectancy related to levels of deprivation in neighbourhoods.
There have been several major global reviews of evidence,\textsuperscript{2,3} which describe close relationships between social, economic, environmental, cultural and political factors and health outcomes — known as the social determinants of health. There is now widespread and increasing recognition that most inequalities in health are caused by inequalities in the conditions in which people are born, grow, live, work and age.

Local authority data show that for both men and women there are inequalities in health within, as well as, between local authorities\textsuperscript{4} As Figure 3 shows, between local authorities there is a female life expectancy difference of seven years ranging from 79 years in Manchester to 86 in Kensington and Chelsea.

Figure 2. Life expectancy and disability free life expectancy, females, based on the 2011 Census

Figure 3. Female life expectancy at birth and healthy life expectancy by local authority, 2013-2015
Moreover, within local authorities there is a significant inequality in life expectancy for women, based on level of neighbourhood deprivation. This ranges from less than two years in Islington to 12 years or more in Stockton on Tees and Middlesbrough.

European countries are experiencing an ageing population, and the UK has seen dramatic increases in life expectancy, with a longer life expectancy for both men and women. However, the trend now seems to be changing, raising new challenges in terms of policies and healthcare with life expectancy in England stalling and declining for women in some areas. To improve health and tackle health inequities effectively and at the necessary scale, the role of policy makers, health professionals and practitioners in other sectors (education, early years, work for instance) is fundamental.

A discussion of the evidence

At European level, even though life expectancy is increasing, it has registered a slowdown in the rate of increase in all countries since the global financial crisis, with the United Kingdom showing one of the worst trends. Compared to other countries, in the United Kingdom the increase in life expectancy from 2011 to 2015 was the slowest in Europe. For women there was no increase – the lowest in Europe – and there was second slowest increase among men (0.08%). As shown in Figure 4 this trend is confirmed by the recent Marmot indicators in England, which show that the improvements in life expectancy at birth have slowed. In particular, looking at the period 2000-2015 the trend for women is worse than that of men: female life expectancy increased by one year every five years, while for men the increase was one year every three and a half years.

Taking the period since 2010, the trend for women shows further deterioration: life expectancy at birth for women rose one year every 10 years while for men the figure was one year every six years. For female life expectancy at age 65 in England, life expectancy increased one year every six years, compared to one year every five years for men in the period 2000-2015. Moreover, from 2010 to 2015 life expectancy at age 65 slowed to a one year increase every 16 years for women and every nine years for men.

Figure 4. Life expectancy at birth, England, 2009-2015
Leaving aside specific biological factors, such as reproduction, men and women also tend to have differing experiences of social determinants across life shaped partly by gender roles – the socially constructed characteristics of women and men, such as the norms and relationships which exist between them.

Considering the average age of death: three-quarters of female deaths are at age 75 and over, with two-thirds of these occurring at ages 85 and over. In contrast, for men three-fifths of deaths are at ages 75 and over, half of which are at ages 85 and over. For disability-free life expectancy (DFLE) which estimates the average number of years an individual is expected to spend free from a limiting long-term illness or disability, in England from 2012 to 2014 females at birth could expect to spend a lesser proportion (76.0%) of their lives free from disability compared with males (79.5%). Moreover, the inequalities in DFLE across upper tier local authorities is wider for females (19.4 years) than males (16.8 years).

The leading cause of death for women aged 80 and over is dementia and Alzheimer disease (37,252 deaths) and for men aged 85 and over (12,248 deaths). Since 2002 the rates of dementia and Alzheimer among women aged 85 and over have been rising. In particular, from 2002 to 2015 there was an increase of around 175% in dementia as the cause of death in women aged 85, as shown in Figure 5.

**Figure 5. Deaths due to dementia, females by single years of age, England and Wales, 2002-2015**

For both men and women, lower socioeconomic groups have a higher incidence of poor mental health and are more likely to have earlier onset of dementia compared to the higher socioeconomic groups. Women represent two thirds of all people with dementia, with higher dementia prevalence rates than men (62.7% for males and 71.2% for females). Women are more likely than men to experience the death of their partner, move into residential care and experience physical ill health and poor mental health and cognitive decline. Depression can be a risk indicator for converting cognitive impairment to dementia and women have higher rates of depression than men.

Evidence suggests that women with dementia have fewer visits to the GP, receive less health monitoring and take more potentially harmful medication than men with dementia. Furthermore, women were found to be at particular risk of staying on antipsychotic or sedative medication for longer, probably due to the lower number of appointments where their treatment can be reviewed.
A study of socioeconomic position as a risk factor for death due to dementia showed that in women there is an association between leaving full-time education at a younger age and dementia-related death, which is not evident in men.\(^{15}\)

Research found a positive association between poverty measures and common mental disorders.\(^{16,17}\) For example, in England, Wales, and Scotland it has been shown that some forms of mental disorder are correlated with levels of debt the individual has.\(^{18}\) As shown in Figure 6, in women the pattern of social distribution of common mental disorders follows the social class gradient more markedly than men.\(^{19}\) Women have a higher percentage of mental disorders than men in each income bracket reported.

**Figure 6. Prevalence of any common mental disorder by household income, England 2007**

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Additionally, there are wider factors that may influence gender differences in health in older age: women live longer than men and with more limiting illnesses which affects their ability to continue in employment, and women have higher rates of poverty in old age than male pensioners. Single retired women have higher risk of poverty than married retired women.\(^{20}\) Women have on average only 57% of men’s income with fewer women (60%) having pensions compared to men (80%).\(^{21}\) Moreover, a 2016 study found that, at age 60–64 a third of women, compared with half of men, continued to work part-time after the state retirement age and the employment rates further declined with age, with a gap between men and women, for whom just 5% continued to work between the ages of 70 and 74 compared with 10% of men at the same age.\(^{22}\)

There are also clear inequalities in health between migrant women and the host population. Migrants are 13.3% of the UK population and they contributed to more than half of the increase in the UK population between 1991 and 2014,\(^{23}\) being younger\(^{24}\) and with a higher fertility rate than native British.\(^{25}\)

An analysis of migrant health for people aged 60 years and more reveals that there are no significant differences among UK and non-UK born men. In contrast, non-UK-born older women, who have spent between 10 and 39 years in the UK, have 71% higher odds than UK-born women of reporting that health is limiting their typical activities.\(^{26}\)

As shown in Table 1, non-UK-born women have a slightly higher rate of maternal mortality (MM rate of 8.8) than UK born (7.87) women, the figure is even worse when analysing the specific country of origin. In this case, women born in certain countries have a significantly higher risk of death compared to UK-born women. For Jamaicans, for example, the relative risk (RR) compared with UK-born women (RR=1) is 6.36 and for Nigerians or Pakistanis the relative risk is respectively 2.25 and 2.24. Looking at the same phenomenon in terms of UK born ethnic minority groups, Black and Asian groups’ RR is 4.19 and 1.36 compared with Whites (RR=1).\(^{27}\)
There are also inequalities in health for women related to ethnicity in England and Wales where women of over half of the ethnic minorities for whom data is available (9/16) have lower DFLE at birth than White British (64.1 years), particularly among Black, Asian and mixed ethnic groups. Pakistani women registered the lowest DFLE (55.1 years) while Indian women, whose LE was similar to that of White British women, had in contrast 4.3 fewer disability-free years.29 A recent Scottish study showed that the life expectancy of White females was 79.4, overlapping with Mixed Background (79.3) but shorter than some specific ethnic groups, such as Pakistani (84.6), Chinese (83.4), Indian (83.3), Other White British (82.6), Other White (82.0) and White Irish (81.0).30

To summarise, there are clear inequalities in health related to gender — as well as to socio-economic status and ethnicity — and these factors are all interlinked. Poorer, migrant women suffer the worst health of all and there are differences in health outcomes between ethnic groups for women. For all these groups poorer women have relatively low health outcomes.

**Actions required**

There are clear, systematic differences in health between genders and there are clear and stark inequalities in health between women in different socio-economic groups, ethnicities and geographic regions. There are important actions which can be taken by policy makers nationally and locally and by those within the health system to help reduce those inequalities.

Policy makers can help reduce health inequities, maintaining and improving universal health and welfare systems. A proportionate universal approach to policy interventions and welfare should be central to the development of policies and approaches. A proportionate universal approach includes everyone — the universal element, with actions on a scale and at an intensity that is proportionate to need. This means addressing women’s health with specific actions to take into account women’s different needs at different stages of life and for those with different levels of risk.
The Marmot Review\textsuperscript{31} presented the following six policy objectives with specific policy recommendations that could be implemented at national and local level:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

At national and local levels policy makers must be committed to creating conditions in which individuals, communities and the public take control of their own lives.

The life-course approach shows that there is an accumulation of positive and negative effects on health and well-being, among all phases of life (prenatal, pre-school, school, training, employment and retirement). Consequently, equity policies must follow the life course perspective in order to address the inequalities between women and between women and men which are appropriate to each stage and aim to prevent an accumulation of inequities over the life course.

**Case study: MAMTA**

A good example of actions tackling health inequities between women in England is the recent experience of Coventry as a Marmot city. To address the first and the sixth Marmot review recommendations during the first Marmot city phase 2013-2015, Coventry implemented the MAMTA (‘motherly love’ in Hindi) peer model to improve Child and Maternal Health outcomes and ill-health prevention for BME (Black and Minority Ethnic) women. The MAMTA model existed before the Marmot city interventions, and was initiated in 2001.\textsuperscript{32} It was adapted to the Marmot City objectives, focusing on peer workers’ support for women in the community.

In particular, for child and maternal health care the Foleshill Women’s Training (FWT) staff supported antenatal clinics; postnatal clinics; parent craft sessions at FWT centre; and work in partnership with midwives, health visiting teams and other health professionals, educating women on key health messages. The project was implemented across community settings in specific areas to educate women on child and maternal health, and encourage women to access services and book early into maternity services.

Addressing the sixth Marmot review recommendation, FWT provided culturally-oriented education and support regarding cervical screening in migrant women by the MAMTA model. In particular, migrant women supported other women and explained the importance of the exam and booking the test, using communication material in different languages.\textsuperscript{33}

As the data shows, life expectancy in women is no longer increasing and in some parts of the country is actually decreasing. Women also have a higher probability of living in disability than men and women with lower socio-economic status are likely to spend longer living with a disability than women with higher economic status, as well as dying earlier.

The greater risk of dementia in women, particularly poorer women, requires particular focus including strategies throughout life, such as ‘improved workplace health in mid-life; supporting social interactions and lifelong learning and stimulation in later life; and supportive care from services and from carers/families\textsuperscript{34} and appropriate strategies to reduce poverty for women in later life.
Although much of the required action lies outside health care, health professionals play a key, if so far, underdeveloped, role in reducing health inequalities between women and men and between women. The following approaches should be adopted to strengthen health professionals’ roles in tackling health inequalities:35,36

- Improving education and training. Undergraduate and postgraduate education could include social determinants of health as a mandatory topic and could provide specific practice-based skills such as communication, partnership and advocacy. Student placements in a range of health and non-health organisations could be included in the course.

- Building evidence though international, national and locally disaggregated (by sex, socio-economic status and ethnicity) data to design appropriate services.

- Working with and for individuals and communities by building relationships of trust and respect with patients, effective and appropriate social prescribing and creating networks in neighbourhoods.

- Enhancing healthcare organisations by means of equitable recruitment and good quality employment.

- Working in partnership and as advocates, by promoting partnerships inside and outside health services (local organizations, cross governmental sectors) and at the same time working as advocates for health improvement, rather than just health care at all levels — from local to international level.
References

5. Ibid
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33 Coventry City Council, Making a difference in tough times, Coventry, 2015.


Addressing unmet needs in global women’s health

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Actions required
1. Ensure that all girls and boys complete free, equitable and quality primary and secondary education
2. Mandatory relationship and sex education
3. Contraception available over the counter at pharmacies
4. Access to free and safe medical and surgical abortion care

Introduction
The UN Sustainable Development Goals (SDGs) 2016-2030 represent a set of targets for countries across the world, designed to end poverty, protect the planet and ensure prosperity for all. The SDGs follow and expand on the millennium development goals (MDGs). Two of the 17 SDG goals explicitly recognise the importance of girls and women, and their health, to achieving this ambitious aim, and that the key to the success of one goal involves tackling issues more commonly associated with other goals. SDG 3, ‘Ensure healthy lives and promote wellbeing for all at all ages’, includes a commitment to ‘reduce the global maternal mortality ratio to less than 70 per 100,000 live births’, and to ‘ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes’. SDG 5, ‘Achieve gender equality and empower all women and girls’, again underlines the importance of sexual and reproductive health, while also including commitments to ‘eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation’ and ‘eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation’. Unlike its predecessor (MDG3), the goal calls on governments to achieve, rather than just promote, gender equality and the empowerment of all girls.

‘Let the 21st century be the century of women.’ These were the words of the former UN secretary general, Ban Ki-moon, during his annual report on the post-2015 development agenda. Implementation of all 17 goals would have the potential to change the course of the 21st century, by addressing key challenges such as access to education, poverty, inequality and violence against girls and women. However, underlying all 17 goals is the need to achieve the targets set out in SDG 3 and SDG 5. The health and wealth of any society depends on the health and wealth of its girls and women — only by empowering girls and women, and ensuring they are treated equally in all areas of society, will individuals and nations be able to achieve their full potential.

However, there is still much to do to improve the health care provided to girls and women around the world. While improvements are being made, we need to address the underlying inequity. Every girl and woman should be able to lead a healthy life, no matter where they are born, how wealthy their parents are, or where they went to school. But we know that a woman’s life expectancy and ability to lead a healthy life is dictated in large part by the economic circumstances she was born into and the education she receives. The wealthier your parents are, the longer your life expectancy. And the poorer your family is, the more likely you are to die young. That’s why we need to take a life course approach to health and focus on prevention rather than treatment. We need to give adolescents the tools early on, enabling them to flourish and make informed choices about their health and life. In the words of Professor Mahmoud Fatahah, founder of the Safer Motherhood Initiative and a world-renowned academic, clinician and activist for women’s health, ‘Women are not dying of diseases we cannot treat. They are dying because societies have yet to decide that their lives are worth saving’.

2
Maternal mortality and morbidity

The MDGs, the predecessors to the SDGs, included a commitment to improve maternal health, with a specific target of reducing the maternal mortality ratio (MMR) by 75% between 1990 and 2015. While any decrease in the MMR is to be welcomed, the actual figure of a 45% reduction fell far short of the target.

It must be remembered that for every one maternal death, there are 30 women who have life-changing comorbidities as a result of their pregnancy and birth. Current figures demonstrate the scale of the challenge that faces us. Each year, there are 213 million pregnancies of which 75 million are unplanned. There are over 50 million induced abortions, of which 22 million are unsafe. In 2016, there were 303,000 maternal deaths, of which 25% were adolescent girls.

Figure 1 shows the MMR for each country, demonstrating the far higher rate in low and middle income countries.

**Figure 1: Maternal mortality ratios (per 100,000 live births), 2015**

![Maternal Mortality Ratios](image)

Table 1: Top five global causes of maternal mortality (adapted from WHO 2015 data)

<table>
<thead>
<tr>
<th>Factor causing maternal death</th>
<th>Maternal deaths (% of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemorrhage</td>
<td>28%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>16%</td>
</tr>
<tr>
<td>Unsafe abortion</td>
<td>15%</td>
</tr>
<tr>
<td>Pre-eclampsia/eclampsia</td>
<td>13%</td>
</tr>
<tr>
<td>Obstructed labour</td>
<td>9%</td>
</tr>
</tbody>
</table>

Table 1 lists the top five global causes of maternal mortality. All five of these factors are easily treatable, with medical treatments or preventive measures routinely being offered to women in high-income countries. However, in low and middle-income countries, the facilities and resources required to manage an obstructed labour often pose significant barriers for women to access prompt assistance. Nevertheless, it is important to note that this category of obstructed labour accounts for only 9% of the total deaths worldwide. The other 91% of maternal deaths are due to problems for which we have cheap, easily distributed, temperature-stable medications and simple interventions to prevent women dying from these complications of pregnancy and delivery.
Historically, global health experts have cited the “Three Delays” model when describing the multiple factors that lead to delays in these girls and women receiving care resulting in such high rates of maternal mortality. The three delays being:

– Women or their families may delay the decision to seek care. This can be attributed to a lack of understanding of complications; a cultural acceptance of maternal death; the low status of women; and socio-economic barriers to seeking care.

– Once a decision to seek care has been made, there may be a delay in the woman reaching a healthcare facility where care can be provided. This may be due to geography (mountainous areas, islands and rivers, for example, can make it difficult to travel), and/or to poorly organised or poorly resourced transport networks. A lack of escalation pathways may also prevent women at high risk from obtaining an appropriate level of care.

– Women may then experience a delay in receiving care. This may be due to a lack of supplies or personnel, or to a lack of finances. It may also be due to poorly trained staff, or a punitive attitude towards women among healthcare staff.

However, if we are to make a sustainable improvement to maternal mortality, I think we need to recognise that the five factors that appear in table 1 are all complications that occur at the time of delivery and that the preventative measures and emergency interventions are effectively firefighting interventions. If we really want to address the problem then we need to shift our focus upstream and empower girls and women with the education and tools they need to take control of their reproductive health. In short, we need to introduce health policies and interventions that allow girls and women to be in control of if, when and how many times they become pregnant during their lives.

Family planning

Across the world, there are 214 million women with no access to family planning. The unmet need is greatest where the MMR is highest (compare Figures 1 and 2). The statistics for adolescents show the scale of the impact of a lack of family planning on this demographic. Worldwide, pregnancy and childbirth is the number one killer of girls and young women aged 15–19 years, with 50,000 deaths per year. The figures for their children are also stark: one million babies born to adolescent girls die in their first year of life.
Access to family planning has a positive impact on both the woman and her child. For example, birth spacing of 18-24 months prevents maternal deaths and dramatically improves infant survival. Providing all women with the choice of using effective contraception would reduce the number of unplanned pregnancies by 70% and reduce the unsafe abortion rate by 74%. In turn, this would result in a two-thirds reduction in maternal deaths and a three-quarters reduction in neonatal deaths. Access to family planning also has wider benefits for society, by allowing women to plan for the future, complete their education and find employment. In addition, the health economics argument strongly supports provision of family planning services: every £1 spent on family planning saves £4 which would otherwise be spent on treating complications of pregnancy or birth.

Abortion
Access to abortion is another key issue in global women’s healthcare. Figure 3 depicts the level of legal restriction placed on women’s access to abortion services across the globe. Generally speaking, in areas with little or no legal restriction on access to abortion, the procedure is safe. Where the law is restrictive, demand remains the same, with women seeking illegal and/or unregulated abortions which are often unsafe.

Worldwide, 25% of pregnancies end in abortion. In 2011, rates of unsafe abortion were four times higher in countries with restrictive laws (26.7/1000 women) compared with countries with liberal policies (6.1/1000 women). Restrictive policies do not reduce abortion rates. In 2010-14, rates were estimated at 34 (29-46) per 1000 in countries where abortion is legal on request but 37 (35-51) per 1000 women in countries with no legal grounds for abortion. Each year between 4.7% – 13.2% of maternal deaths can be attributed to unsafe abortion. Although the official figures are undoubtedly an underestimate, this equates to eight deaths an hour from unsafe abortion. Adolescents are, again, disproportionately affected, with one in four unsafe abortions sought by this demographic.
It is clear that improving both access to health care and the quality of health care across the globe could bring real improvements to women’s health. However, looking at the underlying issues surrounding maternal mortality and morbidity and women’s access to family planning and abortion services, it is also clear that in order to effect change more quickly, and ensure any change is sustainable, cultural and economic factors also need to be addressed. This would need to include both a top-down and a bottom-up approach – ensuring there is the political will to invest in women’s health care, but also addressing the factors that have an adverse impact on the status of women and girls in society. This will require us to move upstream and focus on preventing problems occurring rather than trying to salvage situations after they have deteriorated.

The only way in which this will be achieved is by educating girls and women and empowering them to take control of their own health, and indeed their own lives. Sir Michael Marmot, Director of the Institute of Health Equity at University College London and former chair of the World Health Organization’s Commission on Social Determinants of Health, is clear that health inequalities stem from social inequalities. This stems from analysis of the factors that underpin the causes of health inequalities. For example, unhealthy behaviours and biological risk factors are caused by the circumstances in which people are born, grow, live, work and age. Bluntly, the poor are more likely to be unhealthy, and there is a significant social gradient in health. The solution to this issue is education: those with the best chances of health and life expectancy are those who have had a secondary education.

This is particularly true of education for girls and women, given the impact it has not just on the individual but also on their family and wider society. Education has a positive impact on child survival, on fertility control and family spacing and on the woman’s own health, all of which has a positive impact on the development of the country in which the woman lives. In the words of Sir Marmot himself, “If I had to choose a single recommendation to improve health it would be education. And in a global context – the education of women. Education is central to women’s empowerment.”

As the health of women is so intrinsically linked to education, then so too is it intrinsically linked to the value society places on women. Taking maternal mortality as an example, we can see it as an indicator of the extent to which society values women and prioritises their
reproductive health, and a measure of inequities that intersect across gender, ethnicity, race, socioeconomic background and geography of residence. The social determinants of this indicator and these measures include the status of girls in society, their level of empowerment and their ability to make healthy choices – all of which are reflected in the lack of educational opportunities for girls in many countries worldwide.

There must therefore be global agreement that investing in education for girls and women is a priority, as part of a broader commitment to ending discrimination based on gender. This must be accompanied by commitments to eliminate gender-based violence and eradicate child, early and forced marriage. Healthcare policy must likewise treat women’s health and healthcare equitably, ensuring universal access to sexual and reproductive healthcare and ensuring all women have access to high-quality care during pregnancy and birth. Until this equity is achieved, healthcare professionals must continue to work with the women for whom they provide care to advocate for investment in women’s health.

The SDGs provide a unique opportunity for countries across the world to join forces to achieve gender equality by 2030. We must do whatever we can to seize this opportunity, not least because it coincides with a demographic opportunity: the biggest cohort of adolescents in history. If we do not do all we can to ensure the girls and young women of this generation have access to education, we will have missed the chance to make a great stride forward towards a healthier global population for years to come.
References
