



BMA Response to the Department of Health and Social Care Women's Health Strategy: Call for Evidence

About the BMA

The BMA (British Medical Association) is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. We are a leading voice advocating for outstanding health care and a healthy population. We are an association providing members with excellent individual services and support throughout their lives.

Our vision for women's health

The UK health and care system has been designed around the needs of just half the population. Men have historically been treated as the default patient in medical research and clinical practice, while women's healthcare needs have been marginalised and stigmatised. Strong action is needed to ensure that women's needs are placed at the centre of their health and care.

In our response, we provide evidence for areas in which women's health and care can be improved. In line with the Government's six core themes for this strategy, we recommend that the Women's Health Strategy ensures that:

1. All women, particularly those who have historically been marginalised, can access healthcare without fear of stigmatisation. The design and provision of health and care services should take the needs of all women into consideration.
2. The quality and accessibility of information on women's health is improved through broader teaching on women's health in medical training and curricula and evidence-based sex and relationships education.
3. Women have access to high quality sexual and reproductive healthcare, maternity services, and other women's health services.
4. Women's health is maximised in the workplace through occupational health and wellbeing support, and improved support for pregnancy and parental leave, menstrual health, and menopause.
5. Women are included in clinical research.
6. Steps are taken to understand and respond to the impacts of COVID-19 on women's health.

We acknowledge that not only individuals who identify as women require access to services traditionally designated as women's health services. These services must be appropriate, inclusive, and sensitive to the needs of individuals whose gender identity does not align with the sex they were assigned at birth. The terms 'woman' and 'women's health' are used in this response in line with the language used in the Government's consultation, with the

understanding trans men and non-binary individuals assigned female at birth also require access to many of these services.

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

Centring marginalised voices

Women's experiences in healthcare settings, as well as their healthcare outcomes, are shaped by their identities and lived experiences. The Women's Health Strategy should take into consideration the healthcare needs of all women, particularly those who have been historically marginalised. This includes asylum seekers, refugees,¹ migrants, women with disabilities, victims of domestic abuse, women from ethnic minorities, women in prison, transgender and non-binary individuals, and lesbian, bisexual, and queer women.² Negative experiences of the health and care system are often exacerbated for women in these groups. The Women's Health Strategy should acknowledge the differences in women's identities and lived experience and ensure that proposals to improve healthcare access meet the needs of all women.

Inclusive healthcare for transgender individuals

It is important that a comprehensive strategy for women's health is inclusive of the specific healthcare needs of transgender and non-binary individuals. The Women's Health Strategy should reflect:

- The need to ensure that transgender and non-binary individuals can access routine healthcare services in line with their gender presentation
- The need to ensure continued access to organ-specific healthcare interventions, including preventative screening programmes, for trans men who retain physiological features of their sex assigned at birth
- The need to ensure that people who identify as non-binary can access appropriate healthcare, including organ-specific interventions
- The need to ensure that maternity, sexual, and reproductive healthcare services are inclusive of trans and non-binary people

Mental health services

Sex and gender have a significant impact on the prevalence, symptomatology, and risk factors of mental health illnesses.³ This is seen in the prevalence of mental illness (particularly common mental disorders such as anxiety and depression, self-harm, substance misuse and suicide), pathways into treatment, and in therapeutic preferences.⁴

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, responsibility for childcare and other caring responsibilities, and exposure to sexual abuse and domestic violence. We have explored these issues in detail in our report 'Addressing unmet needs in women's mental health'.⁵

¹ British Medical Association (2020) [Managing language barriers for refugees and asylum seekers](#)

² Public Health England (2018) [Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women](#)

³ Richer- Rössler (2016) [Sex and gender differences in mental disorders](#)

⁴ World Health Organization (2021) [Gender and women's mental health](#)

⁵ British Medical Association (2018) [Addressing unmet needs in women's mental health](#)

Approaches to mental health service provision that do not account for sex and gender differences often fail to recognise the specific needs of women. Women and girls have distinct and specific needs and, therefore, policies, services and practice need to be gender informed. For example, the WHO (World Health Organization) recommends that mental health strategies should consider the mental health consequences of domestic violence, sexual abuse, and acute and chronic stress experienced by women.⁶

To ensure that mental health services truly meet the needs of women, national and local leadership is needed, in partnership with women. Policies, services, and therapeutic options should be co-designed with women who have experience of poor mental health.

GP consultation times

The current standard consultation time for GP appointments is 10 minutes. Short consultations impede GPs' ability to provide comprehensive care, particularly when considering that more and more patients live with several complex conditions. The BMA, along with RCGP (Royal College of General Practitioners) and RCOG (Royal College of Obstetricians and Gynaecologists) have repeatedly called for the standard consultation time for GP appointments to be increased to 15 minutes. Increased investment in general practice, training and retention of GPs is needed to support this.

Longer consultation times can significantly improve the quality of patient care for all genders, allowing GPs to discuss a wider range of healthcare issues with their patients. For women, longer appointments can be particularly beneficial as they give them the opportunity to discuss sensitive healthcare needs more fully with their doctor. Longer consultations would also improve the accessibility of care for women with communication support needs, particularly those who require language interpreters.⁷

Abortion services

We welcome the Government's statement that 'embarrassment or stigma should not be a barrier to women seeking the help and care they need.'¹ We have long called for measures to protect the safety and privacy of women accessing abortion services. We have repeatedly raised serious concerns about the intimidation and harassment of patients accessing abortion services, and of staff providing those services. It is estimated that (prior to the national lockdowns) one in four women undergoing an abortion in England and Wales was likely to have encountered anti-abortion activity outside services. For example, our members report patients (and staff) being filmed, shouted at, made to feel unsafe or fearful – in some cases physically harmed – and ultimately being deterred from accessing confidential lawful health services.

Current legal and policing powers afforded by Public Space Protection Orders (PSPOs) are inadequate to guard against this, as they can require significant resources and apply only for finite periods of time. They do not therefore protect *all* women accessing services from experiencing unacceptable harassment and abuse. We are calling for this to be addressed at a national level through the introduction of exclusion zones outside all abortion services. Legislative protection is needed to ensure that such harassment and intimidation can be stopped swiftly and decisively.

Another important legislative measure supported by the BMA is decriminalisation of abortion services. Abortions carried out in the UK today are a safe procedure, for which major complications and mortality are rare at all gestations. Treating abortion as a criminal offense rather than a medical issue is stigmatising for both women and healthcare professionals who are providing a legal and necessary service. The BMA believes that doctors' ability to

⁶ World Health Organization (2021) [Gender and women's mental health](#)

⁷ British Medical Association (2020) [Managing language barriers for refugees and asylum seekers](#)

provide supportive care and treatment for women is hampered by this punitive approach. Abortion should therefore be regulated through professional and clinical regulations, rather than through criminal legislation.

Decisions around abortion are guided by regulations, professional standards, and clinical guidelines which promote good practice and are responsive to changes in the delivery of healthcare. We have previously put forward policy proposals on how abortion could be effectively regulated in the UK if criminal sanctions are removed.⁸

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

The BMA has long called for high quality, accessible health information to be made available to all. It is especially important that vulnerable groups and those who regularly experience poorer health outcomes have access to such education and information. The importance of this is now recognised globally, with our policy on health information for all adopted by the World Medical Association in 2019, calling on governments worldwide to 'ensure that the public, patients and health workers have access to the healthcare information they need to protect their own health and the health of those for whom they are responsible'.⁹ The BMA's Patient Liaison Group also hosts the longstanding and well-regarded annual BMA Patient Information Awards to recognise exceptional patient information services, and promote greater awareness and understanding of health matters and patient choice.¹⁰ Gaps still exist in the quality and accessibility of information on women's health. We outline three ways in which this knowledge can be improved among healthcare practitioners and educators.

Medical education

To ensure that all patients receive the best possible care, medical education must prepare students for the diversity of patients they will see. In 2020, the BMA published a statement and wrote to the GMC (General Medical Council) to propose that medical curricula needed to better meet the needs of the UK population.¹¹ We specifically highlighted the need for teaching on how skin conditions present on darker skin tones. The Medical Schools Council and the GMC have committed to doing further work to ensure that medical schools are teaching curricula that reflect the population.

Further work is now needed to ensure that medical education includes comprehensive teaching on women's health. The BMA has been clear in its report 'Health inequalities and women - addressing unmet needs'¹² that health professionals' roles in tackling health inequalities for women need to be strengthened, and that changes to medical education would help to achieve this. Undergraduate and postgraduate medical curricula should include women's health as a core topic and should provide specific practice-based skills such as communication, partnership working, and advocacy. Student placements in a range of healthcare settings, including community settings, could be included to embed this approach.

In medical education, teaching on women's health focuses primarily on obstetrics. While this is a vital part of women's health, education must be broadened to include teaching on women's health across the life course. Particular areas where teaching could be improved include menstrual health, female anatomy, fertility, endometriosis, and menopause.

Improvements are also needed in domestic violence and abuse (DVA) training, both in the medical curriculum and among healthcare providers. Research indicates that medical students in the UK do not receive adequate teaching

⁸ British Medical Association (2019) [How will abortion be regulated in the United Kingdom if the criminal sanctions for abortion are removed?](#)

⁹ World Medical Association (2019) [WMA statement on healthcare information for all](#)

¹⁰ British Medical Association Patient Liaison Group (PLG), [PLG patient information awards](#)

¹¹ British Medical Association (2020) [Racial harassment charter for medical schools](#)

¹² British Medical Association (2018) [Health inequalities and women – addressing unmet needs](#)

on DVA.¹³ Medical students and healthcare professionals must be trained with the skills to identify, treat, and refer victims of violence appropriately.

Evidence-based Relationships and Sex Education

We welcome the introduction of compulsory Relationships and Sex Education (RSE) for secondary school pupils. For this education to be effective, government education departments across the UK must provide consistent training for teachers on all aspects of RSE, including menstrual health, contraception, violence against women, FGM, abortion, and LGBTQ+ identity and relationships. Teachers should also be supported with medically accurate, evidence-based materials. For example, the RCOG and FSRH (Faculty of Sexual and Reproductive Healthcare) have produced an abortion care factsheet¹⁴ for educators to use in RSE lessons.

Female Genital Mutilation (FGM)

We recognise that doctors have a vital role in breaking the generational cycle of FGM. This illegal and harmful practice is a serious crime and form of abuse that no child or woman should have to suffer. In previous years there has been an unprecedented rise in resources, initiatives, parliamentary and media coverage, policy developments, legislative changes, and new requirements on doctors, aimed at eradicating FGM.

The Women's Health Strategy should set out a new national approach to eradicating FGM. Ongoing awareness and resourcing are needed to ensure we now capitalise on the focus on this area in recent years, so that healthcare professionals continue to be trained in how to meet the physical and psychological needs of girls and women who have undergone FGM. There must be adequate resourcing of care pathways to support survivors and potential victims of FGM. Finally, an FGM Commissioner should be appointed to lead public health interventions to prevent FGM and to carry out a full, independent evaluation of mandatory reporting of FGM and the effectiveness of FGM Protection Orders.

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

Access to sexual and reproductive healthcare (SRH) across the life course

While we recognise that SRH will be addressed by the Government in a specific strategy on SRH later this year, it is important that these issues are also addressed in the Women's Health Strategy, and that both strategies complement one another.

Funding for SRH has declined significantly in recent years, resulting in reduced access to vital services, particularly for the most vulnerable women.¹⁵ Analysis shows that the public health grant had been cut by 22% in real terms between 2015/16 and 2020/21 and that there has been an 18% decrease of contraceptive spend in real terms since 2015.¹⁶ The Women's Health Strategy must commit to a real terms increase in the public health budget, and ring-fenced funding for sexual and reproductive healthcare to rectify past cuts to this budget.

Structural change is also needed to ensure that women can access services. The fragmentation of SRH commissioning has resulted in disjointed care, whereby healthcare providers with the skills to provide care are unable to do so due to commissioning restraints.¹⁷ This has resulted in women having to attend multiple different

¹³ Potter & Feder (2017) [Domestic violence teaching in UK medical schools: a cross sectional study](#)

¹⁴ Faculty of Sexual and Reproductive Healthcare (2019) [FSRH-RCOG abortion care factsheet to support RSE lessons](#)

¹⁵ APPG Sexual and Reproductive Healthcare (2020) [Women's lives, women's rights](#)

¹⁶ Health Foundation (2020) [Health Foundation response to the public health grant allocations](#)

¹⁷ Academy of Royal Medical Colleges (2021) [Holistic integrated commissioning of sexual and reproductive healthcare](#)

services to meet their SRH needs. An integrated approach to commissioning and SRH provision would enable women to have all their SRH health needs met in one place and with fewer appointments. The Women's Health Strategy should set out an approach for integrated, holistic SRH commissioning, and ensure that any review of SRH commissioning should focus on women's health.

Finally, the Women's Health Strategy should include steps to rectify the "postcode lottery" around fertility services in England. IVF provision is subject to variation across England according to decisions made at local levels. The lack of access to services in many areas drives women into the private sector, widening inequalities in access to care. To redress the imbalance between regions, The Women's Health Strategy should set out steps for national guidance to guide provision and promote standardisation across the country.

Maternity services

The Women's Health Strategy should set out an approach to improving maternity facilities. Our members have outlined ways in which maternity services could be improved to better support women. For example, breastfeeding support could be provided in all healthcare settings, including access to lactation consultants seven days a week in hospitals and in the community (currently this is usually offered 2-3 days per week in hospitals). Breast pumps could be made available free of charge for breastfeeding women in all hospital settings, with storage facilities for expressed milk (fresh and frozen) provided in hospitals. Facilities for partners or another adult to stay with them, including overnight, would allow others to help care for the child and ensure individuals who have just given birth can receive the care they need.

Miscarriage and stillbirth

The Women's Health Strategy should set out an approach to improving support for women who experience loss of pregnancy and stillbirth. Our members have outlined a number of areas in which this care could be improved. For surgical procedures required in missed or incomplete miscarriages, women could be given the option to have a general anaesthetic, rather than need to be awake for manual vacuum aspiration and other surgical procedures. Women's emotional wellbeing could be improved through access to psychological support and referral to specialist miscarriage clinics on request following miscarriage. Women who have had a miscarriage should have access to complex care midwives who are experienced in pregnancy loss.

Women's wellbeing could also be improved through access to soundproof rooms for labour and delivery of a stillborn baby, cold cots (refrigerated bassinets), memory boxes, and hospital photography services, should they wish it. Wider access to bereavement midwives, access to psychological support, and access to complex care midwives in future pregnancies could also make this experience easier for women and their partners.

Menopause care

The menopause affects every individual who menstruates in their lifetime, but many do not know what to expect or what care they may need. Shame, discrimination, and stigma relating to ageing and the menopause are highly prevalent and can have a huge impact on a woman's quality of life. These issues are particularly challenging for the 25% of menopausal women who experience severe symptoms, which can lead to the onset of potentially avoidable health problems.¹⁸ The RCOG's 'Better for Women' report¹⁹ explores a range of healthcare issues related to menopause, and provides recommendations for improving care.¹⁹ In section 4 of this response, we outline the specific issues women face in the workplace when going through the menopause.

¹⁸ Royal College of Obstetricians and Gynaecologists (2020) [Better for women](#)

¹⁹ Royal College of Obstetricians and Gynaecologists (2020) [Better for women](#)

Inclusive healthcare for disabled women across the life course

The World Health Survey estimates that the global prevalence of disability among women is 60% higher than among men.²⁰ In the UK, around one in five adults are disabled. Disabled people experience greater barriers to accessing healthcare than non-disabled people, and disabled women face greater barriers to accessing healthcare than disabled men. The existing and disproportionate barriers that all women face in accessing healthcare are exacerbated for women with disabilities. These barriers include unmet need for healthcare due to financial constraints, waiting times for treatment, and sociocultural barriers such as being ignored or judged.^{21, 22}

A comprehensive Women's Health Strategy must address the health and access inequalities faced by disabled women. In particular, the strategy should reflect the urgent need to address access to public health and preventative health interventions, such as screening programmes, for physically disabled women.²³ We also urge the Government to ensure all NHS facilities have fit for purpose healthcare access for patients with disabilities, and to provide dedicated funding to achieve this. All healthcare commissioning groups in the UK should guarantee provision of a hoist, with appropriately trained staff, and an appropriate examination couch in at least one practice within their groups, enabling timely and accessible examinations of patients with disabilities.

Access to healthcare for D/deaf women

D/deaf women are more likely to suffer ill health than the rest of the population, largely because they face problems accessing health services that should be available to all. Basic interactions, like making an appointment, or getting advice from a doctor, are harder for those with hearing loss. D/deaf women face many challenges, such as lack of appropriate communication or reasonable adjustments, lack of appropriate time for consultations, poor attitudes of staff, and a lack of D/deaf awareness. We are also concerned about the negative experiences of D/deaf women who use sign language. The Government should ensure investment in sign language support services in healthcare settings and engage in meaningful consultation with D/deaf women and the organisations that support them.

D/deaf women can face particular challenges in pregnancy, as they are often labelled as high risk and offered a care pathway that is unsuitable to their needs.²⁴ Identifying the gaps in maternity that exist in current guidelines and practice can help midwives to ensure women get appropriate, high-quality care. The Women's Health Strategy should ensure that plans for the improvement of women's health services consider the needs of D/deaf women.

Women with learning disabilities

People with a learning disability have worse healthcare outcomes than people without a learning disability. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population.²⁵

The death rate from COVID-19 for 18-34-year-olds with a learning disability is 30 times higher than the rest of the population. The pandemic has amplified the stark health inequalities faced by this group of patients and it is vital that the Women's Health Strategy sets out specific actions to address barriers to accessing services experienced by

²⁰ World Health Organization (2011) [World report on disability](#)

²¹ Sakellariou & Rotarou (2017) [Access to healthcare for men and women with disabilities in the UK: Secondary analysis of cross-sectional data](#)

²² Matin et al (2021) [Barriers in access to healthcare for women with disabilities: a systematic review in qualitative studies](#)

²³ Jo's Cervical Cancer Trust (2019) ["We're made to feel invisible" Barriers to accessing cervical screening for women with physical disabilities](#)

²⁴ Crowe (2020) Inequalities and [Unreasonable Adjustments: Are D/deaf women being given a detrimental care pathway in the name of risk assessment?](#)

²⁵ University of Bristol Fry Centre for Disability Studies (2019) [The Learning Disabilities Mortality Review Programme Annual Report 2019](#)

women with learning difficulties. This should include meaningful consultation with women with learning disabilities and the organisations that support them.

Sexual and reproductive healthcare services

Lack of access to SRH services experienced by disabled people is increasingly documented.²⁶ Contributing factors include structural inaccessibility, communication barriers and negative attitudes from service providers. Evidence highlights wide-ranging and long-standing prejudices including assumptions that disabled women are sexually inactive or do not wish to become parents, or that disabled women do not experience sexual violence.²⁷ The strategy should explicitly recognise the need for SRH services to become disability inclusive and set a clear plan of action to achieve this aim.

4. Maximising women's health in the workplace

Occupational Health Services and health and wellbeing support

Health and wellbeing services must be fully aware of women's health and work against the culture of downplaying conditions that specifically or more often impact women, such as endometriosis. Access to health and wellbeing services that are free, confidential, comprehensive, and meet individuals' needs are essential to maximising women's health in the workplace and retaining women in the workforce.

Research conducted prior to the pandemic showed that 66% of women had suffered psychological, behavioural, or physical symptoms of mental health caused from work at some point in their life, compared to 58% of men.²⁸ More recent evidence suggests that gender differences in wellbeing have been exacerbated by the pandemic, as women have taken on more family and caring responsibilities in addition to working.²⁹

The BMA has put forward several recommendations to increase health and wellbeing in the healthcare workforce. This includes access to specialist physician-led and high-quality occupational health services, improved health and wellbeing services at work, training and support for managers to handle health and wellbeing issues, and building a culture which makes staff comfortable seeking support from health and wellbeing services. The Women's Health Strategy should outline similar steps for improving women's occupational health across the UK workforce.

Pregnancy and maternity leave

Strategies to improve women's health in the workplace must include ensuring a supportive and safe environment for pregnant women, women on maternity leave, and new mothers returning to work. There are legal requirements in place which aim to prevent pregnant women facing discrimination at work and protect their safety, such as workplace risk assessments, maternity leave pay, time off for antenatal appointments, and protections from dismissal. However, many employers are falling short of even these minimum expectations.³⁰

There needs to be a cultural shift in the workplace on attitudes towards pregnancy. Women still feel the need to conceal their pregnancies so as not to face career barriers, pressure to continue working when experiencing

²⁶ Matin et al (2021) Barriers in access to healthcare for women with disabilities: a systematic review in qualitative studies

²⁷ Hameed et al (2020) [From words to actions: Systematic review of interventions to promote sexual and reproductive health of persons with disabilities in low- and middle-income countries](#)

²⁸ The Prince's Responsible Business Network (2020) [Gender and mental health at work](#)

²⁹ Etheridge and Spandig (2020) [The gender gap in mental well-being during the Covid-19 outbreak: Evidence from the UK](#)

³⁰ TUC (2019) [Pregnancy, breastfeeding and health and safety](#)

pregnancy-related illness, and experience expectations from colleagues that they will be less committed to work after having a child.

Feedback from our members shows that pregnant doctors often face barriers in how their training schedules, placements and exams are managed to take account of their pregnancy and/or maternity leave. As in many other professions, women in the medical profession face pay and career penalties due to childcare responsibilities. We want to see enhanced pay for shared parental leave extended to all doctors and call on the Government to work with the BMA to fulfil the contract commitment to allow GP partners to offer more generous parental leave rights to their staff. More broadly, all employers should offer better parental leave rights to incentivise both parents to take leave so that childcare responsibilities can be shared.

To enable mothers to return to work, workplaces should have suitable breastfeeding facilities, such as access to a quiet room and access to fridges to store milk. Employees should also have the time within their workplans to express milk. Employers should make the return to work as seamless as possible and understanding of additional support and flexibility mothers may need after taking a period of leave. This should go beyond the existing legal requirements of facilitating keeping in touch days and carrying out risk assessments, and include examples of good practice that some employers are already demonstrating. This should include access to resources that allow for employees to get back 'up to speed', access to mentoring or coaching, and arrangements around flexible hours or staged returns to work that may be necessary.

Menstrual health in healthcare settings and the workplace

The BMA have campaigned to end period poverty across the UK and have taken action to increase accessibility of sanitary products in healthcare settings and within the BMA. In 2019, we successfully campaigned to secure sanitary product provision in hospitals across the UK.³¹

In the workplace, employers must recognise the impact that menstruation can have on a colleague's health and wellbeing. Menstruation policies, often linked with menopause policies, will make it easier for employees and managers to be supported at work. Women going through menstruation should have frequent access to toilet breaks and requests such as home working for those who have heavy bleeding or painful menstruation should be considered.

One in ten women suffer from endometriosis, this is a long-term condition that is usually worse during periods and can cause significant physical pain, discomfort, and distress.³² Employers must recognise the seriousness of this condition and allow employees to take the needed sickness absences, flexible working, and make any wider adjustments that would make employees' working life more manageable. Employees should also have access to an occupational health assessment.

Menopause in the workplace

Menopause is often considered to be a taboo subject in the workplace. Clinical environments bring up specific challenges for healthcare practitioners working through the menopause. To better understand these challenges, The BMA's 2019 all member survey on this topic,³³ which received 2,000 responses, found that:

- 93% of respondents had experienced menopause symptoms, with 65% experiencing both physical and mental symptoms. Symptoms included hot flushes, migraines, joint pain, fatigue, and difficulty sleeping.
- 90% said that these symptoms had impacted their working lives, with 38% saying that the impact was significant.

³¹ British Medical Association (2020) [Sanitary product provision for inpatients](#)

³² Royal College of Nursing (2015) [Endometriosis fact sheet](#)

³³ British Medical Association (2020) [Challenging the culture on menopause for working doctors](#)

- 36% of respondents had made changes to their working lives due to menopause and 9% intended to make changes. This included changing working hours, changing career path, and retiring early. A further 38% wanted to make changes to their working lives as a result of menopause but said they were not able to do so. Some respondents wanted to step down from senior positions, move to lower paid specialties, or even leave medicine altogether because of the impact that menopause.
- Only 16% had discussed their menopause symptoms with their manager, while 47% wanted to but did not feel comfortable doing so.

The significant negative impact of the menopause on many women's wellbeing and careers is extremely concerning, particularly given that some of this negative impact is due to inflexibility and lack of support in the workplace. Employers can and should do more to support women through the menopause. The BMA recommends that employers introduce a menopause policy that includes a focus on breaking the taboo around menopause. Employers should ensure that flexible working is available to all employees, and that flexible working policies are visible. They should also review working conditions and facilities to make menopausal symptoms more manageable in the workplace, for example through easy access to toilet facilities and access to cool drinking water. Finally, employers should develop a supportive culture so that those experiencing menopause symptoms feel comfortable to speak openly with their manager.

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

Including women in clinical studies

Women have historically been underrepresented in clinical trials, as well as in wider medical research. While women's participation in clinical trials is improving, this historic underrepresentation means that women continue to be prescribed medication for which data is predominantly derived from men. It has also resulted in a lack of evidence of treatment efficacy, safety, pharmacokinetics, and pharmacodynamics in women.

Despite substantial evidence showing the importance and far-reaching benefits of considering sex in health and medical research, men are still more likely to be enrolled into clinical studies than women. Evidence from men is often extrapolated to women, and sample sizes are very rarely sufficient to enable identification of sex-based interactions or sub-group effects. Frequently, sex-based analyses are not conducted, or conducted as afterthoughts, rather than as a primary component of the study design. For example, autism has historically been thought to predominantly affect boys and men, at a ratio of 10 to 1 woman. Much of the research on autism has thus included all-male or predominantly male participants. However, recent research into gender variance in autism diagnosis has indicated that autism is underdiagnosed in girls and women, and that the ratio is in fact 3 to 1.³⁴ To develop better diagnostic tools and to better understand gendered variances in autism, girls and women should be included in future research on autism.

There has also been a lack of research into conditions that affect only or predominantly women. As of January 2021, only six major pharmaceutical companies were listed as running medicines' trials as part of women's health programmes.³⁵ These include conditions which affect a significant proportion of women, such as uterine fibroids, endometriosis, polycystic ovary syndrome, and menopausal symptoms. The absence of research into these conditions has individual and wider public health implications for women. For example, recent evidence suggests that women with polycystic ovary syndrome are at increased risk of COVID-19.³⁶ However, due to lack of research, little is known about this disease and it is often misdiagnosed. As a result, many sufferers may be unaware that they are at increased risk.

³⁴ Estrin et al (2020) [Barriers to Autism Spectrum Disorder Diagnosis for Young Women and Girls: a Systematic Review](#)

³⁵ Medical Women's Federation (2021) [Keeping women in health](#)

³⁶ Miller (2021) [COVID-19 may be more common in women with PCOS, a condition that's often ignored](#)

Pregnancy presents a specific challenge as pregnant women are generally excluded from clinical trials. In 2020, 80% of COVID-19 studies actively excluded pregnant women.³⁷ The WHO has recently highlighted that approximately 68% of COVID-19 studies exclude women and children. Pregnant women have increased exposure to COVID-19 due to the need to attend regular hospital appointments, and may be more clinically vulnerable to serious outcomes.³⁸ Yet, a recent review reported that of 927 trials related to COVID-19, 52% explicitly excluded pregnancy, 46% did not mention pregnancy, and only 1.7% specifically included pregnancy, of which just three were interventional trials.³⁹ The WHO⁴⁰ advocates for the inclusion of women in research as the default, unless there is good scientific rationale for their exclusion. The Women's Health Strategy should set out steps for ensuring women's participation in health research.

Improving information gaps in reproductive health

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 reversible methods of contraception. Access to information about choice, uptake and satisfaction with contraception method is limited, particularly from general practice where 70-80% of women receive their contraceptive care.

The Women's Health Strategy should include plans to resolve information gaps on reproductive health. Identifying and understanding the prevalence of unplanned pregnancy is vital to enable sensitive, responsive approaches to improving preconception and long-term health, as well as reducing healthcare inequalities across the UK. For example, the London Measure of Unplanned Pregnancy is a validated measure for use in pregnant populations and gives a more robust measure of reproductive choices. If implemented at population-level, it would enable the incidence of unplanned pregnancy to be estimated accurately and routinely.⁴¹

6. Understanding and responding to the impacts of COVID-19 on women's health

The COVID-19 pandemic has had a detrimental impact on women's health and wellbeing. COVID-19 policies have often not taken women's needs and responsibilities into consideration, leading to a wide range of issues such as unsuitable personal protective equipment for healthcare providers, stress and anxiety for pregnant women, and increased childcare responsibilities. Immediate action is necessary to improve these issues, as well as to improve access to women's healthcare services and domestic abuse services in particular.

Access to healthcare services

The COVID-19 pandemic has significantly impacted women's access to healthcare services. To ensure patient safety as well as protect healthcare professionals, service providers have limited face-to-face consultations and increased remote consultations. Services requiring face-to-face interaction, such as consultations for Long-Acting Reversible Contraception (LARC) and have been particularly impacted.⁴² Providers of these services are now facing severe backlogs and must receive the resources needed to help tackle them, as well as support to increase system capacity while protecting staff wellbeing.

Remote consultations can sometimes make it more difficult for healthcare providers to pick up on safeguarding issues and domestic abuse. On the other hand, remote consultations can enable women to access healthcare

³⁷ Modi et al. (2021) [Equity in coronavirus disease 2019 vaccine development and deployment](#)

³⁸ EH, Spong CY., JAMA (2021) [COVID-19 Vaccination in Pregnant and Lactating Women](#)

³⁹ Smith et al (2020) [Exclusion of pregnant women from clinical trials during the coronavirus disease 2019 pandemic](#)

⁴⁰ World health Organization (2020) [TDR Intersectional Gender Research Strategy](#)

⁴¹ British Medical Association (2018) [Reproductive health and wellbeing](#)

⁴² APPG Sexual and Reproductive Healthcare (2020) [Women's lives, women's rights](#)

services in situations where they are unable to physically attend a service. Childcare responsibilities, distance from clinics, and abusive partners place significant barriers on women's access to care. The availability of remote consultations can remove this barrier. The Women's Health Strategy should ensure the availability of different types of consultation - face-to-face, telephone and online - which are vital to provide comprehensive care for all women now and beyond the pandemic.

Domestic violence and abuse (DVA)

DVA is well-recognised as a public health issue that affects at least one million people in the UK. Since the beginning of the COVID-19 pandemic, rates of domestic abuse have increased dramatically. In the first month of lockdown in March 2020, the number of calls to DVA services rose by 49%, while police received an average of 380 calls per week related to DVA.⁴³

The BMA's Domestic Abuse report⁴⁴ emphasises the vital role of healthcare providers in identifying signs of DVA. With the right training and support, healthcare professionals can learn to identify the indicators of DVA before a 'crisis point' is reached. On average, female victims are subjected to 35 incidents of DVA before they involve the police, yet many of these women will have attended their GP long before seeking help from the authorities.

As the professional association representing doctors in the UK, the BMA is encouraging all health professionals in all disciplines to raise awareness of the problem of DVA and to develop strategies to identify and reduce the substantial impact upon the health and welfare of adults and children. To respond effectively, healthcare professionals should be trained to recognise and manage DVA, with appropriate capacity and financial resource to support this activity provided by Government.

We also urge the Government to ensure that strategies to address DVA are explicitly highlighted in Government public health strategies, that refuges are accessible to all victims of abuse, including transgender victims, and that information about support services is readily available in healthcare settings such as GP surgeries, Accident and Emergency units and maternity departments. Finally, the Government must work to identify and combat the barriers to reporting incidents of DVA. This should help identify the true prevalence of DVA.

Maternity services

Pregnant women have faced many challenges during the pandemic, particularly those from black and minority ethnic (BAME) backgrounds. In May 2020, Oxford University published research that found that pregnant women from BAME backgrounds were more likely to be admitted to hospital for COVID-19. They found that Black women were eight times more likely to be admitted to hospital with COVID-19 than white women, with Asian women four times more likely.⁴⁵ This difference in health outcomes should be viewed alongside the evidence that Black women are five times more likely than white women to die in pregnancy or childbirth in the UK.⁴⁶ This stark disparity is concerning and must be addressed in the Women's Health Strategy.

The needs of pregnant women were not taken into consideration in the development of healthcare protocols during the pandemic. Many pregnant women had to go through scans, appointments, and labour alone because their local service was unable to accommodate visitors, causing a great deal of distress for women and families. Any future pandemic response preparation must therefore take the particular needs of pregnant women into consideration.

⁴³ Centre for Women's Justice (2020) [COVID-19 and the surge in domestic abuse in the UK](#).

⁴⁴ British Medical Association (2014) [Domestic abuse](#)

⁴⁵ Knight et al (2020) [Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population based cohort study](#)

⁴⁶ MBRRACE-UK (2019) [Saving lives, improving mothers' care: Lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2015-2017](#)

Though maternity services have struggled throughout the pandemic, a silver-lining has been the increased provision of immediate postpartum contraception in maternity services. Prior to the pandemic, there was almost no provision of postpartum contraception in hospitals. Midwives would routinely enquire about women's contraceptive plans and direct them to general practice for advice and initiation. However, to limit face-to-face contact in the postnatal period, maternity units introduced immediate postpartum contraception during the pandemic. This not only reduced the risk of COVID-19 transmission, but increased access to contraception, particularly for vulnerable women who experience more challenges to accessing postnatal appointments.⁴⁷ In line with the RCOG, FSRH, and RCN (Royal College of Nursing), we recommend that all maternity units are supported to provide immediate postpartum contraception beyond the pandemic.^{48,49}

Childcare

The UK's costly and inflexible childcare system has led to many parents leaving the workforce and the many problems with the system have been enhanced by the pandemic. Childcare responsibilities have disproportionately fallen on women during the pandemic.⁵⁰ Government policy failed to mitigate against the challenges that those with caring responsibilities would predictably face from the measures introduced, particularly during the first lockdown. Although the Government allowed early-years settings to remain open for critical workers, this was not accompanied by the financial backing for services to remain open, and many were forced to temporarily or permanently close.⁵¹

Lack of childcare kept critical workers, who were fit to work, at home. A BMA survey in May 2020 found that 13% of doctors had been unable to work or reduced their hours as they could not find sufficient childcare.⁵² Others faced significant extra costs as they had to fund more expensive provision to cover additional working hours. Difficulties in finding childcare cover and having to put their young children in new, unfamiliar settings created additional stress for key workers and their families at an already highly emotional time. These issues are further explored in the BMA 'Briefing on COVID-19 and childcare'⁵³ and Department of Health and Social Care 'Mend the Gap' report.⁵⁴

An expansion of NHS nurseries and other support for childcare would enable more parents, particularly healthcare workers, to return to work. The Women's Health Strategy should set out steps to improve equitable access to childcare services beyond the pandemic.

Personal Protective Equipment (PPE)

Among the first issues raised by BMA membership during the pandemic was the lack of diversity in PPE. The PPE procured did not represent the NHS workforce and this led to certain groups being less safe than others. Women found that there was a lack of PPE in smaller sizes, and that even the small sizes are designed around a male body, despite women making up over 75% of the NHS workforce. We also consistently heard from members that there

⁴⁷ Campbell et al (2020) ['Our COVID-19 cloud silver lining': the initiation and progress of postnatal contraception services during the COVID-19 pandemic in a UK maternity hospital](#)

⁴⁸ British Medical Association (2018) [Reproductive health and wellbeing – addressing unmet need](#)

⁴⁹ Royal College of Obstetricians and Gynaecologists (2021) [Guidance on the provision of contraception by maternity services after childbirth during the COVID-19 pandemic](#)

⁵⁰ Goswami (2021) ['We need to reflect on why women still do most of the childcare'](#)

⁵¹ Adams (2020) [UK childcare industry 'crushed' by coronavirus crisis](#)

⁵² British Medical Association (2020) [Childcare support for doctors must improve](#)

⁵³ British Medical Association (2020) [Briefing on COVID-19 and childcare](#)

⁵⁴ Department of Health and Social Care (2020) [Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England](#)

was short supply of powered air-purifying respirators hoods, a form of PPE that allows Muslim women to wear a hijab.⁵⁵

Whilst confidence in PPE has gone up during the pandemic, there have consistently been differences in the protection afforded to men and women. A BMA survey in February 2021 found that, when asked whether current PPE was fit tested and adjusted to meet their needs, just 27% of female doctors said they felt fully protected, compared with 37% of male doctors.⁵⁶

The Women's Health Strategy should set out steps for a review of the adequacy of its PPE for healthcare staff amid evidence that inadequate PPE is placing many at serious risk of COVID-19.

⁵⁵ British Medical Association (2020) [BAME doctors hit worse by lack of PPE](#)

⁵⁶ British Medical Association (2021) [BMA COVID tracker survey February 2021](#)