Women's Health Plan

A plan for 2021-2024

Scottish Government
Riaghaltas na h-Alba
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Foreword by the Minister for Public Health, Women's Health and Sport

I am proud to present the Scottish Government's Women's Health Plan. I believe that our vision for Women's Health is an ambitious one – and rightly so. Women's health is not just a women's issue. When women and girls are supported to lead healthy lives and fulfil their potential, the whole of society benefits.

In our debate on Women's Health I quoted from Caroline Criado Perez's thought-provoking book 'Invisible Women' and I wish to do the same here at the beginning of our Women's Health Plan, as she says so much in the few words: *'women are not, to state the obvious, just men.'*

She goes on to explain: *'Historically, it has been assumed that there wasn't anything fundamentally different between male and female bodies other than size and reproductive function, and so, for years, medical education has been focussed on the male "norm", with everything that falls outside that designated as "atypical" or even "abnormal".'* This has to change. Women are not atypical – they are 51% of Scotland's population.

Whilst we know that across Scotland there are examples of excellent and innovative services for women there is a clear need for wider systemic change to ensure that all our health and social care services meet the needs of all women, everywhere. Together, we are working to address the inequalities in all aspects of health that women are facing. The Women's Health Plan focusses on specific priority areas where a need for improvement was identified. But the Plan is one part of a much wider picture when it comes to women's health and wellbeing.

The Scottish Government is committed to a range of actions to improve women's health. The mental health of women and girls is a priority within the Mental Health Transition and Recovery Plan. We have taken decisive action in relation to mesh, including halting its use in 2018, and we will pursue the outcomes set out in the Mesh Survivors' Charter. Cancer screening remains a priority and we will continue to deliver our Screening Inequalities Fund to tackle inequalities in the national population screening programmes, setting aside £2 million over the next two years to tackle inequalities including those that have arisen as a result of COVID-19. We are continuing to implement our Recovery and Redesign: Cancer Services Action Plan. We are tackling violence against women and girls through the implementation of our Equally Safe Strategy. The Gender Pay Gap Action Plan is driving forward the changes needed to reduce the gender pay gap for employees in Scotland.

Additionally, the Government's 2021 Manifesto made a range of new proposals in relation to women's health. Work is underway now to develop new actions connected to these proposals. So, while they are not addressed in this iteration of the Women's Health Plan, they will be progressed by the Scottish Government during this parliamentary term.

This includes new action in relation to:

- establishing a dignified and compassionate miscarriage service tailored to the needs of women;
- the provision of paid leave for miscarriage and stillbirth, delivering this within the public sector and calling on the UK Government to make the necessary changes to employment law to make it available for everyone;
- a review of midwifery and health visiting pathways;
- unexpected pregnancy complications;
- age thresholds for Screening; and
- the establishment of a Scottish Institute for Women's Health.

The work on the Women's Health Plan began before the pandemic – and the evidence was already stark about the inequalities impacting women's health and the need for decisive action to address them. But Covid-19 shone an even brighter light on these inequalities.

Women have been even more adversely impacted by the Covid-19 pandemic. Inequalities have been exposed and exacerbated. The challenges of balancing childcare, paid work and caring responsibilities with the stresses and uncertainties of the pandemic have been truly daunting for many women, and have undoubtedly affected their health.

Learning from the pandemic – the needs of women, and its impact on services – has been central. Changes in service delivery have also highlighted positive opportunities for change and these have been brought into the Plan.

But we know that the inequality women face throughout their lives existed before Covid. For too long women have been disadvantaged, and this has impacted their right to health. It is time that this disadvantage is addressed and the inequality that women experience in relation to their health is eradicated.

For example, when we provide high-quality information and education on menstrual health, young women and girls are empowered to understand what is 'normal' and when they need to ask for help. When women are well informed and supported about the menopause, they can make informed choices about what they need, in healthcare, in the workplace and beyond. When research includes women, medicine can become more equitable. When we understand that heart health does not manifest 'abnormally' in women, we can save lives. When women's needs are taken into account, we all flourish.

Women's Health is not only about reproductive health. Our Women's Health Plan aims to reduce avoidable health inequalities for women and girls across the course of their lives – from puberty to the later years – focussing on those areas that are stigmatised, disregarded or dismissed as 'women's problems'. By supporting health in women and girls we can expand their choices and opportunities to achieve their potential.

Central to the development of the Plan have been women's voices. It is vital that women continue to inform their health and the health of women in Scotland – I look forward to hearing from them as we implement the Plan and drive forward improvement.

As Minister for Women's Health, I am ambitious for women in Scotland. I am determined that we drive change in women's health. This, our first Women's Health Plan, signals this ambition and determination that we see change for women in Scotland, for their health and for their role in society. We can be World Leaders in Women's Health – starting here and now.

Maree Todd, MSP
Minister for Public Health, Women's Health and Sport

Introduction by the Chair of the Women's Health Group

It has been a great privilege to lead on the development of the Women's Health Plan – as a woman, as a doctor, and as Interim Deputy Chief Medical Officer for Scotland. Contributing not just to ensuring we support the best possible health outcomes for women, but also to ensuring all girls and women of Scotland are able to reach their full potential is very close to my heart.

'Women's health' can be traditionally thought of solely in terms of reproductive health, despite the fact that slightly more than half of the population accessing healthcare are actually women. There are excellent examples of first-class care and innovative approaches to improving the health of women. But undertaking the work to produce this Plan has brought into sharp focus the way that women and their health needs are not necessarily considered as different to men within our health services, and how our services can be failing to fully meet the needs of women. The lack of inclusion of women in medical research, which then impacts on the availability and efficacy of treatments for women, is a very tangible example and illustration of how we have not done enough to date to ensure services equally recognise and meet the needs of women.

Whilst this Plan focusses on how changes in healthcare can improve the health of women, it is, of course, far from the full story. As a public health doctor, the importance of the social and economic determinants of health, and the way they can disproportionately impact on women is very much on my mind. The factors which impact on a woman's health stretch far beyond healthcare services and include educational opportunities, employment options, housing, caring responsibilities and income.

Whilst outside the scope of this Plan, the very significant impact of social and economic determinants of health on women in particular must be fully recognised.

The themes of Realistic Medicine resonate throughout this Women's Health Plan. One of the themes that emerged strongly from our lived experience work was that women wish to take an active role in decisions around their health. Shared decision-making means ensuring women have access to accurate and relevant information as well as being proactive in including women in discussions about their health and healthcare. Women also want a personalised approach to their care, recognising that one model will not work for all women. For example, women experience the menopause in a variety of ways. For most women, their GP and the primary care team will be able to support them where required through their menopausal years. However, some women will require more specialised support and will need onward referral. Healthcare professionals must work with women to understand their individual circumstances, health needs and preferences in order that personalised and tailored care is provided. Finally, Realistic Medicine calls on us all to be 'improvers and innovators'. In order to improve care for women we must work across sectors and organisations and look at innovative ways in which healthcare can be provided. Covid-19 has introduced and accelerated many of these innovations, for example in the provision of virtual abortion care, but there is far more work to be done.

I would like to extend my very sincere thanks to all the people involved in the development and creation of this Plan. Firstly, to Dr Catherine Calderwood, former CMO, who had the vision to set this work in motion. Secondly to the members of the Women's Health Group, particularly Vice Chair Corinne Love, and the sub-group chairs Alison Scott, Heather Currie, Maggie Simpson, Irene Oldfather and the late Emma Ritch. I also want to pay tribute here to Emma Ritch who represented the First Minister's National Advisory Council on Women and Girls on our Women's Health Group, and chaired the Gender and Health sub-group. Emma was a tireless campaigner for women's

equality and in her contribution to the development of this Plan she challenged us all to think differently. Her recent death leaves a huge void in the women's equality movement, but where she led we must now follow. And finally, thank you to the women of Scotland who engaged with our lived experience work. It is so crucial that the work to improve the health of women in Scotland is driven by the needs and wishes of women themselves.

This Plan represents only the beginning of the work to address the inequalities that impact on women's health. It illustrates that we have some way to go in adequately shifting our focus to women's health, and that will need commitment, leadership and effort from all those who provide services to women. My ask of my fellow health and social care professionals is to think about how you specifically consider women in the design and delivery of your services, to ensure that the different ways diseases can manifest in women, and the different treatments that might be appropriate for them are fully considered, to appreciate and understand the systemic barriers women may face when seeking healthcare and to play your role in breaking these barriers down. There is much work to be done but I am more than confident that we have the skills and the will to do this. Working together, we can and will improve women's health in Scotland.

Professor Marion Bain
Interim Deputy Chief Medical Officer for Scotland

1

Why we need a Women's Health Plan

The aim of this Plan is to improve health outcomes and health services for all women and girls in Scotland. It is underpinned by the acknowledgement that women face particular health inequalities and, in some cases, disadvantages because they are women.

> Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.
> **World Health Organisation (WHO).**

A range of biological factors impact on women's health. Women and girls experience various health needs and risks during their lives which are not the same as those of men. This may relate to starting and managing periods, choosing contraception, accessing abortion services, planning for pregnancy, managing menopause symptoms and the manifestation of chronic conditions such as heart disease.

In its 2019 publication 'Better for Women' the Royal College of Obstetricians and Gynaecologists (RCOG) highlighted some of the unmet needs of women in the UK and concluded that too many women are struggling to access basic healthcare and, when they do, health services too often miss opportunities to ask the right questions, optimise the resources available to prevent illness and ensure the best outcomes.

This is not just about differences in reproductive health: various studies have shown that women do not always receive equal healthcare to men and that outcomes for women are poorer than those for men. For example, when it comes to heart health, women are less likely than men to be prescribed drugs that reduce the chance of a second heart attack and women are less likely to receive diagnostic testing, such as coronary angiography imaging, within 72 hours of hospital admission[1].

According to a British Heart Foundation Report, in Scotland there are inequalities at every stage of a woman's medical journey[2].

There is also considerable evidence of women being undertreated or presenting disease in a different way to men. However, there is a significant data gap in medical research which further contributes to health inequalities in the UK. Women make up 51.5% of Scotland's population[3] and yet women are less likely to be invited to, or participate in, medical trials and research.[4] There is a historic, and ongoing, failure to include sex and gender differences in the design, delivery and analysis of clinical research studies. A 2016 Oxford University report[5] highlights this issue, stating that for many years it was widely assumed that the occurrence and outcomes of disease were the same for men and women, and that our understanding of disease processes based on studies involving only men would be equally relevant for women. An increasing body of evidence suggests that this is not the case, and that we can improve our knowledge about disease occurrence and disease outcomes – for both men and women – by undertaking analyses of health data disaggregated by sex and informed by a gender perspective, as well as by including sufficient numbers of women in scientific studies[6].

> This document will use the term 'women'/'woman' throughout. It is important to highlight that it is not only those who identify as women who require access to women's health and reproductive services. For example, some transgender men, non-binary people, and intersex people or people with variations in sex characteristics may also experience menstrual cycles, pregnancy, endometriosis and the menopause. The actions included within this Plan make clear that all healthcare services should be respectful and responsive to individual needs.

In the UK one in three women will experience a reproductive or gynaecological health problem at some point in their lives[7]. Despite this in 2018 just 2.1%[8] of publicly funded research spend was dedicated solely to reproductive health and childbirth, a reduction from 2.5% in 2014[9]. Endometriosis affects around 10% of women and girls globally, it is therefore estimated that one in ten women in Scotland have endometriosis[10]. Despite this high prevalence, the average time to diagnosis from onset of symptoms in Scotland is 8.5 years[11]. Although endometriosis is as common in women as diabetes and asthma, it has failed to attract the same attention, support and funding as those diseases[12].

Simply put, we know less about how best to treat diseases in women.

Research suggests that patients' health outcomes can be related to the gender of who they are treated by. For example a study, published in 2021, suggested that that gender concordance (when a female doctor treats a female patient) increases a women's access to treatments and specifically that gender concordance reduced the risk of death following a heart attack.

Does Patient-Physician Gender Concordance Influence Patient Perceptions or Outcomes?

Inequities are also faced by the health and social care workforce. Women make up the vast majority of the NHS workforce and whilst in the past ten years the proportion of female doctors and consultants has increased[13], patterns of occupational segregation remain, with women significantly under-represented in areas such as cardiology and surgery. Women's health is also impacted by various social factors, including where they are born, their age, their ethnicity, their sexual orientation and much more.

Some NHS boards are involved with the Equally Safe at Work accreditation programme. The programme supports employers to improve their employment practice to advance gender equality at work and prevent violence against women.

It is important to consider and understand the conditions in which women live, as this significantly impacts overall health and women's ability to access healthcare services. For example, the risk of poverty is much higher for women, disabled people, minority ethnic people, lone parents (the majority of whom are women) and children and young people[14]. Between 2017 and 2020 the poverty rate in Scotland was highest for single women with children and 20% of single female pensioners were living in relative poverty[15]. Being in employment is not necessarily protective against poverty and women are more likely to be in working poverty than men[16]. Women are heavily over-represented in occupations which tend to be lower paid and undervalued compared to those which are male dominated[17]. Living in poverty is known to be damaging for health and one of the main causes of poor health and health inequalities[18]. Public Health Scotland note that gender-based violence (GBV) is a major public health, equality and human rights issue and is experienced unequally, with 17% of women and 7% of men having experienced the use of force from a partner or ex-partner at some point in their lives[19]. The latest annual data for Scotland shows that 82% of domestic abuse incidents reported had a female victim and male perpetrator[20]. 20% of women have experienced sexual abuse before the age of 18[21].

The Scottish Government is committed to tackling poverty, addressing the Gender Pay Gap and the eradication of male violence against women and girls. Significant work is being undertaken across the Scottish Government, the public and third sectors to address these major societal issues (see section 5). While the primary focus of this Plan is on the reduction in inequalities in health outcomes and the improvement of health services for women, it is vital that the wider determinants of health are considered (see section 4).

All of this adds to avoidable health inequalities for women.

It is also clear that the impacts of the Covid-19 pandemic have not been felt equally across the population and that the most negative impacts fall on those least able to withstand them[22]. The majority of unpaid carers are women, women make up the majority of the health and social care workforce, the vast majority of lone parents are women[23] and women are more likely to be victims of domestic abuse[24]. Research conducted by Close the Gap suggests that Covid-19 has had a disproportionate impact on women, particularly in the area of employment[25]. In Scotland, women have accounted for the majority of furloughed staff since July 2020[26]. According to the Institute for Fiscal Studies mothers are more likely to have quit or lost their job, or to have been furloughed, since the start of the lockdown[27]. The challenges of balancing childcare, paid work, caring responsibilities alongside managing the stresses and uncertainties

of the pandemic should not be underestimated, particularly how this has, and continues, to impact women's health.

Another aspect of inequality that has been particularly prominent has been the disproportionate impact on minority ethnic people. The reasons for this are complex and include the interplay between socio-economic disadvantage, high prevalence of chronic diseases and the impact of long-standing racial inequalities. To address these issues an Expert Reference Group on Covid-19 and Ethnicity was established to provide advice and recommendations to the Scottish Government. The Women's Health Plan has not specifically investigated the impact of Covid-19 on women and women's health, but presents in some of its proposed actions opportunities to focus on groups of women who may have been disproportionately affected by the pandemic. The Covid-19 pandemic has also created opportunities to implement new ways of providing patient care, particularly in respect of the provision of contraception and the delivery of abortion care. A number of the new and innovative ways of working have developed quickly in response to the pandemic and are captured in this Plan for longer-term implementation.

We have an opportunity to address these inequalities. That is why we have developed this Women's Health Plan to focus on the specific health needs of the women of Scotland.

This Women's Health Plan sets out how the Scottish Government intends to reduce inequalities in health outcomes affecting women over the next three years, and beyond.

We need to be careful to avoid bias in how patients are diagnosed and treated. Women and men should have an equal chance of receiving the correct diagnosis and treatment. This is work in progress.

Professor Colin Berry, Professor of Cardiology and Imaging (Institute of Cardiovascular & Medical Sciences)

2

Women in Scotland today

Around 400,000 women in Scotland are of menopausal age

In Scotland **over a third** of the female workforce **is over 50**

Average life expectancy at birth for a woman in Scotland is **81.1 years**

In 2020 **63%** of women in Scotland were between 16 and 64, and **21%** were 65 and over.

It is estimated that endometriosis affects **1.5 million** (1 in ten) women in the UK of reproductive age, and it takes an average of **8.5 years** to diagnose.

61% of unpaid carers are women

In 2020 there were **46,809** live births in Scotland

Almost 1 in 10 deaths in women in Scotland each year are caused by **ischaemic heart disease**

Women's life expectancy at birth in the most deprived areas is **75.6 years**, compared to **85.6 years** in the least deprived areas.

In the most affluent areas of Scotland, women experience **25.1 more years of good health** compared to the most deprived areas.

In 2019 **1.35 million** women in Scotland were in employment

In 2020, **13,815** terminations of pregnancy were recorded in Scotland (13.4 per 1000 women aged 15-44)

51% of Scotland's population are **women**

In Scotland, women aged under 25 are the group **most at risk of being diagnosed with an STI.**

Heart disease is the leading cause of maternal death in the UK

Over three quarters of the overall NHSScotland workforce are women

In 2019-20 around **400 women** were in prison in Scotland on an average day

37% of women in Scotland report living with a limiting **long-term condition** or **disability**

The average age at which a woman will reach menopause is **51**

In 2020 the termination rate was **2.2 times higher** in the most deprived areas compared to the least deprived areas

Women make up an estimated **83%** of the social care workforce in Scotland

On average, the life expectancy of women with a learning disability is **18 years shorter** than for women in the general population

Twelve is the average age at which a woman has her first period

Part-time employment accounts for **41.2 %** of all women's employment compared with **12.4%** of all men's employment

Death from stroke is more common for women than men

It is estimated that there are currently **300,000** people in Scotland living with osteoporosis, a condition which is more common in women than men

3

Our ambition

Our ambition is for a Scotland where health outcomes are equitable across the population, so that all women enjoy the best possible health throughout their lives.

4

Principles underpinning the Women's Health Plan

The Plan is underpinned by the following principles:

Addressing inequalities

Responding to the unjust and avoidable differences in people's health across the population and between specific population groups.

A life course approach

Taking advantage of the different stages in a woman's life which present both health challenges and opportunities to promote and protect health and wellbeing.

Acknowleging and responding to the many characterisitics and factors which shape women's lives such as ethnicity, disability, sexual identity and background.

Gender equality and intersectionality

Everyone who uses and provides NHS services has a right to be treated as an individual and with consideration, dignity and respect.

Respectful and inclusive services

4.1 Addressing inequalities

Inequalities in health outcomes exist between both men and women and between different groups of women in Scotland. In the most affluent areas of Scotland, women experience 25.1 more years of good health compared to the most deprived areas[28]. Health inequalities such as this are unjust and preventable.

We can reduce some health inequalities by identifying gaps in health service provision, considering areas of best practice and developing actions to address these gaps, tailored to meet the needs of all women. However we recognise this is only part of a wider picture when it comes to health and wellbeing.

Women are individuals with individual needs, experiences and backgrounds which impact their health and wellbeing. Multiple factors affect how women care for themselves, access information, seek advice, make choices, and their risk of illness.

Social determinants of health

Health inequalities are socially determined by circumstances largely beyond an individual's control. These circumstances can disadvantage people and limit their chance to live longer, healthier lives[29].

The fundamental causes of health inequalities are an unequal distribution of income, power and wealth. This can lead to poverty and marginalisation of individuals and groups.

Public Health Scotland
Health inequalities: What are they? How do we reduce them?

These factors cannot be solely addressed by the Women's Health Plan, however improving access to health services has an important role to play in reducing health inequalities.

Health policy and resources need to take account of the social determinants of health and delivery of healthcare has to be joined up and accessible to be most effective. By working together, health, social care and third sector organisations can support and empower women to make changes to their lifestyles and live healthier lives. Health services cannot themselves address health inequalities which relate to deprivation, homelessness and poor housing or education and lack of opportunities.

Health services can however work alongside other professionals, with different expertise. Working with local authorities, the third sector and other partners in a holistic approach to women's care can allow women the opportunity to address, for example, accessing social security support at the same time as attending her doctor for contraception or her children's health.

Social determinants of health

The social determinants of health are the conditions in which we are born, we grow and age, and in which we live and work. The factors below impact on our health and wellbeing.

By working together we can address some of these gaps and meet the specific and individual needs of women.

I met up with the nurses again and the whole team at the clinic, honestly I haven't looked back, the clinic is welcoming and friendly and they listen to me and advise me to take better care of my health… I know this clinic is a place I can be totally honest about my health and how I feel, I feel totally at ease with the staff and can discuss most things including my alcohol problem, I wouldn't feel comfortable discussing this anywhere else, there is no judgement and they have a supportive feel to their service, I know I will always have someone to reach out to. There is free coffee and snacks and food to take away, toiletries, you just help yourself.

WISHES (Women's Inclusive Sexual Health Extended Service), **Service User.**

4.2 Life course approach

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

RCOG Better for Women

The life course approach emphasises the importance of identifying opportunities to prevent disease and promote health at key stages of life from pre-pregnancy through pregnancy, childhood and adolescence, to adulthood and later life. Promoting health and disease prevention can include ensuring women have information about the benefits of building and maintaining a healthy lifestyle including being physically active and maintaining a healthy weight. It also recognises that the social determinants of health shape our health and wellbeing throughout life, and that if we can improve the conditions of daily life we can reduce health inequalities throughout a person's life.

Current women's health services often focus on one issue at once which can lead to women falling through the gaps. If key life stages, such as puberty and menopause, were identified to target women, then holistic wellbeing assessments could help to reduce health inequalities, inform healthy lifestyle choices and increase early interventions.

Lived Experience Engagement Report

Within healthcare services the life course approach presents multiple opportunities not only for disease intervention but also in prevention of future ill health. In addition to women's health services (obstetrics, gynaecology, sexual health), other clinical services can use opportunities during consultations to discuss pre-pregnancy care, fertility, cervical screening, bone health etc. For example, a woman attending with her child for immunisation or accessing contraception services could also be given information about mental health support, how to access cervical screening or options for her if she is a victim of domestic abuse. Similarly a woman attending for cervical or breast screening could be offered information about menopause and risk of heart disease or osteoporosis. Health services working together, for example obstetrics and gynaecology along with cardiology, can assist women who have had complications such as pre-eclampsia and as such are at risk of heart disease in later life.

A life course approach throughout women's life stages

Lack of, or poor transition from paediatric to adult healthcare services can mean people miss out on routine follow-up and present with more complex or acute needs further down the line. This has a significant impact on the person and is often at increased cost to healthcare services. For young women, a lack of transition can mean they don't have the necessary information relating to their condition and how this can impact contraceptive choices or pregnancy.

Maggie Simpson, Senior Nurse Specialist and Lead Clinician Scottish Obstetric Cardiology Network

The different stages in a woman's life present both health opportunities and challenges. Many aspects of women's health are present in more than one life stage. Each stage presents important and differing

opportunities to promote and protect health and wellbeing. Life changes and roles, including work and caring responsibilities, can impact women's wellbeing and their ability to access health services at any stage of life.

Girls and young women – puberty to around 25

This stage of a woman's life sees the onset of periods, sexual activity and fertility for many. It is important for children and young people to learn about their bodies and how to stay healthy and safe from an early age. It is particularly important for girls and young women to understand what is normal or abnormal in relation to periods and their bodies as they grow and to be supported throughout this life stage.

For many young women with long-term health conditions, the transition from paediatric to adult care is a crucial phase. It is essential that women have adequate education about their condition, self-management options, and risk reduction factors. Appropriate transfer to the right adult healthcare professional and medical specialties is also important. This includes access to pre-pregnancy care and counselling with healthcare professionals with expertise in this area. In this life stage many women will also require pregnancy support.

From an early age women's experiences can also include responsibilities such as caring, work, as well as school, college or university and developing independence. All these things can impact women's physical and mental wellbeing and their ability to access health services.

Middle years – around 25 to 50 years

Disease prevention and promotion of a healthy lifestyle should continue throughout adulthood. During their reproductive years many women will need help to manage their periods, to access contraception, abortion care and sexual health services, and to manage the impact of existing long-term health conditions. These services should be easily accessible for all women, culturally competent and centred on the woman's needs and preferences. In this life stage women will be invited to attend cervical screening, and may require support to attend for this if, for example, they have a disability or have experienced trauma.

It can be very difficult for those who have experienced neglect in childhood, abuse, violence, rape, trafficking or torture to undergo intimate examinations or to even discuss these. That is why it is so important that healthcare staff in particular should be aware of the impact of trauma and adopt a gentle, patient-centred approach to work towards any necessary examinations.

Dr Alison Scott, Consultant Obstetrician and Gynaecologist, specialising in sexual health, NHS Lothian.

In Scotland the average age of first-time mothers is currently around 31[30]. Planning for pregnancy and optimisation of health and lifestyle before pregnancy improves outcomes for both mother and baby. Accessible information about pre-pregnancy care should be available and health professionals can use opportunities such as attendance for routine contraception to discuss the importance of planning a pregnancy and signpost to sources of information. Pregnancy represents a major life change and a stress challenge to a woman's body. Sometimes this leads to the development of conditions such as gestational diabetes or pregnancy-induced hypertension. These conditions may be indicators of increased risk of heart disease in later life. Women should be aware of this and management of such conditions may require joint working between clinical specialities such as obstetrics, primary care, diabetes care and cardiology. For women with pre-existing health conditions, collaborative working between these teams for pre-pregnancy health optimisation is essential.

Many women in their 40s will begin to experience symptoms of peri-menopause. Some women will also experience early (before the age of 45) or premature menopause (before the age of 40).

Later years – around 51 years and over

In this period of life, women often experience increasingly complex health needs.

For most women this life stage includes the onset of menopause. For some women transition through the menopause is straightforward. Other women have multiple physical and mental health symptoms which can impact their quality of life.

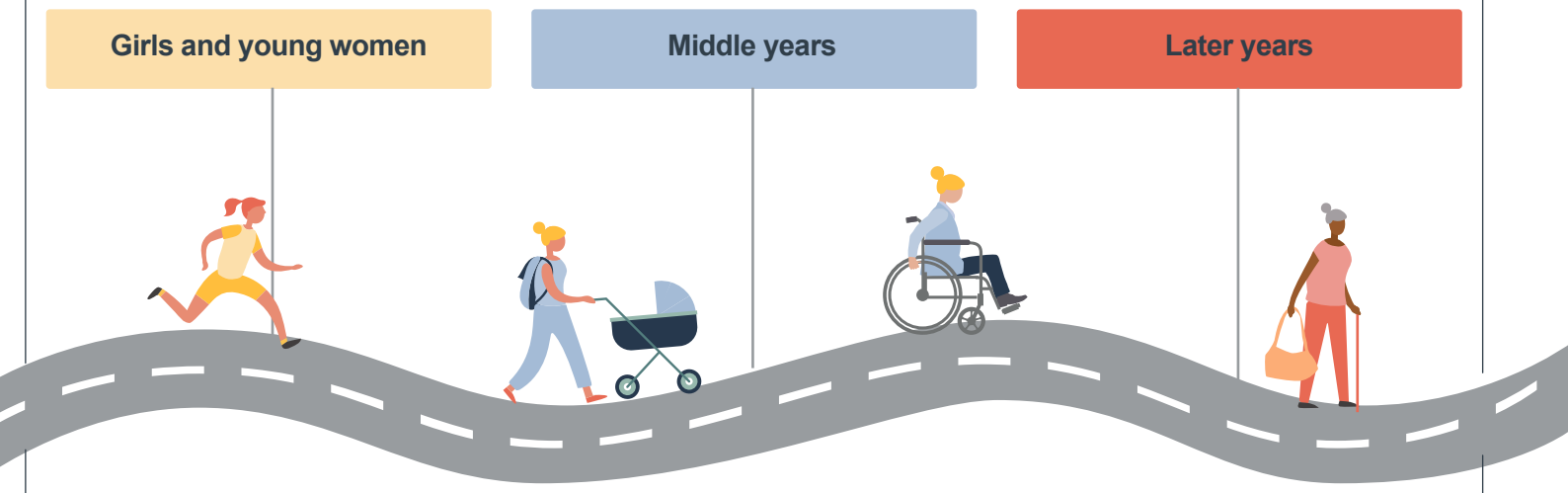
During, and leading up to, this life stage it is important that women have access to information on the options for managing the physical and mental symptoms of the menopause. Whilst not all women will choose or require medical interventions, it is important that they are supported to manage their menopause in ways that are appropriate for their lives and personal choices. Women will also start to be invited to attend breast screening, bowel screening and continue to access cervical screening, and may require support to access these services. Women may also require ongoing sexual health support and services.

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

RCOG Better for Women

Additionally, musculoskeletal conditions and osteoporosis can affect quality of life as women get older. Appropriate lifestyle advice, including being physically active, and treatment of these conditions can lead to increased ability to interact socially, work and participate in family life. As women age, the risk of dementia, cancer and cardiovascular disease increases. Proactively supporting women to transition through menopause provides further opportunities for promotion of a healthy lifestyle, which may decrease the risk of early onset of some of these conditions.

Women's Life Course



Women's health needs at life stages include

Girls and young women

Relationships,
RSHP Education (relationships. sexual health and parenthood),
HPV vaccination,
Menstrual health,
Sexual health, including contraception and abortion care,
Pregnancy care,
Mental health,
Management of long-term conditions, and Pelvic health.

Middle years

Menstrual health,
Sexual health, including contraception and abortion care,
Cervical screening,
Pregnancy care,
Assisted conception,
Mental health,
Management of long-term conditions,
Early menopause, and
Pelvic health.

Later years

Menopause,
Sexual health,
Cancer screening,
Heart health,
Osteoporosis and bone health,
Dementia,
Mental health,
Management of long-term conditions, and
Pelvic health.

4.3 Gender equality and intersectionality

Multiple social, structural and individual factors lead to health inequalities. Every individual has different needs and different experiences.

The Women's Health Plan aims to take an intersectional approach which recognises that many women and girls in Scotland will face multiple, and often overlapping, disadvantages and barriers to accessing good healthcare.

Intersectionality acknowledges that there are many different factors that make up people's identities, for example their sex, gender, ethnicity, sexual orientation, socio-economic background, disability, religion and more. Relationships between ethnicity, socio-economic position and health for example, are extremely complex[31].

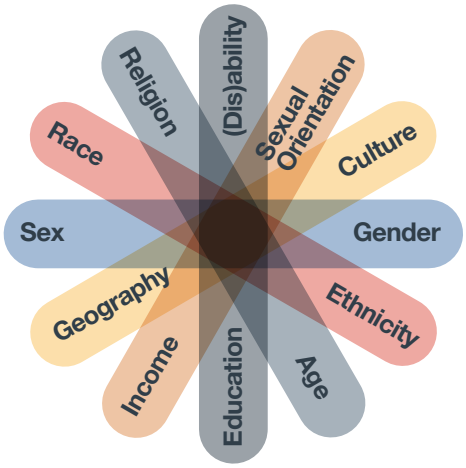
A research report, 'Our Bodies, Our Rights'[32] published by Engender in 2018 describes how disabled women in Scotland report experiencing specific barriers when accessing a range of services, such as sexual health services, including lack of accessible facilities, specialist equipment, and accessible information. This highlights the importance of considering, in this case, how sex, gender and disability intersect and the specific needs and experiences of disabled women. It is important for healthcare professionals, and health policy makers, to recognise that a failure to take an intersectional approach can lead to further discrimination or disadvantage.

Similarly, a report in 2020 of the All-Party Parliamentary Group's Inquiry on Endometriosis in the UK explained how potential cultural barriers may deter women from accessing help for menstrual problems – so this highlights the importance of understanding how sex, gender and culture and religion can intersect.

In certain cultures, menstruation is still considered as dirty, and many are subject to missing out on aspects of their daily lives such as family occasions or visiting religious institutions because they are menstruating. This can lead to young people growing up with limited knowledge of menstruation because their families shy away from discussing the issues with them, and thus delay seeking medical help or treatment.

Natalie – contributor to APPG on Endometriosis Inquiry Report

Intersectionality How different aspects of a person's identity overlap to form their unique experience.



Gendering health policy

We are committed to ensuring gender is a foundational consideration in the development of health policy going forward, acknowledging that women often face inequalities because they are women. We have developed a set of principles which will be integral to how we make change.

Our Principles for Gendering Health Policy

1. The right to health is a fundamental human right, everyone has the right to the highest attainable standard of physical and mental health.
2. All health services and systems must be accessible, available, appropriate and high quality.
3. Systematic inequality which negatively impacts women's health should be addressed and challenged.
4. Healthcare provision should be intersectional, gender-competent and culturally competent.
5. Health policy decisions should be aligned with the European Convention on Human Rights and the Convention on the Elimination of Discrimination Against Women, and other international human rights treaties (see Annex D).

4.4 Respectful and inclusive services

The right to health is a fundamental human right. It means the right of everyone to the highest attainable standard of physical and mental health.

For this to happen, services and systems that help us to live long healthy lives should be

- accessible
- available
- appropriate
- high quality[33].

Healthcare services must be responsive and adaptive to the individual needs of women, with practitioners adequately trained to be able to help women, particularly those who have been affected by trauma or adversity. These principles recognise the importance of promoting services for all women, providing women with information on the availability of services, and allowing women to choose how, when and where they can access services.

We must listen to the people we care for, understand what matters to them, and give the information and support they need to make informed decisions about their care.

Chief Medical Officer - Realistic Medicine

What do we mean by 'Trauma Informed' Practice?

Being 'Trauma Informed' means being able to recognise when someone may be affected by trauma, adjusting how we work to take this into account and responding in a way that supports recovery, does no harm and recognises and supports people's resilience.

Opening Doors: Trauma Informed Practice for the Workforce on Vimeo

Healthcare Improvement Scotland have developed standards to ensure consistency in approach to healthcare and forensic medical services for anyone who has experienced rape, sexual assault or child sexual abuse.

Healthcare and forensic medical services for people who have experienced rape or sexual assault standards

Cultural competence

Scotland's population has become increasingly ethnically diverse[34]. Different ethnic population groups can often experience very different health outcomes, representing stark inequalities[35].

The proportion of the population belonging to a non-White ethnic group increased four-fold in Scotland between 1991 and 2011 and projections suggest that by 2031, around 20% of the total population (and 25% of children) of Glasgow, Scotland's largest city, will belong to a non-White minority group[36]. It is important that the healthcare system is responsive to these changes. It is also important that all health and social care professionals approach people from all cultures with openness and without judgement and are responsive to the individual needs of their patients and community. The importance of healthcare professionals acknowledging and addressing unconscious bias has also been highlighted by the RCOG in their position statement on racial disparities in women's healthcare[37].

For services to be truly accessible it is vital that women have choice about how and when they access care which takes into account the complexities of women's lives.

Women told us that while they felt uncomfortable about talking about intimate health issues with male GPs or interpreters they also felt uncomfortable specifically requesting a female GP and interpreter. They expressed concerns over confidentiality if they come from a small community where they may know or know of the interpreter personally and feel uncomfortable sharing intimate issues.

Lived Experience Engagement Report

All women must be able to make informed choices about their health, including those who do not have access to digital technology, whose first language is not English or who have a learning or other disability. Actions included within the Plan recognise the importance of ensuring that all women are appropriately informed about their options and supported to make choices that are right for them as individuals.

The NHS Charter of Patients' Rights and Responsibilities, summarises what everyone is entitled to when using NHS services and receiving NHS care in Scotland.

Public health messaging should take into account language barriers, literacy levels, cultural factors, religious beliefs and differential access to health-related information among diverse communities.

Expert Reference Group on COVID-19 and Ethnicity

5

Strategic context

The Women's Health Plan supports work already being undertaken on women's health across the Scottish Government, NHSScotland, Local Authorities and the Third Sector and aims to reduce health inequalities and drive forward improvement in health services for all women in Scotland. It sets out actions to address gaps in service provision, and to reduce the inequalities between women and men as well as between different groups of women.

5.1 National Performance Framework

The Plan is aligned with, and underpinned by, the Scottish Government's National Performance Framework (NPF). The NPF provides a clear long-term purpose and set of outcomes for Scotland's wellbeing. The NPF recognises that Government alone cannot deliver those broad societal outcomes, and that it requires all of us from all sectors - public, private and third – and as individuals to help take this work forward.

The Women's Health Plan will contribute to the following National Outcomes:

- **Children and Young People** – we grow up loved, safe and protected so that we realise our full potential
- **Communities –** we live in communities that are inclusive, empowered, resilient and safe
- **Fair work and Business** - We have thriving and innovative businesses, with quality jobs and fair work for everyone
- **Human Rights** – we respect, protect and fulfil human rights and live free from discrimination
- **Health** - we are healthy and active
- **Poverty** - We tackle poverty by sharing opportunities, wealth and power more equally

The Scottish Government is committed to the achievement of the United Nations Sustainable Development Goals. These are 'global goals' and targets that are part of an internationally agreed performance framework. All countries are aiming to achieve these goals by 2030. The First Minister committed Scotland to the global goals in July 2015[38].

The NPF and the goals share the same aims and the Plan contributes to the following goals:

5.2 Other policies

In addition to being underpinned by the NPF, the Women's Health Plan will complement existing health-related strategies and policies in Scotland. It sits alongside activities already underway and sets out actions and activities which will encourage new and innovative approaches to delivering health services for women in Scotland. See Annex B for more detail.

5.3 Pregnancy and Maternity

The Scottish Government is developing a range of improvements in services for pregnancy and maternity, including:

The Best Start: Transforming Maternity and Neonatal Care
In 2017, the Scottish Government published The Best Start: A Five Year Forward Plan which made 76 recommendations which will fundamentally reshape maternity and neonatal services.

Continuity of Carer is a cornerstone recommendation of The Best Start, and the vision is relationship-based continuity of carer, tailored to the individual's needs, and delivered as close to home as possible. As well as improved relationships between the women and midwife, evidenced benefits include reduced preterm and stillbirths, reduced interventions during labour and an increase in breastfeeding. In addition, we are redesigning the pathways for maternity clinical care for women which will support delivery of timely, compassionate and proportionate care for those with complex social and clinical needs. This will improve care for all women, and particularly for those at increased risk of poorer outcomes.

Ready, Steady, Baby and Parent Club
Ready, Steady, Baby is a guide to pregnancy, labour and birth and early parenthood up to 8 weeks and a copy is given to all pregnant women in Scotland. The family support content on Parent Club Family Support Directory | Parent Club sets out the support entitlement for pregnant women and parents with young children.

Miscarriage and Unexpected Pregnancy Complications
The Scottish Government is committed to establishing a dignified, compassionate miscarriage service tailored to the needs of women. This includes supporting the development of individualised care plans after a woman's first miscarriage, taking forward the recommendations made in the Lancet series, "Miscarriage Matters" published on 26 April 2021 and ensuring women's services in NHS Boards have dedicated facilities for women who are experiencing unexpected pregnancy complications.

The Scottish Government will work with patient groups, including women with lived experience, to ensure improved accessible information for women who have a miscarriage is available and signposted across NHS Boards by early 2022.

5.4 Screening

Cancer is one of the major causes of death in Scotland; breast cancer is the most common cancer affecting women.

Over the next year, there are three areas we will focus improvement activity on: self-sampling in the cervical screening programme; the breast screening programme review; and ongoing work to address inequalities.

Self-Sampling
Evidence tells us that there is unequal uptake in the cervical screening programme – women from higher socio-economic areas are more likely to take up cervical screening than those from more deprived areas. We also know that the screening test itself is a barrier to take-up for many reasons, including previous trauma, embarrassment and difficulties accessing screening appointments.

Self-sampling has the potential to overcome many of these barriers by allowing women to take a test in their own homes and at a time that is convenient for them. Introducing it to the cervical programme could therefore reach more people who may not ordinarily engage.

Breast Screening Review
A review of the Breast Screening Programme is underway to ensure it is as effective as it can be, and reaches all women who would benefit from it. The review was recommended by the Scottish Screening Committee, an expert Committee, comprising clinicians, screening programme managers and NHS Board representatives whose aim is to consider strategic policy for all six of Scotland's national screening programmes. This review is expected to report at the end of 2021, and will help shape how the programme is delivered in the future.

Inequalities in screening
We will also launch a wider programme of work to specifically target inequalities across the screening programmes. As a life-saving tool, it is essential that screening is equally accessible to women across Scotland. We know that, at present, issues such as disability, race, age and socio-economic status all impact on how women take up screening, and we also recognise that the Covid-19 pandemic may have exacerbated these existing inequalities.

5.5 Mental health

The importance of mental health, and the specific mental health challenges faced by women, has been raised throughout the development of this Plan, particularly through our lived experience engagement with women themselves. This includes the need for more specific mental health information, support and policy for women.

The inequalities that drive differences in physical health outcomes are the same inequalities that detrimentally impact on mental health. The Scottish Government's guiding ambition for mental health is simple: it must prevent and treat mental health problems with the same commitment, passion and drive as physical health problems.

The Scottish Government recognises that across most aspects of mental health, outcomes for women and girls are poorer than for men and boys[39]. That is why the Mental Health Transition and Recovery Plan[40], published in October 2020 in response to the Covid-19 pandemic, commits to making women and girls' mental health a priority. It sets out specific actions to address women and girls' mental health including engaging with women's organisations to better understand and respond to the gender-related mental health inequalities that have been exacerbated by the Covid-19 pandemic. This includes for example, stressors and trauma experienced by women in key worker jobs and the disproportionate emotional and physical burden on women of caring for relatives of all ages.

A Mental Health Equality and Human Rights Forum has been established to inform the implementation of the Transition and Recovery Plan and wider Mental Health Policy. This group will take into consideration wider health issues, as well as the specific health conditions we have raised throughout this Plan.

Whilst a specific mental health focus was not one of the initial priorities for the Women's Health Plan it is important to recognise the key importance of mental wellbeing in overall health.

Life factors such as being an unpaid carer, a job that falls disproportionately to women, and hormonal changes during menopause can affect women's mental health. There is a feeling that many women 'just get on with it' and may not realise they could benefit from mental health support.

Lived Experience Engagement Report

6

Priorities

This Women's Health Plan marks the first stage of a long-term commitment to reducing health inequalities for women.

This initial Plan has a specific focus on the following priority areas:

- ensure women who need it have access to specialist menopause services for advice and support on the diagnosis and management of menopause;
- improve access for women to appropriate support, speedy diagnosis and best treatment for endometriosis;
- improve access to information for girls and women on menstrual health and management options;
- improve access to abortion and contraception services;
- ensure rapid and easily accessible postnatal contraception; and
- reduce inequalities in health outcomes for women's general health, including work on cardiac disease.

Additionally, the 2021 SNP Manifesto committed to:

- establish a dignified, compassionate miscarriage service tailored to the needs of women, taking forward the findings of The Lancet report and supporting the development of individualised care plans after a woman's first miscarriage;
- emulate New Zealand where families who experience miscarriage or stillbirth are entitled to 3 days of paid leave by delivering this within the public sector and calling on the UK Government to make the necessary changes to employment law to make it available for everyone;
- review midwifery and health visiting pathways for new families and babies, improve access to practical breastfeeding support, physical therapy advice and increase postpartum and mental wellbeing support;
- ensure maternity departments have dedicated facilities for women who are experiencing unexpected pregnancy complications;
- reduce waiting times for diagnosing endometriosis from over 8 years to less than 12 months by the end of the parliament and look to improve the experience and diagnosis of women who visit their GPs with other menstrual problems;
- ensure women have improved access to specialist services for advice and support on the diagnosis and management of menopause. We will launch a public health campaign to remove stigma and raise awareness of the symptoms of menopause;
- ask clinical experts in the National Screening Committee to examine the merits of lowering the current age thresholds and commit to acting on their advice. Alongside this, we will invest in research to improve the accuracy of screening; and
- support the development of a new Scottish Institute for Women's Health to drive changes to policy, guidance and medical training on the basis of sex and gender medicine as well as provide funding to dedicated research into women's health.

Some of these priority areas, menopause and endometriosis in particular, build on themes included in this Plan. The majority of these commitments are not included within this iteration of the Women's Health Plan but will be progressed within this parliamentary term.

There are other important areas of women's health, highlighted by both women and clinicians during the process of developing this Plan, where health inequalities exist or where women are disproportionately impacted. These topics could form the basis of future iterations or stages of the Women's Health Plan. Future priorities and aims will be developed in collaboration with women and girls and informed through an ongoing lived experience group.

7

Our approach

This Plan has been developed through a collaborative process involving a wide range of people with expertise in various aspects of women's health.

We have also considered a number of recent publications, reports and articles focusing on women's health, describing and discussing women's experience of healthcare services in terms of accessing information and services, diagnosis and treatment. Some of these are listed in Annex E.

To ensure women's voices and experiences are central to the Plan, we have heard directly from a diverse range of women through our Lived Experience Survey and discussion events, led and facilitated by the Health and Social Care Alliance Scotland (The ALLIANCE).

Reports from both the survey and the discussion events have been used to inform this Plan, and quotes and suggestions from women are included throughout this document.

> The ALLIANCE, as a national third sector strategic intermediary, has strong expertise in engaging people with lived experience in policy and practice development across health and social care in Scotland.
>
> The ALLIANCE believe an equalities, intersectional, rights-based and person-centred approach is necessary to understand the challenges faced by women in Scotland to ensure policy, interventions and services reflect the needs of individuals and their families.
>
> The ALLIANCE

7.1 Women's Health Group

A Women's Health Group (WHG) was established to develop this Plan. The Group included organisations and individuals with specialist knowledge, expertise and experience in women's health. A full list of members is at Annex A.

The WHG was established to:

- provide a focal point for discussion, leadership and direction to focus policy development and quality improvements on the needs of all women across Scotland;
- link strategically with other developments and policy areas across the Scottish Government to ensure women's health and wellbeing is considered in all policy output by the Scottish Government;
- identify gaps in the provision of services, consider existing areas of best practice and develop actions to address these gaps; and to
- support NHS Boards, Local Authorities, partner agencies and professional organisations to work collaboratively to ensure services best meet women's health needs.

7.2 Sub-groups

In addition to the WHG, five sub-groups were established to develop actions for this Plan.

1. Sexual health, contraception, abortion, pre-pregnancy care
2. Menopause and menstrual health, including endometriosis
3. Heart health
4. Gender and health
5. Lived experience

These sub-groups brought together experts from a range of specialties, in the public and third sectors, who work on women's health related issues. The sub-groups worked to identify gaps in the provision of services, consider areas of best practice, and develop practical actions to address these gaps. These actions are presented in section 9.

8

Context

This section provides a summary of the findings which informed this Plan and includes some of the things women have told us.

8.1 Access to information and services

A key theme which has been raised consistently in the development of this Plan, and which cuts across all of our priorities, is the importance of accessible health information and accessible services.

> Women highlighted the importance of good communication by illustrating that they cannot take responsibility for their own health without enough information about it. Participants highlighted that those with low literacy or digital skills may not benefit from a website.
>
> Lived Experience Engagement Report

There are many potential sources of information for women, including social media, but not all of these provide reliable information. Responses to our Lived Experience Survey suggest that women generally know where to access information about their health concerns, but information could be improved with the provision of a trustworthy comprehensive health website for women and girls and healthcare professionals.

Access to evidence-based information in a format that is user-friendly and accessible to all women is essential to empower women to take control of their own health and wellbeing. It must be recognised that not all women will have access to the internet, and so information must be presented in a variety of different formats, including alternative languages.

- 88% of households in Scotland have access to the internet[41].
- 21% of adults in social housing do not use the internet[42].
- 71% of adults who have some form of limiting long-term physical or mental health condition or illness reported using the internet[43].
- only half of those over 60 in the most deprived areas use the internet[44].
- in our Lived Experience Survey over 80% of respondents said they had accessed information through their GP, and just over 50% had used the internet to access information[45].

> Poor access to basic women's health services leads to a rise in unplanned pregnancies, abortions, poor patient experiences and increases damaging postcode lotteries. It is essential that we develop a more integrated approach to the delivery of women's healthcare services.
>
> **RCOG,** Better for Women Report

Additionally, one of the strongest themes from our lived experience engagement days was that many women experience difficulties in accessing services due to the challenge of getting an appointment that works around work commitments and caring responsibilities. There are additional difficulties for disabled women, women with visual impairments, those with learning disabilities and women who have experienced trauma or abuse.

- 61% of Scotland's 1.1 million unpaid carers are women[46].
- The vast majority, 92%, of lone parents in Scotland are women[47].
- Across the UK 37% of women cannot access contraception services locally[48].
- 42% of respondents to a survey conducted by the RCOG think that more flexible appointment times would improve their access to women's services, with 35% believing that more time with healthcare professionals would improve their use of services[49].

Women want to see a system which provides them flexibility around their lives, both when accessing appointments and for treatment and support options.

Lived Experience Engagement Report

8.2 Sexual health, contraception and abortion

Sexual health is an important aspect of our overall health. Good sexual health is an important part of a women's overall wellbeing, and can in addition reduce the risk of unintended pregnancies and sexually transmitted infections. The incidence and impact of poor sexual and reproductive health on women and girls varies between different groups and is influenced by factors such as age, geographic location, and socio-economic status[50].

'All the risks and responsibilities are on the girl.'

Young women expressed a strong sense of frustration that contraceptive work such as research, booking and attending appointments, navigating systems and services, using methods correctly and the management of side effects, falls to them.

CONUNDRUM Report, Understanding young people's use and non-use of condoms and contraception

Access to, and information on, contraception and abortion are key components of good sexual health and enable women to determine if and when they have children.

- Women aged under 25 are the group most at risk of being diagnosed with an STI[51].
- In 2019/20 around 54 per 1,000 women were prescribed long acting reversible contraceptive (LARC). The most common method of LARC is the contraceptive implant[52].
- 1 in 3 UK women will have an abortion by the time they are 45 years old[53].
- In 2020 13,815 terminations of pregnancy were recorded in Scotland (13.4 per 1000 women aged 15-44)[54].
- In 2020 the abortion rate in Scotland was 2.2 times higher in the most deprived areas compared to least deprived areas[55].
- Termination rates in the 40-plus age group in Scotland have been steadily rising[56].
- In a recent survey, approximately 1 in 3 intercourse-experienced young people indicated difficulty getting an appointment for contraception or STI testing[57].
- Almost half (46.0%) of respondents to a recent survey of young people did not know or were unsure where to access free condoms in their local area[58].

I wanted to find out more about the options available, but was pretty much told to take the pill without any discussion as to side effects or current experiences with periods.

CONUNDRUM Report, Understanding young people's use and non-use of condoms and contraception

When it came to accessing information, participants spoke of the importance of understanding their options, particularly in relation to contraception… It was also highlighted during the conversation that in some cultures women will not raise topics such as contraception themselves, but would talk about it with a healthcare professional if asked.

Lived Experience Engagement Report

8.3 Menstrual health

A girl's periods usually begin at around the age of 12. Despite the fact that most girls and women will experience periods monthly for around 40 years of their lives, many remain unaware of just how common menstrual health disorders, or period problems, are or what options are available to control or stop the menstrual cycle and associated effects.

When discussing the stigma that exists around periods and menstrual health, the women in the events focussed on early and comprehensive education in schools.

Lived Experience Engagement Report

- In our lived experience survey, 70% of respondents told us that they had sought medical care or advice regarding their menstrual health. When asked where they accessed the service, 96% of those asked had accessed through their GP[59].

- 1 in 5 women of reproductive age suffer with heavy menstrual bleeding[60].
- The psychological impact of menstrual disorders is underestimated; a recent survey of women with heavy menstrual bleeding found that of 1000 surveyed:
  - 74% experienced anxiety;
  - 67% suffered with depression[61].
- As reported by the RCOG, 49% of girls say that they have missed an entire school day because of their periods, of whom 59% have made up a lie or an alternative excuse[62].
- The proportion of women reporting at least one PMS symptom ranges between 40–90%[63].
- The proportion of women reporting severe PMS symptoms or symptoms that interfere with daily activities ranges between 3–30%[64].

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

8.4 Endometriosis

Endometriosis is a common long-term condition where tissue similar to the lining of the womb is found elsewhere in the body. While endometriosis is generally found within the pelvic cavity, it is sometimes found in other parts of the body, such as the lungs. The most common symptoms of endometriosis include: painful periods; pain in the lower abdomen, pelvis or lower back; pain during and after sex; difficulty getting pregnant and discomfort when going to the toilet. It can be difficult to diagnose because symptoms can vary considerably and many other conditions can cause similar symptoms.

> Research is pivotal to understanding the cause of the disease, better treatment options, and one day a cure. Without research, people with endometriosis will continue to face huge barriers in accessing the right treatment.
>
> **Professor Andrew Horne**, University of Edinburgh, APPG Endometriosis Report

The cause of endometriosis is unknown and there is no specific cure.

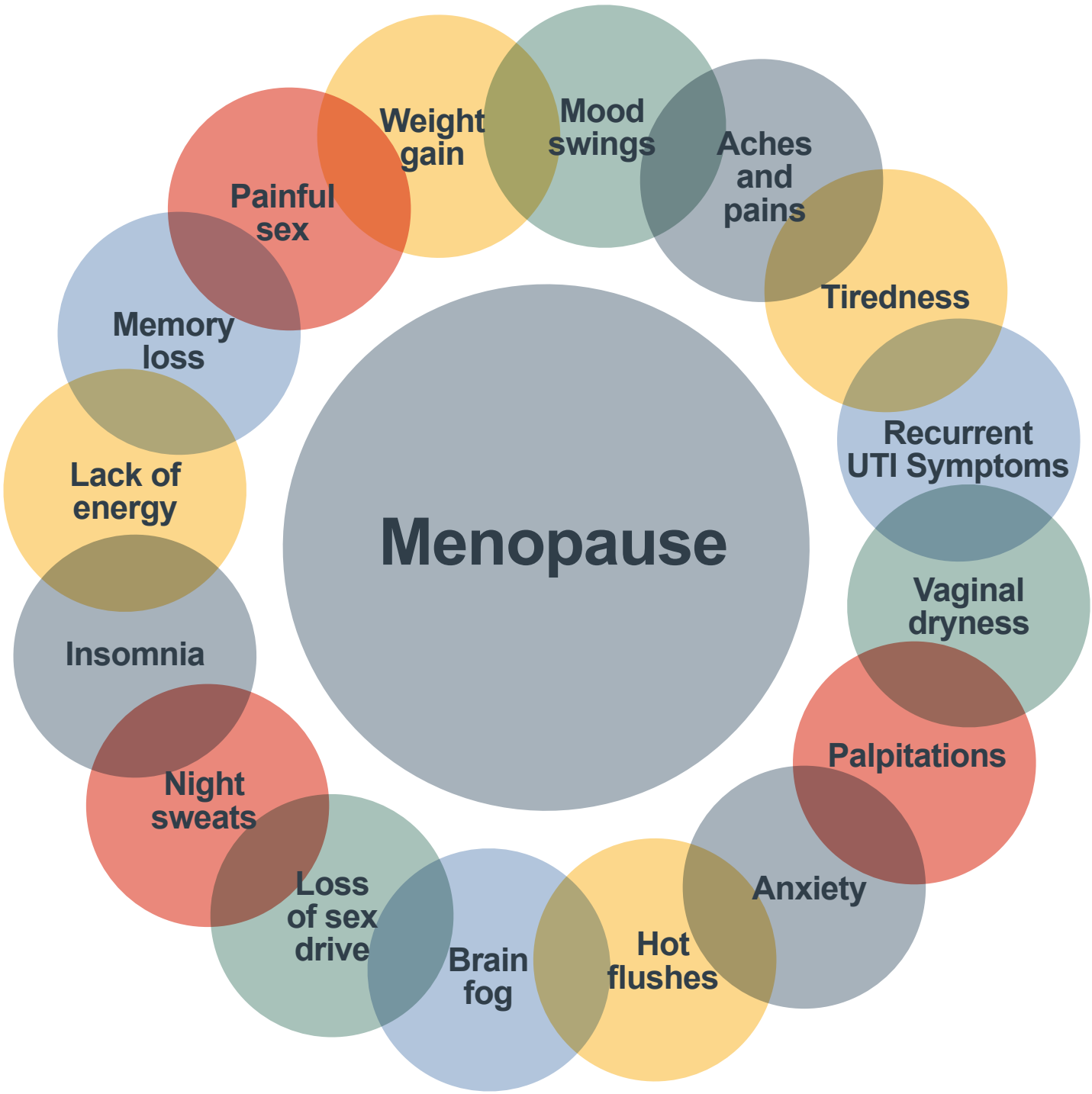
- It is estimated that endometriosis affects around 1.5 million women in the UK[65]. Most are diagnosed between the ages of 25 and 40[66].
- On average in Scotland it takes 8.5 years from onset of symptoms to be given a diagnosis[67].
- A survey by the All-Party Parliamentary Group (APPG) Inquiry into endometriosis found that 58% of respondents visited their GP 10 or more times due to their symptoms prior to diagnosis and 53% of respondents visited A&E prior to receiving a diagnosis[68].
- Endometriosis costs the UK economy £8.2bn a year in treatment, loss of work and healthcare costs[69].

> I missed school on a regular basis because of my periods… I was told by doctors, teachers and my family that this was normal and was what a period was like…I wish so much that we had been taught what was absolutely not a 'normal' period.
>
> Endometriosis APPG Report

8.5 Menopause

The menopause is a natural part of ageing that usually occurs between 45 and 55 years of age, as a woman's oestrogen levels decline. In the UK, the average age for a woman to reach the menopause is 51[70]. However, around 1 in 100 women experience the menopause before 40 years of age[71]. This is known as premature menopause or premature ovarian insufficiency; it can happen naturally or as a side effect of some treatments, and this can increase the risk of osteoporosis.

> The majority of women are able to manage menopause symptoms with lifestyle modifications and with support from their GP, therefore will not require specialist services. However, all women should have the ability to access specialist support should they need it.
>
> **Dr Heather Currie**, Associate Medical Director, NHS Dumfries and Galloway


Menopause
Weight gain
Mood swings
Aches and pains
Tiredness
Recurrent UTI Symptoms
Vaginal dryness
Palpitations
Anxiety
Hot flushes
Brain fog
Loss of sex drive
Night sweats
Insomnia
Lack of energy
Memory loss
Painful sex

Most women will experience menopausal symptoms. Some of these can be severe and can have a significant impact on women's lives. The menopause is a key time to consider women's bone health because the oestrogen hormone that is important for keeping bone density stable decreases. As a result, bone density starts to decrease, which reduces bone strength and increases the risk of breaking bones. Menopausal symptoms can begin months or even years before periods stop and last for several years after periods stop[72].

The main thing women wanted from employers was flexibility to manage their own symptoms, such as being able to work from home or change hours slightly if needed.

Lived Experience Engagement Report

- Around 400,000 women in Scotland are of menopausal age (between 45 and 54)[73].
- Women report feeling unprepared for the impact the menopause can have on their life and according to a 2019 survey conducted by the Scottish Women's Convention, with 1,000 respondents from Scottish Women, almost two thirds of women felt there was not enough information available at the beginning of their menopause[74].
- In a survey of 1,000 adults in the UK, the British Menopause Society found that 45% of women felt that menopausal symptoms had a negative impact on their work and 47% who needed to take a day off work due to menopause symptoms say they wouldn't tell their employer the real reason[75].
- 2,000 women members of the British Medical Association (BMA) were surveyed regarding their experience of menopause. 93% said that they had experienced symptoms such as insomnia, fatigue, loss of confidence, and debilitating hot flushes as a result of menopause, and 65% had experienced physical and mental symptoms. 90% said that these symptoms had impacted their working lives, with 38% saying that the impact was significant[76].

Respondents raised that improving the general knowledge and awareness among GPs of women's health and GPs being proactive in starting conversations around menstrual health would improve experiences of seeking help. Many respondents were made to feel dismissed or like they were 'wasting GPs' time' when presenting with symptoms, particularly of menopause or endometriosis.

Lived Experience Survey Report

8.6 Heart health

Ischaemic heart disease

Ischaemia occurs when blood flow to the heart is reduced, preventing the heart muscle from receiving enough oxygen. Heart attack and angina are symptoms of ischaemic heart disease.

BHF, Bias and Biology Report

Cardiovascular disease

Cardiovascular disease (CVD) is an umbrella term that describes a range of conditions that affect the heart, the blood vessels, or both.

CVD risk assessment and management – NICE Guidelines

Cardiovascular (CVD) diseases are the leading cause of death in the world[77] and ischaemic heart disease (including heart attacks and angina) is a leading cause of death for women in Scotland.

Women have unique risk factors such as endometriosis, polycystic ovarian syndrome (PCOS) and pregnancy-associated complications that likely increase future risk of CVD. Women also have different manifestations of CVD, and studies have shown sex differences in their response to risk factors and treatments.

For many people heart disease simply means 'heart attack' when there are a range of cardiac conditions that the general population and women need to be aware of. Although risk factors for CVD such as smoking, diabetes and high blood pressure affect both men and women, the risk of CVD with the presence of these risk factors is greater for women.

There are a number of heart conditions that disproportionally affect women more than men, such as takotsubo cardiomyopathy, spontaneous coronary artery dissection (SCAD) and microvascular angina. A lack of awareness can lead to delayed presentation to healthcare systems for timely treatment which can have an impact on outcomes.

- Ischaemic heart disease kills nearly three times as many women as breast cancer in Scotland[78].
- Around 100,000 women in Scotland today are living with ischaemic heart disease[79].
- Seven women die every day in Scotland from ischaemic heart disease[80].
- Women are less likely to be prescribed drugs that help reduce the chance of a second heart attack[81].
- Women in Scotland have a worse rate of survival after a heart attack than men[82].
- Heart disease is the leading cause of maternal death in the UK[83].
- It is estimated that information about risk in pregnancy is only provided to 10% of women attending cardiology appointments in Scotland[84].
- Women are under-represented in many cardiovascular clinical trials despite the fact that important sex and/or gender differences are present within most areas of heart disease[85].
- Pre-eclampsia is linked with a greater risk of heart disease in the future[86].
- Cardiac rehabilitation is associated with improved quality of life, however across the UK, the proportion of women recruited to cardiac rehabilitation programmes from those eligible is lower than expected. There is no easily accessible national data for cardiac rehabilitation currently available in Scotland[87].

Many women felt that messaging stereotypes around health issues partly contributed to the lack of awareness of health issues in women, particularly around heart health.
For example, it was mentioned that messaging about heart attacks often feature an older man with a belt around his chest, showing that chest tightness is a symptom, but women do not relate to this.

Lived Experience Engagement Report

9

Priorities, aims and actions

This section details work undertaken by sub-groups and the actions each group has developed.

These actions have been separated by priority area then into their anticipated timescales for delivery; short, medium and long-term. We will begin the implementation of some of the longer term actions within the next one to three years, but acknowledge they will take longer to fully deliver.

More detail, including who has responsibility for implementation of each action, will be provided in an Implementation Plan.

Short Term
– delivery within one year

Medium Term
– delivery within one to three years

Long Term
– delivery within three years or more

Corinne Love, Vice Chair Women's Health Group, Consultant Obstetrician and Gynaecologist, Senior Medical Officer - Scottish Government

As an obstetrician and gynaecologist I have a specialist clinical interest in women's reproductive health so have been delighted to be Vice Chair of the Women's Health Group. I am acutely aware that this is just one part of a woman's journey through life and if we are to improve the health of women in Scotland we need to look beyond reproductive health.

In our discussions, both in our sub-groups and with the women we spoke to, we have identified some themes that cut across all areas and key actions that will go some way to ensuring that women have better access to information about their health and how to make positive life choices. This section includes actions to ensure that services are joined up, accessible and inclusive, and that we are innovative in our approach to addressing the needs of all, but particularly the most disadvantaged or marginalised, women in Scotland.

The actions that cut across all of our priority areas are set out below, and will underpin many of the other actions in this Plan. Many of these actions were recommended by more than one sub-group.

9.1 Actions which cut across all priority areas

Actions

Short Term

- Establish a central platform for information on women's health on NHS Inform.
- Seek women's lived experience, through the continuation of a lived experience group, to inform health policy and improve healthcare services and to ensure women are meaningfully involved in decision making and priority setting going forward.
- Share examples of good practice to encourage primary care to consider different and more flexible options for provision of women's health services to best meet the needs of their communities.
- Promote the use of video or telephone consultation where appropriate to support access to services for women, particularly those who may otherwise be required to travel long distances or who may have difficulty travelling to appointments.

Medium Term

- Establish a national Women's Health Champion and a Women's Health Lead in every NHS board to drive change and share best practice and innovation.
- Promote use of Relationships, Sexual Health and Parenthood (RSHP) resources to teachers and parents as part of the school curriculum and to support workers to ensure young people who are non-attenders or not in mainstream education have access to resources.
- Improve collection and use of data, including qualitative evidence of women's lived experiences, ensuring disaggregation by protected characteristics. Robust intersectional analysis of this data should be used to inform service design and improve healthcare services and women's care and experiences.

Long Term

- Adopt a life course approach in all services to improve women's health holistically.
- Provide and promote a 'Women's Health' Community Pharmacy service.
- Establish a Women's Health Research Fund with the aim of closing gaps in scientific and medical knowledge in women's health for both sex specific and non sex-specific conditions.
- Develop a programme to ensure that cultural competence, gender competence, trauma informed practice and human rights is embedded as a core component within all clinical education, training and Continuing Professional Development (CPD).

9.2 Contraception, abortion, sexual health and pre-pregnancy

Alison Scott, Consultant Obstetrician and Gynaecologist, specialising in sexual health, NHS Lothian

I was very privileged to chair the sub-group of the Women's Health Plan which was tasked with reviewing contraception, abortion and pre-pregnancy care. Having worked as a consultant gynaecologist in sexual health, I am passionate about equitable access to healthcare. Some years ago, I established a service for women who are socially excluded, have complex medical and social histories and are at high risk of unintended pregnancies and sexual ill health. I quickly learned how difficult it was for some people to access healthcare whilst also struggling to manage issues such as poverty, substance misuse, having children removed and/or trying to cope with domestic abuse, sexual assault or other traumas. Whilst as clinicians, our priorities relate to health and wellbeing, for the women I met their priorities often related to securing their housing, avoiding violence or ensuring they had money to feed their children. Working together with the third sector changed how we engaged with women. It allowed women to be supported in multiple ways and once their social issues were resolved, they could then focus on positive choices regarding their health.

There are other groups of women too who may struggle to access healthcare, for example those living in geographically remote areas, those from minority ethnic groups, and disabled women, who all face barriers to receiving care and enjoying healthy, safe lives within their communities.

Members of the Sexual Health sub-group included specialist clinicians, GPs, nurses, third sector representation and Scottish Government policy leads, bringing with them years of experience of working with and supporting women directly. I am very grateful for their commitment to improving care for women through the Women's Health Plan.

The specific actions developed by the sub-group are set out below. In developing these one of our main considerations was that care must be accessible, holistic and person-centred. Care should be dictated by the woman's needs, priorities and preferences and not restricted to what a service provides. Women are about more than reproduction and simply addressing sexual health issues misses opportunities to provide other information or interventions that can hugely improve quality of life, health and wellbeing.

Moving to provision of more holistic care, for some, will be a big cultural shift. It involves deploying staff in different settings and taking services to women rather than expecting women to travel to services which only address reproductive needs. How these services are delivered will vary according to geographical area and also population need. Creative models of care are needed, and we must build on the examples of these that already exist in many areas of Scotland. Women need to be supported to address the needs they feel are the most important for them. Doing this leads to an increased likelihood of positive choices, stability and better health outcomes in the longer term.

We want to achieve the following:

Priority

Improve access to abortion services.

Aims

1. All women will be able to access timely abortion care without judgment.

2. All women will have choice about how and where they access abortion care.

Actions

Short Term

- Make telephone or video consultation universally available as an option for abortion services.
- For post abortion contraception, provide all women with 6 or 12 months progestogen only pill with their abortion medications. Fast track to long acting reversible contraception if desired.
- Review data collected on abortions to ensure it is relevant, whilst protecting anonymity.

Medium Term

- NHS, Local Authorities, Justice agencies and Scottish Government to work together to find ways of preventing women feeling harassed when accessing abortion care due to protests or vigils.
- Increase options for women around where they can take abortion medication (mifepristone).
- Provide mid-trimester abortion care locally or regionally for all indications.

Long Term

- Build on the recommendations above by reviewing the provision of abortion services in Scotland to ensure services for all those deciding to terminate their pregnancy are fully accessible and person-centred.

Priority

Improve access to contraception services, including rapid and easily accessible postnatal contraception.

Aims

1. All women will be able to access a full range of contraception easily, quickly and confidentially.

2. All women will be able to access sexual health services easily, quickly and confidentially.

3. All women, who choose to become pregnant, will have easy access to the information and advice they need to best prepare themselves for pregnancy.

Actions

Short Term

- Promote use of video or telephone, in addition to face-to-face, consultation for women, including those in prisons, to provide greater privacy, dignity, choice and flexibility.
- Provide accessible information and advice on pre-pregnancy care.

Medium Term

- Develop a Framework for Pre-pregnancy Care, to raise awareness and understanding of the importance of optimising health before pregnancy, including healthy diet, keeping active, stopping smoking and the risk of drinking alcohol during pregnancy or when planning for pregnancy.
- Provide training for non-NHS staff to support conversations with women about health and healthcare services.
- Provide creative, holistic and outreach models of care for sexual health and contraception services.
- Increase availability of LARC (Long Acting Reversible Contraceptive) as one of a range of options for contraception available to women.
- Ensure that discussions on contraception take place during pregnancy. Women should be given adequate and appropriate information on their options, as well as rapid access to their preferred method where applicable.

Long Term

- Provide more routine sexual healthcare through primary care, community pharmacies and online where appropriate, to enable specialist sexual health services to prioritise those most at risk of sexual ill health or unintended pregnancy.

9.3 Menopause, menstrual health including endometriosis

Heather Currie, Consultant Gynaecologist and Associate Medical Director – NHS Dumfries and Galloway

As a gynaecologist with special interest in menopause, I have been delighted to have the opportunity to help develop the Women's Health Plan for Scotland, by chairing the sub-group addressing menopause, and menstrual health, including endometriosis.

Most women and girls experience menstrual cycles and yet many are unaware of, and unprepared for, the impact that each cycle can have. The impact can be both from the physical aspect of bleeding and how that is dealt with, but also the multitude of symptoms that can arise from the natural hormonal fluctuations.

Endometriosis can cause significant morbidity and additional distress exists due to delay in diagnosis and appropriate management.

Menopause affects all women and yet many feel unaware of and unprepared for the range, severity and impact of symptoms, and of treatment options. In addition, there is little awareness of the impact of menopause on later health, especially when menopause occurs early, and opportunities are missed to inform and advise. The general lack of awareness is sometimes compounded by inconsistent messages provided by healthcare professionals.

Working with representatives from primary care, gynaecology, sexual health, community pharmacy, third sector, and Scottish Government policy leads we have developed a number of actions which we hope will address many of the issues highlighted in research and by women with lived experience. Some of these will be straightforward to implement, all are achievable, and some will be life-changing. The combined expertise and commitment of this group to providing the best care possible for women has been invaluable.

While our aims are set out below, key points are worth additional mention in line with key themes identified by this sub-group; information and consistency. With the focus on provision of information, education from an early age is paramount, with additional opportunities identified to reinforce key messages at later stages, in line with the life course approach. Cognisance has been taken of the need for information to be consistent, reliable and accessible, in line with the overarching ambition of the Plan. Of all aspects of Women's Health, the area which often leads to inconsistent advice being given is around menopause. The need for education of healthcare professionals has been recognised and addressed, with the aim of women receiving consistent advice throughout Scotland.

Priority

Improve access to information for girls and women on menstrual health and management options.

Improve access for women to appropriate support, speedy diagnosis and best treatment for endometriosis.

Aims

1. All young people will be aware of normal menstrual health.

2. Average diagnosis time for endometriosis will be reduced.

3. All women will be able to access the right support and effective treatment for endometriosis.

4. When required, all women will have access to a specialist endometriosis centre.

Actions

Short Term

- Promote the use of positive language around menstrual health.
- Where appropriate offer women who are eligible for combined hormonal contraception, the option of a continuous or extended regimen and raise awareness of the option of no bleeding, even if contraception is not required.

Medium Term

- Use existing programmes, such as the HPV vaccination programme, to provide general information to young people about periods, menstrual health and management options.
- Provide access in each primary care team to a Healthcare Professional (HCP) or HCPs who have a specialist knowledge in menstrual health including awareness of the symptoms of PMS, PMDD, heavy menstrual bleeding, endometriosis and their treatment options.
- Implement and raise awareness of current national guidelines on endometriosis and develop and implement further pathways for care where these don't currently exist – for example endometriosis outside the pelvis.
- Commission endometriosis research to find the cause of the condition, leading to the development of better treatment and management options, and a cure.

Long Term

- Strengthen collaborative working between regional specialist endometriosis centres, territorial and special NHS boards and primary care providers, to drive improvement in patient pathways and achieve equitable access to care and treatment.

Priority

Ensure women who need it have access to specialist menopause services for advice and support on the diagnosis and management of menopause.

Aims

1. When required, all women will have timely access to menopause support and services.

2. Healthcare professionals (HCPs) will be aware of the impact medical or surgical treatments to induce menopause have on subsequent health.

3. All women will have access to a healthcare professional with an interest in menopause through primary care.

Actions

Short Term

- Develop, maintain and promote a support network for Menopause Specialists throughout Scotland. Each healthcare professional (HCP) with special interest in menopause should have access to at least one Menopause Specialist for advice, support, onward referral and leadership of multidisciplinary education.
- Provide a holistic approach to care by promoting greater joint working between healthcare professionals on menopause diagnosis and treatment across primary and secondary care and specialist clinics, including through joint education sessions starting with pre and post qualification training on gynaecology.
- Establish a dedicated menopause policy post within Scottish Government.

Medium Term

- Provide access in each primary care team to a HCP who has a special interest in menopause.
- Provide a specialist menopause service in every NHS Board, and where sub specialisation is impractical (eg. islands) develop a buddy system.
- Develop a menopause and menstrual health workplace policy, as an example of best practice, starting with NHSScotland, and promote across the public, private and third sector.
- Ensure women are properly supported around the time of menopause to assess their future risk of osteoporosis and fractures and given appropriate lifestyle advice.
- Launch a public health campaign to remove stigma and raise awareness of the symptoms of menopause.

Long Term

- Build a basic understanding of menopause among all healthcare professionals. This should include awareness of the symptoms of perimenopause and menopause and awareness of intermediate and long-term consequences, and know where to signpost women for advice and support.
- Acknowledge the importance of menopause, menstrual health and endometriosis within mental health policy, ensuring policies recognise the impact these conditions can have on women's mental as well as physical health, including awareness of the symptoms of PMS and PMDD.

9.4 Heart health

Maggie Simpson, Senior Nurse Specialist and Chair of the Scottish Obstetric Cardiology Network

Heart disease remains the leading cause of death for women in Scotland and is responsible for significant morbidity and reduced quality of life. When we talk about cardiovascular disease (CVD), we often do so in relation to specific conditions such as heart attacks and usually in the context of CVD in men. Therefore, there is a need to expand the narrative of CVD in Scotland, raising awareness of the range of CVD as well as CVD risk in women. This is required, not only in the public domain, but also among policy makers and healthcare professionals.

Women face several challenges in maintaining optimal heart health. There is a growing body of evidence which demonstrates that women presenting with symptoms of heart disease are under-investigated, less likely to access guideline recommended treatments and often have worse outcomes following interventions. Women are also less likely to have appropriate management of CVD risk factors such as diabetes and high blood pressure. This is further compounded by unique risk factors for CVD in women, including adverse pregnancy outcomes (hypertensive disorders of pregnancy, pre-term delivery, gestational diabetes or small gestational age), use of contraceptives that increase risk in CVD as well as endometriosis and menopause. In addition, there is often a failure to recognise CVD in younger women who present to healthcare services.

Women in Scotland who are born with CVD, either inherited or congenital, or who acquire heart disease, require lifelong care. The frequency and extent of that care will vary across the woman's lifespan and there are specific points in their care pathway that require particular focus. This includes the period of transition from paediatric to adult cardiac services, where there is a risk of patients being lost to follow-up. Women require appropriate education on the importance of safe contraception, the impact of pregnancy on their heart condition as well as reducing lifetime risk of CVD. It is therefore essential that women at risk of, or who have a CVD diagnosis, have access to healthcare professionals (HCPs) who are aware of sex-specific differences in the risk factors, presentation and management of CVD in women. These HCPs should be opportunistic in promoting good heart health.

Disparities in CVD outcomes for women are also associated with social determinants of health including access to healthcare services that meet the needs of women. Women are under-represented in health research related to CVD which has implications for recommendations on optimal care for women at risk of or who have a diagnosis of CVD. There remains under-representation of female cardiologists and of female clinicians in roles that design and develop guidelines and research in CVD.

Addressing disparities in CVD care for women in Scotland requires a life course approach that acknowledges their specific needs. Cross-specialty and multi-professional collaboration with the woman at the centre is essential.

The configuration of the 'Heart Health' sub-group of the Women's Health Plan reflects the multi-disciplinary approach required to improve outcomes and quality of life for women at risk of or living with heart disease in Scotland. Actions to address the disparities in cardiovascular health for women developed by the sub-group are set out below. These focus on raising awareness of CVD in women, providing a consistent message for the public and healthcare professionals, developing educational opportunities and promoting multi-disciplinary collaboration supported by pathways of care. This also includes the sharing of best practice.

It has been a pleasure to develop these actions with colleagues who are passionate about improving CVD outcomes. I would like to give special thanks to the women with lived experience of CVD whose voice has inspired us and provided additional motivation to take this work forward.

Priority

Reduce inequalities in health outcomes related to cardiac disease

Aims

1. Opportunities for optimisation of cardiovascular health and risk reduction will be taken across a woman's life course.

2. Healthcare professionals will be aware of sex-related differences in presentation and management of heart disease in women and act to reduce inequality of care and improve outcomes.

3. All women will have access to information on the risk factors for and symptoms of heart disease enabling them to quickly and confidently describe their own symptoms when speaking to healthcare professionals.

4. All women with heart disease will receive appropriate support in managing their risk factors, recovery and living with a long-term cardiac condition through appropriate follow up and access to cardiac rehabilitation and psychological support.

5. All women with heart disease will be provided with individualised advice and co-ordinated care to access safe contraception, abortion, assisted conception, pregnancy and gynaecological care.

Actions

Short Term

- In all heart health consultations, opportunities should be taken to provide individualised advice and care to women, and in all pregnancy and pre-pregnancy discussions and interactions opportunities should be taken to optimise women's heart health to optimise women's holistic health as part of the life course approach.
- Where research shows there are sex-related differences in prevention, diagnosis, investigation or treatment of CVD these should be detailed in guidelines and pathways.
- Improve information and public awareness of heart disease symptoms and risks for women.

Medium Term

- Ensure women with CVD have access to mental health support, regardless of whether they are accessing a cardiac rehabilitation programme.
- Establish appropriate representation of women in clinical research and where appropriate pregnant and postpartum women should be included in clinical trials.
- Establish a peer support forum for women with lived experience of CVD.

Long Term

- Improve awareness and education among healthcare professionals of sex-related differences in presentation and management of heart disease in women of all ages.
- As part of Cardiac Rehab, provide an individualised biopsychosocial assessment and a shared decision care plan with interventions specific to women's needs and choices.
- Encourage increased representation of women clinicians by promoting diverse role models and encourage mentoring for trainees.
- Every cardiology department will have access to a clinician with expertise in women's heart health.
- Establish appropriate representation of women clinicians on guideline committees and within research design and development teams.

9.5 Gender and health

Emma Ritch, National Advisory Council on Women and Girls and Executive Director of Engender

Sadly Emma Ritch died on 9 July 2021 prior to publication of the Women's Health Plan. As a member of the Women's Health Group and chair of the Gender and Health sub-group she was central to its development. Her personal reflection on the Plan and the work of her sub-group is presented here, as she drafted it:

I was delighted to represent the National Advisory Council on Women and Girls on the Women's Health Group and to be invited to chair a sub-group tasked with thinking about how to overcome gendered barriers to women's health. Women have specific health needs because of physiology but also because of social norms, stereotypes, and persistent gendered inequalities.

The National Advisory Council on Women and Girls has focused, in its first three years, on making recommendations for system change. The Gender and Health sub-group has brought together clinical experts with gender equality experts, data experts, and academics to consider what needs to change in the system to make health policy, planning, and services more responsive to women's gendered needs. I am grateful for the energy and enthusiasm of the sub-group members and their ambition to see decision-making done differently.

At the moment, too many women are less healthy than they could be. Structural inequality like the gender pay gap, women's experience of poverty, men's violence against women, and a lack of women around health decision-making tables undermines women's health. Too many curricula, health services and interventions are designed around the needs of the white, non-disabled male 'default human'. All of this means that women's ill-health takes longer to diagnose, and longer to treat effectively. Women's disease is less likely to be prevented. Black and racialised women and disabled women are even more likely to experience worse health outcomes, at great cost to them, their families, and wider communities.

Changing norms requires leadership, investment, commitment, and sustained focus. The actions we have developed are a first step towards creating systems that enable all women to live healthy lives. We know that they will not make all the change that women need to see, especially for disabled women, racialised women, lesbian and bisexual women, trans women, and older women.

We have focused on creating the conditions for change:

- Gender-competent sex-disaggregated data that will enable improvement to healthcare policy, planning and service design and provision.
- Health improvement of, and healthcare for, women and girls should be holistic, inclusive, respectful and fulfil women's right to the highest attainable standard of health.
- Health budget decisions should be reflective of the needs and rights of women and girls.
- Undervaluation of caring professions must be addressed in the health and social care sectors.
- Gender and cultural competence should be built into health policy and healthcare services, including training and coaching in equality, diversity, and human rights for clinicians and policymakers.

Priority

Reduce inequalities in outcomes for women's general health.

Aims

1. Gender and cultural competence will be built into health policy and healthcare services.

2. Undervaluation of caring professions will be addressed.

3. Accountability, transparency and participation should be the basis for budget decisions and public expenditure will be reflective of the needs and rights of women and girls.

4. Clinical training and CPD will include education, training and long term coaching, in equality, diversity and human rights.

Actions

Short Term

- Establish a Health Equality team within Scottish Government, to pursue intersectional healthcare policy with a particular focus on sex, race, disability and sexual orientation.
- Encourage NHS boards to engage with the Equally Safe at Work employer accreditation programme.
- Ensure National Performance Indicators are disaggregated where appropriate.

Medium Term

- Build an intersectional evidence base around women's health inequalities ensuring women's healthy life expectancy and quality of life are used as measures in addition to total life expectancy.
- Build an evidence base on women's health inequalities, with specific focus on the impact of sexism, racism, ableism, and other forms of discrimination including homophobia and transphobia on women's health.
- Develop gender competency across Scottish Government and NHSScotland, starting with the knowledge, information and data workforce and key decision makers such as those in finance and procurement.
- Increase awareness and understanding of how to effectively use and apply the Public Sector Equality Duty within health and social care, and work to close the implementation gap, as a means to improving women's health.
- Encourage greater transparency in budget decision making, through intersectional gender budget analysis, within health-specific budget processes.
- Establish Gender Equality and Gender-based Violence policy lead positions to work within Health Directorates and with NHS Boards.

Long Term

- Ensure mental health policy and service provision is gender and culturally competent, and that the implementation of actions in the Mental Health Transition and Recovery Plan takes account of women's specific mental health inequalities. Ensure gender and cultural competence is reflected in any future mental health policy.
- Develop tools, including a toolkit and coaching, to support HR managers in the health and social care sector to develop and implement employment practices and policies which are intersectional and gender-competent.
- Address undervaluation within health and social care sector pay, taking into account recommendations from the independent Review of Adult Social Care.

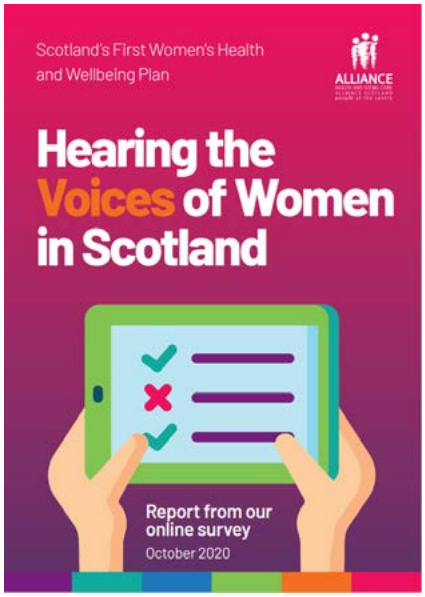
9.6 Lived experience

Irene Oldfather, Director of Strategy and Engagement – Health and Social Care Alliance Scotland (ALLIANCE)

The Women's Health Plan has the potential to change and improve the lives of women, and narrow the gender equality gap. For myself as Chair of the Lived Experience Group, it was heartening to see such a huge response to our work – our online survey alone attracted over 400 responses.

Over the course of what we heard through both our survey and our development session, I suppose for me the asks of women are not unreasonable. Strong themes of breaking down barriers, providing choice and flexibility and educating everyone about women's health issues emerged. It was also vitally important for women that symptoms are taken seriously and there is a robust investigation carried out to determine the causes of illness.

Report from our online survey



Women want to see a system which provides them flexibility around their lives, both when accessing appointments and for treatment and support options. One of the strongest themes was difficulty getting an appointment that works around their work commitments and caring responsibilities. The same issue was identified by disabled women and those with long-term conditions who felt that their capabilities were questioned when they missed appointments due to their health. Women suggested the need for diversity in delivery of service to meet each woman's needs, and discreet and easy access.

Report from our online engagement sessions

When it came to accessing information, participants spoke of the importance of understanding their options, particularly in relation to contraception, though this applies to all areas of health. Women who have different communication needs want easy access to interpreters and information in various languages and formats. Women highlighted the importance of good communication by illustrating that they cannot take responsibility for their own health without enough information about it. It was also remarked that the way that healthcare professionals engage with women is very important and women have been made to feel hysterical when not being taken seriously in a medical context.

Women want to see stigma broken down around mental health, menstrual health and contraception. They feel this could be achieved through more information raising and conversations in communities and better understanding of potential cultural barriers from staff.

Education, peer support (particularly for women experiencing menopause symptoms) and periodic health and wellbeing assessment for all women were highlighted as important steps required to ensure that no woman falls through the gaps of support and services.

Overall, women want services and information that fit their lives instead of needing to disrupt their life to access a service. They want to be taken seriously no matter their concern, without feeling judged for their skin colour, culture or choices.

Action

Seek women's lived experience, through the continuation of a lived experience group, to inform health policy and improve healthcare services and to ensure women are meaningfully involved in decision making and priority setting going forward.

10

How will we make change happen and who needs to be involved?

This is a long-term commitment to improving women's health and it is clear that developing the actions identified and the implementation of this Plan will require a collective and collaborative effort.

10.1 Creating the conditions for change

Change cannot happen overnight. Many of the actions identified in this Women's Health Plan relate to starting the conversation about women's health. As this is the first iteration of the Women's Health Plan many of the actions are dependent on creating the conditions for change and developing a sound foundation to ensure that women's needs are considered in all future Scottish Government and NHSScotland policies.

> The most important places to facilitate immediate change, with [with regard to women's health inequalities] are in educational curricula, research, and clinical practice guidelines.
>
> **Dr Alyson McGregor, 'Sex Matters: How male-centric medicine endangers women's health and what we can do about it'**

The realisation for this vision for women's health is dependent upon achievement of the following:

- **Empowering women and girls**
  Women and girls should be empowered to help themselves to improve their health. This must involve improved access to reliable information and services that meet their needs. We are committed to ensuring an ongoing lived experience group to ensure women inform the priorities for future work.
- **Enhanced education of the health and social care workforce**
  Improving the understanding of women's health amongst the whole workforce, including an awareness of sex-related differences in the manifestation of different conditions is central to improving women's health and their experience of healthcare. This will involve engaging with current staff in addition to ensuring women's health is a central consideration in the training of our future workforce.
- **High-quality data and research that is disaggregated by sex and gender**
  The availability of robust and sex and gender-specific data is central to our ability to develop evidence based policy and to measure our success in reducing inequalities for women. This will require collection and analysis of data relevant to women's health alongside increasing the representation of women at all stages of clinical research both as participants and investigators.

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

10.2 Who needs to be involved

The Women's Health Plan has been developed with partners in health and social care, the third sector and most importantly with women themselves. We need to continue and strengthen this collaboration as we work towards achieving our vision for women's health.

Achievement of this vision will involve not only the Scottish Government and NHSScotland, but also organisations and individuals operating at various levels and in various sectors across Scotland, from local community organisations and those who provide advocacy support to specialist health services and clinicians, third sector partners, local authorities, government policy makers and finance leads. We do not underestimate the collective effort that will be required to deliver this vision.

Women's Health Champion

This Plan for women's health will require long-term cultural change, much of which begins with starting the conversation about women's health. To ensure this conversation happens at a strategic level, we intend to appoint a national Women's Health Champion to drive forward this strategic change. The Women's Health Champion will be the linchpin that coordinates efforts from the many different groups involved in the achievement of our vision for women's health in Scotland. They will be central to ensuring the key areas highlighted above are the catalyst for a continued focus on women's health going forward.

The Women's Health Champion will:

- drive forward strategic change nationally;
- raise awareness of women's health;
- promote the Women's Health Plan;
- support a network of local women's health experts and leaders; and
- have an integral role in the implementation of this, and subsequent, women's health plans.

Women's Health Plan Implementation Programme Board

In order to ensure that progress is achieved and that the actions within this Plan are implemented effectively and in partnership, we will establish a Women's Health Plan Implementation Programme Board. Membership of this board will include the Women's Health Champion and organisations and individuals directly involved in the implementation of actions included within this Plan.

Reporting

An annual update will be produced detailing progress made in the implementation of the actions included within this Plan.

An implementation report will be published in 2024-25 which will capture progress made, analyse the impact of the Plan and consider lessons learned.

These are some of the groups who will be integral to reducing health inequalities for women and for achieving this vision for women's health, including the central role of the Women's Health Champion.

11

Conclusion

The implementation of the actions identified in this Plan will be challenging, particularly in light of the Covid-19 pandemic. The impact of the pandemic, particularly on the health and social care workforce, should not be underestimated, nor should the health inequalities which have been brought into sharp focus throughout the pandemic.

This Plan will be implemented alongside Covid-19 recovery and renewal plans. We acknowledge the resourcing challenges faced across the health and social care sector and the need for this Plan to align with other priorities.

Despite the challenges faced, the pandemic has provided opportunity for innovation and scope to do things differently for women's health, particularly as we consider how services will recover and remobilise post-Covid-19.

In bringing this Plan together we have highlighted the systemic failures that exist for women in Scotland. This is our opportunity to address these inequalities and build a fairer future where health outcomes are equitable across the population of Scotland so that all women enjoy the best possible health throughout their lives. Put simply, it is time to act for the women of Scotland.

ANNEX A - List of those involved

Women's Health Group Members

Chair: Professor Marion Bain, Interim Deputy Chief Medical Officer, Scottish Government

Vice Chair: Dr Corinne Love, Vice Chair Women's Health Group, Consultant Obstetrician and Gynaecologist, Senior Medical Officer - Scottish Government

Professor Colin Berry, Professor Cardiology and Imaging, University of Glasgow

Professor Sharon Cameron, Consultant Gynaecologist and lead for sexual health services, NHS Lothian

Dr Alastair Campbell, Co-Chair Scottish Committee, Royal College of Obstetricians & Gynaecologists

Dr Heather Currie, Consultant Gynaecologist and Associate Medical Director, NHS Dumfries and Galloway

Professor Ann Holmes, Chief Midwifery Adviser and Deputy Chief Nursing Officer, Scottish Government

Dr Sigi Joseph, Executive Officer (Professional Development), Royal College of GPs Scottish Council

Professor Clare McKenzie, Lead Dean, Training and Management, NHS Education for Scotland

Dona Milne, Director of Public Health, NHS Fife

Jackie Montgomery, **Valerie Clarke**, Lead Physiotherapists for the Pelvic, Obstetrics and Gynaecological Physiotherapy service, NHS Greater Glasgow and Clyde

Irene Oldfather, Director of Strategy and Engagement, the Health and Social Care Alliance Scotland (the ALLIANCE)

Professor Lindsey Pope, Professor of Medical Education, University of Glasgow

Emma Ritch, National Advisory Council on Women and Girls and Executive Director, Engender

Karen Ritchie, **Dr Fiona Wardell**, Healthcare Improvement Scotland

Dr Alison Scott, Consultant Obstetrician and Gynaecologist, specialising in sexual health, NHS Lothian

Maggie Simpson, Senior Nurse Specialist and Chair of the Scottish Obstetric Cardiology Network

Fiona Stalker, Journalist

SUB-GROUP MEMBERS

Sexual Health/Contraception/Abortion
Pre-Pregnancy Care
Chair: Dr Alison Scott

Dr Audrey Brown, Consultant Gynaecologist, Sandyford, Glasgow

Dr Michelle Cooper, Obstetrics and Gynaecology ST 7, NHS Lothian

Katie Cosgrove, Gender-based Violence Lead, Public Health Scotland

Dr Rebecca Devine, Public Health Registrar

Eilidh Dickson, Policy and Parliamentary Manager, Engender

Kirsten Kernaghan, Senior Sexual Health Nurse and Young People's Lead, Chalmers Sexual Health Centre

Rhona Innes, Manager, Another Way Project, SACRO

Dr Hame Lata, Consultant, Sexual & Reproductive Health, NHS Highland

Inger McGowan, Nurse Case Manager, The Willow Service

Dr Nora Murray-Cavanagh, GP at Wester Hailes

Maggie Simpson, Senior Nurse Specialist and Chair of the Scottish Obstetric Cardiology Network

Felicity Sung, Scottish Government, Directorate for Children & Families

Rachel Tatler/Sam Baker, Scottish Government, Population Health Directorate

Carolyn Wilson, Scottish Government, Supporting Maternal and Child Wellbeing

Louise Watson, Scottish Government, Population Health Directorate

Women's Heart Health
Chair: Maggie Simpson

Kylie Barclay, British Heart Foundation (now on secondment to Directorate for Healthcare Quality and Improvement, Scottish Government)

Professor Colin Berry, Professor of Cardiology and Imaging, University of Glasgow

Dr Anna Maria Choy, Clinical Lecturer, University of Dundee, Consultant Cardiologist, NHS Tayside

Margaret Davis, Lived Experience Representative

Professor Dana Dawson, Consultant Cardiologist, Aberdeen Royal Infirmary & Professor of Cardiovascular Medicine, University of Aberdeen

Frances Divers, Cardiology Nurse Consultant, NHS Lothian

Professor Andrew Horne, Professor of Gynaecology and Reproductive Sciences at the University of Edinburgh

Lisa MacInnes, Director, Save a Life for Scotland

Becki MacPherson, Directorate for Healthcare Quality & Improvement, Scottish Government

Dr David Murdoch, Chair, NACHD and Speciality Advisor Heart Disease

Professor Lis Neubeck, Professor of Cardiovascular Nursing, Edinburgh Napier University

Dr Alison Scott, Consultant Obstetrician and Gynaecologist, specialising in sexual health – NHS Lothian.

Dr Novalia Sidik, British Heart Foundation Clinical Research Fellow, University of Glasgow

Vicki Waqa, Specialist Lead (CPD), NHS Education for Scotland

Dr Margaret McEntegart, Consultant Cardiologist, NHS Golden Jubilee & Honorary Clinical Associate Professor, University of Glasgow

Gender and Health
Chair: Emma Ritch

Anna Ritchie Allan, Executive Director, Close the Gap

Katie Cosgrove, Emma Kennedy, Public Health Scotland

Eilidh Dickson, Policy and Parliamentary Manager, Engender

Eileen Flanagan, Head of Gender Equality Policy, Equality Unit, Scottish Government

Dr Ima Jackson, Senior Lecturer, Department of Nursing and Community Health, Glasgow Caledonian University

Kristi Long, Equality and Diversity Advisor, NHS Education for Scotland

Lucy Mulvagh, Director of Policy and Communications, the ALLIANCE

Kathryn Ramsay, Policy Manager, Scottish Women's Aid

Karen Ritchie, Dr Fiona Wardell, Health Improvement Scotland

Dr Alison Scott, Consultant Obstetrician and Gynaecologist, specialising in sexual health, NHS Lothian

Marsha Scott, Chief Executive, Scottish Women's Aid

Menopause and Menstrual Health including Endometriosis
Chair: Heather Currie

Dr Sineaid Bradshaw, GP Wester Hailes

Dr Alastair Campbell, Co-Chair Scottish Committee, Royal College of Obstetricians & Gynaecologists

Carolyn Chalmers, Modern Patient Pathways Programme, Scottish Government

Emma Cox, Endometriosis UK

Professor Hilary Critchley, Professor of Reproductive Medicine, University of Edinburgh and Consultant Gynaecologist NHS Lothian

Eilidh Dickson, Policy and Parliamentary Manager, Engender

Mayrine Fraser, Royal Osteoporosis Society

Dr Heike Gleser, Consultant in reproductive & sexual health (Menopause specialist)

June Grant, Lead Clinical Pharmacist, Obstetrics, Gynaecology & Neonates, Women & Children's Services, NHS Greater Glasgow & Clyde

Professor Andrew Horne, Professor of Gynaecology and Reproductive Sciences at the University of Edinburgh

Inger McGowan, Nurse Case Manager, The Willow Service

Lucy Mulvagh, Director of Policy and Communications, the ALLIANCE

Dr Jackie Paterson, Consultant, Chalmers Sexual Health Centre

Dr Alison Scott, Consultant Obstetrician and Gynaecologist, specialising in sexual health, NHS Lothian

Anita Stewart, Team Leader, Clinical Priorities Team, Scottish Government

Theresa Burns, Policy Manager, Clinical Priorities Team, Scottish Government

Women's Health Plan Team, Scottish Government

Anne Lillico, Team Leader (jobshare)

Denise McLister, Team Leader (jobshare)

Nicola Cogan, Policy and Engagement Manager

Felicity Sung, Menopause Lead

Claire Austin, Scottish Clinical Leadership Fellow

ANNEX B - Strategic context: policy documents

- Equally Safe Strategy
- Work of the Expert Reference Group on COVID-19 and Ethnicity
- The Fairer Scotland Action Plan
- A Fairer Scotland for Disabled People
- Race Equality Framework
- A fairer Scotland for women: gender pay gap action plan
- Period Products (Free Provision) (Scotland) Bill
- Getting It Right For Every Child (GIRFEC)
- Achieving excellence in pharmaceutical care: a strategy for Scotland
- Realistic Medicine
- Adult social care: independent reviewHealth and Social Care Delivery Plan
- Mental Health Strategy 2017-2027
- National Clinical Strategy
- The best start: a five-year forward plan for maternity and neonatal care in Scotland
- Ready, Steady, Baby!
- LDP Early Access to antenatal services
- Recovery and redesign: cancer services - action plan
- Heart disease: action plan 2021A Scotland for the future: opportunities and challenges of Scotland's changing population
- A More Active Scotland: Scotland's Physical Activity Delivery Plan
- Housing to 2040
- A Connected Scotland: our strategy for tackling social isolation and loneliness and building stronger social connections
- Healthcare and forensic medical services for people who have experienced rape, sexual assault or child sexual abuse: Children, young people and adults standards

The 2020-2021 Programme for Government included the commitment to develop an equality and human rights mainstreaming strategy, which is underpinned by a comprehensive approach to improving data collation and analysis, and will ensure that the voices of those impacted shape our approach and policies.

ANNEX C - Legal framework

This Plan is underpinned by domestic and international legislation.

Human Rights

All human beings are entitled to basic rights and freedoms. The Scottish Government is committed to building an inclusive Scotland that protects, respects, promotes and implements internationally recognised human rights. We aim to make human rights considerations part of the day-to-day business of government – the development of the Women's Health Plan is an example of this.

Domestic

This Plan is underpinned by domestic human rights and equality legislation including:

Equality Act (2010) and the Public Sector Equality Duty

The Equality Act 2010 provides a framework to combat discrimination in areas of life such as employment, education, access to goods and services, the exercise of public functions and membership of clubs and associations. As well as the characteristic of sex, the Act covers a number of other characteristics – age, disability, marriage and civil partnership, race, religion or belief, sexual orientation, gender reassignment and pregnancy and maternity.

The Public Sector Equality Duty

The public sector equality duty (or general duty) in the Equality Act 2010 came into force in 2011. As outlined by the Equality and Human Rights Commission[88], the public sector equality duty requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people. The purpose of the equality duty is to integrate consideration of equality in the day-to-day decision making and activities of the public sector. The general equality duty requires organisations to consider how they could positively contribute to the advancement of equality and good relations. It requires equality considerations to be reflected into the design of policies and the delivery of services, including internal policies, and for these issues to be kept under review.

In Scotland, we have set a framework to help public authorities improve their performance of the duty – the Scottish specific duties. These help the Scottish Government to deliver on ambitions for a more equal and just Scotland.

In accordance with our equality duties, a full Equality Impact Assessment (EQIA) will be published alongside this Plan. This EQIA provides further detail of how the development of the Plan has been underpinned by a commitment to reducing inequality.

The Abortion Act 1967

The Abortion Act 1967 sets out the legal requirements which should be met before an abortion can be carried out lawfully in Scotland. This Act still applies across Great Britain, although policy on abortion is now a devolved matter and so the Scottish Parliament has the ability to legislate on abortion.

The Abortion Act did not legalise abortion. While the act provides a set of criteria for when abortion is permissible, abortion in Scotland still requires two registered medical practitioners (doctors) to certify that they are of the opinion that at least one of the grounds under the Act for an abortion have been met.

International

Scotland's approach to human rights is also governed by international law. Seven major UN human rights treaties, along with eight Council of Europe human rights treaties, currently apply to Scotland.

As such, this Plan is also underpinned by international human rights legislation and treaties[89], including:

- the Convention on the Elimination of All Forms of Racial Discrimination (CERD);
- the International Covenant on Civil and Political Rights (CCPR);
- the International Covenant on Economic, Social and Cultural Rights (ICESCR);
- the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW);
- the Convention on the Rights of Persons with Disabilities (CRPD); and
- the United Nations Convention on the Rights of the Child (UNCRC).

UN Convention on the Elimination of All Forms of Discrimination against Women

CEDAW[90] has been described as a 'bill of rights' for women. The United Kingdom ratified the Convention in 1986. The Scottish Government contributes to the United Kingdom's periodic reports to the UN and is an active participant in the oral examinations of the UK conducted by the UN Committee on the Elimination of All Forms of Discrimination Against Women.

In March 2021, the National Taskforce for Human Rights Leadership published 30 recommendations for a new human rights framework for Scotland. The Scottish Government has accepted all of these recommendations, and a new multi-treaty Human Rights Bill will be introduced to Parliament during this parliamentary session. The Bill will incorporate CEDAW into domestic legislation, so far as possible within devolved competence. This Plan has been drafted with consideration of CEDAW.

Article 12 of CEDAW relates to health and states that:

> States Parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning.

With future-proofing in mind, recommendations have been drafted with consideration to CEDAW and Article 12 in particular.

ANNEX D - Glossary of terms and acronyms

Equality terminology

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) - A United Nations treaty, adopted in 1979 by the UN General Assembly and is often described as an international bill of rights for women.

Cultural competence - being respectful of, and responsive to, peoples beliefs, behaviours and needs in order to deliver effective healthcare. It means being inclusive, non-stereotypical and non-judgemental.

Disaggregated data - is data that has been broken down by detailed sub-categories, for example by sex, race, disability.

European Convention on Human Rights (ECHR) - An international treaty to protect human rights and fundamental freedoms in Europe.

Equality and Human Rights Commission (EHRC) - The Commission has responsibility for the promotion and enforcement of equality and non-discrimination laws in England, Scotland and Wales.

Empowerment - Empowerment of women and girls concerns women and girls gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources. The core of empowerment lies in the ability of a person to control their own lives and choices.

Equality Impact Assessment (EQIA) - An activity or process that helps you to look at the impact of a policy on different groups of people. This is a legal requirement in Scotland.

Gender-based violence (GBV) - Gender-based violence is a major public health, equality and human rights issue. It covers a spectrum of violence and abuse, committed primarily but not exclusively against women by men. This includes, but is not limited to:

- domestic abuse;
- rape and sexual assault;
- childhood sexual abuse;
- stalking and harassment;
- commercial sexual exploitation; and

- harmful practices - such as female genital mutilation, forced marriage and so-called 'honour-based' violence.

Gender competence - refers to the skills, knowledge and analytical capability to develop policy that is well gendered, i.e. that takes into account the socially constructed differences between men's and women's lives and experiences in an intersectional way.

Gender Budgeting/Gender Responsive Budgeting (GRB) - a way of analysing a budget and budget decisions to understand the impact and potential impacts on women. Government planning, programming and budgeting that contributes to the advancement of gender equality and the fulfilment of women's rights. It entails identifying and reflecting needed interventions to address gender gaps in policies, plans and budgets. GRB also aims to analyse the gender differentiated impact of revenue-raising policies and the allocation of domestic resources.

Gender-responsive programming and policy - intentionally employing gender considerations to affect the design, implementation and results of programmes and policies. Gender-responsive programmes and policies reflect girls' and women's realities and needs, in components such as site selection, project staff, content, monitoring, etc. Gender-responsiveness means paying attention to the unique needs of women and girls, valuing their perspectives, respecting their experiences, understanding developmental differences between girls and boys, women and men and ultimately empowering girls and women.

Intersectionality - how different aspects of a person's identity overlap to form their unique experience.

LGBTI- lesbian, gay, bisexual, transgender and intersex

Occupational/subject Segregation - Women/girls, men/boys being channelled into different types of employment or subject choices, for example over representation of women in subjects such as biology and under-representation in physics and maths. Vertical occupational segregation is the clustering of men at the top of occupational hierarchies for example female teachers and predominantly male head teachers/teachers in leadership positions.

Protected Characteristic - There are nine characteristics protected under the Equality Act 2010. They are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

Public Sector Equality Duty (PSED) - The Equality Act 2010 imposes a duty on public authorities to: eliminate unlawful discrimination, harassment and victimisation; advance equality of opportunity between people who share a protected characteristic and those who do not; and foster good relations between people who share a protected characteristic and those who do not.

Sex disaggregated data - data that is separated/broken down by sex, presenting information separately for men and women, boys and girls. When data is not disaggregated by sex, it is more difficult to identify real and potential inequalities. Sex-disaggregated data is necessary for effective gender analysis.

Structural discrimination/systemic discrimination - a form of discrimination resulting from policies, despite apparently being neutral, that have disproportionately negative effects on certain societal groups.

Trans/Transgender - It is currently common to use the terms transgender people or trans people as an 'umbrella' to cover the many diverse ways in which people can find their personal experience of their gender differs from the assumptions and expectations of the society they live in.

Clinical/Medical terminology

Abortion - An abortion is a procedure to end a pregnancy. It's also sometimes known as a termination of pregnancy. The pregnancy is ended either by taking medicines or having a surgical procedure.

Antenatal (prenatal) - before birth.

Antenatal care - Antenatal care is the care women receive from health professionals during pregnancy.

Arrhythmia - an abnormal heart rhythm. This is usually due to faulty conduction of electricity through the heart. There are many different types of arrhythmia which can be managed differently, including medication, a pacemaker or an ICD (an internal defibrillator).

Atrial Fibrillation (AF) - This is a common abnormal heart rhythm that happens when electrical impulses fire off from different places in the atria (the top chambers of the heart) in a disorganised way. This causes the atria to twitch, and results in an irregular heartbeat or pulse. Atrial fibrillation is a major cause of stroke.

Cardiac Arrest - This occurs suddenly and without warning. The most common cause of a cardiac arrest is a heart attack, but there are other causes. In cardiac arrest there is an electrical malfunction in the heart, resulting in an irregular heartbeat that disrupts the effective pumping action of the heart. As a result, the heart cannot pump blood to the brain and other organs. Death can occur within minutes if cardiopulmonary resuscitation (CPR) and defibrillation are not carried out.

Cardio Vascular Disease (CVD) - is the medical term that covers all diseases involving the heart and circulation. These include coronary heart disease (CHD), heart attack (myocardial infarction or MI), atrial fibrillation, heart failure and stroke.

Congenital heart disease: Congenital heart disease is a defect in the structure of the heart that is present from birth. It is the most common birth defect affecting around 1% of all live births.

Coronary angiography imaging – This is a technique that can be used to help diagnose heart conditions, help plan future treatments and carry out certain procedures; it is considered to be the best method of diagnosing coronary heart disease. Coronary angiography gives video images (angiograms) that can show whether the blood vessels surrounding your heart are narrowed or blocked.

Disease - an abnormal condition in the body causing harm.

Chronic - something that continues/persists for at least six months.

Clinical guidelines - statements based on properly researched evidence which help healthcare professionals and patients to make decisions about medical care and treatments.

Conception - when an egg is fertilised by sperm and then starts to grow in the womb.

Contraception - Contraception aims to prevent pregnancy. A woman can get pregnant if a man's sperm reaches one of her eggs (ova). Contraception tries to stop this happening by keeping the egg and sperm apart, or by stopping egg production, or by stopping the combined sperm and egg (fertilised egg) attaching to the lining of the womb.

Contraceptive implant (Nexplanon) - It is a matchstick sized implant which is inserted under the skin of the upper arm and provides hormonal contraception for 3 years.

Coronary Heart Disease/Ischaemic heart disease - This refers to the disease process, atherosclerosis, which causes narrowing of the blood vessels supplying the heart muscle. This results in impaired blood flow to the heart muscle causing symptoms including chest pain (angina) and shortness of breath. This disease process can ultimately result in a heart attack.

Diagnosis - The way a medical professional recognises a condition or disease.

Dysmenorrhoea – painful periods.

Endometriosis - a condition where cells similar to the lining of the womb (the endometrium) are found elsewhere, usually in the pelvic cavity and near the womb.

Endometrium - the lining of the womb (uterus).

Faculty of Sexual and Reproductive Healthcare (FSRH) - FSRH is a UK-wide professional organisation with a devolved committee in Scotland. It looks at professional standards, education and training and aims to promote high quality sexual and reproductive healthcare.

Fertility - the ability to conceive a baby and, for a woman, to become pregnant.

Guideline - recommendations for good medical practice. They help patients and their medical teams make decisions about care and are developed by specialist teams who look at the best evidence available about care or treatment for a particular condition.

Gynaecologist - a doctor who treats medical conditions and diseases that affect women and their reproductive organs.

Heart failure - is a condition whereby the heart muscle is unable to pump blood around the heart effectively. This usually occurs because the heart muscle has become stiffened or weak. It is a long-term condition which worsens over time and requires medical management. Symptoms include shortness of breath, leg swelling and lethargy. Symptoms can develop quickly and suddenly (acute heart failure) or over a longer period of time (chronic heart failure).

Heavy menstrual bleeding - Heavy menstrual bleeding (HMB) is defined as excessive menstrual blood loss which interferes with a woman's physical, social, emotional and/or material quality of life. It can occur alone or in combination with other symptoms.

Hormones - naturally occurring substances made in the body which control the activity of normal cells. They include: follicle stimulating hormone, gonadotrophins, human chorionic gonadotrophin, luteinising hormone, oestrogen, progesterone, prostaglandin.

Incontinence - not having full control over the bladder and/or bowel. Problems with incontinence can range from slight to severe.

I**nherited cardiac conditions:** Inherited Cardiovascular Conditions (ICC) are a group of genetic disorders that mostly affect the heart. They include conditions such as cardiomyopathy, inherited electrical conditions called channelopathies and problems with the main blood vessel carrying blood from the heart, the aorta.

Informed decision/choice - providing enough quality information about a suggested treatment to help a patient decide whether to go ahead. This information must be balanced, up to date, evidence-based and given in a way that the patient can understand.

Intrauterine contraceptive device (IUCD) - a small device fitted into the womb to prevent conception. Made of plastic and copper, it has one or two soft threads at the end which emerge through the cervix into the top of the vagina. Also known as 'the coil'.

Intrauterine system (IUS) - a small T-shaped contraceptive device that is fitted into the womb. Made of plastic, it slowly releases the hormone progestogen.

Ischaemic heart disease/ Coronary Heart Disease - This refers to the disease process, atherosclerosis, which causes narrowing of the blood vessels supplying the heart muscle. This results in impaired blood flow to the heart muscle causing symptoms including chest pain (angina) and shortness of breath. This disease process can ultimately result in a heart attack.

Laparoscopy - keyhole surgery involving up to four small cuts in the abdomen. A telescopic microscope (called a laparoscope) is inserted into the body to help diagnosis or treatment.

Medical Abortion – a way of ending a pregnancy by using medicines.

Menopause - is when a woman stops having periods and is no longer able to get pregnant naturally. Periods usually start to become less frequent over a few months or years before they stop altogether. Sometimes they can stop suddenly. This usually happens around 51 years of age.

Menstrual cycle - the monthly process in which an egg develops and the lining of the womb is prepared for possible pregnancy. If the egg is not fertilised, it is reabsorbed back into the body and the lining of the womb (the endometrium) is shed. This is known as a period or menstruation. The cycle is controlled by hormones and on average a cycle lasts 28 days.

Obstetrician - a doctor who specialises in the care of pregnant women.

Oestrogen - female sex hormone produced by the ovaries as part of the menstrual cycle. It encourages an egg to mature and prepares the womb for a pregnancy. Levels vary during the menstrual cycle.

Osteoporosis - a condition where bones lose strength, making someone more likely to break a bone than the average adult.

Ovulation - the process by which the ovaries produce and release an egg each month. Ovulation usually takes place around 10-16 days before a period.

Pelvic floor muscles - layers of muscle which support the bladder and other organs in the pelvis.

Pelvic inflammatory disease (PID) - an infection in the womb, fallopian tubes and/or pelvis caused by infections such as chlamydia and gonorrhoea.

Period - a bleed from the vagina between every 3 to 5 weeks which forms part of the menstrual cycle.

Physiotherapy - special exercises and physical activities to improve body function and strength.

Polycystic ovaries - ovaries which have at least twice as many developing follicles as normal ovaries in the early part of the menstrual cycle.

Polycystic ovary syndrome (PCOS) - a condition which can affect a woman's menstrual cycle, fertility, hormones and aspects of her appearance. It can also affect long-term health.

Postnatal/Postpartum - relating to the period of time immediately after a baby has been born.

Pregnancy - the term used to describe the period in which a fetus develops inside a woman's womb or uterus. Pregnancy usually lasts about 40 weeks, or just over 9 months.

Premenstrual dysphoric disorder (PMDD) - Symptoms of PMDD are similar to PMS (see below) but are much more intense and can have a much greater negative impact on your daily activities and quality of life.

Symptoms can include:

- physical symptoms such as cramps, headaches and joint and muscle pain;
- behavioural symptoms such as binge eating and problems sleeping; and
- mental and emotional symptoms, such as feeling very anxious, angry, depressed or, in some cases, even suicidal.

Premenstrual Syndrome (PMS) - is the name for the symptoms women can experience in the weeks before their period. Most women have PMS at some point. The most common symptoms of PMS include:

- mood swings
- feeling upset, anxious or irritable
- tiredness or trouble sleeping
- bloating or tummy pain
- breast tenderness
- headaches
- spotty skin
- greasy hair
- changes in appetite and sex drive

Pre-pregnancy/pre-conception - before pregnancy or conception.

Reproductive organs - the parts of the male and female body needed to create and sustain a pregnancy.

Reproductive years - in women, the time from the start of menstrual periods (menarche) to the menopause.

Royal College of Obstetricians and Gynaecologists (RCOG) - the professional body which oversees the medical education, training and examination of obstetricians and gynaecologists in the UK and many places overseas. It sets internationally recognised standards and produces clinical guidelines for treatment and care.

Screening - a test or set of tests to check for a condition in a person who shows no symptoms, but who may be at risk (perhaps because of their age or sexual behaviour, for example).

Sexually transmitted infection (STI) - an infection that is passed on through close physical contact during sex.

Stress incontinence - leaking urine during everyday activities like coughing, laughing or exercising. This usually happens because the muscles that support the bladder are too weak.

Surgical abortion – a procedure to end a pregnancy.

Symptom - a specific medical sign of a condition, illness or disease.

Syndrome - a collection of different signs and symptoms that are all part of the same underlying medical condition.

ANNEX E - Library of resources and endnotes

Women in Scotland today

1. 51% of Scotland's population are women. National Records of Scotland (2019), Mid-2018 population estimates Scotland – accessed 02 July 2021
2. Around 400,000 women in Scotland are of menopausal age (402,544 between 45 and 54). National Records of Scotland (2019), Mid-2018 population estimates Scotland – accessed 02 July 2021
3. In Scotland over a third of the female workforce is over 50. Centre for Better Ageing (2021), Work: State of Ageing in 2020 – accessed 02 July 2021
4. 61% of unpaid carers are women. Carers Week (2020), Carers Week 2020 Research Report, p.29
5. Average life expectancy at birth for a woman in Scotland is 81.1 years. National Records of Scotland (2020), Life Expectancy in Scotland, 2017-2019 – accessed 02 July 2021
6. In 2020 63% of women in Scotland were between 16 and 64, and 21% were 65 and over. National Records of Scotland (2021), Mid-year Population Estimates, 2020: Report – accessed 15 July 2021
7. In 2020 there were 46,809 live births in Scotland.
National Records of Scotland (2021). Deaths up 10% as births fall to new low in 2020 – accessed 15 July 2021
8. Almost 1 in 10 deaths in women in Scotland each year are caused by ischaemic heart disease. National Records of Scotland (2019). Vital Events Reference Tables 2018 - Section 6: Deaths – Causes – accessed 02 July 2021
9. It is estimated that endometriosis affects 1.5 million (1 in 10) women in the UK of reproductive age, and it takes an average of 8.5 years to diagnose. All-Party Parliamentary Group (APPG) (2020), Endometriosis in the UK: time for change, APPG on Endometriosis Inquiry Report 2020, p.4 – accessed 02 July 2021
10. In the most affluent areas of Scotland, women experience 25.1 more years of good health compared to the most deprived areas. National Records Scotland (2021), Healthy Life Expectancy 2017-2019 p.5
11. In 2019 1.35 million women in Scotland were in employment. Scottish Government (2019), Scotland's Labour Market: People, Places, and Regions - Statistics from the Annual Population Survey 2019 – accessed 02 July 2021
12. Women's life expectancy at birth in the most deprived areas is 75.6 years compared to 85.6 years in the least deprived areas. National Records of Scotland (2020), Life Expectancy in Scotland, 2017-2019 – accessed 02 July 2021
13. In 2020 13,815 terminations of pregnancy were recorded in Scotland (13.4 per 1000 women aged 15-44). Public Health Scotland (2020) Termination of pregnancy statistics Year ending December 2020, accessed 02 July 2021
14. Heart disease is the leading cause of maternal death in the UK. Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. University of Oxford (2019), – accessed 02 July 2021. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17. Oxford: National Perinatal Epidemiology Unit,
15. In 2019-20 around 400 women were in prison in Scotland on an average day. Scottish Government (2020), Scottish prison population: statistics 2019 to 2020
16. In Scotland, women aged under 25 are the group most at risk of being diagnosed with an STI. NHS National Services Scotland. (2019), Surveillance report Genital chlamydia and gonorrhoea infection in Scotland: laboratory diagnoses 2009 – 2018, p.1 – accessed 02 July 2021
17. Over three quarters of the overall NHSScotland workforce are women. Public Health Scotland (2020) Workforce Dashboards, Health Topics
18. The average age at which a woman will reach menopause is 51. NHS (2019), Menopause
19. Women make up an estimated 83% of the social care workforce in Scotland. Scottish Government (2021), Independent Review of Adult Social Care in Scotland, p.80
20. 37% of women in Scotland report living with a limiting long-term condition or disability Scottish Government, Scottish Health Survey 2019 - volume 1: main report, p.33
21. In 2020 the termination rate was 2.2 times higher in the most deprived areas compared to least deprived areas. Public Health Scotland (2021), Termination of pregnancy statistics - Year ending December 2020 - accessed 02 July 2021

22. Part-time employment accounts for 41.2 per cent of all women's employment compared with 12.4 per cent of all men's employment. Scottish Government (2020) Scotland's Labour Market: People, Places, and Regions - Statistics from the Annual Population Survey 2019, p.18 – accessed 02 July 2021

23. 12 is the average age at which a woman has her first period. NHS (2019) Starting your period – accessed 02 July 2021

24. Death from stroke is more common for women than men. NHS National Services Scotland, Scottish Stroke Statistics, Year ending 31 March 2018, p.3 – accessed 02 July 2021

25. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population. MENCAP. (2020) Learning Disability - Health Inequalities Research – accessed 02 July 2021

26. It is estimated that there are currently 300,000 people in Scotland living with osteoporosis, a condition which is more common in women than men. NHS, (2020) NHSGGC : World-leading bone health consultant receives top accolade – accessed 02 July 2021

Endnotes

1 British Heart Foundation (2019) Bias and Biology Policy Report p.15-17
2 British Heart Foundation (2019) Bias and Biology Policy Report p.3
3 Scottish Census (2011) – accessed 30 April 2021
4 The Royal College of Obstetricians & Gynaecologists (RCOG) (2020), Position Statement – Racial Disparities in Women's Healthcare – accessed 30 April 2021
5 R Norton, S Peters, V Jha, S Kennedy, M Woodward, Women's Health: A New Global Agenda (2016), University of Oxford, p.4
6 Ibid
7 Public Health England, (2018) Reproductive health: what women say, p.23
8 UK Clinical Research Collaboration (2020), UK Health Research Analysis 2018, p.33
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