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Women's Health Strategy: Call for Evidence:

Royal Pharmaceutical Society submission

1. Women's voices

We agree that the voice of women is not often heard when seeking help with their health problems and that part of the solution is identifying what are real gender issues and what are issues across all genders. There are other inequalities in the system, for example low socioeconomic groups who are less likely to go and see their GP at early stages of a condition or health problem and this can also impact on women's health. As mentioned in the consultation document, there are numerous reports which demonstrate that women are not being listened to.

There is also a question about whether people are uncomfortable talking about health issues associated with for example, the menopause, solely because it is a female condition, or is it just because it is a sensitive condition to discuss?

At least 50% of the patient cohort in England is female. The different needs that women face should be a big part of the approaches taken by the health service and integrated into overall care.

As the complexity of women's health increases it is difficult for those healthcare professionals in generalist roles, such as GPs and community pharmacists, to understand all of the issues. Those working in generalist roles need to be supported by the specialists in their local systems.

Women's health issues can be exacerbated by a lack of personalised care. Whilst this is being addressed by the NHS Long Term Plan, healthcare is often seen as a conveyer belt which means that some problems and issues are being missed. Men tend to have a high hurdle to raising an issue whereas women will tend to report issues more but because of this women's issues become defused and their problems become labelled too easily. There needs to be more listening and empathy rather than trying to label and reach a diagnosis too soon. A system specific diagnosis is too prominent rather than a focus on general wellbeing and a more nuanced approach. There needs to be a more personalised care approach to women's health.

In terms of education and training we are unaware how often healthcare professionals are up to date on the treatments and latest developments in terms of women's health. Ongoing skillsets and knowledgebase of healthcare professionals must stay up to date and healthcare professionals should have access to relevant training and support. Professionals across a system must work together more closely so they are not working in isolation and can speak to colleagues who may have more specialist knowledge in these areas.

Another question is around how we make women aware of the services that are available to them and then empower them to use the services they need. In some instances, language can be a barrier. Over recent years there have been big advancements in translation services. In some areas, though, this can be difficult as the translator could often be a family member, or someone from the same community which may make it difficult for the woman to raise sensitive issues.

In terms of exploring women's health issues and being better at addressing them, the transgender population also need to be considered.

2. Information and education on women's health

Cultural sensitivity can play a significant part in terms of information and education. If we take female genital mutilation as an example there is a fear from healthcare professionals who may wish to raise the issue, as being seen as culturally unsensitive. This may mean that healthcare professionals avoid having these difficult conversations. Healthcare professionals should be trained and supported to have these types of conversations.

Pharmacists have a good skill set in terms of critical analysis and have a good understanding of medicines and how they should be used. These skills could be utilised more widely so that pharmacists could have a role in being a critical friend to both patients and within the multidisciplinary team (MDT) to advise on different paths and routes available. Pharmacists need to be part of MDT and be encouraged to share their important perspective in explaining all the options available to women in their care. Pharmacists spend a lot of time understanding and triangulating data on risk / benefit balance. This is a unique skill amongst healthcare professionals and should be utilised more widely in terms of women's health.

Most of the ways of working in multidisciplinary teams still have a way to go in offering personalised care to women. Healthcare professionals need to be supported in terms of education and training to really listen to their patients and to undertake the principles of shared decision making as part of all their patient interactions.

It can often be difficult for healthcare professionals to find the relevant information, for example whether food, drugs/supplements can affect fertility or those trying to get pregnant. This information needs to be made more widely available.

It is also very important to gather data for specific groups such as use of medicines in pregnancy and breastfeeding

It is important that healthcare practitioners understand female specific symptoms and recognise them, particularly for conditions like ovarian cancer which is quite a common problem but often detected too late.

3. Women's health across the life course

There is a lack of understanding and education about the impact of health conditions in pregnancy and this can result in worse health conditions for some women. Pre-eclampsia in pregnancy is linked to blood pressure in older age and not a lot is known about this. Pre-eclampsia results in worse menopause symptoms and there is little information available on this. Also, in terms of mental health, postnatal depression can result in more disruption in menopause

There is a role for community pharmacists to support women post pregnancy as well as during. All aftercare is normally focused on the baby, but pharmacists could be there to help support the mother. Due to their location, community pharmacies can often support around culturally sensitive issues and potential language barriers.

In terms of cardiovascular disease, we know that detection and treatment is far worse for women than men. Signs and symptoms are different between men and women and prognosis and treatments are different. All healthcare professionals need to be aware of this

During the COVID–19 pandemic blood pressure monitoring for pregnant women was deprioritised. As the professional leadership body for pharmacists, RPS should be involved in some of these decisions taken at a national level in terms of deciding priorities, as our members have specialist knowledge on medicines and their use and the potential impact on patients.

It is reported that NHS business services data show twice as many prescriptions for women as men, for codeine and tramadol in recent years. There is also a growth rate of this type of prescribing of about 4 times more in women than men. This cannot all be explained by issues such as terminal

conditions in the very elderly. Opting to treat the pain instead of the underlying condition seems to be the problem, and this is happening more for women than men.

A lot more needs to be done around sexual health and pregnancy, including fertility and menopause and a better understanding of osteoporosis. Often women are considered to be exaggerating their symptoms and this then means they are embarrassed to talk about them. Women often experience more, or different side-effects to medicines but these aren't always taken seriously e.g. a woman going through early menopause may need different doses of medicines. Medicine doses are given as a universal dose and this needs to be explored as this potentially needs adjusting for women.

Pharmacists could be supported to take more responsibility to understand women's health issues and support women more fully.

Some of the training around women's health is lacking at an undergraduate level as the lecturers may be male and may not be comfortable in discussing these subjects and topics.

4. Women's health in the workplace

As female healthcare professionals we should empower women to help women in the profession and initiate and take a lead on those conversations. Conversations around women's health should become normal, with a similar emphasis as wellbeing conversations. As healthcare professionals we have a responsibility to educate ourselves, to support each other and talk more openly to staff and patients on women's health issues. There should be national campaigns that focus on women's health such as a menopause campaign.

In the workplace, you need to assume that you are not just looking after the women in front of you but also their family as the women in the family will most likely be undertaking the caring responsibilities for other members of the family.

Urinary tract and bladder infections are a common problem for women as is incontinence. These need to be seen as women's health issue and potentially supported in a different way to when a male presents with these conditions. Some of the anti-microbial stewardship (AMS) solutions are causing difficulties for women in terms of accessing the right treatment in a timely manner.

5. Research, evidence and data

This under-representation in research is wider, and more complex, than just women as race, age etc also come into it. For example, in terms of post birth pain, women of black origin will say their voices are not heard in regard to pain relief and they are not treated in the same way as white women.

There are a number of case studies that demonstrate health issues for women, but research doesn't always listen to women's voices and doesn't always acknowledge these case studies. The case studies are not always used to feed the evidence and raise awareness amongst everyone, not just those with an interest. There is power in people's experiences.

Research could help provide good quality evidence that would shape the way clinicians speak and listen to women. Anecdotal evidence needs to be turned into qualitative data.

By focussing on specific areas, such as pregnant women, other groups get forgotten, such as those going through the menopause. We need to ensure that everyone is listened to and this also applies wider than women.

There are a vast number of studies which explore the underrepresentation of women in research (including clinical trials) across disease areas and demographical breakdowns (ethnicity, pregnancy, disability, socioeconomic status, care-taking roles), and the phenomenon has long been widely accepted (Bismark, 2015, Kim, 2010, Pilote 2018):

Results from a RCOG survey in 2017 explored mental health issues for women during pregnancy and asked questions around how their mental health was managed. This was particularly helpful in singling out areas of concern and similar methods could be used to pull together more information and raise awareness.

Recently there have been several articles on women's health concerns being ignored or that they are listened to too late in the process. The reasons for why this is happening need to be explored. There is definitely more work and research to be done in the area to ensure women's health concerns are being taken seriously.

Initial research of women could flag up particular groups or areas that are not doing as well as others. Consideration needs to be given as to how difficult to reach groups are accessed, such as pregnant women or new parents. The value of gathering data needs to be demonstrated and this data made available to the women who need it in a timely manner i.e. prior to giving birth rather than at the time of giving birth. The data needs to be accessible for everyone; significant numbers of women are not digitally literate, or have English as their first language, so we consideration needs to be given as to how these women are provided with information.

In more affluent areas there is an expectation that patients will have a greater knowledge and potentially undertaken some background reading about their condition. This is very unlikely for people from lower socio-economic groups. Most women will not know NICE guidance exists let alone have read it. There is a danger of peer reviewed research being less accessible than less reputable articles found via google search. Health education is key to helping people.

In terms of NICE guidance, we recommend that there a principle to demonstrate equality and that there are no marginalised groups, should be applied as it is currently for any legislation.

In terms of getting women interested in research there is a need to target social media which will also raise awareness of guidance and support wider engagement in women's health issues. Forums such as Mumsnet for example, are very active and can often lead to misinformation being rapidly spread. Consideration should be given to the inclusion of women of childbearing age and pregnant women (when appropriate) in clinical trials, for example, pregnant women are now accepted as participants in the COVID-19 Recovery trial.

Women are often told facts about medicine that may or may not be correct and they need to know that they can go to their local pharmacy to get support and relevant advice such as which medicines you can take whilst breastfeeding.

In terms of cardiovascular disease, women experience different pathology, symptoms and outcomes from men, yet often clinical trials have poor representation of females and findings are extrapolated/generalised which may not be truly reflective of women's experience (Melloni 2014, Tahhan 2018, Vitale, 2017). Similar issues are seen in enrolment of women in stroke clinical trials (Carcel, 2021), cancer research (Jagsi 2009, Duma 2018), new molecular and therapeutic biologics (Chen, 2018), lupus (Falasinnu 2018),

The above issues are compounded for women from minority groups who face additional barriers in being recruited to and represented in research (Clark, 2019, Nazha 2019, Tan 2018, Killein, 2004) while pregnant women are often excluded outright (Graaf, 2018). Racial disproportionality has been seen most recently in research exploring the management of COVID-19 (Chastain, 2020)

6. Impacts of COVID-19 on women's health

The burden of care during lockdown has largely fallen on women. The consequences of this have been both negative (hard to manage, mental wellbeing) and positive (spending more time with children and family).

Working from home has generally been seen a positive outcome as it has increased flexibility and, perhaps, provided a greater recognition that people have child/ family caring responsibilities and are still able to be productive. This has become much more acceptable during the pandemic.

The pandemic has also highlighted areas where working from home is not possible for a lot of women. There has been an imbalance for some women who need access to childcare but were unable to get it. The impact of having to access hubs rather than their usual care setting could be unsettling.

COVID-19 has been a barrier to accessing contraception services. Women were physically unable to be seen so were unable to be given contraception, putting lives at risk in some cases. Even those women who were well-educated and digitally literate struggled with using the birth control app. There is a significant reduction in funding of pharmacy-based emergency contraception and contraceptive services which has had an impact on access to these services. These women need to be better supported and there could be a role for hospitals to support these women if the services are not available in primary care. There was a large increase in the number of requests for emergency contraception in the initial months of lockdown. There was also an issue around sexual health services not being available. Funding decisions and changes can have a big impact on service delivery and the types of services offered.

Claire Anderson

Chair, English Pharmacy Board, Royal Pharmaceutical Society