The 10 Year Health Plan for England

Department of Health and Social Care / NHS England

(Organisation Response) DECEMBER 2024

Introduction

- Muslim Women's Network UK (MWNUK) is a national Muslim women's organisation in Britain (www.mwnuk.co.uk) that has been advancing equality, promoting women's empowerment, and connecting voices since 2003. We are a small national charity (reg. no. 1155092) that works to improve social justice and equality for Muslim women and girls. Our membership also includes women of other faiths or of no faith and men who support our work. We find out about the experiences of Muslim women and girls through research and our helpline enquiries. We identify policy and practice gaps and use this information to inform decision makers in government as well as informing our community campaigns at a grassroots level.
- We also develop resources and train women, so they are better aware of their rights. We have a separate website for our national helpline (www.mwnhelpline.co.uk) that provides advice and support on a range of issues including domestic abuse, forced marriage, honour-based violence, sexual exploitation and abuse, female genital mutilation, hate crimes, discrimination, mental health etc.
- The impact of our work is particularly felt in reducing the vulnerability of Muslim women and girls, reducing the prejudice they face, and giving them greater access to rights and services – all of which allow them to contribute to society like any other citizen. We are also creating a critical mass of voices to influence change with more women being confident to challenge discriminatory practices within their communities and in society and to influence policy makers.

Terminology

- The term 'racialised minority (communities)' has been used because unlike 'BAME,' it does not privilege or erase any particular social group according to real or imagined physical characteristics such as skin colour, within a system where 'whiteness' is considered the norm. Conversely, it does acknowledge that all groups are subjected to processes of racialisation, that they are not part of a single minority but may be located at the intersection of several different minoritised groups. However, the term 'BAME' (Black, Asian, and Minority Ethnic) or 'minority ethnic groups' has also been used because its use is more widespread in the UK.

Overview

- To contextualise our responses to this consultation it is important to state that the women's health strategy did not sufficiently address the health needs of women from racialised minority communities that is why are responding to this specific inquiry. In order to improve services and raise standards of care, it is essential that women's voices and experiences (particularly Muslim/ racialised minority women) inform the development and delivery of health care services. Their experiences should be considered throughout the decision-making structures and processes. Before addressing the questions set out in this consultation it is imperative to stress that existing data and studies that have been already published including our **INVISIBLE - MATERNITY EXPERIENCES OF MUSLIM WOMEN** (July 2022) demonstrate that there is significant barriers and disparities for BAME women in reproductive health. As stated in the Women's health strategy for England that women's experiences of health services varied by characteristics such as age, ethnicity and disability. Some of the barriers and challenges faced by Muslim women also will be faced by other minority groups especially those with intersectional identities.

Q1. What does your organisation want to see included in the 10-Year Health Plan and why

In developing the 10-Year Health Plan for the UK, it is essential to recognise and address the significant health disparities faced by Muslim women, in particular, encounter additional barriers such as the language differences, and the risk of discrimination or misunderstanding within the healthcare system. These disparities contribute to poorer health outcomes, with certain groups experiencing higher rates of maternal mortality, mental health issues, and chronic conditions. By prioritising the specific needs of Muslim women, the health plan can create a more inclusive and equitable healthcare system that addresses these inequalities. This includes improving access to culturally sensitive services, tackling the social determinants of health, and providing targeted support for mental and physical health. Addressing these issues is not only a matter of fairness, but it is also crucial for improving the overall health of the population and ensuring that no group is left behind in the delivery of healthcare services in the UK.

The social and economic disruption by the Covid-19 pandemic has already had a devastating impact on the lives of people, including increasing the risk of millions falling into extreme poverty. Those living in the most deprived areas are even more likely to be affected, with BAME women and girls being more likely to bear the brunt of the long-term negative. For example, BAME workers[1] have suffered the brunt of job cuts during the pandemic. Also, research already shows that poverty has an impact on people's health throughout their life from having a lower birth weight to having a shorter life expectancy. Thus, those living in the most deprived areas are more likely to suffer from chronic diseases. Given that Pakistani and

[1] https://www.theguardian.com/business/2021/jan/19/black-and-minority-ethnic-uk-workers-hit-worst-by-covid-job-cuts

Bangladeshis ethnic groups are more likely to live in the most deprived areas, health inequalities will widen further for women living in these communities[2].

Earlier this year, MWNUK partnered with the government Cabinet Office Equality Hub and the Department of Health and organised a roundtable meeting with Muslim women so they could share solutions that could help to bridge the gap in health services so their needs are met. The meeting was held in Birmingham and twenty women attended from young women to older women who were from diverse ethnicities and very different experiences. Some women were carers and also worked with domestic abuse victims and the elderly.

Here are some key recommendations made:

- **Equality and diversity training for healthcare professionals:** should be mandatory with refreshers because some of the women have experienced unconscious bias and felt discriminated against because of their choice of clothing (i.e., wearing the hijab). Addressing 'attitudinal issues' and 'listen to what the person is saying' were considered important to bettering health outcomes for Muslim women.
- **Culturally appropriate care:** to be practiced more widely, as this will promote a service that is person-centred, inclusive, and empowering for women. More importantly, cultural diversity in healthcare will help to build a better understanding of specific health related issues Muslim women experience which will lead to better communication and trust.
- **Spirituality care:** while this form of care is yet to be promoted widely, it can be of added value.
- **Continuity care**: it is important for people with mental health problems trying to access GP appointments. Having "one point of contact throughout day…if somebody took responsibility" this would prevent feelings of 'desperate' and 'dehumanised.'
- **Cross-sector collaboration**: tackling health inequalities will benefit from a multi-agency collaboration as this could reduce demands on the healthcare system. Suggested were women's charities, digital media or local pharmacists could act as conduits in providing additional support for women to accessing health services.
- **Social prescribers:** local GP surgeries need to do more to make referral to increase access to information, activities and support in the community. It could empower people to be better informed about their own health
- **Privacy:** many of the women stated there was 'no confidentiality' in the open spaces of GP surgeries. Being asked by reception staff the reason for wanting to see the doctor in an open space where others can hear you were found to be intrusive. There

[2] : https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-living-in-deprived-neighbourhoods/latest

needs to be some sort of indicative health concern that does not require a person to fully divulge their medical concerns.

- **Wrap around specialist centre:** availability of women centred clinics will provide collaborative services that will ensure the care is person-centred, time-sensitive, and integrated.

Investment in Community centred Mental Health provision

Mental health services are in crisis, leaving individuals waiting for extended periods without support, often for months or even years. A huge investment must be made in mental health services to address the crisis, reduce wait times, and ensure timely support for those in need. One way to address this is by developing community-centred partnerships that prioritise inclusive, feminist approaches to mental health, ensuring that care is accessible, empowering, and responsive to the diverse needs of all individuals.

We have provided a faith and culturally sensitive counselling service since 2016 and demand has increased every year. Our clients report negative experiences with mainstream mental health services and cite a lack of understanding of cultural and religious factors as one of the most significant reasons. Those who have accessed our counselling service have contrasted their experiences with our service with mainstream services. We strongly would like to see more funding allocated to specialist counselling services like ours. These quotes from clients highlight how important understanding and considering cultural factors and faith is to recovery and equipping them with the skills needed to aid recovery.

"I have had counselling previously with a non-Muslim counsellor and I did not feel seen or heard. I felt they did not understand how things affected me, given my life circumstances. I did call a non-Muslim helpline and it was a waste of time. Their view of stuff is completely different, it seemed like they were reading off a prepared script. The way their viewed things was very individualistic, telling me to only take care of myself." (T, MWN client)

"And the counsellor ever that I was speaking to through Mind, didn't get the issues that I was talking about. Religious, spiritual things, even just general cultural aspects that I didn't feel comfortable discussing. Whereas the counsellor with your service was absolutely in tune with all aspects from the Western concepts to the Eastern concepts. Also, religious concepts, so I thought it was really beneficial." (H, MWN client)

"I would be worried I wouldn't get the right advice, if that makes sense. Would I get the cultural understanding? It would be almost as though they think that you're being weird. They don't understand our cultural norms. Yeah, I think I would be so worried all the time." (K, MWN client)

For those from racialised minority groups and communities of faith there can be additional barriers to accessing help for mental health problems such as stigma, language barriers, socio-

economic status, institutional racism and discrimination[3]. Studies have confirmed that risk of suicide and suicidal attempts are higher in young South Asian women[4]. This may be due to:

- Pressure to preserve family honour and maintain tradition and culture
- Being expected to suffer in silence due to shame and honour
- Restrictions on their freedoms leading to social isolation
- Being blamed for familial problems e.g., domestic violence, divorce, marital affairs
- Language barriers to accessing support
- Polygamy
- Religious pressure
- Abuse from partners, extended family, and in-laws

There continues to be a great demand for a faith and culturally sensitive service. Muslim women feel overlooked by mainstream mental health services and report high barriers to access. When they do avail of them, many experience racism, a lack of cultural context on the part of mental health professionals and an inability to build authentic therapeutic relationships. This can be an incredibly isolating experience that can make women feel trapped in their circumstances. Mental health services should address women-specific concerns, such as postnatal depression, menopause-related mental health issues, and anxiety disorders, which are more prevalent in women.

Services like ours should be able to receive support from local NHS service providers to provide more diverse options of therapeutic care, including more informal activity-based group therapies (e.g., walking groups, cooking groups) and art therapies, to meet the diverse needs of those we support. Informal therapeutic interventions, such as cooking interventions, can support communities that may have stigma towards accessing formal therapy or counselling but has been shown to be effective in engaging and retaining people from Muslim and racialised minority communities in therapy[5].

Improvements in Reproductive Health

Deep inequalities are perhaps the most evident in gynaecological health. For example, there is a lower uptake of cancer screening (cervical screening is a case in point) among minority

[3] The Synergi Collaborative Centre. (2018) The impact of racism on mental health, briefing paper.

Bignall T, Jeraj S, Helsby E, Butt J. (2019) Racial disparities in mental health: Literature and evidence review. Race Equality Foundation.

[4] Ineichen B. (2008) 'Suicide and attempted suicide among South Asians in England: who is at risk?', Mental Health in Family Medicine, 5(3), pp.135-138.

[5] Hammad, J., El-Guenuni, A., Bouzir, I., & El-Guenuni, F. (2020). The Hand of Hope: A Coproduced Culturally Appropriate Therapeutic Intervention for Muslim Communities Affected by the Grenfell Tower Fire. Journal of Muslim Mental Health, 14(2).

ethnic women and cancer incidence and mortality rates are higher among more deprived communities (including many cancers in women). For example, Black women in England are almost twice as likely to be diagnosed with advanced breast cancer[6]as white women. Do these statistics show that they are not being reached by healthcare services with information about symptoms or screening services or do women find it hard to access services for some other reason? It is important to investigate the factors contributing to lower uptake of screening and the delay in diagnosis.

A 2017 investigation coordinated by the All-Party Parliamentary Group on Women's Health[7] concluded that there were serious shortcomings in the provision of women's physical, mental and gynaecological healthcare. It found that negative attitudes, lack of information and choice, cost considerations and short-term thinking were the key issue areas. The Royal College of Obstetricians & Gynaecologists (RCOG) published its 'Better for Women'[8] report in December 2019 which also found that, too often, women and girls are struggling to get the right information and that health services were missing opportunities to ask the right questions, prevent illness and ensure the best outcomes.

Muslim women may receive suboptimal care due to factors such as lack of cultural competence among healthcare providers, language barriers, or implicit biases. This can lead to delayed or inaccurate diagnoses, inadequate treatment options, and poorer health outcomes.

Addressing these disparities requires a multi-faceted approach, including improving access to healthcare, promoting cultural competence among healthcare providers, addressing implicit biases, increasing diversity in research and clinical trials, and raising awareness about gynecological and urogynecological conditions to reduce stigma and encourage early diagnosis and treatment.

Some Muslim women may not be willing to try contraceptive methods as part of the management of gynaecological conditions such as pre-menstrual syndrome or endometriosis. For some women this may be due to religious or cultural reasons. They should be provided with alternative options. However other Muslim women may be willing to consider contraceptive methods but are not provided with these options due to stereotypes.

cultural taboos regarding discussions about sex and gynaecological problems and lack of education on the importance of cervical screening is likely to be contributing to the lack of uptake of cervical screening. language barriers will also prevent access to educational information. Information resources in multiple languages on cervical screening and reassurance that the procedure is carried out by a female practitioner is really important to improve uptake of the procedure. Having healthcare professionals or training health champions who are women from those communities to educate the women in their languages is also vitally important.

[6] https://www.bbc.co.uk/news/health-37991460

[7] 16 APPG on Women's Health (2017): http://www.appgwomenshealth.org/inquiry2017

[8] RCOG (2019): https://www.rcog.org.uk/better-for-women

Another example of informational needs of minority ethnic women not being met is access to information about contraception, particularly in respect of long-acting contraception. Not having this information may be resulting in unintended pregnancies and abortions, which in turn can have a negative impact on mental health. How women receive this information should also be widened further. For example, Muslim women may not feel comfortable speaking to their GP about such a personal issue, especially if the GP is a man and/or from the same ethnic/faith background; women have indicated they find it awkward and embarrassing. New approaches should include addressing inequalities in sexual health and reproductive health by working with the BAME women's voluntary/charity sector as they can access women, are trusted by them and can also advise on the best approaches for different segments of the BAME women's population. It is also important to remember the faith elements which may be involved in so far as Muslim women are involved. They may have been told from an early age that contraception is wrong and it is important that correct information and advice is provided to them that challenges spiritual myths.

Another common theme is Muslim women and women racialised minority ethnic backgrounds not being believed about the level of pain and suffering they are experiencing or the impact of the pain on their quality of life; resulting in them not being offered treatment to alleviate symptoms or given pain relief.

Additionally, a health issue that needs to be prioritised is more attention is menopause in minority ethnic women. The visual imagery used to highlight menopause does not often 'speak' to them. If the images used in communications materials resonate with them, messages are more likely to be impactful.

Urgent action is needed to address the higher mortality rates of Black and Asian women and their babies. recommendations made in a number of reports must be actioned and clear plans set out detailing how and when these will be actioned. Our maternity report '**Invisible – Maternity Experiences of Muslim Women from Racialised Minority Communities** (July 2022) found a hierarchy of discrimination with 1 in 5 Muslim women saying their maternity care is 'poor' or 'very poor,' particularly during their labour, birth and the post birth period in hospital. The report made 45 recommendations with four calls to action, which were:

- Better data collection: analysis and utilisation of equality data to hold individuals and organisations to account.
- Maternity services better adapted and tailored to meet the needs of ethnically diverse local populations
- A cultural shift in attitudes and behaviours towards racialised minority communities by healthcare professionals and maternity service providers
- Improving maternal empowerment through better information provision about their risks, their rights and complaints processes so that they are better equipped to hold maternity care providers to account

Support for Caregiving Women

Muslims[9] are one of the two groups who have the highest percentage of unpaid carers and additionally Muslims have a higher percentage of lone parent households with dependent children 10.4% (77,000) compared to the general population (7.2%). The NHS should offer specific support to caregiving women, such as respite care, mental health services, and caregiver training, to help balance caregiving responsibilities with maintaining personal health.

Support for Women with Disabilities

Ensure that women with disabilities have equitable access to healthcare services, including preventive care, reproductive health, and mental health services. This may include improving accessibility to physical healthcare facilities and providing tailored support for those with learning disabilities.

Primary Care Accessibility

Ensure that women have easy access to general practitioners (GPs) and preventive services, especially in deprived and low-income areas. Extend access to GP services outside working hours, childcare support, and digital consultations to improve convenience for working women and mothers.

Health Education

Public Health campaigns should be included in the 10-year heath plan in order to educate communities on prescribing to healthier lifestyles especially to reduce obesity and diabetes which are more prevalent in BAME communities. Enhance education around menstrual health and conditions such as endometriosis and polycystic ovary syndrome (PCOS). This should also involve improving the understanding and management of period poverty.

Health in the Workplace

Employers need to gain knowledge about gynaecological issues such as endometriosis, menopause and miscarriages and create a safe space/channel for women to be able to disclose domestic abuse and mental health issues without fearing it impacting job security or career progression. The NHS should collaborate with employers to improve healthcare access, mental health support, and flexible care options for working women.

Inclusivity in Research

Conducting research on Muslim /BAME women's experiences is crucial to addressing knowledge gaps within healthcare, particularly by encouraging their participation in studies through focus groups, one-on-one interviews, or clinical trials. It is vital to involve researchers from similar backgrounds, as this can help build trust and improve engagement. However, there are several barriers to participation that must be overcome, including:

[9] (Source 2011 Census, England and Wales).

- ❖ Ensuring women have a clear understanding of the research, its significance, and how it can positively impact their lives.
- ❖ Providing compensation for women's time and involvement in the research process.
- ❖ Collaborating with Muslim women's charities to help reach these women, with compensation for the charities' time and resources.

Additionally, it is essential to collect data on faith, as this is a key aspect of identity for many Muslim women and can influence their experiences and needs within healthcare. Including faith-based perspectives will provide a more comprehensive understanding of their health and wellbeing, leading to more effective and inclusive healthcare outcomes in the NHS.

Complaints Procedures

It is essential for women to understand the complaints procedure when they receive poor service in the NHS. Clear communication about how to raise concerns ensures women feel empowered to voice their experiences and seek resolution. Knowledge of the process helps them navigate the system effectively, ensuring their complaints are heard, investigated, and addressed appropriately. This transparency fosters trust in the healthcare system and encourages improvements in service delivery, ultimately leading to better care and outcomes for women. Complaints data across should be analysed and low complaint rates from certain groups should be addressed by increased awareness raising.

BAME Women's Health Working Group

The Women's Health Strategy for England strategy established under the previous Government set out a six-point long-term plan for transformational change one which includes: Addressing disparities in outcomes amongst women – ensuring that a woman's age, ethnicity, sexuality, disability, or where she is from does not impact upon her ability to access services, or the treatment they receive. Whilst the women's health strategy s long term plan aims to improve women's health over the next ten years nevertheless to tackle the barriers faced by ~~BAME~~ minority ethnic women with gynaecological and urogynecological conditions we recommend that an impendent specialist working group should be setup to develop a robust and detailed health strategy for specialist group such as those with protected characteristics.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Challenges

- ❖ **Lack of capacity in community to provide increased levels of care** - care in the community (or primary care) is already overstretched and under resourced. Shifting care from hospitals to the community is a great idea but this must be resourced adequately with both increased levels of funding for existing services and provision of new services. Eventually the increased cost of community care can come from hospital

funding however this cannot happen immediately as hospitals are already struggling to meet demand (7 million waiting list, etc).

- Therefore, there must be additional funding to start the increased provision of care in the community, whilst the backlog of hospital care is cleared. Increased care in the community should eventually lead to reduce hospital costs but this will take time.
- **Existing community care provision does not reach or work for all in an equitable way** - the stark and shameful health inequalities that exist cannot be addressed by "more of the same." New models of working and reaching those that need it most must be co-produced and delivered with those from the community including the voluntary, faith and charity sector. These sectors have the reach and influence that statutory organisations don't.
- **Reduction of community spaces** - community spaces where people come together have been lost during the recent economic downturn and due to austerity measures imposed by the last government.
- **Patient Acceptance** - Patients will need to be educated and encouraged to accept and utilise community-based services instead of hospital care.

Enablers

- **Strength of VCSE and Faith sector** - this sector has reach and influence especially into those communities that face the starkest health inequalities.
- **Incentives and Payment Frameworks** - appropriate incentives and payment frameworks should be implemented to support community-based care.
- **Community Engagement** - Engaging with the community to understand their needs and ensure that services are patient-centred and co-produced.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

For NHS England, addressing the challenges and enablers of using technology in health and care is particularly important when considering women's health needs. Digital inequality, for example, can disproportionately affect women, especially those from lower socioeconomic backgrounds, who may have limited access to technology or digital skills. This can make it harder for them to access essential services like online consultations or health monitoring tools, which are increasingly used for maternal care, reproductive health, and chronic condition management.

One barrier that repeatedly comes up is patients being told to fill in pre-operation / treatment questionnaires online. Patients are not provided with options where they can be supported to have the forms filled in at a community setting. Providing options where the patient can attend to get the forms filled in should be standard practice. Also, online appointments have sometimes become standard practice and should not be. Patients should be given a choice.

Some may communicate better in person even if they can use technology. Face to face appointments is even more important for the most vulnerable where safeguarding concerns would be more easily identifiable.

Data security and privacy concerns are also significant for women, as sensitive health information, including reproductive health and mental health data, needs to be protected. The integration of new technologies with existing NHS systems can also impact women's access to integrated care services, especially for conditions that affect women more, such as breast cancer, menstrual disorders, or menopause-related care.

However, there are enablers that can support better healthcare for women. Government investment in digital health services, including those for maternal and sexual health, can ensure women receive timely care and support. Better data sharing across NHS services can improve coordination, especially for women with complex health needs, like those managing multiple conditions or accessing reproductive health services. Collaboration with tech companies can bring in solutions like AI for early detection of conditions like breast cancer or virtual consultations for women who may face barriers accessing in-person care, particularly in areas such as sexual and reproductive health. Ultimately, leveraging technology can help address specific health challenges.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Spotting illnesses early and tackling the causes of ill health for Black, Asian, and Minority Ethnic (BAME) women presents several challenges. One of the biggest issues is health inequality, as many minority ethnic women, especially those from lower-income backgrounds, face barriers to accessing healthcare. This can result in delayed diagnoses, meaning health problems are often discovered too late. Conditions like diabetes, heart disease, and mental health issues are more common in some minority ethnic communities, but these conditions are frequently not diagnosed until they have become serious. Even when conditions are diagnosed, research shows that minority ethnic patients, especially those who live in deprived areas have to wait longer for treatment, which means their health conditions worsen while they are waiting, costing even more to the NHS. It is important that funding announcements in Labour's first budget to reduce waiting times addresses the longer wait times experiences by minority communities.

Even getting a GP appointment is difficult. Previously an appointment could be obtained within one week which can now be three weeks. If bloods are needed, it could mean a further wait of 2-3 weeks for another appointment with the nurse. Furthermore, phoning at 8am for an appointment, waiting in a queue to be told all appointments are gone and to have to repeat the cycle again must be stopped, a practice employed by some GP surgeries. It can be very stressful for the most vulnerable, the elderly and those with mental health issues.

Cultural and language differences also play a significant role. Many minority ethnic women may struggle to communicate with healthcare providers due to language barriers or because staff are not familiar with their cultural needs. This can lead to misunderstandings and delayed care. In addition, some women may not seek medical help because of a lack of trust in the

healthcare system, which is often rooted in past experiences of discrimination. Mental health is another area where stigma can be a problem. In many minority ethnic communities, there is still a reluctance to discuss mental health issues, which can prevent women from seeking help for conditions like depression and anxiety.

However, there are ways to address these challenges. One key approach is through outreach programs led by women's charities, which can help raise awareness of health risks and the importance of early diagnosis. These organisations have the reach and are trusted by the community and can encourage women to seek care and help them overcome fears of discrimination or misunderstanding. It is important that funding is provided to these types of organisations. Unfortunately, mainstream organisations and sometimes for-profit companies tend to be given the funding through tenders, who then turn to local women's groups to deliver for them without compensating them for their time. This is exploitative. Communities should be empowered to help themselves.

Improving the cultural competency of healthcare providers is also essential. When healthcare staff are trained to understand and respect cultural differences, and when translation services are available, it makes it easier for minority ethnic women to access care and communicate effectively with their doctors. Discriminatory and insensitive language and attitudes will put off women from disclosing health concerns and symptoms.

Public health campaigns can also help by directly addressing cultural misconceptions about health, encouraging women to participate in health screenings, get vaccinations, and seek mental health support. Making healthcare more accessible is another important factor. Offering services like mobile clinics, flexible hours, or health services in community spaces like local centres or places of worship can help overcome logistical challenges. It's also important that minority ethnic women are included in health research, as this helps ensure that the healthcare services they receive are based on accurate data and meet their specific needs. Finally, providing education about health risks and promoting mental health awareness can empower minority ethnic women to take charge of their health and seek care sooner, ultimately leading to better health outcomes.

On behalf of Muslim Women's Network UK,
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