WRITTEN EVIDENCE TO THE DEPARTMENT OF HEALTH AND SOCIAL CARE IN RESPECT OF THE WOMEN'S HEALTH STRATEGY

JUNE 2021

Introduction

1. 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 for change for over 18 years. 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 and 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, as well as through our online membership platform, the MWN Hub. 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.

2. We also develop resources and train and capacity-build women so that they are better aware of their rights and feel empowered to exercise their own choices. We have a separate website for our national helpline (MWN Helpline: www.mwnhelpline.co.uk) that provides advice and support on a range of issues including: domestic abuse, forced marriage, honour based abuse, sexual exploitation, female genital mutilation, employment issues and mental health matters. Our online membership platform (MWN Hub: www.mwnhub.com) is another means by which we share information and resources on a range of issues, encourage Muslim women to share their views and opinions on contemporary issues (including health matters) and engage with one another.

3. 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. To this effect, MWNUK also acts as the Secretariat for the APPG on Muslim women.

4. When talking about Muslim women and girls, we take an intersectional approach because their experiences will be affected by different aspects of their identities. For example, the Muslim population is ethnically diverse and an analysis of the broad ethnic groups from the 2011 Census show that the Muslim population of England and Wales was, at the time, made up of the following[1]: Pakistani (38%), Bangladeshi (14.9%), Indian (7.3%), Arab (6.6%), Black African/Black Caribbean/Other Black (10.1%), Other Asian (7.2%), White

[1] Muslim Council of Britain (2011), British Muslims in Numbers: https://mcb.org.uk/report/british-muslims-in-numbers/

(7.8%), Mixed Race (3.8%) and Other (4.1%). As the majority of our service users identify as Muslim BAME, our points and recommendation are done so having taken into account the intersectionality of experiences of our service users and beneficiaries.

5. Additionally, although we work predominantly with Muslim women and girls and will generally focus on the experiences of Muslim women and girls within our Evidence, we wish to clarify that the points we raise may equally apply to non-Muslim women (and generally to the wider population).

6. We now make the following points:

Evidence

7. In 2008 MWNUK held small, facilitated workshops in Blackburn and Bolton with Muslim women to discuss issues around access to healthcare, including their needs and concerns. The findings were documented in MWNUK's written report, Muslim Women and Health Services[2]. The key issues the women raised over a decade ago as to what can contribute to poorer outcomes and health inequalities continue to be applicable today. For example:

    - Distance/travel time to attend hospital appointments.
    - Not being able to communicate their health needs and concerns.
    - Delayed diagnosis.
    - Gaps in information needs.
    - Not reaching out to women with information through the appropriate channels to make them aware about opportunities, such as cancer screening.
    - Lack of support about maintaining healthy diet and weight.
    - Muslim women and girls not seeking help for drug or alcohol addictions
    - Not being able to always access female health professionals to discuss intimate issues such as sexual reproductive health.
    - Not being provided with all relevant information, especially about all options for treatment to enable informed choice
    - Better cultural awareness amongst healthcare staff needed about the patients they serve.
    - Lack of awareness of menopause symptoms, including poor mental health.
    - Lack of awareness of post-natal depression symptoms.
    - Getting help for depression and anxiety that is culturally sensitive.

8. MWNUK is now building on this research by focussing on one specific area of women's health, maternity care, due to the poor outcomes for Black and Asian mothers and their babies. As Secretariat for the APPG on Muslim Women, we are conducting (on behalf of the APPG) a study into the maternity experiences of Muslim women from diverse ethnic backgrounds. Although this report will be published towards the end of 2021, some emerging findings have been included within this Evidence.

Women's Voices - Ensuring women and girl's voices are heard

9. In order to improve services and raise standards of care, it is essential that women's voices and experiences (particularly Muslim/BAME women) inform the development and delivery of health care services. Their experiences should be considered throughout the decision-making structures and processes. Having lay member involvement (inclusion and

[2] Muslim Women's Network UK (2008): Muslim women and health services: https://www.mwnuk.co.uk/go_files/resources/548441-Muslim%20Women%20and%20Health%20Services%20(2008).pdf

engagement) is therefore essential. However, such involvement is largely inconsistent and not always done in a meaningful way, with patient representativeness also varying considerably. BAME women are often not involved in a meaningful manner and are regarded as 'hard to reach' to justify poor patient engagement. However, they can be reached if time and adequate resources are committed to such efforts, which would actually lead to faster and more streamlined referrals into the right care pathways that would ultimately result in improved outcomes and save lives. Better engagement of BAME women would also save costs of unplanned admissions, treatment of chronic health conditions and mental ill-health triggered by poor, long term physical health. Additionally, whilst we use the term BAME, fact of the matter is that local level data on ethnic breakdown is needed so that engagement issues can be identified and addressed; this is essential to tackle local health inequalities.

10. The voices of BAME women must also be heard where funding decisions that shape future health care are made. In the NHS the majority of leadership roles are still held by men[3], despite women making up over three quarters of all NHS staff. BAME women are even more rare in such leadership positions, which means their experiences and perspectives are absent in discussions at a senior level. This under-representation must now be proactively addressed. This could include finding ways to bridge the gap between BAME female applicants who have the skills and knowledge but lack NHS board experience. One way of achieving this could be by recruiting Associate Non-Executive Directors. Although these positions do not have any voting powers, they will allow BAME women to develop the additional skills and experiences they require and once sufficient experience has been gained, such positions could be used to proceed to full trust board memberships when vacancies arise. By way of an example, in June 2021 Shaista Gohir who is the Co-Chair and trustee of MWNUK, was appointed as an Associate Non-Executive Director at the University Hospital North Midlands NHS Trust.

11. Language also matters. During health conversations some Muslim women and girls have encountered tones and phrases that have made them feel judged and unwelcome. They feel that such phases and tone have been used due to their race and/or faith (which could have been indicated by their clothing, such as wearing hijab). If Muslim women detect negativity through such micro-aggressions then they are generally less likely to ask questions or raise concerns about their symptoms or ask important questions about their healthcare. It is therefore crucial that the language used and mannerisms are inclusive and respectful. Phrases that imply bias or may be stigmatising, even inadvertently, must be avoided as otherwise those already marginalised in the healthcare system are at risk of being excluded further.

12. Another common theme is Muslim/BAME women 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. It does appear from information available to MWNUK, through its service users and beneficiaries, that there is a stereotype of BAME women exaggerating their pain and suffering. For example, one Muslim woman was repeatedly not provided with treatment for hyperemesis gravidarum (severe pregnancy sickness) and was not given any help until she became suicidal due to the severe impact on everyday functioning; due to the seriousness of this particular case, awareness of this case was highlighted via our MWN Hub as we were worried that other women may be in a similar position, and there could be a risk to the lives of others[4].

[3] NHS Digital (2018): https://digital.nhs.uk/news-and-events/latest-news/narrowing-of-nhs-gender-divide-but-men-still-the-majority-in-senior-roles
[4] MWN Hub: https://www.mwnhub.com/read-detail.php?id=64

13. As mentioned, BAME women are more likely to have poorer outcomes. For example, Black women are five times more likely to die during childbirth[5] and during the period after childbirth, when compared to white women. South Asian women are two times more likely to die when compared to white women during the period mentioned. These statistics appear to have worsened over the last 20 years and urgent action is now needed to address the factors in the healthcare system that are contributing to both higher rates of BAME maternal and infant mortality. In addition to the research being conducted by MWNUK (for the APPG on Muslim Women), other research studies are currently underway. The Department of Health and Social Care must use all of the experiences of BAME women's maternity experience that will be contained in all these studies to develop a concrete, detailed action plan which must show what actions will be taken to reduce BAME infant and maternal mortality. This must include requiring each hospital trust to devise their own bespoke plans to achieve equitable outcomes.

Information and education on women's health

14. Accessing the right information at the right time and according to specific needs throughout the life cycle should not be the sole responsibility of Muslim/BAME women. According to the equality legislation, health and social care providers have a legal duty to reduce inequalities between patients in access to health services and the outcomes achieved. This should include ensuring patients are provided with information through education and awareness raising so they can recognise symptoms, understand the importance of screening as well as be provided with options for treatment and care (including risks). This will allow them to make informed choices that best meet their needs. However, there are a number of information gaps, (some of which are mentioned in the following paragraphs) which highlight the level of work required to truly support BAME women to feel empowered and make informed choices.

15. Deep inequalities are perhaps the most evident in gynaecological health. For example, there is a lower uptake of cancer screening (cervical screening[6] is a case in point) among BAME women and cancer incidence and mortality rates are higher among more deprived communities[7] (including many cancers in women). For example, Black women in England are almost twice as likely to be diagnosed with advanced breast cancer[8] 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.

16. Even where prevalence of certain conditions is higher in certain ethnic groups such as for example, black women suffering disproportionately from uterine fibroids (reasons for which are not clear), health care providers should be ensuring these women are reached and have access to information as early as possible in their life stages, so that they do not delay in seeking help. They should also be informed of all options available to them so they can make choices that best meet their needs. For example, fibroids result in higher rates of hysterectomies for black women, which can also cause unsightly scarring because black skin is likely to develop keloids. However, black women are not always informed

[5] Please see following: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2020/MBRRACE-UK_Maternal_Report_Dec_2020_v10.pdf

[6] Please see following article in The Sun: https://www.thesun.co.uk/news/9943249/cervical-cancer-hotspots-mapped-smear-tests/

[7] Please see following link: https://www.bma.org.uk/media/2112/bma-womens-health-cancer-in-women-aug-2018.pdf

[8] Please see following BBC article: https://www.bbc.co.uk/news/health-37991460

about alternative less invasive treatments[9] (such as fibroid embolisations). If all relevant information is not provided, then women may feel pressurised into making particular decisions and may also feel regret and sadness later in life when they realise that other options were available to them. This could then also impact their confidence (in terms of making other decisions) and mental health.

17. Not being provided with all the relevant information is also resulting in women not recognising concerning symptoms and/or raising concerns. For example, intrahepatic cholestasis of pregnancy (ICP) is a serious liver disorder that can develop during pregnancy. It affects 10% of pregnant women and is more common in South Asian women. Developing the condition increases the risk of serious pregnancy complications including premature and still birth. It is therefore essential that women are made aware of the symptoms such as itching, as otherwise they may not ask for help. Unfortunately, this information is not always provided or women are not sufficiently made aware of the seriousness of the condition.

18. Another example of informational needs of BAME 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.

19. As mentioned above, we launched an online platform called the MWN Hub that provides a space for Muslim women to share, contribute and access information on topics important to them through blogs, video discussions, podcasts and forum posts. This was launched during the Covid-19 pandemic (in October 2020) to respond to the fact that Muslim women were now spending more time online and it was necessary to provide an appropriate outlet to reduce isolation, provide support and promote community spirit (as well as raise awareness of pertinent issues). However, public bodies could also use this space to reach Muslim women as part of their marketing and awareness-raising strategy. Despite our limited resources (by virtue of being a small charity), we have tried to address information gaps on BAME women's health by highlighting particular topics through video discussions and blogs. Examples include:

    - Cervical Screening – We produced a short myth busting information video[10] to challenge some of the reasons why Muslim/BAME women thought they may not need them and emphasised that screening could be life-saving.

    - Cancer – We highlighted the story of a breast cancer survivor[11] to encourage more women to check their breasts, and seek help if they spot any concerns.

[9] Please see following link: https://www.unison.org.uk/motions/2015/women-members/black-women-and-fibroids-2/
[10] Please see following link: https://www.mwnhub.com/video-detail.php?id=17
[11] Please see following link: https://www.mwnhub.com/video-detail.php?id=44

- Hyperemesis Gravidarum – We interviewed a Muslim woman who had experienced severe morning sickness[12] who shared the impact on the quality of her life, how she struggled to be listened to and the help that is available.

- Infertility – We interviewed a fertility professor[13] who shared their expertise about lifestyle choices that could impact fertility and provided advice on improving for fertility health, as well as options available.

- Menopause – We highlighted Muslim women's menopause experiences via a podcast[14] so that other Muslim women going through menopause can see that they are not alone and are able to better understand the changes they are going through.

- Mental health – We shared a video which involved a discussion between a group of women sharing personal and professional perspectives on mental health and the role of faith and spirituality to improve outcomes[15].

20. For information to be effective, it cannot just be limited to promotional information adverts. Such promotional material tends to be limited in scope and short – women may think the information does not apply to them. Deeper and meaningful discussions are more likely to resonate, have an impact, be shared and also be accessed for many years. During our information videos we therefore ensured the messengers (of the information) varied. We have used a combination of professionals, voluntary sector and authentic women' voices. The NHS could consider working collaboratively with MWNUK to address information gaps. However, any such initiatives would need to be well resourced.

Women's health across the life course

21. It is evident from women reporting their experiences (thorough various research) that the health care system is not meeting their needs, particularly where Muslim/BAME women are concerned. Their specific health requirements continue to be overlooked across all life stages - from adolescence and young adulthood, to the middle and reproductive years and to menopause and later years. Women of a lower socio-economic status and BAME women lag even further behind in accessing care, receiving quality of care and improved outcomes.

22. A 2017 investigation coordinated by the All Party Parliamentary Group on Women's Health[16] 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' report[17] 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.

23. We have already mentioned the problem of women not being believed and being treated as if they are over-reacting to pain or discomfort experienced, and that BAME women are even less likely to be believed. The upshot is that they are expected to simply 'put up' with the pain, including where the cause may be heavy menstrual bleeding, endometrial pain,

[12] Please see following link: https://www.mwnhub.com/video-detail.php?id=76
[13] Please see following link: https://www.mwnhub.com/video-detail.php?id=23
[14] Please see following link: https://soundcloud.com/user-454496265/podcast-surgical-chemical-menopause
[15] Please see following link: https://www.mwnhub.com/video-detail.php?id=83
[16] APPG on Women's Health (2017): http://www.appgwomenshealth.org/inquiry2017
[17] RCOG (2019): https://www.rcog.org.uk/better-for-women

severe pregnancy sickness and even labour pains. If women are struggling to be heard, then teenage girls are even less likely to be understood or listened to. Doctors do not always recognise when symptoms may be having a major impact on women's quality of life, thus leading to under-treatment. For example, Polycystic Ovarian Syndrome (PCOS) is one of the most common endocrine disorders in women and is more prevalent amongst young South Asian adolescents and women. However, it can often be overlooked even though it can result in obesity, excess body hair, and acne, which in turn can cause physical scarring and emotional distress. As mentioned earlier, language matters. During health conversations some women and girls have encountered tones and phrases that make them feel judged and unwelcome e.g. when diagnosing polycystic ovary syndrome (PCOS) in adolescents, weight gain is not always spoken about sensitively despite the high incidence of eating disorders in this population. Later in life the PCOS can also result in diabetes, heart disease and infertility. Given that PCOS is potentially linked to higher incidence of perinatal morbidity from gestational diabetes, pregnancy-induced hypertension, and preeclampsia and that South Asian women (and their babies) have a higher mortality rates, such conditions should be given greater attention much earlier in a woman's life.

24. Another health issue that requires more attention is menopause in BAME women. The visual imagery used to highlight menopause does not often 'speak' to BAME women. If the images used in communications materials resonate with them, messages are more likely to be impactful. Also, to provide the best care during this time, a good understanding is required of the factors that influence how Muslim/BAME women experience menopause such as cultural attitudes. For example, Muslim/BAME women may find it difficult to talk about vaginal dryness, painful sex and loss of libido due to cultural factors and therefore may be less likely to report such symptoms and seek help. They may also not realise that hormone changes could affect moods and cause poor mental health. In fact, different BAME groups are more likely to face particular mental health problems. For example, South Asian women are already at an increased risk of suicide. This should cause additional concerns given that the latest data shows that suicide is now the second leading cause of maternal death in the UK.

Women's health in the workplace

25. The first point to mention in respect of women's health in the workplace is that unconscious bias remains a key issue across all sectors which can mean that regardless of the actual health issue at hand, women can find themselves often penalised for health conditions much more than male colleagues. This may be because stereotypes are already in play about women (such as that they cannot cope with workloads etc) and as such, any health issues they may face which may impact their work productivity (temporarily or permanently) then feeds into stereotypes. This can mean that women will generally not discuss any health conditions they may have because of concerns over how they may be treated or scrutinised. They also ultimately be penalised by not being put up for promotion. This situation can be exacerbated for women experiencing menopause as they may then have to contend with age-ism (combined with sexism) and are therefore even less likely to speak. One key consequence of such silence is that conditions which may result in hormonal changes or behaviours and therefore impact the way a person may behave at work (such as menopause leading to difficulties in sleeping and therefore making a woman feel tired or irritable during the day), are not known and their performance is likely to be judged without taking into account their health conditions. Women therefore face a double-edged sword whereby speaking up about their health conditions could result in being penalised due to unconscious bias at play, whilst remaining silent could result in being penalised due to being judged without their health matters being taken into account.

26. We recommend employers 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.

27. Mental health in the workplace is also a very serious issue for women in the workplace, which has very much been exacerbated by the pandemic. During the pandemic, we have seen women trying to juggle their work commitments with their childcare and school tasks (where children have been of school age). This has been naturally very difficult for single parents but also for women from some Muslim communities where unfortunately the burden of childcare and house-hold responsibilities are placed predominantly on women. Increased work pressures have contributed to poor mental health and information available to us suggests that this has been especially problematic in the legal sector where expectations have been to continue to work at the usual pace. However, women are unlikely to disclose concerns about their mental health due to fear of losing their jobs or it impacting promotional prospects at a later date. Although the government had introduced the furlough scheme to avoid redundancies and allowed the scheme to be used for those who are unable to work due to caring responsibilities, this has not necessarily translated into reality and individuals who were furloughed have in fact been then made redundant and were first in line for redundancies. Moreover, even where employers have shown flexibility, those unable to work at a usual pace have been made to feel guilty by peers; thus highlighting how overall organisational messages do not always translate into actual change.

28. Another feature of the pandemic has been homeworking and flexible hours. Once lockdown is over and employees are allowed to return to work, these options should be retained. However we also wish to make the point that it is also important to address the costs of childcare because ultimately that is a key barrier to women being able to enter and remain in the workplace, is a major stress and can have an impact on their health where they are having to juggle too many responsibilities due to not having enough childcare support.

Research, Evidence and Data

29. As highlighted by the many examples in this consultation response, deep inequalities are perhaps the most evident in gynaecological health. Data on a whole range of health issues indicates poor access and outcomes. The needle does not appear to be shifting for any of the issues. Does this indicate that health service providers just accept the higher rates of poorer access to information, access to services and poorer outcomes? Improved understanding is urgently needed of BAME women's perspectives and health experiences on a range of health issues (some of which have been mentioned here) and this must include robust data collection and research.

30. So much data is collected about women throughout their life cycle. This information and data needs to be collected in a way that can be broken down so that it can be analysed to better understand the different outcomes for different groups of women according to their protected characteristics, and other demographics such as location, education, socio economic status etc. Far too often when stakeholders in the healthcare system mention Black women, they regard them as one homogenous group. However, Black African women may have different experiences to Black Caribbean women. In a similar manner, experiences and outcomes may differ for Pakistani, Bangladeshi and Indian women whilst in some instances they may share similarities as a result of their shared South Asian identity.

31. Conducting research on BAME women's experiences can help to fill in knowledge gaps by getting them to take part in research either through focus groups, one to one interviews or to take part in trials. Using researchers from a similar background can be helpful in gaining their trust. However, there are other barriers to participation that need to be addressed such as the following:

- Ensuring women are given a clear understanding about the research and its relevance for them including how it can help improve women's lives for the better.
- Women being compensated for their time.
- Working collaboratively with BAME women's charities to reach women, which must also be compensated for their time

32. Another method of identifying BAME women's perspectives, especially if they have had a poor service, is by analysing any complaints albeit we must note that BAME women may also be less likely to complain. For example, MWNUK was contacted by the Public Health Ombudsman in 2014 to conduct workshops to find out why South Asian women were less likely to put in a complaint. We found that this was because they had not been not made aware of the complaints service, when they wanted to complain they have been prevented from complaining, they didn't think anything was going to change so did not want to waste time, or thought it would have a negative impact of their care as it would appear on their notes.

6) Impact of Covid-19 on women's health

33. The social and economic disruption by the Covid-19 pandemic is already having 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[18] 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 Bangladeshis ethnic groups are more likely to live in the most deprived areas, health inequalities will widen further for women living in these communities[19].

34. Period poverty has also worsened due to the pandemic. Economically disadvantaged groups such as BAME women are even less able to afford sanitary products. As the menstrual cycle is not talked about openly in Muslim communities due to cultural attitudes, women may not have the confidence to ask for menstrual hygiene products. Free products should be provided for those who cannot afford it, in a safe and dignified manner.

35. Another impact of the Covid lockdown has been a rise of domestic abuse. We have observed that the number of women contacting our MWN Helpline has increased in the last 15 months by 16% (compared with previous years). There has been a large increase in calls about mental health, isolation and loneliness, some of which related to domestic abuse. Women also tend to be more likely to be responsible for caring for family members suffering from Covid-19 and long Covid, as well as supporting children who have missed

[18] Please see following Guardian article for reference: https://www.theguardian.com/business/2021/jan/19/black-and-minority-ethnic-uk-workers-hit-worst-by-covid-job-cuts

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

out almost a year of their education. This could contribute to poorer mental health. Increasing access and provision of bespoke therapeutic services such as faith/spiritual and culturally aware counselling should be made a priority and not limited to the usual six sessions

36. Telephone consultations have been a feature during the Covid pandemic. While we welcome partially retaining such an approach because it will benefit those who are time poor, its use should be utilised carefully as it could widen health inequalities. Measures should be taken to ensure those who want to be seen face-to-face have the choice to do so and vulnerable patients should be identified (such as ex-offenders, those with disabilities, those who do not have access to technology) and provided with appropriate support as they may not be able to access and navigate the increasingly technology dependant healthcare environment.

37. Tailored services could encourage more women from ethnic minorities to seek help. Advanced communications training for health professionals and improved understanding of BAME women's health could mean not missing opportunities to ask the right questions at the rights time.

Final Comments

38. A number of intersecting factors may contribute to poorer outcomes for certain groups of women such as: structural inequalities impacting on socio-economic status, levels of education and language affecting the capacity to communicate effectively; and insecure immigration status which may be leading to delays in seeking help. However, even when some of these factors are removed, BAME women still report experiencing differential treatment. This therefore suggests that conscious and unconscious gender and racial bias exists in the health care system. Such uncomfortable truths need to be acknowledged and tackled in an effective, inclusive and meaningful way if we want to be able to promote women's health. We hope that the government's Women's health strategy will take this into account.

39. We would like to thank the DHSC for seeking opinions on the government's Women's Health Strategy and thank you for providing us with the opportunity submit evidence. We hope our submissions prove to be useful in your considerations and would be happy to assist further.

On behalf of Muslim Women's Network UK,
Shaista Gohir OBE
Co-Chair

13th June 2021

54-57 Allison Street
Digbeth
Birmingham
B5 5TH
board@mwnuk.co.uk