Prevention and empowerment
Introduction

As we have already seen, supporting girls and women to make good health choices needs to start from a young age and should continue throughout their lives. We know that promoting health literacy and healthy behaviours makes an important contribution to preventing avoidable ill-health and encouraging women to take control of their own future health. There is clear evidence that preventative strategies can help to improve health outcomes for women and their families throughout their life course.

However, our health and care services often fail to take a preventative approach to women’s health, which results in missed opportunities to support women to access the care they need and make the decisions that are right for themselves and their families.

Preventing unplanned pregnancies

The National Survey of Sexual Attitudes and Lifestyle (NATSAL) has revealed that 45% of all pregnancies and around one third of births are unplanned or associated with feelings of uncertainty. 1

It is important to note that many of these pregnancies which continue to term are not unwanted and have positive outcomes for mothers and their babies. However, there is clear evidence that unplanned pregnancies result in poorer outcomes for women and their babies due to late presentations for antenatal care and a wide range of obstetric complications during the pregnancy, delivery and postnatal period. For some women, an unplanned pregnancy can lead to mental health issues including antenatal and postnatal depression.2

Additionally, an unplanned pregnancy can have a negative impact on the child both in-utero and later on in life.

Problems such as low birth-weight, prematurity, mental health issues and lower scores in intelligence quotient (IQ) or cognitive testing at the age of four years are some of the best recognised poor outcomes.

They are more likely to occur in women living in disadvantaged areas with lower educational attainment and poor dietary intake. In turn, these same women are less likely to follow infant feeding advice and hence the cycle of poorer health is passed to the next generation.3

There is also clear evidence that providing girls and women with contraceptive advice and support throughout their reproductive years reduces the number of unplanned pregnancies. Societal changes have resulted in many women choosing to delay childbearing or to have no children. These longer intervals between first sexual intercourse and childbearing mean that an increasing number of women can spend up to 30 years of their lives wanting to prevent an unplanned pregnancy.
There are numerous opportunities for healthcare professionals to provide girls and women with advice about pre-conception care and contraception. These include but are not limited to discussions during the following routine healthcare checks and interactions:

- School based Human papillomavirus (HPV) vaccination programmes and other immunisations
- Sexually transmitted infection (STI) checks at all sexual and reproductive healthcare services
- Cervical cancer screening visits
- At every consultation with women of reproductive age living with a long-term medical condition
- During and following a miscarriage, abortion or ectopic pregnancy
- Before, during and after pregnancy, within and without the maternity unit or hospital setting

Hospital-based early pregnancy and emergency gynaecology units already offer easily accessible services for large numbers of women on a daily basis. They are extremely well placed to provide reliable, personalised contraceptive advice and treatment but are not currently resourced to routinely do so for all attendees. Similarly, women are ideally placed to receive advice and support about their future contraceptive choices during these visits, during an ongoing pregnancy and following birth.

Planning future contraception should be viewed as an integral part of our maternity care services but all too often this opportunity is missed.

45% of pregnancies and around 33% of births are unplanned or associated with feelings of uncertainty.

Abortion rates for women aged 35 and over have increased over the last 10 years from 6.7 per 1,000 women to 9.2 per 1,000 women.
Providing a full range of contraceptive options after pregnancy is a simple but effective way to avoid short intervals between pregnancies. An interval of less than six months is an independent risk factor for preterm delivery and neonatal death in the next pregnancy. Viewed in a positive context it is well recognised that intervals of more than 18 to 24 months between births lead to improved outcomes for both mother and baby.1

Many women still think that their contraceptive options are limited to condoms or the pill. However, long acting reversible contraception (LARC), which includes intrauterine contraceptives, contraceptive implants and injections, are significantly more effective in preventing pregnancy than contraceptive pills or barrier methods. They are also highly cost effective even if the duration of usage is limited to an interval of one year or less.2

Despite lessons learned from the successful national teenage pregnancy strategy, which achieved a 41% reduction in the under-18 conception rate following a collaborative effort by local government, health partners and individual practitioners, a recent audit of contraception and abortion services in England has shown that in many areas, access to the full range of contraception (including LARC) is declining or completely lacking. It is also frequently restricted to younger women which is making it increasingly difficult for women who have already had a pregnancy to access suitable contraception.

As a result, conception rates are rising among older women, as are the rates of abortion, indicating that women are having unplanned pregnancies at later stages of their reproductive lives. There is an urgent need to reverse this trend and ensure that all women can easily access evidence-based contraception services. Getting this simple and cost-effective intervention right will dramatically improve quality of life for women.

An important factor contributing to the high unplanned pregnancy rate is that commissioning of contraceptive services in England has become very fragmented and the most vulnerable girls and women are the worst affected (see chapter five). We have to tackle this short sighted approach to the commissioning of contraception in order to reduce the number of unplanned pregnancies and abortions and the health care expenditure that results.

Contraception is the single most cost-effective intervention in healthcare.6 Public Health England (PHE) estimates that every £1.00 invested in the provision of contraception achieves a £9.00 saving7 across the public sector.
Health indicators before, during and after pregnancy

Before pregnancy

Supporting women to be as healthy as possible before pregnancy, in order to increase fertility, have an uncomplicated pregnancy and achieve the best outcomes for both mother and baby, should be a key priority. However, the continuing prevalence of risk factors such as obesity and smoking during pregnancy, as discussed below, indicates that opportunities to optimise women’s health in the pre-conception period are being missed.

It also suggests that the information currently offered to girls and women about being healthy before pregnancy is either not effective or is not being delivered in the right way. It is clearly not getting through to many of the women we want to reach. Health services need to find innovative ways of communicating with girls and women at an early stage in their reproductive lives, in order to highlight the importance of eating a healthy diet, having a normal body mass index (BMI), being physically active, stopping smoking, avoiding alcohol and recreational drugs and taking supplements of folic acid in the pre-conception period.

The RCOG supports programmes that promote these healthy behaviours, which help to achieve the best outcomes for mother and baby and benefit the NHS purse by helping to prevent the onset of costly long-term conditions.

"I try to support and encourage women to make positive choices about their lifestyle and health."

This is as important for all girls and women as it is for a woman and her baby during pregnancy. Throughout a woman’s life course it is important that she does as much as she can to improve her health.

Professor Janice Rymer, Consultant Gynaecologist at Guy’s and St Thomas
During pregnancy, women interact with health professionals on multiple occasions and often feel motivated to make positive changes to their health and health behaviours. However, some pregnant women in the UK are not being adequately supported to optimise their own health and that of their baby’s at this critical time of life. This is shown by:

- 10.6% of mothers are smokers at the time of delivery despite current antenatal smoking cessation programmes.9
- 4/10 women continue to drink alcohol regularly during pregnancy.
- 21.3% of the antenatal population are obese and a further 31.4% are overweight. This means that less than 50% of all pregnant women have a BMI within the normal range.13
- Every year approximately 1,000 neural tube defects (NTD) are diagnosed in utero in the UK.
- Smoking during pregnancy seriously harms the health of mothers and their babies and is responsible for an increased rate of stillbirths, miscarriages and birth defects.10 Smoking is the biggest modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health.
- The UK has one of the worst rates in Europe for women drinking during pregnancy and one of the highest rates of Fetal Alcohol Syndrome in the world.11 Alcohol-specific deaths among females in 2017 reached the highest rate recorded (8.0 deaths per 100,000 females).12
- Being overweight or obese increases the risk of virtually every complication of pregnancy, delivery and the postnatal period for both the mother and her baby. This includes miscarriage, stillbirth, gestational diabetes, pre-eclampsia and eclampsia, operative delivery, anaesthetic complications, wound infection, severe blood loss and mental health issues.14 Women who are overweight are also less likely to start or maintain breast feeding.
- In 85% of cases with neural tube defects, the pregnancy ends in an abortion – more than two procedures per day. Furthermore, two babies are born every week in the UK with a neural tube defects (NTD) that results in a lifetime need of specialist medical care. The simple fortification of flour with folic acid will prevent approximately half of all neural tube defects.15
- Ethnicity, maternal age and social inequalities have a marked effect on pregnancy outcomes in the UK. Black women are five times more likely to die from pregnancy complications than white women. Asian women are twice as likely to die from pregnancy complications as white women. Mothers aged 40 years or more have a threefold higher risk of dying, as do pregnant women living in the most socially deprived circumstances.14
For example, the 2014-16 MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK) report identified that the marked increase in mortality among black women could be accounted for by pre-existing medical problems, anaemia during pregnancy, diabetes, previous pregnancy problems, multiple pregnancy, poor antenatal care, substance misuse, maternal age and unemployment.

Since all of these risk factors are recognisable during pregnancy, the NHS needs to develop robust methods to capture and share these data for each individual woman, in ways that ensure that everyone involved in her care can access and utilise them.
After pregnancy – reviewing predictors of future health

A woman’s physiological response to pregnancy may be an early sign of future health problems. It is essential that this information is collected and that the future implications of these physiological signs are discussed with women postnatally, in order to avoid preventable problems later in life.

Mental health
Women who suffer from mental health issues during pregnancy are more likely to have mental health problems later in life. 16

Diabetes
Women who have gestational diabetes are more likely to have Type 2 diabetes at a later stage. 17

Unplanned
Women who have an unplanned pregnancy are more likely to have poorer outcomes for themselves and their babies.

Miscarriages
Women who have repeated miscarriages are more likely to have cardiovascular disease or stroke later in life.

Smoking
Women who smoke during pregnancy are more likely to have a stillbirth, a miscarriage or birth defects.

Pre-eclampsia
Women who have had pre-eclampsia are more likely to suffer from stroke or cardiovascular diseases at an earlier point in their life.

Obesity
Women who are obese during pregnancy are more likely to have a stroke earlier in life.
Currently, this does not happen routinely, meaning that opportunities to improve individual women’s health in the future are missed. There are four areas where this is particularly important:

**Pre-eclampsia**

Pre-eclampsia affects up to 6% of pregnancies in the UK and severe pre-eclampsia develops in 1-2% of these pregnancies. Women who become hypertensive during pregnancy or postnatally are nearly twice as likely to suffer cardiovascular disease (frequently developing at an earlier age) than those who have a normal blood pressure during pregnancy.

**Gestational diabetes**

Women with gestational diabetes are seven times more likely to suffer Type 2 diabetes in the future. It is estimated that 50% of gestational diabetics have become Type 2 diabetics within 10 years of their pregnancy. Gestational diabetes affects around 5% of pregnant women. It is increasing in prevalence due to demographic changes in the childbearing population – more women are now overweight before, during and after pregnancy and maternal age is increasing.

**Obesity**

Maternal obesity places mother and baby at a markedly increased risk of obstetric complications – including maternal death – and can lead to serious health problems for both later in life. In the 2014-16 MBRRACE-UK report, 37% of the women who died were obese and a further 20% were overweight. There is clear evidence that weight loss between pregnancies reduces the risk of stillbirth, hypertensive complications and large babies and increases the chances of a normal vaginal delivery following previous caesarean section.

Obese women are also at increased risk of suffering a venous thromboembolic event (VTE), heart attack or stroke in later life and of developing some types of cancers, particularly breast and uterine.

The children of obese mothers are at greater risk of congenital abnormalities, stillbirth, prematurity, macrosomia and neonatal death. In utero exposure to maternal obesity is associated with a six-fold increased risk of the baby developing Type 2 diabetes and obesity later in life if preventative measures to lose weight are not taken.

**Mental health**

One in four women suffer from mental health problems during pregnancy, which increases their risk of suffering a subsequent episode later in life. Mental health problems can have a huge negative impact on all aspects of life, including work, personal and family relationships. They are also detrimental to physical health and serious mental illnesses are estimated to reduce life expectancy by up to 20 years.

While it is very common for new mothers to have a short-lived period of the ‘baby blues’, 10-15% of new mothers develop a much deeper and longer-term depression called postnatal depression (PND). It can be difficult for busy healthcare professionals to spot the signs of PND and opportunities to support women and prevent their mental health from deteriorating are being missed regularly. Alarmingly, psychiatric disease is now a leading cause of maternal deaths during pregnancy the first year after birth.
The six week postnatal check is equally important for the mother as it is for the baby. It is an ideal time to review all the collected pregnancy health data and provides another opportunity for medical follow-up and planning for future health care.

This can include giving a new mother advice about how to lose any weight she may have gained during pregnancy, directing her to services to help her quit smoking, informing her about safe alcohol guidelines and ensuring that she is offered effective, reliable contraception to avoid the future obstetric problems associated with short inter-pregnancy intervals.

Used wisely, this is an important means of spotting and treating physical, mental and emotional issues, making a specialist referral where necessary and preventing problems from escalating. Whilst some women are offered the option of an excellent six week check, not all GP practices are funded to include the mother in the check-up. All too often, there is insufficient time for this pivotal appointment and the baby’s needs are prioritised over the mother’s.

According to a recent National Childbirth Trust (NCT) survey, one in five women say that they were not asked about their emotional or mental wellbeing postnatally.

The 6-8 week postnatal check is a golden opportunity for a conversation to take place with all women about their mental health and wellbeing.

GPs need to be supported to have an awareness of what they are looking for, what questions they should be asking and when and how to refer to specialist services and/or local support groups if needed.

Maria Viner, CEO Mothers for Mothers Bristol and RCOG Women’s Network member

This means that nearly half of new mothers’ mental health problems are missed by health professionals.27 Added to which, the stigma that surrounds mental illness combined with the fear that acknowledging that they are suffering from a mental health problem might result in their baby being taken away from them, may make new mothers reluctant to disclose their mental health problems.28
The many health professionals who are engaged with delivering maternity services are particularly well placed to detect the signs of violence against girls and women and to help safeguard them, both during pregnancy and the postnatal period.

The social and economic cost for victims of domestic abuse in England and Wales is estimated at £66 billion annually.

Domestic violence has no boundaries.

There were an estimated 1,370,000 female victims of domestic abuse in the UK in 2017/18.

One woman in four experiences domestic violence in her lifetime.

Four to nine in every 100 pregnant women are abused during their pregnancy or soon after birth.

Ten women were murdered during or up to six weeks after pregnancy in the UK in 2014-16.

As many as 10% of all women are abused during their pregnancy or soon after the birth of their baby. The latest 2014-16 MBRRACE-UK report found that 10 women were murdered by an intimate partner or former partner during pregnancy and the six week postnatal period. Furthermore, 17 of the women who died by taking their own life during pregnancy or up to one year after pregnancy were known to have a history of domestic abuse.

Around one woman in four will experience domestic violence in her lifetime and in 2017 there were over a million female victims of domestic abuse in the UK. Domestic violence may be triggered by and frequently accelerates during pregnancy.

Training healthcare professionals to recognise the signs of domestic violence, adopting techniques to encourage disclosure and ensuring that all maternity staff are aware of the local support networks available for women and how to refer them for help are vitally important. Hospital staff used to have mandatory training in gender based violence but this is sadly on the decline due to the competing pressures of staff shortages and multiple additional training needs.

However, finding ways to encourage a pregnant woman to disclose what she is experiencing without fear of the consequences can literally be life saving. For example, some hospitals place small stickers in clinic toilets for women to place on the bottom of their urine sample pot, so they can disclose that they are at risk without fear of being found out.
In January 2019, the UK Government published its draft Domestic Abuse Bill. The RCOG is very supportive of this legislation and believes that it is an opportunity to help safeguard women by making real and substantial improvements in the support offered to the survivors of domestic abuse and their families.

A case of Female Genital Mutilation (FGM) is reported in England roughly every 100 minutes. Those girls at greatest risk often live in marginalised communities and do not necessarily come to the attention of local social services. They may be subjected to FGM before they start school, during school holidays or before their family moves to the UK. Depending on the grade and severity of the procedure performed, the consequences of FGM later in life can be highly significant and include painful sexual intercourse, inability to have sex at all, vaginal cyst formation, difficulties passing urine, painful periods, infertility, recurrent urinary and pelvic infections, complications during labour and delivery, significant psychological sequelae and mental health problems.

The physical signs of FGM may become evident for the first time in pregnancy during an antenatal visit. However, opportunities to safeguard victims and minimise delivery complications will be missed unless appropriate examinations are performed and the findings carefully recorded. However, the outdated IT systems used to record information about victims of FGM are not user friendly, which results in further cases being lost to follow up or the data sets remaining incomplete. The announcement of a new network of community FGM support clinics - in Birmingham, Bristol, London and Leeds - in September 2019 is warmly welcomed.

In England and Wales, mandatory reporting to the police of all cases of FGM in girls under 18 years of age by healthcare professionals and teachers was introduced in October 2015. However, there is no legal requirement for healthcare professionals to report cases of FGM in adult women in England, Wales or Northern Ireland and Scotland’s Female Genital Mutilation (Protection and Guidance) Bill introduced in May 2019 does not include mandatory reporting of FGM to the police.

The prevalence of all forms of violence against women has largely remained unchanged since before the UK Government’s strategy on ending violence against girls and women was published in 2016. We all need to work together to ensure that violence against girls and women is eradicated.
Gynaecological cancers – prevention and early diagnosis

A worryingly high number of women are diagnosed with late-stage gynaecological cancers in the UK. Every day, 58 women are diagnosed with one of the five gynaecological cancers and 21 women die of their disease.29

- More than 7,300 women are diagnosed with ovarian cancer and 4,200 women lose their lives each year, or 11 women every day.40 Ovarian cancer is the second most common gynaecological cancer and is often referred to as the ‘silent killer’, since around 70% of patients present with advanced disease due to delayed diagnosis because of non-specific symptoms. The UK has the worst survival rates in Europe. Only 34% of women survive for five years compared to a European average of 41%.41

- More than 9,300 women are diagnosed with uterine cancer every year.42 In the UK, uterine or endometrial (womb) cancer results in some 2,200 deaths each year - 6 women per day.43 Incidence increases with age and peaks in women aged between 70 and 74 years. It is predicted that obesity will further increase the number of cases of uterine cancers to 11,000 per year by 2030 – an increase of 18%.

- There are around 3,200 new cervical cancer cases every year. Around 870 women lose their lives to cervical cancer deaths annually, which is more than two every day.44 The introduction of the HPV vaccination programme for all school children in 2019 should reduce the incidence of cervical cancers significantly.

- Just over 250 women are diagnosed with vaginal cancer each year.45 There are around 100 women that die of vaginal cancer deaths in the UK every year - around two deaths every week.46

- Around 1,000 cases of vulvar cancer are diagnosed each year.47 The risk of vulvar cancer goes up as women age and more than half of cases occur in women over age 70.48 There are around 440 vulval cancer deaths in the UK every year. This means that one woman loses her life to this cancer every day.49
The UK lags behind its European counterparts in terms of gynaecological cancer survival rates due to the combination of a lack of knowledge of symptoms among women, low uptake of screening, which is an essential part of the prevention and early diagnosis of these cancers, and a lack of funded research. Less than 4% of overall medical research funding is focused on research into cancer prevention and less than 3% is focused on women’s specific diseases.50

Supporting women to maintain healthy lifestyles is also central to preventing many gynaecological cancers. Women who lead a healthy lifestyle and are not overweight are less likely to develop some gynaecological cancers.51 For example, Cancer Research UK has argued that being overweight or obese is responsible for 490 cases of ovarian cancer per year.52 Similarly, Ovarian Cancer Action has noted that although treatment options are limited, and prevention via screening for the BRCA gene mutation is vital, maintaining healthy lifestyles is one of the strongest weapons to protect against cancer.53

Currently, 70% of uterine cancers are associated with obesity and oestrogen hormone excess. This figure is predicted to increase by 18% - another 1,700 cases per year by 2030, unless the obesity epidemic can be halted. Women who present early with uterine or endometrial (womb) cancer have a good prognosis if they undergo curative treatment. However, being obese compromises the quality of the surgery and anaesthesia required to achieve the best treatment outcomes. Obesity also shortens the disease free follow up interval and reduces long term survival rates.

Most of these women with uterine or endometrial (womb) cancer present early with postmenopausal bleeding (PMB) and have a good prognosis if they undergo curative surgery with or without radiotherapy.

Hence, reducing obesity will have a marked improvement on the incidence of and mortality rates from uterine cancer. It is predicted that the number of new cases will exceed 11,000 per year in the UK by 2030 if we are unsuccessful in tackling the obesity epidemic. Encouraging women to present swiftly if they experience an episode of PMB will also lead to earlier referrals for treatment and improved outcomes.

Laparoscopic and, more recently, robotically assisted surgery techniques are associated with lower levels of post-operative complications and decreased length of hospital stay. These advantages should allow more women to receive definitive surgery in cases where age, obesity and other co-morbidities mean that their operative risks of major open surgery are high.
Cervical screening

Cervical screening programmes are highly effective and have the potential to prevent 70% of cervical cancer deaths but uptake of the UK’s cervical screening programme has declined for four consecutive years and is now at a 20 year low. In short, one in three women invited for a cervical smear test do not attend.

The number of deaths from cervical cancer is predicted to grow by 143% - from 183 in 2015 to 449 in 2040.

Hence it is of vital importance that we maintain efforts to ensure maximal uptake of cervical screening and HPV vaccination. Women outside of the screening programme because of their age (under 25 or over 65 years of age) who develop symptoms of cervical cancer such as vaginal bleeding after sex, bleeding in between periods or post menopausal bleeding need to be encouraged to seek help and referral for colposcopy if necessary.

Some groups of women are significantly less likely to attend cervical screening than others. NHS England recently highlighted that survivors of sexual abuse and 19% of lesbian, gay and bisexual (LGB) women who are eligible for cervical screening have never been to an appointment. This is partly due to the commonly held but false belief that LGB women are not at risk of HPV.

Black, Asian and Minority Ethnic (BAME) women and women with lower incomes are also less likely to attend screening than other women.

The reasons for this include language barriers, religious beliefs and the belief that screening is unnecessary in the absence of symptoms.

There are additional difficulties for women with physical disabilities, visual impairments and those who are living with mental health problems and learning disabilities. These women will likely need additional support and information to encourage them to attend cervical screening. Other groups of women for whom the cervical screening programme fails are those in detention centres, refugees, asylum seekers, prisoners, homeless women and travellers.

Around 80% of women would prefer to have an alternative, non-speculum test in the comfort of their own home.

The move to HPV primary testing should therefore help to increase uptake among many women.

This could be particularly important for those groups who are less represented at screening, giving them the opportunity to take part without needing to attend an appointment. HPV primary screening was introduced in Wales in September 2018 and the test is expected to be available in Scotland, Northern Ireland and England by late 2019/2020.
I was totally unprepared for the menopause. I knew about hot flushes and night sweats but not about muscle and joint pains, brain fog, loss of cognition, vaginal atrophy, suicidal ideation, digestive problems and extreme mood swings. The only medication that works for me is HRT. My symptoms had an enormous impact on my relationships and I nearly lost my job because of my erratic behaviour.

Rachael Edgerton, RCOG Women’s Voices Involvement Panel Member
As the population is ageing, it is of vital importance for the NHS to aim to prevent osteoporosis and consequential fragility fractures.

To help achieve this, women going through the menopause must be informed about the lifestyle choices they can make to help prevent osteoporosis and improve their overall health as they age.

This includes regular weight bearing exercise, good nutrition and calcium and vitamin D supplements, all of which help to maintain bone density. It is crucial to empower women with this knowledge before and during the menopause as the effects of not doing so can be significant. Furthermore, HRT can help to maintain bone density and reduce the risk of osteoporosis for the duration of the treatment, but long-term use is required.

Maintaining healthy bones

Osteoporosis is a major cause of ill-health and death and affects around three million people in the UK. Post-menopausal women are the most common sufferers and it is estimated that women can lose up to 20% of their bone density during the five to seven years after the menopause.

For women with brittle bones, falls can be a major threat to their quality of life, leading to prolonged stays in hospital which are associated with loss of independence, isolation, depression and in the case of a fractured femur significantly increased rates of both general morbidity and mortality.

Falls also have significant economic consequences due to the cost of inpatient care, loss of independence and residential care. Fragility fractures are estimated to cost the UK around £4.4 billion each year. Hip fractures alone account for 69,000 emergency admissions into hospitals in England, adding up to 1.3 million bed days for already overstretched hospitals at an estimated cost of £1.5 billion per year. With preventative methods such as improving bone health, these figures could be significantly reduced.

In addition, more than 500,000 people receive hospital treatment for fragility fractures - a fracture that has been caused by a fall from a standing height or less - annually as a result of osteoporosis.

Around one in three adults over 65 who live at home will have at least one fall a year, and about half of these will have more frequent falls. One in five women who have broken a bone break three or more before being diagnosed with osteoporosis.
Pelvic floor health

Pelvic floor health is another important area where greater preventative care is needed.

The organs within a woman’s pelvis (uterus, bladder and rectum) are normally held in place by ligaments and muscles known as the pelvic floor. These muscles come under strain during pregnancy and childbirth. This can lead to stress incontinence – leaking urine when coughing, sneezing or straining, and faecal incontinence. It can also lead to pelvic organ prolapse, whereby the pelvic organs can bulge (prolapse) from their natural position into the vagina. It is important to note that pelvic floor problems are age related and can therefore affect women who have not been pregnant or given birth.

Pre- and postnatal appointments need to have a stronger emphasis on pelvic floor exercises and information about the importance of a healthy pelvic floor. It should also be discussed at ongoing interactions with the health service, for example, at the NHS Health Check or at cervical screening appointments, regardless of whether a woman has been pregnant or given birth.

Furthermore, at all interactions with the NHS, women should be encouraged to make healthy lifestyle choices that can reduce the risk of getting a prolapse or could stop mild symptoms from getting worse. As the NHS UK website notes, they include maintaining a healthy weight or losing weight, eating a high fibre diet, avoiding lifting heavy objects and stopping smoking.

While prolapse is not considered a life-threatening condition, it causes significant discomfort and distress, decreasing quality of life for many women, and may necessitate surgery.

Urinary and faecal incontinence affects the lives of over five million women in the UK. After pregnancy 33% and 10% of women report urinary and faecal incontinence respectively. Ten years later 20% of all women who have been pregnant continue to suffer a degree of urinary and 3% report faecal incontinence.
Factors contributing to this disparity, which need to be tackled, include:

- **Delays in seeking medical help:** The average delay between the onset of symptoms and arrival at hospital for men is usually significantly lower than for women, who are less well-informed about the signs and symptoms.85

- **Misdiagnosis:** Women are twice as likely to have an initial misdiagnosis than men, which increases their risk of dying by 70%.86

- **Inferior treatment:** Women are 34% less likely than men to receive standard treatments including bypass surgery and stents.87

- **Risk factors for women:** The risk of CVD greatly increases after the menopause when estrogen levels reduce.88 Pre-eclampsia or gestational diabetes can increase the mother’s long-term risk of high blood pressure and diabetes which increases her risk of heart disease.89 In addition, smoking, high blood pressure and Type 2 diabetes increase women’s risk of heart attack significantly more than they do for men.90

- **Poorer aftercare:** Women are 24% less likely to be prescribed statins, which help to prevent another heart attack, and 16% less likely to be given aspirin, which help to prevent blood clots.91

- **Gender bias in medical research:** Women are less likely to be invited to, or participate in, medical trials and research.92 Diagnostic techniques and treatments for cardiovascular diseases have been based upon research conducted predominantly on men meaning that there is a possibility that treatments could be less effective in women than men.93

Caroline Criado Perez, in her book Invisible Women, discusses the gender data gap, which, in a world built on data, has very real consequences for women. The example of cardiovascular disease is only one way that women are disadvantaged by research and data built and modelled primarily around men. This is despite that fact that women make up 51% of the population. It is important that clinical research properly reflects society, and that we begin to reverse the gender gap that currently persists.
Preventing the early onset of dementia

Dementia is a broad term used to describe a range of conditions affecting the brain. There are over 200 subtypes of dementia. The most common are:

- **Alzheimer’s disease:** this is the most common form of dementia accounting for around 60% of diagnoses in the UK.
- **Vascular dementia:** this is the second most common form of dementia in the over 65 age group, accounting for 17% of diagnoses in the UK.
- **Dementia with Lewy bodies:** this accounts for 10-15% of all cases of dementia in the UK.
- **Frontotemporal dementia:** for people under the age of 65, this is the second most commonly diagnosed dementia. It is less common in people over the age of 65.
- **Mixed dementia:** 10% of people with dementia have ‘mixed dementia’ – a condition where a person has more than one type of dementia. The most common is a combination of Alzheimer’s disease and vascular dementia. Mixed dementia is more common in those over 75 years.

Dementia is the leading cause of death for women in the UK. The biggest risk factor for dementia is age. Women are therefore more likely than men to develop dementia in their lifetimes, due to their longer life expectancy. Indeed, 65% of people living with dementia are women.

At the same time, women are more likely to take on the role of caring for someone with dementia. It has been estimated that the number of people with dementia will rise to over one million by 2025, assuming that there are no major new public health interventions.

Although the exact causes of dementia are unclear, research has concluded that exercise, mental stimulation and maintaining a healthy weight may help to protect people from dementia whilst smoking and drinking can increase the risk. It is essential that women are aware of the importance of maintaining healthy lifestyles as a preventative measure against the early onset of debilitating conditions such as dementia. Furthermore, the importance of clinical trials researching women and dementia cannot be underestimated.

### Economic impact of dementia

A report on the economic impact of dementia in the UK, published by the Alzheimer’s Society, found that it costs the NHS an estimated £26 billion a year, with an additional £5.8 billion in social care costs being covered by people living with dementia and their carers.
RCOG recommendations

1. Post-pregnancy contraception should be a key part of the maternity pathway.
   • NHS England, NHS Scotland, NHS Wales and Health and Social Care Northern Ireland must embed immediate post-pregnancy contraception maternity pathways and support for all women. Until 100% implementation has been achieved, clear referral pathways into general practice or sexual and reproductive healthcare clinics should be provided. All midwives and allied health professionals should be trained to provide this important aspect of this holistic maternity pathway and reproductive care.

2. Accessing the full range of contraception methods should be as easy as possible for all women.
   • Missed opportunities and barriers to women accessing contraception, in particular long-acting reversible contraception (LARC), and contraceptive advice and counselling need to be addressed. The RCOG supports Public Health England’s (PHE) planned efforts to increase uptake of LARC in general practice as part of its action plan on women’s reproductive health (due to be published in 2020). Furthermore, we support calls from the Faculty of Sexual and Reproductive Healthcare (FSRH) for funded training courses on contraception and the introduction of incentives to provide LARC in general practice. The inclusion of a LARC indicator within the Primary Care Quality Outcomes Framework (QOF) would act as a significant step in countering the challenges threatening the training of primary care clinicians to deliver LARC.

3. Introduce a life course approach to preventing non-communicable disease in women and their children supported by data collection before, during and after pregnancy.
   • The data collected during pregnancy should be used more effectively to help identify indicators for future health. Data regarding women’s general health and lifestyle habits including whether they smoke, how much they drink, their BMI and mental health concerns should be collected and monitored throughout the pregnancy and beyond. All health data collected should be made accessible for the woman as well as clinicians and should be updated by both parties regularly.
   • Maternity and SRH data can be integrated by the inclusion of outcomes such as the London Measure of Unplanned Pregnancy in the antenatal booking history which can be used to monitor the effectiveness of preconception and family planning services and identify areas for action.
   • The RCOG supports the work of the Maternity Transformation Programme towards interoperable, digitised maternity records, accessible by healthcare professionals and women alike. This programme of digitisation will help realise our ambition for more effective use of data collected during pregnancy, to help identify and prevent the future onset of disease. For example, GPs would be able to access maternity records at the time of the six-week maternal health check and beyond, to enable discussion with women about the potential future impact of any health problems they experienced during pregnancy. Women would be much more aware of their own health risks and therefore better able to manage their own health and raise any concerns with healthcare professionals in the future.

4. UK Governments should take strong action to improve the health of pregnant women and their babies.
   • The introduction of mandatory fortification of all flour and gluten-free products with folic acid would reach women most at risk in our society who have poor poor diet and low socioeconomic status, as well as those women who may not have planned their pregnancy.
5. Improve identification of women at risk from mental and physical health issues at the six week postnatal check.

- The RCOG welcomed the UK Government’s recent focus on perinatal mental health. We must ensure that opportunities are not missed to prevent physical and mental problems in preparation for future pregnancies or to improve women’s health for later life. The RCOG supports the NCT’s Hidden Half campaign that calls for better six week postnatal check-ups that focus on mothers as well as babies. We support the campaign’s ask for improved guidance, tools and education for healthcare professionals in primary care on best practice around maternal mental health. There also needs to be a more joined-up approach to data sharing about known vulnerable patients between primary and secondary care services. All clinicians should be made aware of local support groups for these patients to make redirection as seamless as possible.

6. End violence against girls and women via an improved collaborative approach, better IT systems and mandatory training.

- NHS Trusts and Health Boards must implement mandatory training in gender-based violence. This training should be undertaken every three years and apply to all hospital staff.
- The RCOG encourages NHS Trusts and Health Boards to adopt innovative and sensitive ways to ensure that women can indicate in confidence that they are a victim or at risk of violence and can get support easily. This is particularly important in maternity services, since 30% of domestic violence starts or escalates in pregnancy.
- NHS Digital and NHS Wales Informatics Service should work with clinicians to improve IT systems used to record and submit cases of female genital mutilation (FGM) in England and Wales. It must be as easy as possible for healthcare professionals to use, so that all cases and girls at risk are documented and safeguarded. Mandatory reporting of FGM must extend to Northern Ireland and Scotland’s Female Genital Mutilation (Protection and Guidance) Bill (introduced in May 2019) must be revised to include mandatory reporting of FGM to the police as is the case in England and Wales.

7. Increase uptake in cervical screening amongst disadvantaged and marginalised women.

- Every person with a cervix needs to be screened. Health care professionals should use every opportunity to encourage women to undergo cervical screening and reassure them about the benefits of screening and the realities of the procedure. In turn, this will help to increase rates of attendance.
- PHE, Health Protection Scotland, Public Health Wales and the Public Health Agency (Northern Ireland) must improve the uptake of cervical screening among LGBTQ+ people. This could include raising awareness around the causes of cervical cancer.
- Human papillomavirus (HPV) primary home-test screening should be implemented by the respective UK Government administrations without delay.
8. **Improve early diagnosis of gynaecological cancers.**
   - The UK Government must fund an ongoing ovarian cancer audit to continue to build understanding and substantially improve survival rates. Healthcare Quality Improvement Partnership (HQIP) could lead this UK-wide project, building on the expertise and knowledge of the Ovarian Cancer Audit Feasibility Pilot.
   - Public Health England, and respective devolved nation bodies, should create a Taskforce to consider ways of raising awareness of urinary and faecal incontinence and prolapse in women, and improving signposting to resources, self-help information and treatment pathways which alleviate these conditions.

9. **Women’s health issues should be embedded in workplace policies.**
   - The challenges of common debilitating women’s health issues – heavy menstrual bleeding, pelvic pain due to fibroids or endometriosis and the menopause – should be recognised in workplace policy and processes.
   - For example, the UK Government administrations should introduce a requirement for mandatory menopause workplace policies to help keep women in work and to break the stigma associated with menopause. These policies should detail the reasonable measures that should be available for women experiencing symptoms, including flexible working patterns and workplace adjustments to make the physical office environment more comfortable. HR departments should offer training and support to line managers. All workplaces should have guidance about the menopause readily available if women request it – the signs and symptoms, self-help advice, and where to seek professional help. As one of the world’s largest employers, the NHS should create robust policies and set an example for all employers to follow.
   - There have already been several cases where women have been successful at employment tribunals related to the menopause, arguing discrimination under the Equality Act 2010. By implementing comprehensive menopause policies employers can both enhance the working lives of women and reduce their risk of legal challenges.
   - Once menopause policies have been put in place, employers should develop policies covering other women’s health issues, such as heavy menstrual bleeding and PMDD. This will further help to break down the stigmas associated with women’s health and provide extra support for women in the workplace.

10. **Increase awareness of pelvic floor dysfunction.**
    - Public Health England, and respective devolved nation bodies, should create a Taskforce to consider ways of raising awareness of urinary and faecal incontinence and prolapse in women, and improving signposting to resources, self-help information and treatment pathways which alleviate these conditions.

11. **End the data gender gap.**
    - 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.
References

1. PHE, Health matters: reproductive health and pregnancy planning (June 2018)
2. Ibid.
4. N. Kozuki et al., Exploring the association between short/long preceding birth intervals and child mortality (2013)
5. NICE, Long-acting reversible contraception guidance (updated 2019)
6. J. L. Glind et al., The contraceptive revolution: focused efforts are still needed (2013)
8. NHSI, Implementing the maternity & neonatal commitments of the NHS Long Term Plan (2019) and Scottish Government, Alcohol minimum unit price to go ahead (April 2017)
13. RCOG, Care of Women with Obesity in Pregnancy (Green-top Guideline No. 72) (2018)
14. Tomlin’s, Obesity and mental health in pregnancy and B. DiBaz et al., Impact of obesity on infertility in women (2015)
15. RCOG, RCOG response to new study into folic acid fortification (2018)
17. Tomlin’s, Pre-eclampsia statistics
19. Diabetes Co UK, Diabetes and Obesity
20. NCT, Gestational diabetes
22. G. Yang et al., The effects of obesity on venous thromboembolism (2012), BHF, Obesity and BMI: Adiposity and cancer at major anatomical sites: umbrella review of the literature (2017)
23. Gestational Diabetes UK, Preventing Type 2 diabetes after gestational diabetes (2016)
25. University of Oxford, Many mental illnesses reduce life expectancy more than heavy smoking (2014)
26. MIND, Postnatal depression and perinatal mental health
27. NCT, Hidden Half campaign (2017)
28. Ibid.
29. ONS, Intimate personal violence and partner abuse (2016)
31. Refuge, The Facts
32. MBRRACE, Saving Lives, Improving Mothers’ Care (2018)
33. Ibid.
34. GOV.UK, Domestic Abuse Bill
37. NHS, NHS ramps up support for survivors of female genital mutilation (FGM) (2019)
38. GOV.UK, FGM: mandatory reporting in healthcare (2015) - Section 5B of the Female Genital Mutilation Act 2003 (as inserted by section 74 of the Serious Crime Act 2015)
39. The Eve Appeal, Our Research
40. Cancer Research UK, Ovarian cancer mortality statistics
41. Swedish Institute for Health Economics, Measuring the Efficiency of Cancer Care in Europe (2018)
42. The Eve Appeal, Womb Cancer
43. Cancer Research UK, Uterine cancer incidence statistics
44. Cancer Research UK, Uterine cancer incidence statistics
47. Cancer Research UK, Vulva cancer statistics
48. The Eve Appeal
49. Y. Feng, The association between obesity and gynecological cancer (2015)
50. GOV.UK, Domestic Abuse Bill
Visit

rcog.org.uk/better-for-women

to read the full report

Join the conversation #BetterForWomen

@RCObsGyn  @rcobsgyn  @RCObsGyn