Royal College of Obstetricians & Gynaecologists

Women's Health Research Priorities (WHRP)

A UK-based consensus to identify the priorities for research that matter most to women

December 2025

Contents:

Contributors

Dr Thomas Hanton

RCOG Clinical Fellow, Education and Quality

Dr Kelsey Lennox

RCOG Clinical Fellow, Education and Quality

Dr Fran Carroll

RCOG Head of Research Partnerships, Clinical Quality

Professor John Allotey

University of Liverpool

Dr Wessel Ganzevoort

Amsterdam University Medical Center

Professor Sanne Gordijn

University Medical Center Groningen

Professor Asma Khalil

RCOG Vice President, Academia and Strategy

Foreword

The RCOG's mission is to improve the health of women and girls across the globe. A core part of this mission is shaping the future of obstetrics and gynaecology through excellence and innovation. We are committed to driving progress in women's health by connecting emerging research, NHS priorities, technological advances and clinical expertise - and ensuring that research reflects the issues that matter most to women themselves.

Women make up 51% of the UK population, yet women's health has long been under-researched and overlooked. Persistent gaps in evidence have affected the prevention, diagnosis and treatment of conditions specific to women. Too often, research agendas have been set without the voices or experiences of women and people with lived experience. The result has been delayed diagnostic tools and treatments, inequitable access to care, limited innovation and poorer outcomes.

There has never been a more urgent need to renew focus on women's health research. We are proud to share the publication of the Women's Health Research Priorities report which identifies the top ten priorities for women's health research in the UK.

This work was shaped through engagement with more than 2,000 women, people with lived experience, and healthcare professionals. We want to thank every person who contributed - your insights and experiences have been central to defining these priorities.

The findings highlight the need for research that includes women, recognises the impact of hormones across the lifespan, and addresses long-term outcomes. These priorities will help drive progress in developing new treatments for conditions such as endometriosis, and breast and gynaecological cancers.

Research and innovation are essential to sustainable progress across the NHS, yet they often struggle for attention in a system under pressure from long waiting lists and financial constraints. It is encouraging to see growing momentum in women's health research, with increasing investment in women's health hubs and reproductive health programmes. Our top 24 and top 10 priorities provide a clear direction for funders and researchers, and an opportunity to translate priorities into real-world impact.

Delivering this impact will require support for clinical academics, embedding research into clinical practice and ensuring protected time for NHS doctors to lead research and education.

With major strategic developments underway - including the 10 Year Health Plan and the refreshed Women's Health Strategy in 2026 - we urge the Government to embed these priorities into future plans, and to ensure research translates into improved health outcomes for women across the UK.

We hope this work acts as a catalyst for collaboration, innovation and lasting change in how we approach women's health research.

Ranee Thakar MD PRCOG

President, RCOG

Asma Khalil, FRCOG

Vice President for Academia and Strategy, RCOG

Executive summary

Women's health research has historically been underfunded and underrepresented, with significant gaps affecting the prevention, diagnosis and treatment of conditions specific to women. Many areas of women's health remain under researched, and the voices of women and people with lived experience have often been overlooked when setting research agendas. This imbalance has led to delays in developing diagnostic tools and treatments, inequitable access to care, poor patient satisfaction and limited innovation.

The Women's Health Research Priorities (WHRP) project was developed by the Royal College of Obstetricians & Gynaecologists (RCOG) to identify the most pressing unanswered research questions in women's health. The project aimed to create a research agenda that reflects the real-world priorities of patients, healthcare professionals and wider society, thereby guiding research funders, policy makers and clinicians toward areas of greatest need and potential impact.

Methodology

Using a modified Delphi process adapted from the James Lind Alliance (JLA) Priority Setting Partnership (PSP) methodology, the WHRP project involved three online survey rounds and one online consensus workshop. Over 2,000 unique participants contributed across the surveys, with 39 participants attending the final workshop. The process began with 1,441 participants proposing 4,298 questions and topics, which were refined through inductive thematic analysis into 35 themes. In the second round, 931 participants prioritised these themes, narrowing them down to 14 overarching themes. In the third round, 601 participants prioritised 161 questions, identifying 49 that were taken forward to the workshop. The workshop participants then narrowed these to a Top 24, and ultimately, a Top 10 list of research priorities.

Key findings

The Top 10 research priorities emphasise structural and systemic issues alongside clinical conditions. The Top 24 priorities cover 12 themes, and include questions that span the life course and reflect the multidimensional nature of women's health, including questions about stillbirth, preterm birth, hypertension and diabetes in pregnancy, postnatal care, pelvic floor health and systemic inequalities in healthcare.

For research funders	For policy makers	For researchers
• We recommend creating dedicated funding calls to address these priorities, similar to existing calls for JLA PSPs.	• These priorities provide a timely framework for the refreshed Women's Health Strategy for England, and should inform NHS England service development.	• We advocate designing studies that answer these prioritised questions while building in equity-sensitive analyses, co-production approaches and strategies to reach underserved groups.

Conclusion

This project establishes a comprehensive research agenda for women's health that is directly informed by those who use and provide women's health services. The priorities align with RCOG commitments to evidence-based care, equity and outcomes that matter to service users. They support the UK Women's Health Strategy's life-course approach and complement ongoing work on perinatal safety, gynaecology access, menopause services and research capacity. By addressing these questions, we can advance women's health research and improve outcomes for women throughout their lives.

Key messages

- **Partnership-driven priorities:** Over 2,000 people – including women with lived experience, healthcare professionals and members of the public – participated in identifying the key research priorities for women's health in the UK.
- **Systemic change required:** Many priorities focus not just on specific medical conditions, but also on fundamental changes to how research is conducted and how care is delivered, including better representation of women in clinical trials and addressing widespread dissatisfaction with obstetric and gynaecological services.
- **Life-course approach:** The priorities span the entire reproductive lifespan, from menstrual health and fertility through pregnancy and childbirth to menopause, reflecting the need for sustained attention to women's health at every stage.
- **Long-term health matters:** Participants prioritised understanding and improving the long-term physical and mental health impacts of pregnancy and childbirth, shifting focus beyond the traditional 6-week postnatal period.
- **Call to action:** These priorities should guide research commissioning, programme design and policy development, to ensure investment targets what matters most to women and addresses persistent inequities in women's health research and care.

"Women who are socio-economically disadvantaged, from ethnic minorities, or living in more deprived areas have worse outcomes and less access in many cases.

These overlap with research gaps too: less evidence on how conditions present in women from different ethnic backgrounds. Sadly, funding is limited, services are under pressure, and researchers may prioritise what is fundable rather than what is most urgent."

Workshop participant

Created in BioRender. Lennox, K. (2025) https://BioRender.com/awv3a5g

Figure 1 – 2025 UK Top 10 women's health research priorities

List of abbreviations

NIHR	National Institute for Health and Care Research
JLA	James Lind Alliance
PSP	Priority Setting Partnership
RCOG	Royal College of Obstetricians & Gynaecologists
WHRP	Women's Health Research Priorities

Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

Introduction

A long history of lack of funding and representation in women's health research has resulted in significant gaps in knowledge that have affected all aspects of care for conditions specific to women. There is a large disparity in research for gynaecology, obstetrics and reproductive health compared with other fields, and research agendas have often not considered the voices of women and people with lived experience. This imbalance has contributed to delays in formulating diagnostic, monitoring and management strategies, as well as inequitable access to care, poor patient satisfaction and limited innovation in treatments. Recent national and international reports have highlighted the urgent need to address these disparities and ensure that women's health receives an equitable strategic focus and investment, as with other areas of medicine.

The Royal College of Obstetricians & Gynaecologists (RCOG) developed the Women's Health Research Priorities (WHRP) project to help shape a research agenda that reflects the real-world priorities of the RCOG workforce and the women, birthing people and families that they serve. It is essential to identify the most pressing unanswered research questions in women's health, so that researchers, funders, policy makers and clinicians can focus their resources on the areas of greatest need and potential impact. By combining clinical expertise, lived experience and insights from advocacy groups, the WHRP project aims to deliver a list of prioritised questions that will inform future funding calls, research programmes and policy.

To achieve this, the WHRP project adopted a modified Delphi process, adapted from the James Lind Alliance (JLA) Priority Setting Partnership (PSP) method. The JLA methodology encourages structured collaborations that bring together patients, carers and healthcare professionals to identify and prioritise unanswered research questions.[1] This was then modified to reflect the broad scope of women's health and scale of responses expected. The

design included multiple survey rounds and a final consensus workshop, enabling iterative refinement of participant input into a prioritised set of research questions. This multi-round process provided a transparent and inclusive way to capture a broad range of perspectives, while progressively narrowing the focus to areas of greatest shared importance.

The WHRP project also aligns with the wider national and international efforts to improve women's health, including the UK Government's Women's Health Strategy for England (2022), which emphasises the need to close the gender health gap. By generating a research agenda directly informed by patients and professionals, the WHRP project provides a practical mechanism for delivering on these policy commitments. The prioritised questions will offer funders and policy makers a clear roadmap to target investment in areas most likely to improve outcomes and equity in women's health.

Existing priority setting partnerships in women's health

A search of PSPs relevant to women's health, performed in conjunction with a JLA advisor using the JLA methodology, identified 22 completed and six ongoing PSP exercises.

Table 1 – Completed JLA PSPs

Completed PSPs	Publication year of Top 10 priorities	Link
Urinary incontinence	2008	https://www.jla.nihr.ac.uk/priority-setting-partnerships/urinary-incontinence
Preterm birth	2014	https://www.jla.nihr.ac.uk/priority-setting-partnerships/preterm-birth
Stillbirth	2015	https://www.jla.nihr.ac.uk/priority-setting-partnerships/stillbirth
Womb cancer	2016	https://www.jla.nihr.ac.uk/priority-setting-partnerships/womb-cancer
Contraception	2017	https://www.jla.nihr.ac.uk/priority-setting-partnerships/contraception
Endometriosis	2017	https://www.jla.nihr.ac.uk/priority-setting-partnerships/endometriosis
Miscarriage	2017	https://www.jla.nihr.ac.uk/priority-setting-partnerships/miscarriage
Pessary use for prolapse	2017	https://www.jla.nihr.ac.uk/priority-setting-partnerships/pessaries-for-pelvic-organ-prolapse
Metastatic breast cancer (Canada)	2018	https://www.jla.nihr.ac.uk/priority-setting-partnerships/metastatic-breast-cancer-canada

Lichen sclerosus	2018	https://www.jla.nihr.ac.uk/priority-setting-partnerships/lichen-sclerosus
Hyperemesis gravidarum	2019	https://www.jla.nihr.ac.uk/priority-setting-partnerships/hyperemesis-gravidarum
Blood pressure in pregnancy	2020	https://www.jla.nihr.ac.uk/priority-setting-partnerships/hypertension-in-pregnancy
Diabetes and pregnancy	2020	https://www.jla.nihr.ac.uk/priority-setting-partnerships/diabetes-and-pregnancy
Post-mastectomy breast reconstruction (Canada)	2021	https://www.jla.nihr.ac.uk/priority-setting-partnerships/post-mastectomy-breast-reconstruction
Breast cancer surgery	2022	https://www.jla.nihr.ac.uk/priority-setting-partnerships/breast-cancer-surgery
Sexual violence	2022	https://www.jla.nihr.ac.uk/priority-setting-partnerships/sexual-violence
Menopause	2024	https://www.jla.nihr.ac.uk/priority-setting-partnerships/menopause
Midwifery practice and maternity care	2025	https://www.jla.nihr.ac.uk/priority-setting-partnerships/midwifery-practice-and-maternity-care
Pregnancy and childbirth (Uganda)	2025	https://www.jla.nihr.ac.uk/priority-setting-partnerships/pregnancy-and-childbirth-uganda
Polycystic ovary syndrome	2025	https://www.jla.nihr.ac.uk/priority-setting-partnerships/polycystic-ovary-syndrome
Premature babies born <25 weeks' gestation	2025	https://www.jla.nihr.ac.uk/priority-setting-partnerships/the-most-premature-babies
Women's cardiovascular health and cardiac rehab (Canada)	2025	https://www.jla.nihr.ac.uk/priority-setting-partnerships/womens-cardiovascular-health-and-cardiac-rehabilitation-canada

Table 2 – Ongoing JLA PSPs

Ongoing PSPs	Status (as of November 2025)	Link
Stillbirth refresh	Ongoing (initial question generation survey not yet open)	https://www.jla.nihr.ac.uk/priority-setting-partnerships/stillbirth-refresh
Perinatal mental health	Ongoing (initial question generation survey not yet open)	https://www.jla.nihr.ac.uk/priority-setting-partnerships/perinatal-mental-health

Women's genital prolapse and incontinence (Ethiopia)	Ongoing (initial question generation survey not yet open)	https://www.jla.nihr.ac.uk/priority-setting-partnerships/womens-genital-prolapse-and-incontinence-gondar-ethiopia
Female fertility preservation	Ongoing (initial question generation survey open)	https://www.jla.nihr.ac.uk/node/32861
LGBTQ+ perinatal care	Ongoing (initial question generation survey closed)	https://www.jla.nihr.ac.uk/priority-setting-partnerships/lgbtqia-perinatal-care
Problematic menstrual bleeding	Ongoing (prioritisation survey open)	https://www.jla.nihr.ac.uk/priority-setting-partnerships/problematic-menstrual-bleeding

The completed PSPs have generated high-quality priority lists that have already influenced research funding. The National Institute for Health and Care Research (NIHR) has specific funding calls for research that will address JLA PSPs.[2] These 28 JLA PSPs are focused on single conditions or specific aspects of reproductive health. It is unclear what strategy the JLA uses to identify topics to focus their PSPs on, and there are some topics that are not covered by existing JLA PSPs, such as postnatal physical health, induction of labour, chronic pelvic pain and fetal monitoring. Alongside identifying key research priorities across women's health, the broad scope of the WHRP project may allow it to identify topics for more specific PSPs, to be carried out using JLA or modified JLA methodology. The WHRP project aims to complement existing PSPs by allowing condition-specific insights to sit within a broader context. This will help provide insights into the systemic issues and societal challenges within women's health research, which may not be addressed by conventional PSPs. The project seeks to determine what women actually want researched across all of women's health, which will allow funders and policy makers to view individual PSPs within the broader women's health field.

Methods

Overview

This UK-based modified Delphi process comprised three online survey rounds and one online workshop, with analysis in-between rounds. As this process aims to prioritise research topics and questions, the methodology was based on the JLA method. The initial project design included two online surveys followed by a consensus workshop. However, given the very large number of items resulting from the first survey, the methodology was adapted, following consultation with the WHRP Steering Group, to add a topic prioritisation round before question prioritisation. This ensured that the large volume of questions could be systematically narrowed down while still allowing for broad engagement and participant input at each stage.

The three online survey rounds included:

Round 1: Topic and question generation	**Round 2**: Topic prioritisation	**Round 3**: Question prioritisation

Table 3 – WHRP project stages

Project stage	Date range	Activities
Project initiation	November 2024 – January 2025	Project start; Steering Group meeting 1 (online, 16 January); project web/content setup; key message development.
Round 1 and analysis	February – April 2025	Survey design and review (early February); launch 10 February; external communications and follow-up through February/March; survey close 26 March; Steering Group meeting 2 (online, 2 April); round 1 analysis (April).
Round 2 and analysis	May – August 2025	Survey design and review (early May); Steering Group meeting 3 (online, 29 May); launch 6 June; external communications and follow-up through June/July; survey close 31 July; round 2 analysis (August).
Round 3 and analysis	September – October 2025	Survey design and review (September); launch 26 September; external communications and follow-up through late September/October; survey close 10 October; Steering Group meeting 4 (online, 25 September); round 3 analysis (October).
Workshop and analysis	October – November 2025	Workshop planning and design (mid-October); online workshop 23 October; workshop analysis (late October/early November).
Wrap-up	November 2025	Final analysis, drafting of WHRP report and academic papers (November).

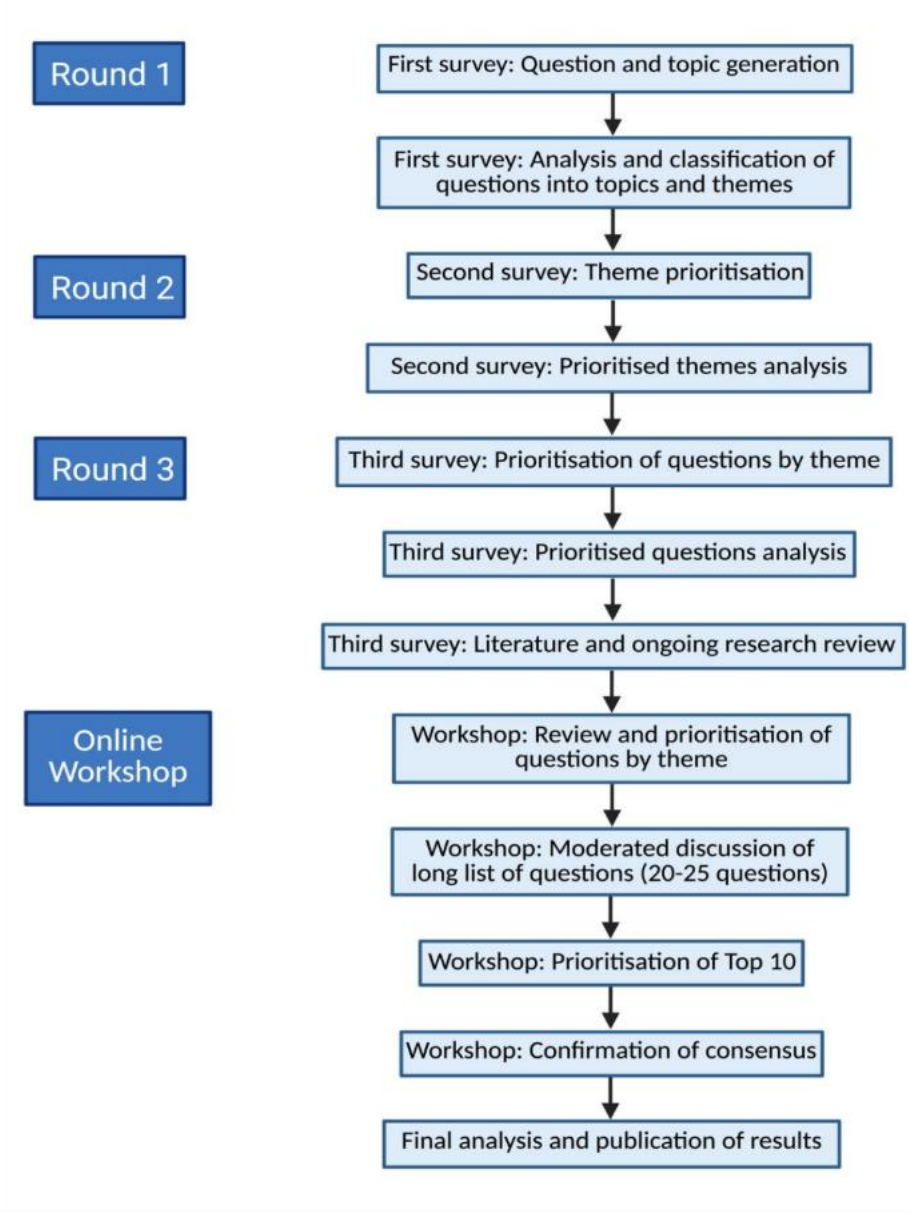


Figure 2 – WHRP project workflow

Survey development

Surveys were conducted with Dotdigital, an online survey tool. Surveys included collection of participant demographic data as well as the specified tasks within the survey. This included age, sex, gender identity, sexual orientation, ethnicity, geographical region, disability, professional background and lived experience. The content and format of each online survey were reviewed by our Patient and Public Involvement and Engagement Team before launch. Participants were given the option to contact the project team if they had any queries about the surveys or process.

Ethics and governance

Potential survey participants viewed an information page describing the study purpose, what participation involved, data usage and contacts for queries or complaints. Proceeding to the survey constituted informed consent. Participation was voluntary; respondents could exit at any time before submission. Workshop participants volunteered during earlier survey rounds and confirmed by email whether they wished to participate in the workshop.

Data were collected with direct identifiers (email addresses) and de-identified for all analyses. Any optional contact details (e.g. email for follow-up) were stored separately from responses. Outputs are reported in aggregate, to prevent re-identification. Access to raw data is restricted to the study team under role-based permissions on secure institutional servers, with audit trails and routine backups. Data handling complies with UK General Data Protection Regulation legislation and institutional data protection policies.

The protocol, participant materials and data protection measures were reviewed and approved by the RCOG, and underwent a Data Protection Impact Assessment (DPIA reference 212).

Project teams and oversight

Our methodology was led by a core project team that included experts in methodology and Delphi consensus procedures, and was overseen by a wider steering group with experts across the field of women's health and women and people with lived experience. The core project team met weekly throughout this process to discuss methodology, engagement, diversity, data analysis and survey design. This process involved an evolving, iterative methodology, as prioritisation exercises with this magnitude of scope are novel and complex.

Steering Group

The WHRP project was overseen by the WHRP Steering Group, chaired by Professor Asma Khalil, RCOG Vice President of Academia and Strategy. Members represented experts in women's health research or clinical practice, or had lived experience. Professionals included obstetricians, gynaecologists, midwives, nurses, sonographers, primary care clinicians, psychologists and allied health professionals (Appendix 1). Members with lived experience brought experience of a range of health conditions and backgrounds, including people from ethnically minoritised communities and those with direct experience of barriers to equitable care. The Steering Group also included representatives from women's health charities and action groups, ensuring that the perspectives of advocacy organisations and community-led initiatives were embedded in the process.

Round 1: Question and topic generation

The first online survey invited participants to propose up to five topics or research questions in women's health. Responses were collected in long-answer text boxes, allowing participants to describe their priorities in their own words. The survey was widely disseminated through newsletters, social media and online publications; an open survey link

through RCOG networks and partner organisations; and Healthwatch teams across the country. This ensured that the survey reached clinicians, researchers, people with lived experience and members of the public. The round 1 survey was open for over 6 weeks, from 10 February to 26 March 2025.

Round 1: Data analysis

The raw responses were reviewed, cleaned and collated using an inductive thematic analysis process. Proposed questions and topics were initially grouped into broad topic headings. Once sorted into these broad topics, questions were subcategorised into themes within the broader topics. A structured codebook was created in this analysis with each of these topics and themes induced from the proposed questions. Julius-AI was used to help sort the questions into each topic and theme.[3] Each question and topic was then checked manually to ensure these had been correctly classified, and misclassified questions and topics were manually re-classified according to the structured codebook.

The proposed questions and topics within themes were then analysed by members of the research team. Duplicates were removed, similar questions merged and questions not relating to women's health were removed. Some of the questions were edited to standardise phrasing where necessary.

Round 2: Prioritisation of themes

The second survey invited participants to refine the themes identified in the round 1 analysis. Participants were presented with the broad topic headings and, within these, the themes. Participants were asked to rank each theme by using a five-point Likert scale with an 'unable to comment' option. Free-text fields captured up to three additional topics/themes not listed. The round 2 survey was open for 8 weeks, from 6 June to 31 July 2025.

The survey was open to new participants (disseminated across similar channels as in round 1) and sent to all previous round 1 participants who had consented to be contacted about future survey rounds and provided a valid email address.

Round 2: Data analysis

Round 2 responses were analysed by calculating the median score for all themes. Before the launch of round 2, prioritised themes were predetermined to be those that had scored above a cut-off of >4 (median score of 5). The mean score for each theme was also calculated to order these themes by the priority determined by the round 2 participants. Some of these themes were consolidated to produce a list of prioritised overarching themes.

The free-text field suggestions of topics/themes were analysed and checked against the structured codebook to see whether they already fell under another theme. If not, these were included in the next round if five or more participants suggested the same additional theme.

Relevant PSPs: Analysis

Relevant PSPs in women's health from the JLA PSP list were assessed, and those that matched or had overlap with the prioritised overarching themes were reviewed. The questions within these PSPs were reviewed individually, and questions that were different from the round 1 questions were added to the list of questions under each overarching theme.

Round 3: Question prioritisation

The third survey invited participants to prioritise questions within the overarching themes from round 2. The questions within the prioritised themes were both those from round 1 and those identified from the search of relevant PSPs. Participants were presented with the list of overarching themes and the number of questions within each theme. Each participant was asked to select up to three themes and vote on whether a question should be prioritised (yes/no). If ≥80% of participants selected 'yes', this question was prioritised. Free-text fields captured up to three additional questions not listed. The round 3 survey was open for 2 weeks, from 26 September to 10 October 2025.

The survey was open to new participants and disseminated across similar channels as in rounds 1 and 2, and was also sent to all previous round participants who had consented to be recontacted and provided a valid email address.

Round 3: Data analysis

From the list of prioritised questions, the research team removed questions that had already been answered in high-quality research (e.g. systematic reviews and meta-analyses, large randomised controlled trials) or had registered studies designed to answer these questions.

The free-text field suggestions of additional questions were analysed and sorted by theme. These were added to prioritised questions if five or more participants suggested a similar additional question that was not already included. This restricted mechanism allowed admission of unprioritised round 3 free-text suggestions where the group identified a genuine blind spot. This list of round 3 outputs formed a shortlist of unanswered priorities for the final workshop.

Workshop

A total of 70 participants who had participated in any of the previous rounds and expressed interest in participating in the online workshop were invited to the workshop, resulting in 40–50 workshop participants. The Steering Group were invited to attend and observe, but not participate, in the workshop. We sought diversity in the participants that were invited to the workshop, and documented the sociodemographic characteristics of attendees (e.g. sex/gender, ethnicity, professional background) and their declared topic interests, to enable us to contextualise results and acknowledge any limitations (e.g. potential under- or overrepresentation of specific groups). The workshop took place on 23 October 2025.

The 2-hour online workshop in Microsoft Teams (Version 25255.703.3981.5698) was carefully planned and tested for functionality of the approach. The Chair (Professor Asma Khalil) followed a pre-written script throughout the process. House rules were presented, including keeping microphones on mute and holding discussion in the Microsoft Teams chat to reduce distraction and ensure participants felt empowered to raise points in discussions. Participants were asked to keep their cameras on to maximise engagement, and to stay for the entire session to reduce participant attrition. Participants were asked not to share results of the workshop until formal publication.

The online workshop employed a modified nominal group technique to narrow down questions. This involves several stages, including participants individually selecting questions, discussing and then further prioritisation. We used the Slido survey tool to enable quick prioritisation, and real-time, in-workshop analysis and presentation. In our workshop, participants initially selected two questions to prioritise within each theme. The top two (or more if ranked equally, or fewer if only one question had been prioritised within the theme from round 3) were selected to create a long list of questions. Before conducting the workshop, we expected this to be around 20–25 questions.

The long list of prioritised themes was presented to participants, and they participated in a 20–25 min moderated discussion. This was done via the Microsoft Teams chat, to ensure that participants had equal opportunity to raise discussion points. The Chair read out comments to highlight these to participants and engaged in conversation regarding topic prioritisation and current evidence.

Following the moderated discussion, participants were then asked to select ten questions they thought should appear in the ‘Top 10’ from the long list of questions. Each of the questions selected by a participant to appear in their personal top 10 carried equal weighting to one another when amalgamated into an overall group Top 10. The Top 10 was ratified by consensus if >70% of workshop participants accepted the results.

Results and analysis

Overview of results

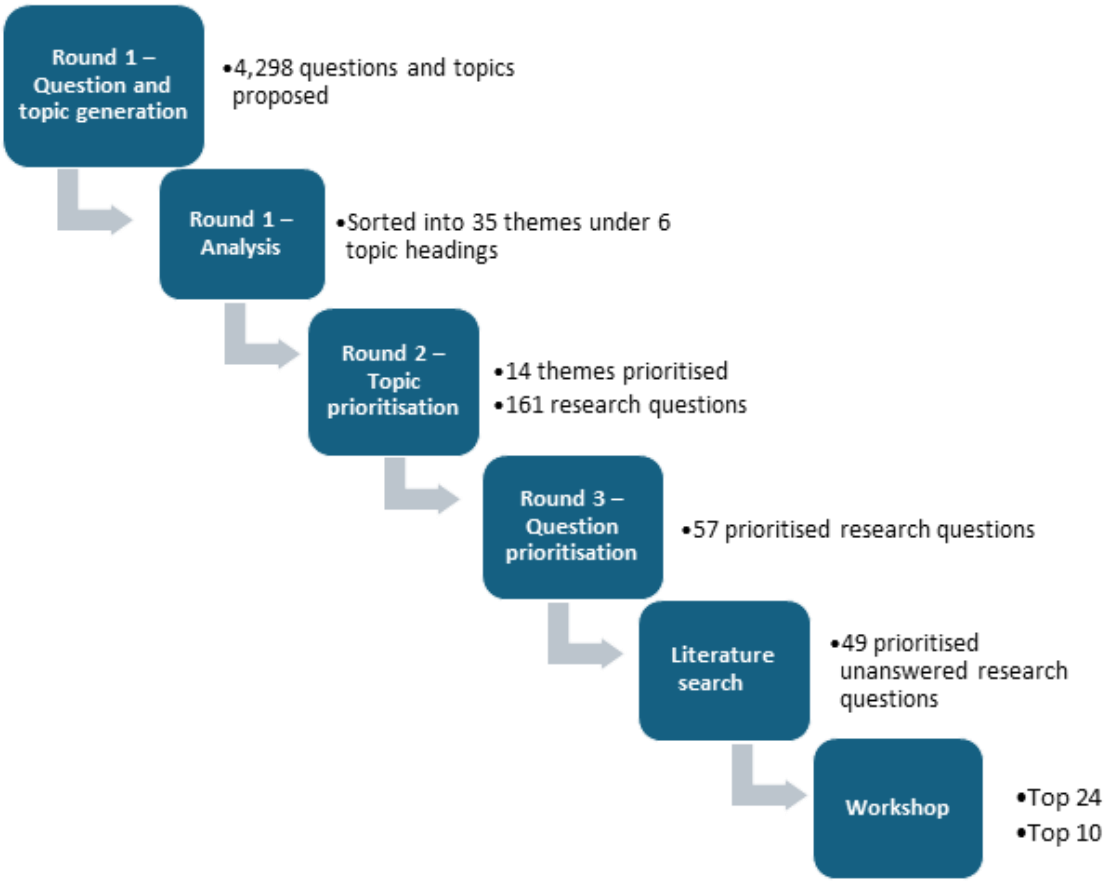


Figure 3 – Overview of project

Initially, 4,298 questions and topics were proposed by 1,441 survey participants. After sorting into themes and topics, and removing duplicates and similar questions, 190 proposed questions remained. In the second round, 931 survey participants (585 round 1 participants and 346 new participants) prioritised the 35 themes to 14 overarching themes. When proposed questions from round 1 and questions from other relevant PSPs were combined, these 14 overarching themes contained 161 questions. A total of 601 survey participants (235 round 1 or 2 participants and 366 new participants) prioritised 57 research questions with a mean score of ≥80%. The literature search identified eight questions with high-quality evidence or ongoing studies designed to answer these questions, which were then removed.

The 49 research questions identified following round 3 were taken to an online workshop. This was attended by 39 participants who narrowed the 49 research questions down to a 'Top 24' by topic. Following a moderated discussion, these participants took a final vote on a Top 10 list of women's health research priorities. The Top 10 was ratified by consensus of the workshop participants (72%).

Demographics of survey and workshop participants

The overall participant profile broadly reflected the demographic spread of the UK population, with representation across major ethnic groups and regions, and no single constituency dominating. Summary counts and percentages for each characteristic, alongside response denominators, are presented in the figures below. To protect confidentiality, small numbers are banded or suppressed in line with standard reporting guidance.

Round 1 survey (1,441 participants)

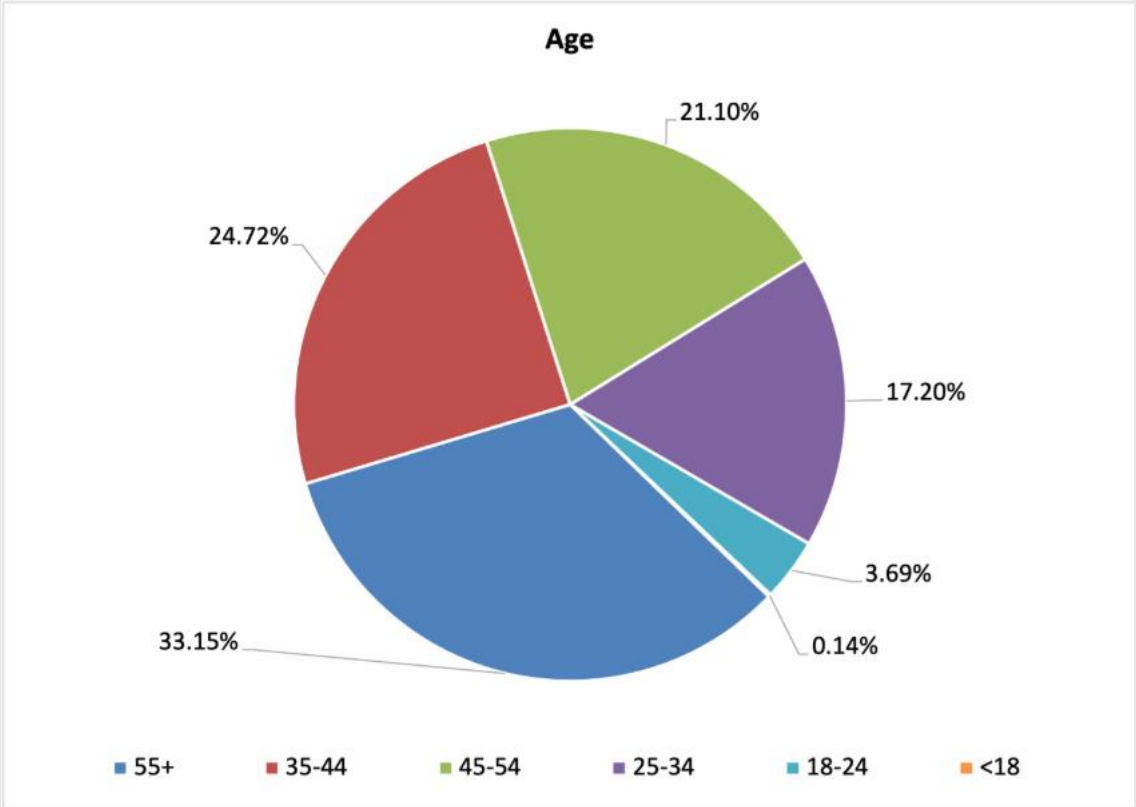


Figure 4 – Age of round 1 participants

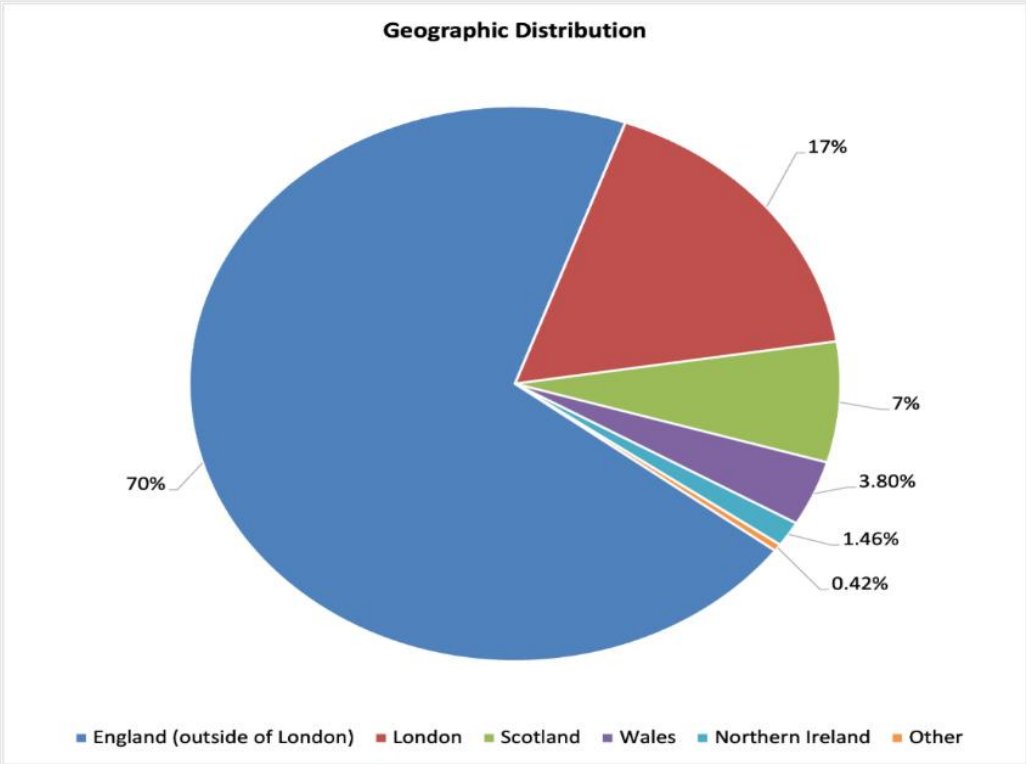


Figure 5 – Geographic distribution of round 1 participants

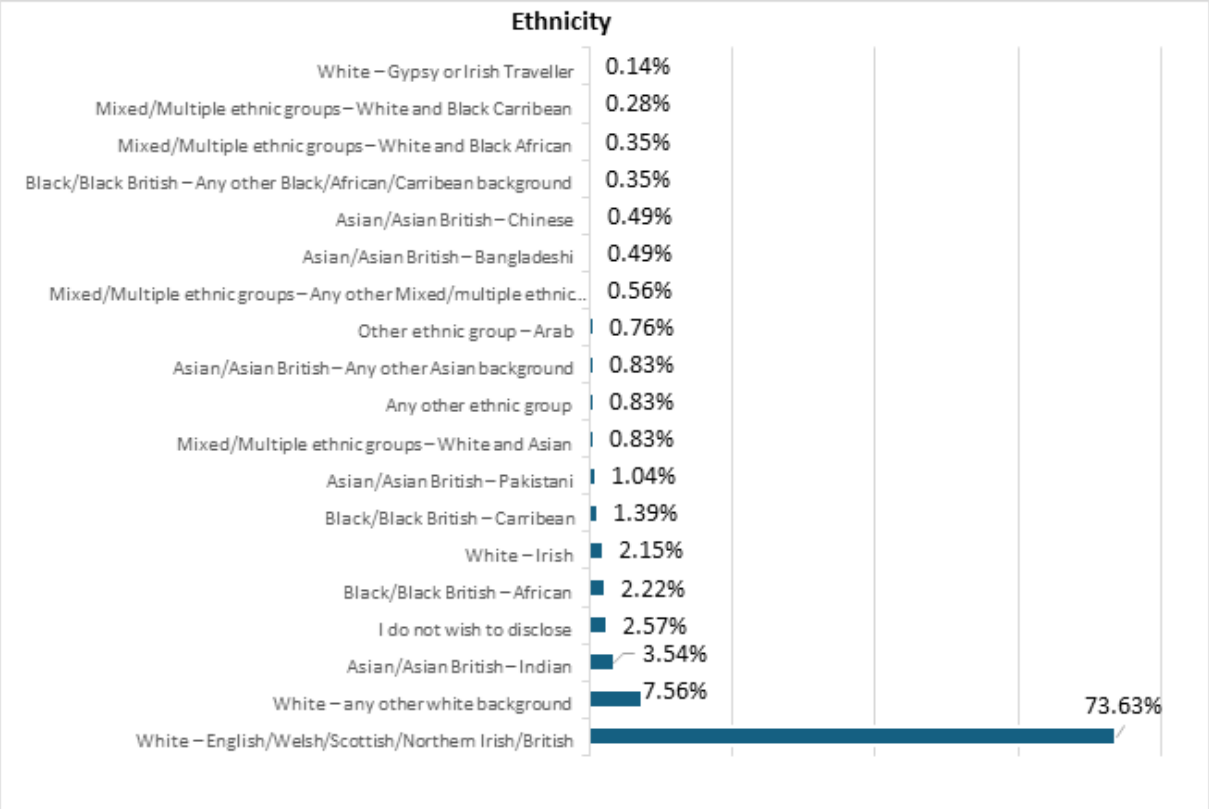


Figure 6 – Ethnicity of round 1 participants

Round 2 survey (931 participants)

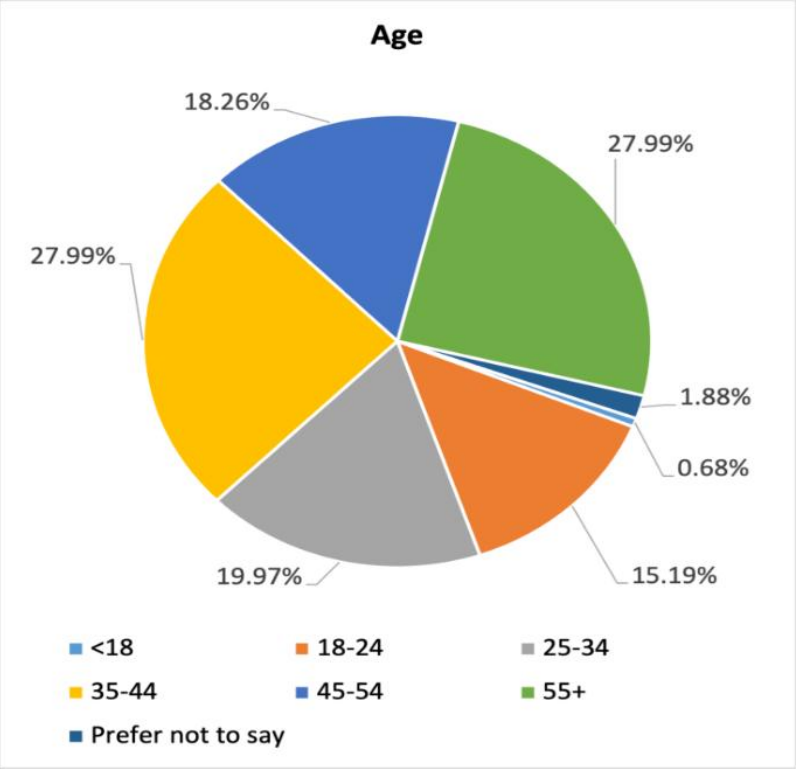


Figure 7 – Age of round 2 participants

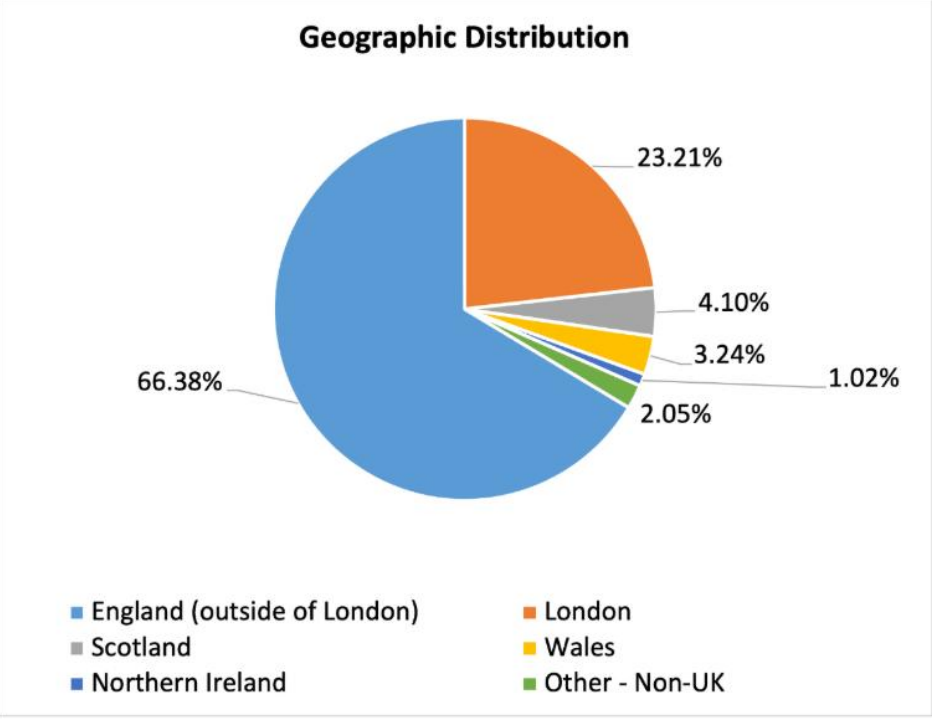


Figure 8 – Geographic distribution of round 2 participants

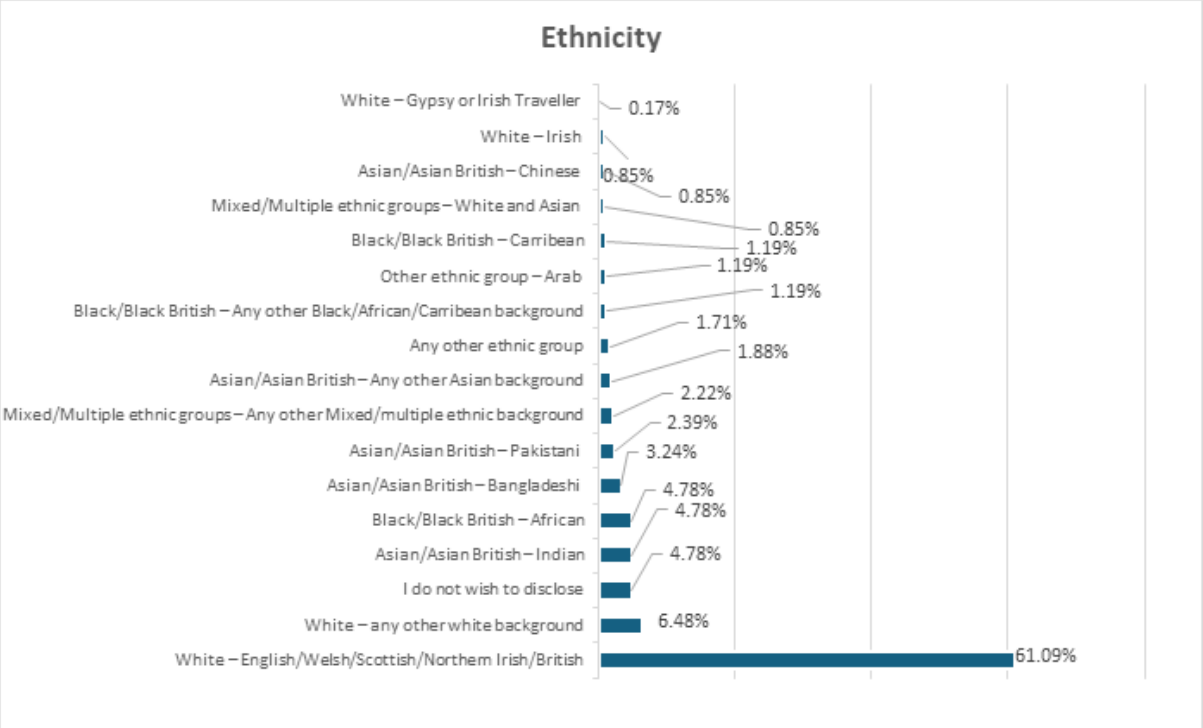


Figure 9 – Ethnicity of round 2 participants

Round 3 survey (601 participants)

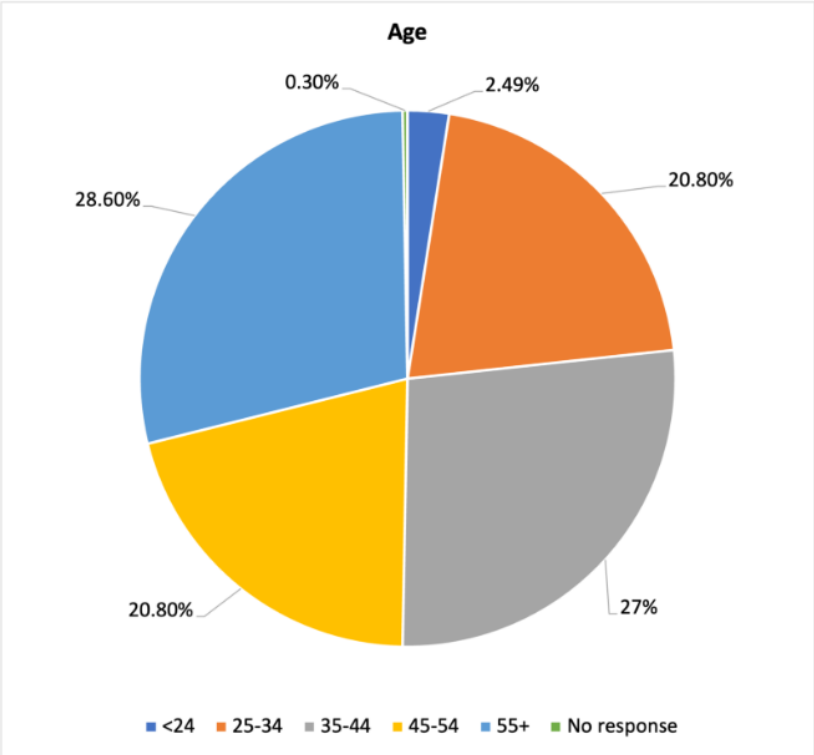


Figure 10 – Age of round 3 participants

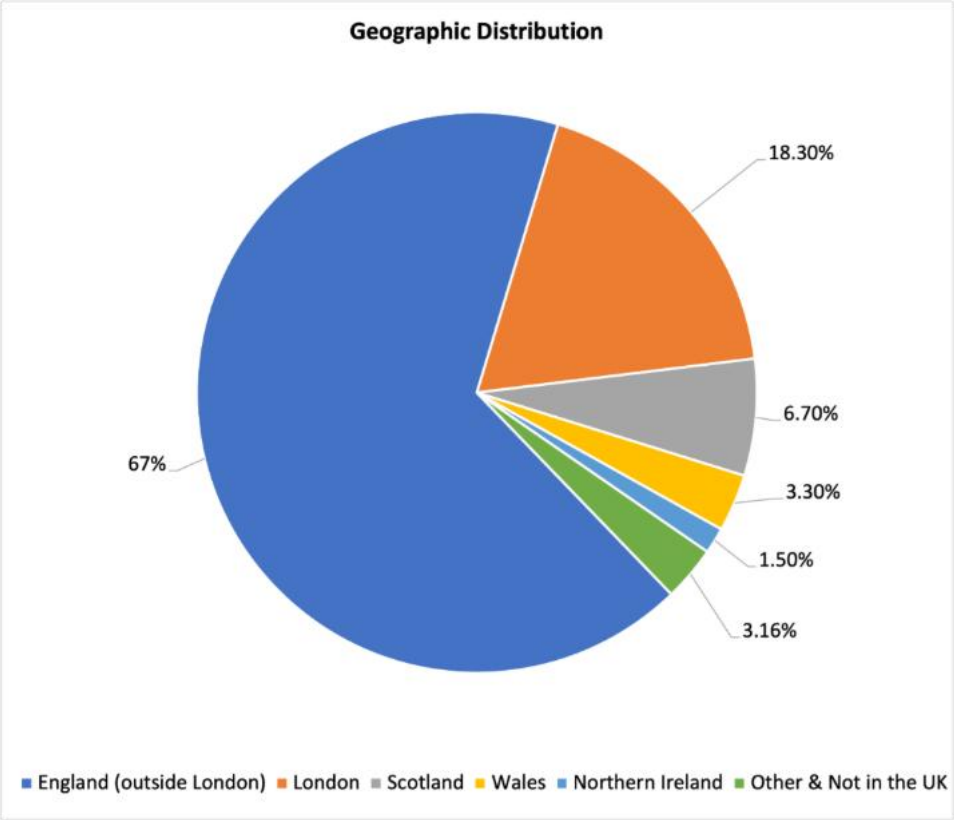


Figure 11 – Geographic distribution of round 3 participants

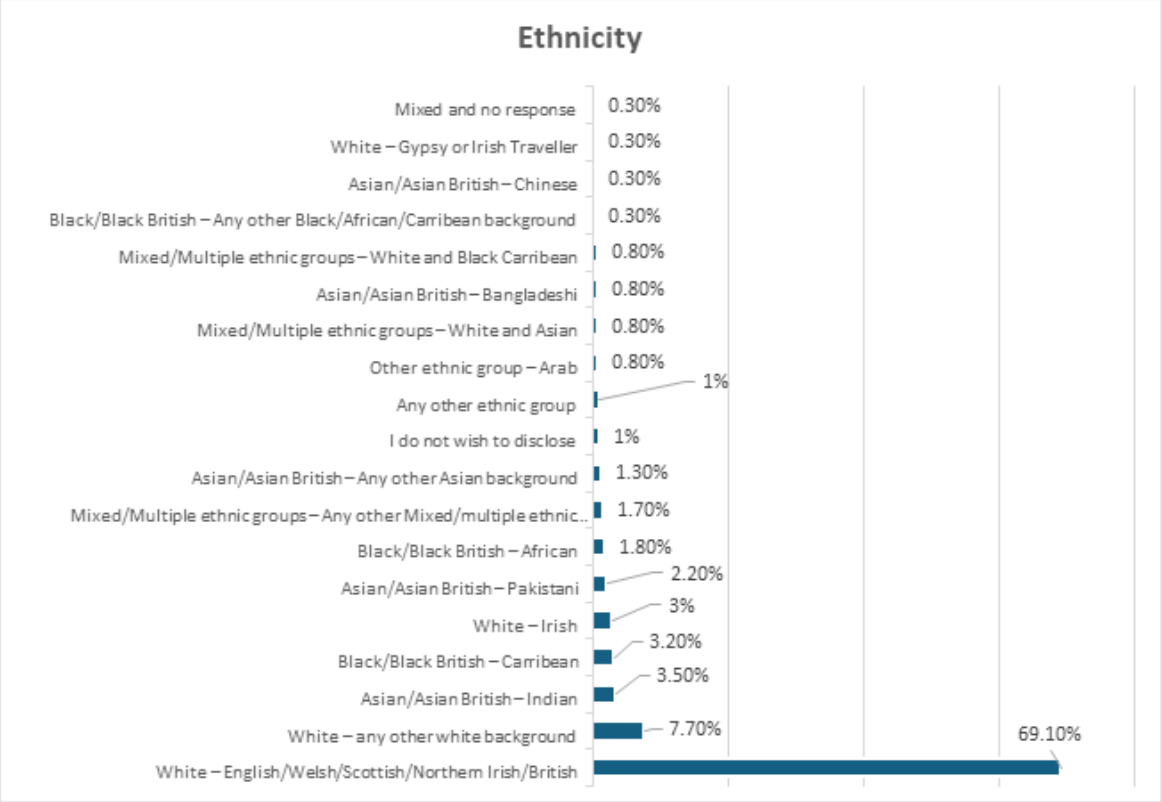


Figure 12 – Ethnicity of round 3 participants

Workshop (39 participants)

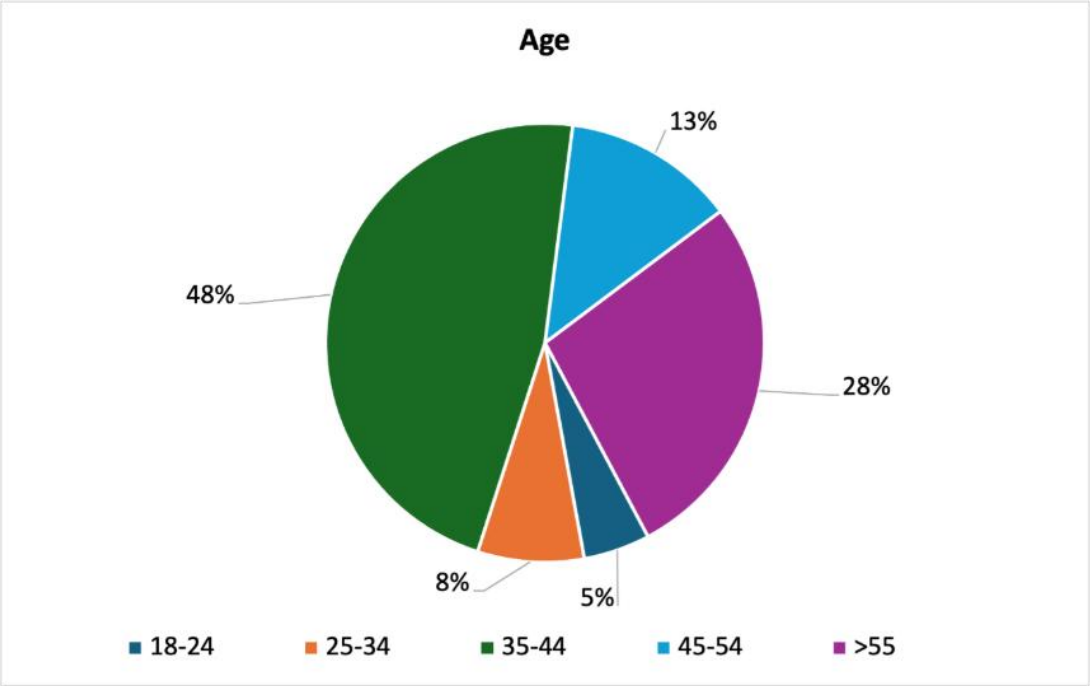


Figure 13 – Age of workshop participants

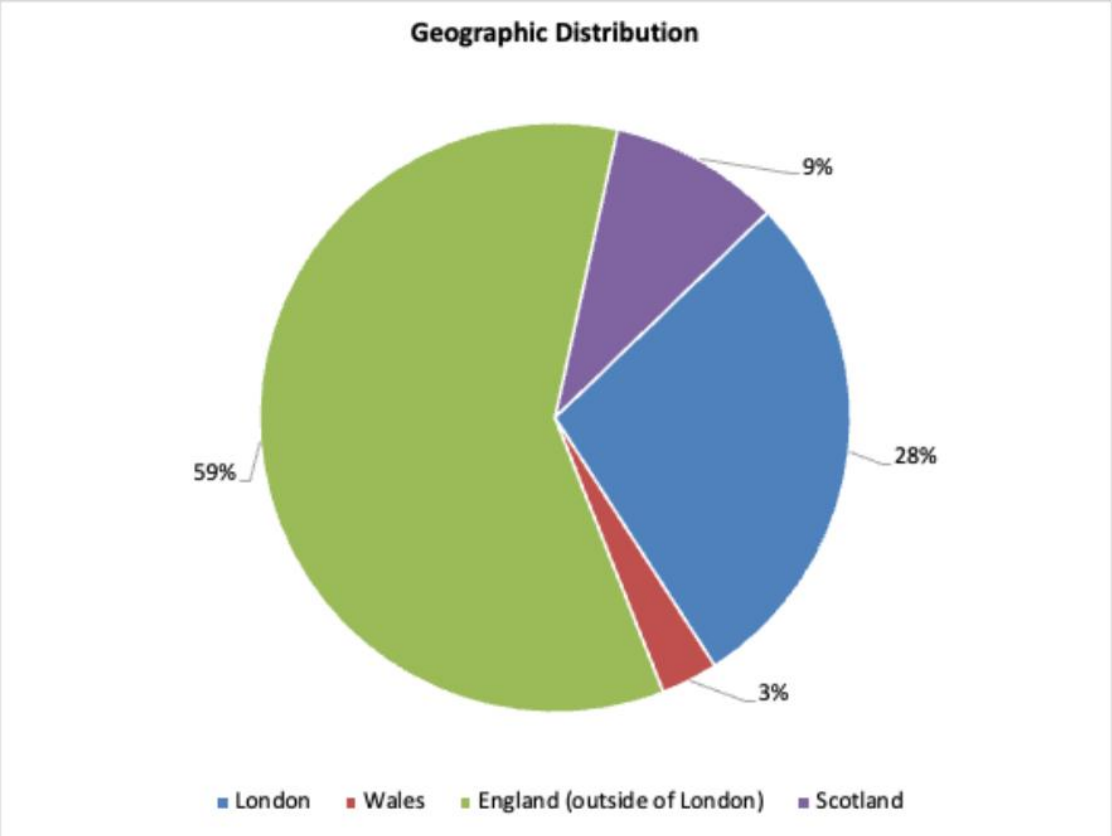


Figure 14 – Geographic distribution of workshop participants

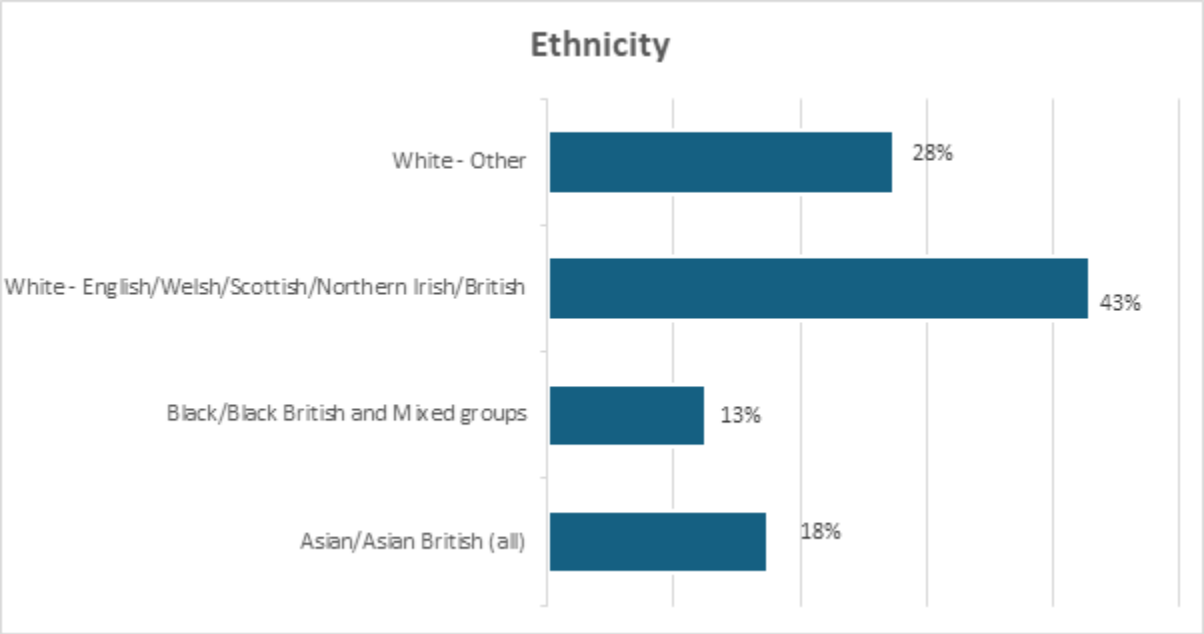


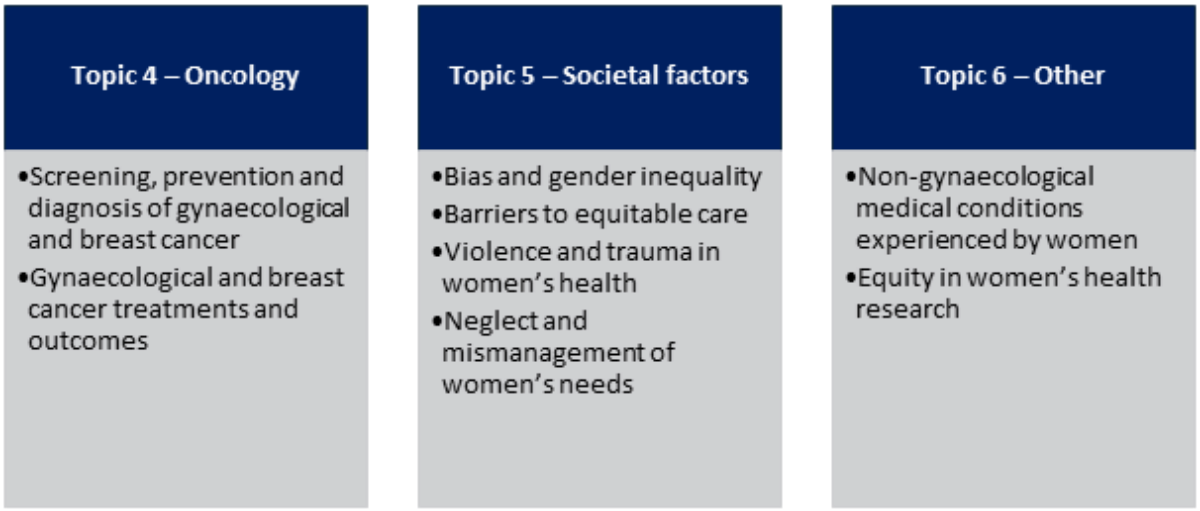
Figure 15 – Ethnicity of workshop participants

Round 1: Question and topic generation

Round 1 received 4,298 question and topic ideas from 1,441 unique respondents. Our inductive thematic analysis highlighted six broad topics that these questions fell under: fertility, gynaecology, obstetrics, oncology, societal factors and other. Within these topic areas, further thematic analysis identified 35 themes.

Table 4 – Question and topic ideas from round 1

Topic 1 – Fertility	Topic 2 – Gynaecology	Topic 3 – Obstetrics
•Miscarriage •Fertility •Polycystic ovarian syndrome (PCOS) •Preconception care •Assisted reproductive techniques (ART)	•Sexually transmitted infections (STIs) •Contraception •Vulvar disease (e.g. lichen sclerosus, lichen planus) •Menopause •Endometriosis •Pelvic floor disorders (prolapse, fistulae, MESH) •Menstrual cycle (to include both physical and mental health) •Chronic pelvic pain	•Early pregnancy •Ectopic pregnancy •Antenatal care •Antenatal screening (e.g. screening for fetal abnormalities or pregnancy complications) •Models of maternity care •Quality of maternity care •Intrapartum care •Induction of labour •Multiple pregnancy •Fetal monitoring •Birth trauma •Preterm birth •Postpartum physical care •Postnatal mental health



These topics and themes served two purposes. First, they enabled faster and more consistent removal of duplicate questions and merging of similar questions, ensuring that questions expressed in different words but addressing the same issue were captured consistently. Second, they generated a list of women's health research themes that are of importance to participants. This provided a framework for developing our topic prioritisation survey.

Round 2: Topic prioritisation

For topic prioritisation, 931 participants (585 participants from round 1 and 346 new participants) used a five-point Likert scale to rank themes. Participants were asked to rank topics and themes from not at all important (1) to very important (5). As participants were given the option of 'unable to comment', it is worth noting that of the 32,585 selections made by participants, 2,202 selected 'unable to comment'. This left different response totals depending on the theme, ranging from 804 to 919. Once the 'unable to comment' entries were removed, the following 19 topics were prioritised.

Table 5 – Themes from round 2

Theme	Median	Mean	Rank
Neglect and mismanagement of women's needs	5	4.63	1
Screening, prevention and diagnosis of gynaecological and breast cancer	5	4.62	2
Gynaecological and breast cancer treatments and outcomes	5	4.61	3
Equity in women's health research	5	4.56	4
Menopause	5	4.47	5
Violence and trauma in women's health	5	4.45	6
Quality of maternity care	5	4.45	7
Postnatal mental health	5	4.43	8

Birth trauma	5	4.42	9
Endometriosis	5	4.32	10
Pelvic floor disorders (e.g. prolapse, fistulae, MESH)	5	4.30	11
Barriers to equitable care	5	4.28	12
Postpartum physical care	5	4.26	13
Menstrual cycle (to include both physical and mental health)	5	4.23	14
Intrapartum care	5	4.22	15
Antenatal screening (e.g. screening for fetal abnormalities or pregnancy complications)	5	4.18	16
Chronic pelvic pain	5	4.18	17
Antenatal care	5	4.17	18
Fetal monitoring	5	4.15	19

Participants had the option to suggest free-text topics/themes that were not included in the list of 35 themes, resulting in a further 801 additional topics/themes. Instead of representing new topics/themes, almost all of these topics were subtopics/subthemes of the initial 35 topics, suggesting that the 35 identified were a comprehensive representation of those deemed important to our participants. In addition, some suggested topics/themes did not fall within the scope of women's health, and some were excluded on the basis that they were not a topic or theme (i.e. one set of responses that stated only 'x'). As a result, none of the additional topic/theme suggestions were added to our initial list of 35.

To make the number of topics and questions more balanced, some were merged and some were divided, resulting in 14 overarching themes.

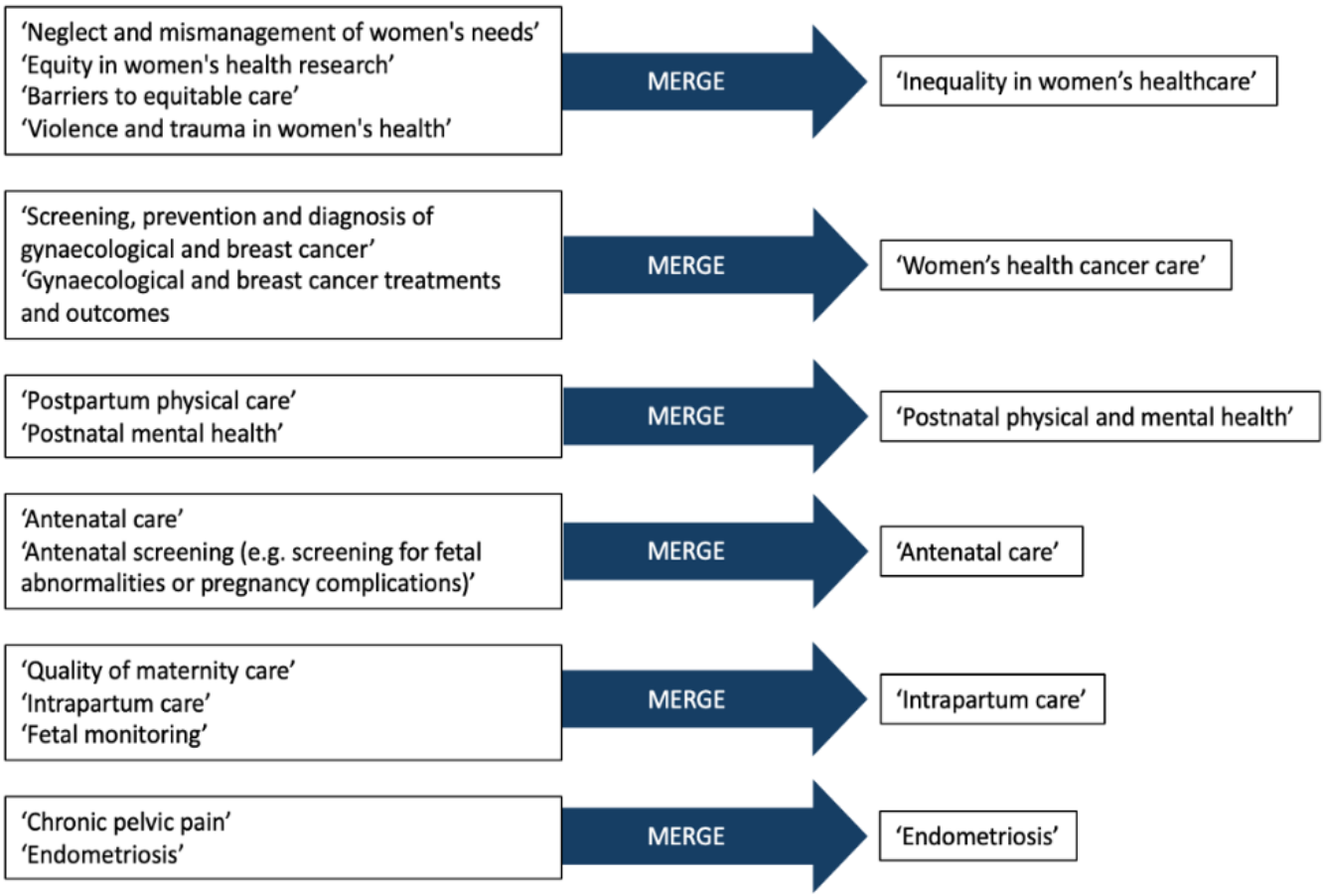


Figure 16 – 14 overarching themes from round 2

PSP analysis

Questions from existing JLA PSPs were reviewed and those relevant to the prioritised themes were incorporated into them. The JLA PSPs that were reviewed included sexual violence, menopause, midwifery practice and maternity care, blood pressure in pregnancy, diabetes and pregnancy, urinary incontinence, preterm birth, stillbirth, womb cancer, endometriosis and pessary use for prolapse.

Incorporating the questions from pre-existing PSPs into the above themes also required some rebalancing of themes to ensure a better distribution of questions per theme. Within the obstetric topics of antenatal care and intrapartum care, there were questions around high blood pressure in pregnancy, diabetes in pregnancy, stillbirth and preterm birth. As such, these were split into their own themes. The theme of 'pelvic floor disorders (e.g. prolapse, fistulae, MESH)' was renamed 'pelvic floor and incontinence' because of the subject of the questions within this theme. A total of 161 questions were contained within the 14 overarching themes.

Table 6 – Overarching themes and questions after PSP analysis

Overarching themes	Number of questions
Menopause	19
Endometriosis	8
Menstrual cycle	11
Antenatal care	8
Intrapartum care	15
High blood pressure in pregnancy	8
Diabetes in pregnancy	8
Stillbirth	11
Preterm birth	12
Postnatal physical and mental health	8
Birth trauma	5
Pelvic floor and incontinence	15
Women's health cancer care	10
Inequality in women's healthcare	23

Round 3: Question prioritisation

Round 3 received 601 responses (235 from round 1/round 2 participants and 366 new participants). Participants were asked to select up to three topic areas and prioritise the corresponding group of questions. The distribution of selected topics can be seen below, with the highest selections for inequality in women's healthcare (62.2%) and menopause (51.3%), followed by pelvic floor health (36.4%) and endometriosis (26.96%). We stratified topic salience into four bands – high (>30%), moderate (20–30%), low (10–20%) and very low (<10%) – to contextualise subsequent prioritisation.

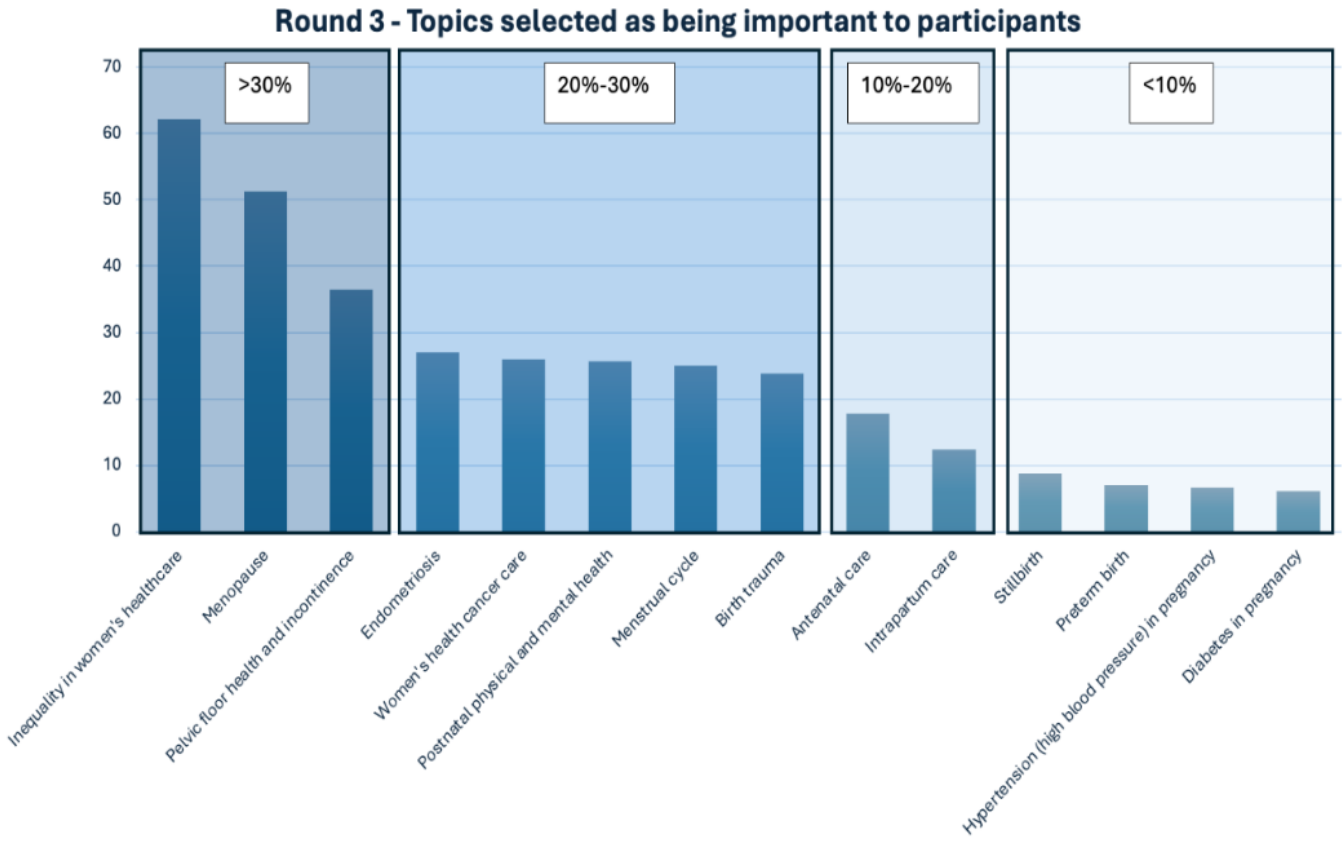


Figure 17 – Topics prioritised by round 3 participants

The number of participants prioritising questions ranged from 374 for inequality in women's healthcare to 37 for diabetes in pregnancy. Fifty-six questions were prioritised by ≥80% of participants and distributed across themes, with zero to six questions prioritised for each theme.

The project team analysed each question to see whether it had been addressed by high-quality research or had registered studies designed to answer these questions. This resulted in eight questions being removed from the list. Further, after analysing the content of the themes, we found that the questions within birth trauma all fit within other themes, and so the theme was removed and the questions redistributed to other themes. Antenatal care had no questions prioritised, and so was also removed.

A total of 606 free-text additional questions were analysed and sorted by theme. The only subject proposed by five or more participants related to the themes inequality in women's healthcare and menopause: '*What methods are effective in increasing access to support for perimenopause and menopause symptoms in women from underserved communities'.* This question was added to those already prioritised in the inequality in women's healthcare theme and brought forward to the workshop.

Table 7 – Remaining questions after analysis and removal

Overarching themes	Questions at the start of round 3	Questions prioritised (≥80%)	Questions prioritised (≥80%) and not already addressed
Menopause	19	3	2
Endometriosis	8	5	5
Menstrual cycle	11	4	4
Antenatal care	8	0	0 (theme removed)
Intrapartum care	15	1	1
High blood pressure in pregnancy	8	6	4
Diabetes in pregnancy	8	3	3
Stillbirth	11	6	6
Preterm birth	12	4	4
Postnatal physical and mental health	8	3	3 (+1 from birth trauma)
Birth trauma	5	3	Theme removed and questions redistributed
Pelvic floor and incontinence	15	6	5 (+1 from birth trauma)
Women's health cancer care	10	5	4
Inequality in women's healthcare	23	7	4 (+1 from birth trauma and +1 from free-text question)

Workshop

The workshop was attended by 39 participants and was managed and observed by six members of the WHRP Steering Group.

At the start of the workshop, participants selected the themes they were interested in from the list of 35 themes generated in the round 1 analysis.

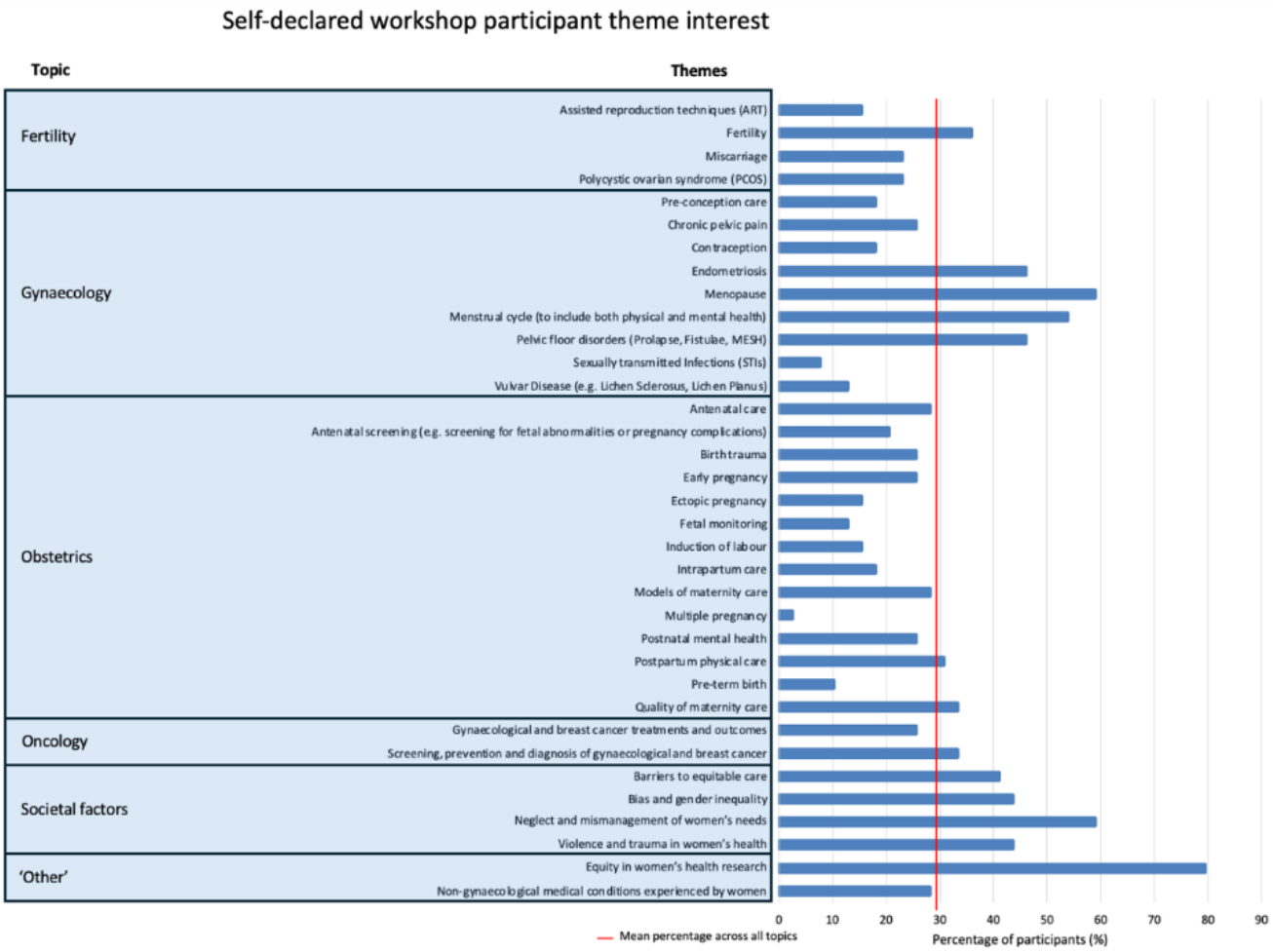


Figure 18 – Participant-selected themes of interest

Workshop attendees generally had a lower interest in the broader topics of fertility and obstetrics, where the themes were selected less frequently than the mean (red line). The group demonstrated a broadly average interest in oncology, and a higher level of interest in the topics of societal factors, gynaecology and 'other'.

The group were then shown the 49 shortlisted questions across the twelve themes. Within each topic, participants voted on which two questions to prioritise. Most themes contributed two priorities, with the exception of pelvic floor and incontinence, which had three priorities. Additionally, menopause and intrapartum care only had two and one questions, respectively, at the start of the workshop; as such, these questions were automatically taken forward to the next stage of prioritisation. A total of 24 questions were taken forward across 12 themes, representing a wide range of women's health topics and avoiding overrepresentation of any single theme.

Top 24 women's health research priorities

Menstrual cycle

- What is the bidirectional relationship between menstrual cycle hormonal fluctuations and mental health across the reproductive lifespan, including impacts on premenstrual syndrome (PMS), premenstrual dysphoric disorder (PMDD) and menopause?
- How do hormonal cycles affect drug metabolism, and how should this be integrated into the design and interpretation of drug trials?

Postnatal care

- What are the long-term impacts of giving birth, and how can we improve long-term postnatal health such as pelvic pain, incontinence and sexual dysfunction?
- What are the underlying causes, effective treatments and preventive measures for maternal mental health conditions such as postpartum depression and anxiety, which are common, but often underdiagnosed and undertreated?

Intrapartum care

- What are the causes of rising rates of induction of labour and caesarean births, what are the appropriate indications, and what are the short- and long-term outcomes for parents and babies? How should this be communicated to ensure informed consent?

Stillbirth

- Why is the incidence of stillbirth higher in the UK than in other high-income countries, and what lessons can be learned?
- Which antenatal care interventions are most effective in reducing stillbirth rates?

Preterm birth

- What are the most effective ways to predict, prevent and manage preterm labour and birth, including the role of specialist antenatal care?
- What should be included in packages of care to support parents, families and carers when a premature baby is discharged from hospital?

Hypertension in pregnancy

- What are the best ways to predict, screen for and promptly diagnose pregnancy hypertension and pre-eclampsia, and to prevent short-term complications such as stillbirth, fetal growth restriction and progression to severe disease?
- Which treatments are most effective to prevent early-onset pre-eclampsia?

Diabetes in pregnancy

- How can diabetes technology be used to improve pregnancy, birth and infant outcomes?
- What are the specific postnatal care and support needs of women and people with diabetes and their infants, and how can the risk of developing later diabetes be reduced?

Inequality and women's health services

- Why are drug trials and clinical studies still not adequately applied to people of both sexes because of physiological differences, and what are the consequences for treatment in women's health?
- What are the reasons for widespread dissatisfaction with obstetric and gynaecological care, and what actions could professional bodies take to address this?

Menopause

- How can we diagnose, manage and prevent cognitive impacts of perimenopause/menopause, and how does menopause cause these cognitive problems?
- What support interventions for menopause-related changes are most effective?

Pelvic floor and incontinence

- What are the most effective treatment pathways for pelvic organ prolapse, including prevention, first-line, long-term and second-line options, how conservative therapies compare with surgical approaches, and why some interventions are unsuccessful?
- What inconsistencies exist in pelvic floor prolapse care across the UK, and are women and people receiving appropriate care from primary care providers, including timely referral to secondary care?
- Can guidance or training for primary care providers improve management of women and people with urinary incontinence through more appropriate use of care pathways?

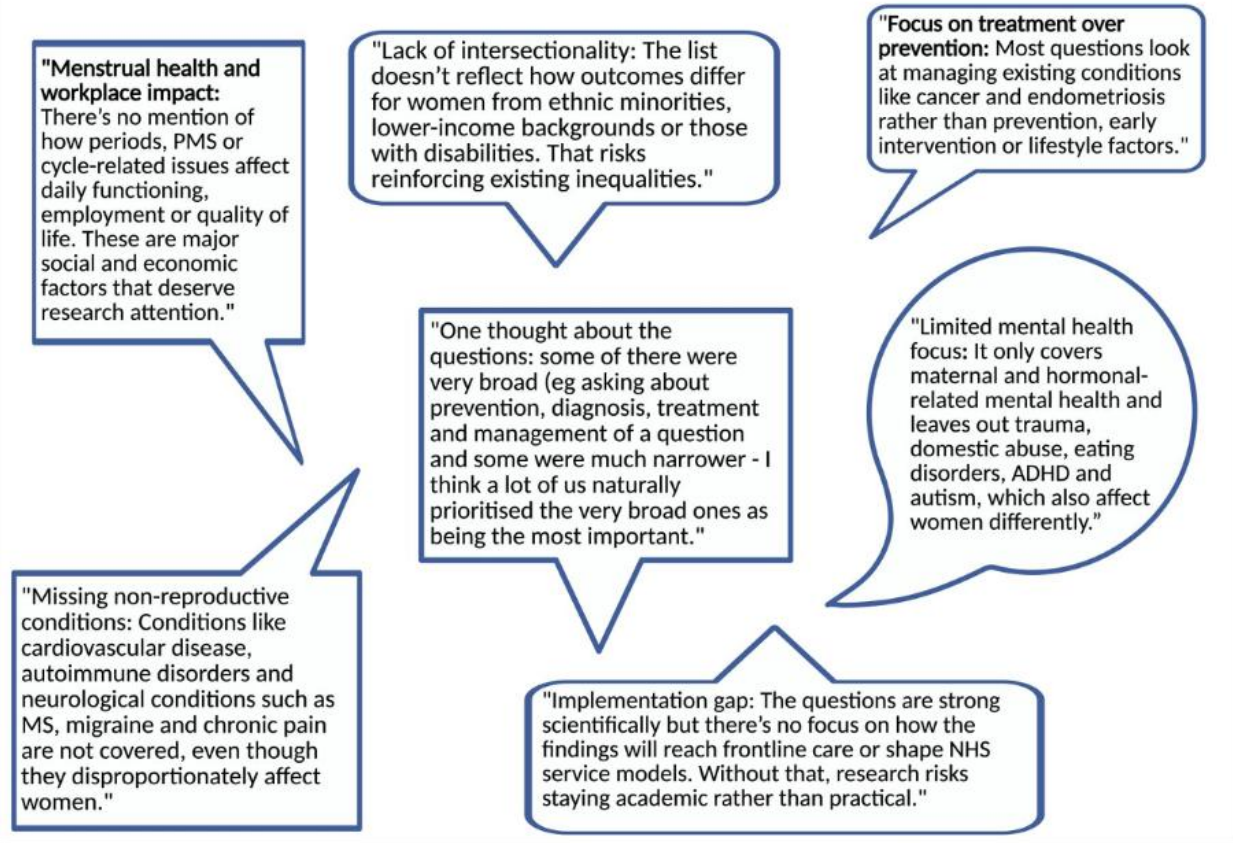
Endometriosis

- What are the most effective current and emerging treatments for endometriosis, including ways to prevent progression or recurrence, and is it possible to develop a cure?
- How can the diagnosis of endometriosis be improved, including the development of non-invasive screening tools?

Women's health cancer care

- What are the most effective current and emerging treatments for gynaecological and breast cancers, including targeted molecular and hormonal therapies, and how can treatment be personalised to maximise benefit and avoid unnecessary toxicity?
- What factors drive rising incidence of gynaecological and breast cancers, and how can risk prediction be improved through personalised risk scores, better understanding of causes and optimal referral pathways (e.g. for abnormal bleeding)?

The priorities from this Top 24 were considered by workshop participants in a moderated discussion. Participants added their comments to the Microsoft Teams chat, and these were read by the Chair. Below is a selection of the quotes from the workshop discussion.



Following the moderated discussion, participants were asked to select the ten questions from the Top 24 that they felt should appear in the Top 10 list of priorities. The list of the Top 10 is presented in a randomised order.

Top 10 women's health research priorities

- What are the most effective current and emerging treatments for gynaecological and breast cancers, including targeted molecular and hormonal therapies, and how can treatment be personalised to maximise benefit and avoid unnecessary toxicity?
- Why are drug trials and clinical studies still not adequately applied to people of both sexes because of physiological differences, and what are the consequences for treatment in women's health?
- What are the most effective current and emerging treatments for endometriosis, including ways to prevent progression or recurrence, and is it possible to develop a cure?
- What are the reasons for widespread dissatisfaction with obstetric and gynaecological care, and what actions could professional bodies take to address this?
- How can the diagnosis of endometriosis be improved, including the development of non-invasive screening tools?
- How can we diagnose, manage and prevent cognitive impacts of perimenopause/ menopause, and how does menopause cause these cognitive problems?
- What are the long-term impacts of giving birth, and how can we improve long-term postnatal health such as pelvic pain, incontinence and sexual dysfunction?
- What are the underlying causes, effective treatments and preventive measures for maternal mental health conditions such as postpartum depression and anxiety, which are common, but often underdiagnosed and undertreated?
- How do hormonal cycles affect drug metabolism, and how should this be integrated into the design and interpretation of drug trials?
- What is the bidirectional relationship between menstrual cycle hormonal fluctuations and mental health across the reproductive lifespan, including impacts on premenstrual syndrome (PMS), premenstrual dysphoric disorder (PMDD) and menopause?

Participants were shown the Top 10 research questions identified, and as a final binary question, were asked whether they could live with the results of this prioritisation exercise; 72% of participants voted 'yes', and as such formed a consensus (>70%).

Discussion

The Top 10 priorities

Perhaps the most striking aspect of the Top 10 priorities is the prominence of structural and societal themes. Rather than prioritising disease-specific questions, participants elevated issues of research inclusivity and healthcare access. Specifically, participants called for the inclusion of more women in clinical trials and sex-specific analyses. Further, they called for drug trials to assess the impact of cyclical hormone changes. Drugs have different pharmacokinetic properties in men and women, with one study of commonly prescribed US Food & Drug Administration-approved medications finding that 96% of drugs were associated with higher rates of adverse reactions in women.[4] These research priorities call for systemic changes in how research is designed and conducted. This highlights that both the public and healthcare professionals recognise that addressing gaps in women's health requires rethinking how research is undertaken, not just increasing funding of more studies.

The prioritisation of long-term maternal physical and mental health represents a shift in priority from the traditional focus on obstetric and perinatal outcomes toward the long-term impacts of pregnancy and childbirth on women's health. This reflects a longer life-course approach to women's health, emphasising that maternal health extends beyond the conventional 6-week postpartum period.

Hormonal impact on cognition and emotions has emerged as a recurring theme across women's health. Participants prioritised the need to understand the effects of hormones on premenstrual syndrome and premenstrual dysphoric disorder during the reproductive years, as well as their impact on cognition later in life, including during menopause.

Two priority questions from the endometriosis theme mirror the findings from the 2017 Endometriosis PSP, which identified the need for improved diagnostic tools and increased treatment options.[5] Despite these recommendations, the average time to diagnosis has increased, from 8 years in 2020 to 8 years and 10 months in 2023.[6]

Finally, a focus on treatments for cancers affecting women was prioritised, with a particular emphasis on the personalisation of treatment. This reflects a broader trend in healthcare toward precision medicine, aiming to maximise therapeutic benefit while reducing side-effects of treatments.

The Top 24 priorities

The Top 24 priorities highlight important themes and questions that span the life course and reflect the multidimensional nature of women's health. As in the Top 10, the longer list of prioritised questions encompass not only clinical conditions, but also the fundamental structures and systems that shape healthcare delivery and research conduct.

Perhaps an interesting aspect of this list is the questions that were eliminated when the Top 10 were chosen. These were largely from the pregnancy-specific themes such as diabetes and hypertension in pregnancy. This may be because of the interests identified by the workshop participants themselves, demonstrating a potential bias in the resulting

prioritisation. It may also reflect the publicly available results of existing PSPs, where 12 out of the 28 JLA PSPs have already examined priorities within obstetrics, and participants may have felt these themes have already had sufficient attention.

Commentary

Across countries, three important areas of work are often considered within women's health: a life-course lens, explicit equity aims and stakeholder participation. Existing government strategies (Australia, New Zealand, USA) have established broad research and policy priorities, but typically have not produced a ranked, evidence-based list.[7-10] By contrast, PSP-style exercises (our WHRP project, JLA Canada, Ireland's listening-led programme) foreground public–clinician co-production, use survey and workshop methods, and deliver a 'Top-X' list suitable for funding calls.[11,12] Canada's National Women's Health Research Initiative sits between these models, funding local, community-driven priorities under a national banner.[13] The WHRP project's prioritisation exercise is distinctive in combining multi-round national surveying, explicit evidence verification (retiring answered items) and a balanced final portfolio that spans conditions, services and cross-cutting concepts – retaining the methodology of a PSP while covering the entire women's health domain rather than a single specialty.

Inevitably, a broad project with such a finite output will lose some research priorities that are important to women, and particularly those from minority groups. We note that although the general topic of inequalities in women's health was prioritised, there were no questions in the Top 24 that directly mention ethnic or socioeconomic disparities, or LGBTQ+ health. There is a known disparity in clinical outcomes for patients of different ethnic and socioeconomic backgrounds in the UK.[14-16] It is therefore imperative that when funders and researchers look at each question, they ensure that the wider social context for these minoritized communities in the UK is incorporated. They need to consider how further research can be designed to address these questions in a way that includes those from minority groups and addresses the issues specific to them (e.g. support interventions for menopause may not be the same across all social and ethnic communities). This further highlights the importance of specific PSPs for minority groups, as the JLA are undertaking.[17]

Strengths and limitations

We recognise that this prioritisation exercise, its methodology and results are not without criticism. It is important that we recognise and acknowledge the limitations of this project, and reiterate that its results are to be viewed within the context of the wider socio-political and economic environment within the UK at the time of its undertaking. Contemporary issues and selection bias may impact the priorities we report.

Challenges in this project lay within three overlapping domains:

- recruitment and representation
- dynamic methodological design
- refining a consensus exercise with such a broad scope.

The numbers of participants engaging in this prioritisation exercise were good compared with other PSP exercises, providing validity to our final priority lists (Appendix 2). By leveraging the RCOG's organisational professional relationships and digital media campaigns (especially via social media and local networks), we were able to recruit a representative sample of the UK for all rounds across a range of characteristics, including geographical location, ethnic groups and age ranges. Despite this, in our final workshop, we acknowledge potential selection bias with a skew toward the topics of societal factors, gynaecology and 'other' topics, with comparatively less interest in fertility and obstetrics. We did note that in some rounds, there were clusters of similar responses on the same theme, which was attributed to the survey being shared in large patient advocacy groups.

The novelty of performing a consensus exercise across such a broad scope meant that we had to adapt our methodology according to the responses we received. We were guided by our project team, which included methodology experts, and by the WHRP Steering Group. This allowed us to narrow down responses to a manageable number before our final online survey round.

This exercise was not done to place our Top 10 in conflict with pre-existing and ongoing PSPs in women's health in the UK. Rather, it was designed to be a broader lens through which all of these priorities can be viewed. By providing a prioritised overview of all women's health research questions and topics, we endeavour to focus policy-level funding and initiatives within our country. Our iterative methodological approach allowed us to examine wider topics as well as single, focused research questions, identify and refine them, and collaboratively decide how they should be prioritised.

Implications

Collaborative identification of research priorities is critical to ensuring that future research addresses questions that are important to women, but this must translate into improvement in outcomes.

For research funders such as the NIHR, we propose creating a dedicated funding call to address the Top 10 or Top 24 priorities like those addressing other priority lists generated through PSPs.[2]

For policy makers, our priorities can provide a framework to use in the refreshed Women's Health Strategy for England, and we would encourage use of these priorities to inform NHS England service development priorities.[18]

For researchers, we would advocate designing studies to answer the questions prioritised within our Top 24 that service users have identified as important. Studies should be designed to account for differences in physiology, including sex-specific analyses, and to account for cyclical hormone effects. Researchers should build in equity-sensitive analyses, co-production from protocol to dissemination, and early planning for process evaluation, economic analysis and data sharing. Tailored strategies should be developed to reach underserved groups.

Regarding the JLA and researchers using JLA (modified) methodology, we have identified a list of priority themes that are important to women. Completing further PSPs looking at

these themes individually will add more granularity to the landscape of unanswered research questions. The range of non-disease-specific themes, particularly those in the societal and 'other' broader topics, may help in investigating societal shifts to improve health for women and people. Furthermore, the JLA PSP methodology facilitates the creation of research priority lists for specific contexts and populations, which would allow for a focus on underrepresented and minority groups.

We call on funders, researchers and policy makers to make use of these priorities to guide future research agendas in women's health. By addressing these questions, we can continue to advance women's health research and improve outcomes for women throughout their lives.

Conclusion

We undertook this project to address persistent evidence gaps and inequities in women's health, ensuring future investment targets what matters most to people who use women's health services and those who provide them. This exercise sets a research agenda across the life course. The findings should guide commissioning, programme design and evaluation, and enable coordinated action by researchers, funders, service leaders and people with lived experience. Researchers should target unanswered, high-impact questions by using robust designs, appropriate comparators and core outcome sets.

The priorities align with RCOG commitments on evidence-based care, equity and outcomes that matter to service users, and support the UK Women's Health Strategy's life-course approach. They complement ongoing work on perinatal safety, access to gynaecology, menopause services and research capacity.

Review of the priorities should occur periodically at intervals determined by funders and policy makers, and after publication of new evidence in the prioritised areas. This will ensure that the UK's Top 10 research priorities remain current with the issues most affecting women's health.

Appendix 1: Acknowledgements

Steering Group members

We would like to acknowledge our Steering Group, who offered advice and strategic direction to this project. Members include women and people with lived experience, as well as health professionals.

- Mrs Jane Plumb
- Dr Stamatina Ilioddromiti
- Dr Fionnuala Mone
- Professor Lucilla Poston
- Dr Sujeewa Fernando
- Dr Abi Merriel
- Professor Colin Duncan
- Professor Shakila Thangaratinam
- Professor Laura Magee
- Professor Peter von Dadelszen
- Ms Freya El Baz
- Dr Michalina Drejza
- Dr Hajra Khattak
- Ms Nafiza Anwar
- Dr Lizzie Evens
- Ms Geeta Nayar
- Ms Jackie Matthew
- Dr Soha Sobhy
- Dr. Sergio A. Silverio

Data analysis support

We would also like to acknowledge data analysis support in our round 1 analysis from:

- Dr Sophia Gron
- Ms Gabi Hakim
- Ms Anjolaoluwa Awe

Survey participants

We would like to thank the women and people, and healthcare professionals, who engaged in this prioritisation project in each round, without whom, this work would not have been possible.

Workshop participants

We would like to thank those who engaged in our online workshop through several rounds of voting and discussion around our final list of research priorities for women's health. Our workshop participants who consented to acknowledgement are as follows:

Angie White, Anita Allenby-Jones, Anjela Heron, April O'Dwyer, Caitríona Tippett, Carole Payne, Chelsey Taylor, Deborah Ferguson, Elaine Matthews, Ella Jackson, Gina Dutton, Jocelyn Bailey, John Reynolds-Wright, Kim Thomas, Leigh Romaniuk, Liezl Rossouw, Lucy Whitaker, Maria Williams, Nahiyat Quadri, Onyinye Udeobi, Priya Vansia, Priyanka Punja, Rachel Dewar-Haggart, Sam Mori, Sarah Bibby, Sarah Cavaliere, Sarah Dixon, Sarah Richardson, Selina, Shailja Verma, Sharandeep Bhogal, Sinead Hering, Toni Seed, Veronica Blanco Gutierrez.

Project partners

We would like to thank our Project Partners who supported this work from inception, and publicised and disseminated the call for survey respondents:

- Abuela Doulas: https://abueladoulas.co.uk/
- Birth Companions: https://www.birthcompanions.org.uk/
- British Pregnancy Advisory Service: https://www.bpas.org/
- Birth Trauma Association: https://www.birthtraumaassociation.org/
- MASIC Foundation: https://masic.org.uk/
- Family Planning Association: https://www.fpa.org.uk/
- Miscarriage Association: https://www.miscarriageassociation.org.uk/
- AiMs – Association for Improvements in the Maternity Services: https://www.aims.org.uk/
- The Ectopic Pregnancy Trust: https://ectopic.org.uk/

Appendix 2: Completed JLA women's health PSPs

Title Year Number of unique respondents (where published)	Research questions (Top 10)
Urinary incontinence 2006 226 respondents	1. What are the optimal pelvic floor muscle training protocols (frequency and duration of therapy) for treating different patterns of urinary incontinence? 2. Can guidance or training for GPs on appropriate care pathways improve management of people with urinary incontinence? 3. What is best practice for treating combined stress urinary incontinence and detrusor overactivity? 4. Which catheter regimens are most effective in preventing urinary tract infections in people using intermittent self-catheterisation for the management of a neurogenic bladder? What is the effectiveness and safety of prophylactic versus symptomatic antibiotic therapy in people with neurogenic bladder dysfunction using intermittent self-catheterisation? 5. Which treatment is most effective for reducing urinary frequency and urgency? 6. Is urodynamic testing before surgery for urinary incontinence associated with better continence rates and quality of life than surgery indicated without such testing? 7. What is best practice for managing stress urinary incontinence following failed tension-free vaginal tape surgery? 8. What are the most effective treatments of daytime urinary incontinence in children?

	9. Are disposable catheters more or less acceptable than reusable catheters, in terms of effective bladder management, patient experience and urinary tract infections? 10. In women with prolapse and stress urinary incontinence, should suburethral tapes be inserted at the same time as repairing the prolapse?
Preterm birth 2014 386 respondents	1. Which interventions are most effective to predict or prevent preterm birth? 2. How can infection in preterm babies be better prevented? 3. Which interventions are most effective to prevent necrotising enterocolitis in premature babies? 4. What is the best treatment for lung damage in premature babies? 5. What should be included in packages of care to support parents and families/carers when a premature baby is discharged from hospital? 6. What is the optimum milk feeding strategy and guidance (including quantity and speed of feeding and use of donor and formula milk) for the best long-term outcomes of premature babies? 7. What is the best way to judge whether a premature baby is feeling pain (e.g. by their face, behaviours or brain activities)? 8. Which treatments are most effective to prevent early-onset pre-eclampsia? 9. What emotional and practical support improves attachment and bonding, and does the provision of such support improve outcomes for premature babies and their families? 10. Which treatments are most effective for preterm premature rupture of membranes? 11. When is the best time to clamp the umbilical cord in preterm birth? 12. What type of support is most effective at improving breast feeding for premature babies? 13. Which interventions are most effective to treat necrotising enterocolitis in premature babies? 14. Does specialist antenatal care for women at risk of preterm birth improve outcomes for mother and baby? 15. What are the best ways to optimise the environment (such as light and noise) in order to improve outcomes for premature babies?
Stillbirth	1. How can the structure and function of the placenta be assessed during pregnancy to detect potential problems and reduce the risk of stillbirth?

2015 577 respondents	2. Does ultrasound assessment of fetal growth in the third trimester reduce stillbirth? 3. Do modifiable 'lifestyle' factors (e.g. diet, vitamin deficiency, sleep position, sleep apnoea, lifting and bending) cause or contribute to stillbirth risk? 4. Which investigations identify a fetus which is at risk of stillbirth after a mother believes she has experienced reduced fetal movements? 5. Can the wider use of existing tests and monitoring procedures, especially in later pregnancy, and the development and implementation of novel tests (biomarkers) in the mother or in early pregnancy, help prevent stillbirth? 6. What causes stillbirth in normally grown babies? 7. What is the most appropriate bereavement and postnatal care for both parents following a stillbirth? 8. Which antenatal care interventions are associated with a reduction in the number of stillbirths? 9. Would more accessible evidence-based information on signs and symptoms of stillbirth risk, designed to empower women to raise concerns with healthcare professionals, reduce the incidence of stillbirth? 10. How can staff support women and their partners in subsequent pregnancies, using a holistic approach, to reduce anxiety, stress and any associated increased visits to healthcare settings? 11. Why is the incidence of stillbirth in the UK higher than in other similar high-income countries and what lessons can we learn from them?
Womb cancer 2016 413 respondents	1. Is it possible to develop a personalised risk score which reflects a woman's individual risk of developing endometrial cancer? 2. Which women with abnormal vaginal bleeding should be referred for specialist review? 3. What are the most effective treatments currently available for advanced endometrial cancer and what key molecular pathways should be targeted when developing new treatments? 4. Can we predict which women will benefit from adjuvant chemotherapy or radiotherapy and avoid ineffective treatments? 5. Are blood tests, including markers like CA125, useful in predicting duration of survivorship and/or recurrent disease? 6. What ways of raising public awareness about endometrial cancer are the most effective and cost-effective?

	7. What are the psychological issues surrounding diagnosis and treatment of endometrial cancer and what interventions might be helpful? 8. What are the underlying causes of different types of endometrial cancer and how do they develop? 9. Can we predict at the time of diagnosis which endometrial cancers and precancerous lesions will respond to hormone treatments? 10. Do changes in lifestyle, including weight loss, reduce the risk of recurrent and improve survival in women who have been treated for endometrial cancer?
Contraception 2017 318 respondents	1. Which interventions (decision support aids, ease of access, motivational interviewing) increase uptake and continuation of effective contraception including long-acting methods (implants, injections and intrauterine contraceptives)? 2. What is the risk of side-effects (vaginal bleeding, mood, weight gain, libido) with hormonal contraception (pills, patches, rings, implants, injections and hormonal intrauterine system)? 3. What are the long-term effects of using contraception (pills, patches, rings, injections, implants, intrauterine) on fertility, cancer and miscarriage? 4. What models of care increase access and support decision-making for vulnerable groups (such as young people, people who don't speak or read English)? 5. Which interventions are safe and effective for women who have irregular bleeding on long-acting hormonal contraception? 6. Does pharmacy provision of contraceptive services increase uptake and/or continuation of contraception? 7. What are the risks or benefits to using combined hormonal contraception (pill, patch or ring) continuously to stop or reduce periods? 8. What factors (advice from friends, family, professionals, beliefs, experience) influence women making decisions about contraception? 9. Are there tests or factors such as age that can reliably identify women who no longer require contraception around the menopause (including women using methods which can stop periods such as implants, hormonal coils, pills)? 10. Are there effective new methods of contraception available for men?
Endometriosis 2017	1. Can a cure be developed for endometriosis? 2. What causes endometriosis?

1,225 respondents	3. What are the most effective ways of educating healthcare professionals throughout the healthcare system, resulting in reduced time to diagnosis and improved treatment and care of women with endometriosis? 4. Is it possible to develop a non-invasive screening tool to aid the diagnosis of endometriosis? 5. What are the most effective ways of maximising and/or maintaining fertility in women with confirmed or suspected endometriosis? 6. How can the diagnosis of endometriosis be improved? 7. What is the most effective way of managing the emotional and/or psychological and/or fatigue impact of living with endometriosis (including medical, non-medical and self-management methods)? 8. What are the outcomes and/or success rates for surgical or medical treatments which aim to cure or treat endometriosis, rather than manage it? 9. What is the most effective way of stopping endometriosis progressing and/or spreading to other organs (e.g. after surgery)? 10. What are the most effective non-surgical ways of managing endometriosis-related pain and/or symptoms (medical/nonmedical)?
Miscarriage 2017 1,093 respondents	1. What are the effective interventions to prevent miscarriage, threatened miscarriage and recurrent miscarriage (e.g. lifestyle, vitamins, aspirin, early scans, human chorionic gonadotrophin (HCG), dopamine agonists, progestogen, polytherapy, steroids, oestrogen, metformin, anticoagulants, intravenous immunoglobulin, intralipid and anti-TNF-alpha)? 2. What are the emotional and mental health impacts of miscarriage in the short term and long term for the mother and the partner? 3. What investigations are of true clinical value (e.g. ultrasound, gene sequencing, natural killer cells, thromboelastography, microarray testing of the fetus, paternal investigations, plasminogen activator inhibitor polymorphism)? 4. To what extent do pre-existing medical conditions cause miscarriage (e.g. vitamin deficiencies, diabetes, previous infertility, endometriosis, polycystic ovarian syndrome, menstrual irregularities, cervical factors, uterine anomalies, polyps, immunological factors or previous pregnancy complications for example, caesarean section or preterm birth)? 5. What types of emotional support are effective in preventing or treating women or their partners after a miscarriage? 6. Do lifestyle factors (diet, stress, exercise, weight, alcohol, sexual activity, smoking, night shifts or flying) cause miscarriage?

	7. To what extent do genetic and chromosomal abnormalities in the fetus cause miscarriage? 8. What preconception tests or interventions prevent miscarriage (e.g. vitamin supplements, folic acid, dehydroepiandrosterone, co-enzyme Q-10 or bariatric surgery)? 9. What are the appropriate investigations for women after one, two or three or more miscarriages? 10. What male factors contribute toward the cause of miscarriage?
Pessary use for prolapse 2017 210 respondents	1. How might a pessary affect sexual activity? 2. Do pessaries have an effect on the psychological wellbeing of women? 3. What is important for a pessary self-management programme? 4. What are the risks and complications of pessary use for prolapse? 5. Are pessaries effective as a long-term treatment for prolapse? 6. What is the best way to assess what type and size of pessary to use? 7. What is the best way to minimise and treat vaginal discharge caused by pessaries? 8. Does pessary use in prolapse have a positive impact on physical activity? 9. When should oestrogen cream be used with a pessary? 10. What is the ideal training to be a 'qualified' pessary practitioner?
Metastatic breast cancer (Canada) 2018 668 respondents	1. What biomarkers or intrinsic features of the tumour can be used to identify response to specific treatments and dosing schedules? 2. What is the role of immunotherapy for metastatic breast cancer? 3. How can treatment resistance be delayed, and minimized? 4. What causes (i.e. cellular, genomic changes) breast cancer cells to metastasize, and what changes allow them to penetrate the blood–brain barrier? 5. What is the right sequence of therapy in metastatic breast cancer? 6. Does local therapy (radiation or surgery to sites of metastatic disease) improve survival outcomes in metastatic breast cancer? 7. Is continuous treatment with systemic therapy (including HER2-targeted therapy and chemotherapy) better than intermittent treatment? 8. Does early palliative care improve outcomes for metastatic breast cancer patients?

	9. What are the best methods of education for patients around treatment options and decision-making that can lead to improved patient outcomes? 10. Can safer, more accurate methods, including blood tests of detecting spread of disease (including following curative intent treatment) be developed?
Lichen sclerosus 2018 652 respondents	1. What is the best way to prevent and manage anatomical changes caused by lichen sclerosus? 2. What is the best way to diagnose lichen sclerosus (diagnostic criteria)? 3. What surgical treatments should be offered for lichen sclerosus? 4. Are there effective topical treatments other than topical steroids in the treatment of lichen sclerosus? 5. What is the risk of developing cancer in patients with lichen sclerosus? 6. Which aspects of lichen sclerosus should be measured to assess response to treatment? 7. Can lichen sclerosus be prevented from occurring and what are the trigger factors? 8. Is it necessary to continue treatment for patients with lichen sclerosus who do not have any symptoms and/or signs of disease activity? 9. What is the impact on quality of life? 10. Does the disease course of lichen sclerosus differ in boys and girls, adult males and females?
Hyperemesis gravidarum 2019 1,009 respondents	1. Can we find a cure? What novel or new treatments are being developed/tested/used elsewhere which could have a curative effect and to address all the symptoms of hyperemesis gravidarum rather than just the vomiting? 2. How can we most effectively manage hyperemesis gravidarum? What clinical support measure is most important to people who have had hyperemesis and what did they find most beneficial (e.g. medical management, pharmaceutical review, nutrition support, rehydration, psychological support)? 3. What causes hyperemesis gravidarum? 4. Is hyperemesis gravidarum preventable? What is the effect of preventative treatment or early intervention on the severity and duration of hyperemesis gravidarum in a subsequent pregnancy? 5. What are the immediate and long-term effects of hyperemesis gravidarum (including malnutrition and dehydration, stress) on the developing foetus?

	6. What are the immediate and long-term effects of the various medications/treatments on the developing foetus throughout the various stages of pregnancy and in varying doses or combinations of treatments? 7. What are the relative efficacies of the current medications and treatment options available? What is the optimal dose, route, timing and combination of the medications and what are the related side-effects? 8. What are the immediate and long-term physical, mental and social consequences and complications of hyperemesis gravidarum (including malnutrition and dehydration) on the pregnant person's body (i.e. metabolic impact, DVT, depression, effects of dehydration)? 9. What clinical measurements and markers are most useful in assessing, diagnosing, managing and monitoring hyperemesis? 10. What are the nutritional requirements of the first, second and third trimesters, and how can people with hyperemesis gravidarum achieve these goals (i.e. oral supplements, fortifying food, dietary measures)?
Blood pressure in pregnancy 2020 278 respondents	1. What are the long-term physical and mental health consequences of pregnancy hypertension (including pre-eclampsia) for the woman, baby and family? 2. How can we predict and prevent shorter term complications of pregnancy hypertension (including stillbirth, fetal growth restriction, neonatal death, progression to pre-eclampsia)? 3. What is the best screening test for pre-eclampsia? 4. Following pregnancy hypertension, what is the best way to prevent future long term problems? 5. What is the cause of pregnancy hypertension (including pre-eclampsia)? 6. How can pregnancy hypertension (including pre-eclampsia) be prevented in a subsequent pregnancy? 7. What are the educational needs of healthcare professionals managing women with pregnancy hypertension? 8. What is the best way to diagnose pre-eclampsia promptly? 9. What is the best way to manage pregnancy hypertension (including optimal antenatal and postnatal antihypertensive medication and optimal timing of delivery)? 10. How can we provide better support for women with pregnancy hypertension and their families?
Diabetes and pregnancy	1. How can diabetes technology be used to improve pregnancy, birth, and mother and child health outcomes?

2019 466 respondents	2. What is the best test to diagnose diabetes in pregnant women? 3. For women with diabetes, what is the best way to manage blood sugar levels using diet and lifestyle during pregnancy? 4. What are the emotional and mental wellbeing needs of women with diabetes before, during, and after pregnancy, and how can they best be supported? 5. When is it safe for pregnant women with diabetes to give birth at full term compared with early delivery via induction or elective caesarean? 6. What are the specific postnatal care and support needs of women with diabetes and their infants? 7. What is the best way to test for and treat diabetes in late pregnancy, i.e. after 34 weeks? 8. What is the best way to reduce the risk or prevent women with gestational diabetes developing other types of diabetes any time after pregnancy? 9. What are the labour and birth experiences of women with diabetes, and how can their choices and shared decision-making be enhanced? 10. How can care and services be improved for women with diabetes who are planning pregnancy?
Postmastectomy breast reconstruction (Canada) 2021 713 respondents	1. How to determine the most suitable breast reconstruction surgery for each individual patient taking into consideration pros and cons of each procedure and the patient's unique medical history and personal values? 2. How can timely access to breast reconstruction services be improved across Canada for immediate and delayed breast reconstruction? 3. What are the rates of breast cancer re-occurrence and what patients are at a higher risk of breast cancer after breast reconstruction? 4. How does breast reconstruction surgery impact future surveillance? 5. How does radiation therapy affect breast reconstruction including the optimal wait time? 6. What are the satisfaction rates associated with each type of breast reconstruction? 7. Are there any rehabilitation treatments or exercises during the waiting period after mastectomy that are proven to help improve outcomes after reconstruction? 8. How can a patient prepare prior to surgery (for example: rehabilitation treatments and exercises) to improve outcomes after breast reconstruction?

	9. What are the pros and cons of the different types (materials) of implants available for breast reconstruction in Canada? 10. What is the evidence and safety behind fat grafting for breast reconstruction?
Breast cancer surgery 2024 260 respondents	1. Can complete lymph node removal (axillary clearance) be avoided in patients with spread of cancer to the armpit (axilla)? What are the alternatives and the outcomes of this approach? 2. What factors increase the risk of breast cancer returning? Is it possible to predict which patients are at higher risk to help them make a more informed decision about breast cancer surgery? 3. Are minimally invasive, image-guided techniques (e.g. vacuum excision or freezing) to remove or destroy the breast cancer a safe and effective alternative to breast cancer surgery? 4. In patients having breast chemotherapy before surgery, what is the best way of monitoring the cancer and is it possible to tell whether the cancer has completely responded to treatment without performing an operation? How long, if at all, after finishing chemotherapy should an operation be performed? 5. What is the best management of ductal carcinoma in situ (pre-invasive breast cancer) and how is this influenced by tumour and patient characteristics (e.g. patient age, hormone receptor status)? 6. Are there some low-risk breast cancers or lesions detected by breast screening that do not need treatment at all and how is it possible to work out which ones these are? 7. How does a breast cancer diagnosis impact on patients' wellbeing? What information and support do patients want around the time of diagnosis, during and after treatment, and what are the best methods to individualise this? 8. What are the outcomes of mastectomy with and without breast reconstruction? How should these be discussed with patients so that they have realistic expectations of outcomes and can make informed decisions? 9. What is the best method of follow-up imaging to detect whether the cancer has returned following breast cancer surgery and how is this influenced by tumour and patient characteristics (e.g. patient age, hormone receptor status)? 10. What is the impact of mastectomy with or without breast reconstruction on quality of life for women at high risk of breast cancer, and when and/or at what age should surgery be performed?

Sexual violence 2022 223 respondents	1. From the perspective of survivors of sexual violence/abuse, what does recovery involve, what outcomes do they value and what factors can promote these outcomes? 2. How can survivors of sexual violence/abuse who identify as People of Colour (POC) or as members of Black and Minority Ethnic (BAME) groups be best supported? 3. How can access to high-quality psychological therapies for survivors of sexual violence/abuse be improved? 4. What interventions with the general public could reduce misconceptions and stigmas about sexual violence/abuse and their consequences on survivors of sexual violence/abuse? 5. How can the process of police reporting and police investigation best support survivors of sexual violence/abuse and avoid re-traumatisation, distress and victim-blaming attitudes? 6. What support is most helpful to and valued by survivors of sexual violence/abuse themselves? 7. How can mental health services and physical healthcare services that are likely to come into contact with survivors of sexual violence/abuse (for example, dental care, general practice, accident and emergency, intimate healthcare and pregnancy termination settings) become more 'trauma-informed' to best support survivors and prevent re-traumatisation? 8. How does involvement in the criminal justice system impact survivors of sexual violence/abuse (for example, their emotional and psychological well-being), and what support do they need during and in the aftermath of criminal justice proceedings? 9. How can support be more accessible, inclusive and effective for survivors of sexual violence/abuse who identify as LGBTQ+? 10. How can survivors of sexual violence/abuse be supported to report sexual violence/abuse that happened many years ago, and what services should be offered to help them recover?
Menopause 2024 593 respondents	1. What are the safest and most effective non-hormone treatments (including prescribed medicines, herbal remedies and complementary therapies) for perimenopause/menopause in people who cannot, or do not wish to take HT (hormone therapy)? 2. What lifestyle changes (e.g. diet, exercise, reducing stress) benefit people at different stages of the menopause? How can people be supported to make these changes? 3. Does perimenopause/menopause lead to cognitive problems e.g. brain fog and memory loss? If yes, why, and how does this happen? How are

	these problems best detected and managed? Can they be prevented and/or reversed? 4. Why and how is sleep affected during perimenopause, menopause and post-menopause? What are the best ways to manage these sleep problems? 5. How long should people take HT (hormone therapy)? What is the best way to stop? 6. What are the best ways to help people prepare for perimenopause/menopause and recognise when it is happening? What helps them know when to seek professional help and to make informed decisions about treatment? 7. How do menopausal experiences vary across different countries, cultures and ethnic backgrounds worldwide? 8. What are the best ways to manage perimenopause/menopause in people who are living with/or have survived breast cancer? 9. Does HT (hormone therapy) change the risk of dementia? 10. How long can people with a personal risk of heart disease or cancer safely take HT (hormone therapy)? If yes, which type and dose of HT is best?
Midwifery practice and maternity care 2024 TBA	1. What is required to create and implement culturally safe maternity care in the UK for women and birthing parents, their babies and staff from the global ethnic majority? What role does decolonisation of the midwifery curriculum and ongoing learning in clinical settings play in improving cultural competence and safety? 2. What are the appropriate reasons for Induction of labour? What are the short- and long-term maternal and baby outcomes associated with it? How should this be communicated to women and birthing parents and their informed consent gained? 3. What are the important components of personalised maternity care to ensure informed choice and decision-making and how should this care be provided? 4. How does the culture within the maternity services, including racism, incivility and other negative behaviours among staff impact on midwives, maternity support workers and maternity care assistants and what can be done to address this? 5. What factors mean that birth is becoming increasingly medicalised, and what are the long- and short-term outcomes resulting from interventions? How does medicalisation impact on the choices that women and birthing parents can make and the clinical care that they receive?

	6. How can the causes and consequences of pre-existing psychological trauma during the perinatal period be better understood and prevented or the impact reduced? What role does trauma-informed care play in addressing it? 7. How can postnatal care be prioritised and improved so that mothers and birthing parents and their babies receive high-quality care that meets their individual needs? 8. How can the maternity services improve bereavement care? How should the best available information be used by maternity services to improve the bereavement care experience for parents who suffer a loss in their current or previous pregnancies? What support and care provision should be available for families following a maternal death? 9. How can midwifery continue to be an attractive career for potential applicants? How can midwifery students and qualified midwives be helped to stay in the profession in a way that provides a positive work environment and supports the provision of safe and compassionate care? 10. What are the specific needs of neurodiverse individuals (including those undiagnosed) throughout their maternity care, and what knowledge, understanding and communication skills should maternity care professionals possess to provide safe and compassionate care?
Pregnancy and childbirth (Uganda) 2025 300 respondents	1. Why do women get high blood pressure in pregnancy and how can its management be improved? 2. What causes excessive bleeding in pregnancy and after birth, and how can it be rapidly and effectively managed? 3. What causes complications in pregnancy and labour, and how can they be effectively managed? 4. What leads to so many women delivering by caesarean section and how can this be prevented? 5. What causes congenital abnormalities and how can they be detected and prevented? 6. What causes infertility and how can we best treat it in a low resource setting? 7. How can we improve communication with health workers at the time of labour and birth so that women understand what is happening? 8. How can the health services best engage with vulnerable high-risk women in the community? 9. How can health education be provided to mothers? 10. What causes infections in the newborn and how can they be prevented?

Polycystic ovary syndrome 2024	1. What are the optimal care pathways for women and people living with PCOS in the UK, and how can they be adequately resourced and delivered so they are all accessible to everyone with PCOS? 2. PCOS is known to be associated with several health conditions (e.g. cardiovascular disease, diabetes, endometrial cancer). What other health conditions are women and people living with PCOS potentially at risk of and why (e.g. fatigue, PMDD (premenstrual dysphoric disorder) endometriosis as some examples)? 3. How can the knowledge and clinical management skills of UK NHS healthcare providers, including GPs, be improved to better meet the needs of people living with PCOS? 4. How does a person's ethnicity affect their experience of seeking a diagnosis and the management of PCOS? 5. What is the effectiveness of non-pharmacological therapies (e.g. healthy eating, exercise, psychological and supplement-based approaches) in managing the clinical symptoms of PCOS compared to standard treatments such as the combined oral contraceptive pill and/or metformin? 6. How can accessible interventions be designed to effectively address the mental health and psychological needs of women and people with PCOS to support wellbeing and optimise physical health? 7. What are the different subtypes of PCOS? How and why do the subtypes affect diagnosis, symptom severity, management and long-term outcomes in women and people living with PCOS? 8. What are the effects of anti-obesity drugs on women and people living with PCOS? 9. Which strategies and treatments are effective in improving fertility and pregnancy outcomes in women and people living with PCOS, including during early reproductive years? 10. What are the effects of anti-androgen therapy on women and people living with PCOS?
Premature babies born <25 weeks' gestation 2025	1. What can be done in the neonatal intensive care unit to improve long-term health and developmental outcomes? 2. How can we improve the care of babies at delivery and in the hours after birth to improve outcomes? 3. What is the best way to prevent brain injury, including intraventricular haemorrhages (bleeding in the brain)? 4. What interventions or treatments during pregnancy and labour can improve outcomes?

	5. What are the long-term outcomes and how are they best predicted? 6. What is the best way to manage pain and distress in babies? 7. What is the most effective postnatal steroid treatment regimen to improve outcomes? 8. What is the best way for families to be more involved in the care of their baby during their hospital admission? 9. How can antenatal counselling be improved for families facing the possible delivery of a baby before 25 weeks' gestation? 10. How can families be best supported during their baby's neonatal intensive care admission?
Women's cardiovascular health and cardiac rehab (Canada) 2025	1. What are effective approaches to individually tailoring cardiac rehabilitation programming for women (i.e. taking into account age, other comorbidities, previous activity levels and individual preferences)? 2. What are effective approaches to reducing barriers to cardiac rehabilitation for women (e.g. related to caregiving, work and parenting responsibilities)? 3. What are the impacts of women's only cardiac rehabilitation programming on process and health outcomes? 4. What are effective approaches to supporting long-term follow-up for women after cardiac rehabilitation completion? 5. What clinical criteria (including stroke and cardiac diagnoses with or without acute events/procedures) should be used to ensure women who would benefit from cardiac rehabilitation are referred? 6. What are effective approaches to educating women about the importance and benefits of cardiac rehabilitation? 7. How can the cardiac rehabilitation environment be optimised to impact women's cardiac rehabilitation process and health outcomes? 8. What are effective approaches to incorporating individual dietary concerns into nutrition counselling as part of cardiac rehabilitation programming for women? 9. What would improve access to cardiac rehabilitation for women living outside urban areas? 10. What clinical parameters should be tracked and communicated to women so they are equipped to monitor their own cardiac rehabilitation exercise safety and progression?

References

[1] Partridge N, Scadding J. The James Lind Alliance: patients and clinicians should jointly identify their priorities for clinical trials. *Lancet* 2004;364(9449):1923–4. https://doi.org/10.1016/S0140-6736(04)17494-1

[2] National Institute for Health and Care Research, 2025. NIHR James Lind Alliance Priority Setting Partnerships rolling funding opportunity (HTA programme). The NIHR website, accessed 26 October 2025; https://www.nihr.ac.uk/funding/nihr-james-lind-alliance-priority-setting-partnerships-rolling-funding-opportunity-hta-programme/2025204

[3] Caesar Labs, 2025. Julius Ai [AI assistant; large language model] Version 4.5. The Julius Ai website, accessed 21 November 2025; https://julius.ai/

[4] Zucker I, Prendergast BJ. Sex differences in pharmacokinetics predict adverse drug reactions in women. *Biol Sex Differ* 2020;11(1):32. https://doi.org/10.1186/s13293-020-00308-5

[5] Horne AW, et al. Top ten endometriosis research priorities in the UK and Ireland. *Lancet* 2017;389(10085):2191–2. https://doi.org/10.1016/s0140-6736(17)31344-2

[6] Endometriosis UK, 2024. "Dismissed, ignored and belittled": the long road to endometriosis diagnosis in the UK. The Endometriosis UK website, accessed 21 November 2025; https://www.endometriosis-uk.org/diagnosis-report

[7] Australian Health Research Alliance (AHRA). Women's Health Research, Translation and Impact Network (WHRTN). The AHRA website, accessed 28 October 2025; https://ahra.org.au/our-work/womens-health-research-translation-and-impact-network/

[8] Ministry of Health – Manatū Hauora (New Zealand), 2023. Women's Health Strategy. The Ministry of Health – Manatū Hauora website, accessed 28 October 2025; https://www.health.govt.nz/publications/womens-health-strategy

[9] Office of Research on Women's Health (ORWH), 2024. NIH-Wide Strategic Plan for Research on the Health of Women (2024–2028). The National Institutes of Health website, accessed 28 October 2025; https://orwh.od.nih.gov/about/strategic-plan

[10] FDA Office of Women's Health, 2024. Women's Health Research Roadmap. The US Food & Drug Administration website, accessed 28 October 2025; https://www.fda.gov/science-research/womens-health-research/womens-health-research-roadmap

[11] Irish Department of Health, 2021. Minister for Health publishes report of women's voices on women's health in Ireland. The Government of Ireland website, 28 October 2025; https://www.gov.ie/en/department-of-health/press-releases/minister-for-health-publishes-report-of-womens-voices-on-womens-health-in-ireland/

[12] James Lind Alliance (Canada), 2025. Women's Cardiovascular Health and Cardiac Rehabilitation Priority Setting Partnership. The Women's Cardiovascular Health and Cardiac Rehabilitation Priority Setting Partnership website, accessed 28 October 2025; https://www.cardiacrehabpsp.ca/

[13] Canadian Institutes of Health Research (CIHR), 2022. National Women's Health Research Initiative. The CIHR website, accessed 26 October 2025; https://cihr-irsc.gc.ca/e/53095.html

[14] MBRRACE-UK, 2023. Saving Lives, Improving Mothers' Care: State of the Nation compiled report—lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity, 2019–21. The MBRRACE-UK website, accessed 21 November 2025; https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2019-2021

[15] Office for National Statistics (ONS), 2022. Socioeconomic inequalities in avoidable mortality in England: 2020. The ONS website, accessed 21 November 2025; https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/socioeconomicinequalitiesinavoidablemortalityinengland/2020

[16] NHS Race and Health Observatory, 2022. Ethnic inequalities in healthcare: a rapid evidence review. The NHS Race and Health Observatory website, accessed 21 November 2025; https://nhsrho.org/research/ethnic-inequalities-in-healthcare-a-rapid-evidence-review-3/

[17] James Lind Alliance. LGBTQIA+ Perinatal Care PSP. The James Lind Alliance website, accessed 13 November 2025; https://www.jla.nihr.ac.uk/priority-setting-partnerships/lgbtqia-perinatal-care

[18] Department of Health and Social Care, 2022. Women's Health Strategy for England. The UK Government website, accessed 13 November 2025; https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england

Find out more at

rcog.org.uk

Royal College of Obstetricians & Gynaecologists

rcog.org.uk |  @RCObsGyn |  @RCObsGyn |  @royalcollegeobsandgynae