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Women and Equalities Committee

Oral evidence: Women's reproductive health conditions, HC 337

Wednesday 13 November 2024

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Members present: Sarah Owen (Chair); Alex Brewer; David Burton-Sampson; Kirith Entwistle; Natalie Fleet; Catherine Fookes; Christine Jardine; Samantha Niblett; Rachel Taylor.

Questions 1 - 48

Witnesses

I: Dr Sue Mann, National Clinical Director for Women's Health; and Professor Dame Lesley Regan, Women's Health Ambassador for England.



Examination of witnesses

Witnesses: Dr Sue Mann and Professor Dame Lesley Regan.

Chair: Good afternoon and welcome to the Women and Equalities Committee—welcome to all the guests here, as well as our witnesses. Today we will look at women’s reproductive health conditions, following a series of evidence sessions held by the previous Committee during the last Session. We will hear from two expert witnesses: Dame Lesley Regan, women’s health ambassador for England, and Dr Sue Mann, NHS national clinical director for women’s health. I am grateful that you are able to join us today. Thank you both for coming. I will hand over to Kirith.

Q1 **Kirith Entwistle:** Thank you very much, Dr Mann and Dame Lesley, for your time; we really appreciate it. I will start by asking something that I am sure you have both heard a lot of, as I have from friends and family. Women have reported having their symptoms dismissed and normalised by GPs all too often. What is being done to address those concerns?

Professor Dame Lesley Regan: That was a major finding of the women’s health strategy, which, as you know, was responded to by over 100,000 people in the country. I believe the figure was that 82% of women felt that they had been dismissed or ignored, or that they had not been taken seriously. The reproductive health survey, which the London School of Hygiene and Tropical Medicine launched last year, has found similar concerns.

One factor that we have both been working on is trying to ensure that the things that women commonly have during their reproductive and post-reproductive life become part of everyday chat. My example is always this: there is nothing else that happens to human beings quite so commonly as 12 periods a year for 40 years of their lives. If, every year, they have 12 days when they cannot function or go to school, it is a massive disability. Rather than saying, “Oh, it’s just a period—forget about it,” because it is embarrassing to talk about, I would like everyone to be talking about it. That is the way we would get our healthcare professionals to understand what a massive impact it has if periods are disabling, and to understand what normal is.

People often ask, “Well, what should I say?” I ask them if they are still having periods and, if the answer is yes—because you have to be a little bit sensitive to people who may be menopausal—I ask, “Do they ever stop you getting on with your life?” If the answer is yes, that is not normal and they need some help. If everyone adopted that, we would not have an enormous number of the problems we have.

Dr Mann: I agree with all that. It is a shocking statistic that we have seen and it is really important that this is known about. There are three aspects: listening to women—that is really important—what we will do about it, and how we will know we have made a difference. In thinking



about how we listen to women, we have asked them for evidence, which has been really useful—how do we continue to do that well? There are some things that need to happen nationally, which we are working on together. How do we bring women to the national decision-making boards? How can we get proper representation for women who have lived experience? That is complicated.

Already, there are some really good groups we can call on. We have the Health Collective, which is a Wellbeing of Women group that we have spoken to quite a lot. The RCOG has women's networks. It would be important to talk to them. We are trying to think about how we get the voices of women who do not often get heard. We are making equalities central to what we do and making sure that it shapes strategy. If you get it right for the women who are least heard, you get it right for everybody.

But we cannot have a homogenous response. One person's experience is different from the next, and that is really complicated. Having good representation at decision-making level is important, but you also have to go more locally, because populations vary. What is true in the centre of London, where we are, will be very different in, for example, rural Devon, so trying a one-size-fits-all approach will not be effective.

We need to think about that and make sure that local areas are equipped to speak to women in their patch. We want to support local areas to reach out to those women and put equalities within the plans that they make, ensuring that it threads into ICB plans properly. They already have a requirement to respond to inequalities, and helping to put women's health issues into that would be really good.

There are a whole lot of things to do in between to make sure that we polish up what women actually get, which I am sure we will cover in a bit. And then it is about coming back and thinking, "Have we done okay? How do we listen to women properly?" The reproductive health survey was really useful for that, in thinking about what else we can run to keep an eye on what is happening.

Q2 Kirith Entwistle: On that last point, from your experiences, do you think that intersectional differences are sufficiently understood by medical professionals? For example, is there understanding of how somebody's ethnicity or culture might affect their reproductive health?

Dr Mann: We have heard from women that there is not and that is important to listen to. Obviously, the differences are not all the same. Intersectionality is really important and, often, ethnicity links with deprivation, for example. Trying to put those things together is important, as is not saying that the experience of one group is the same as another. We need to get smarter as clinicians at not making assumptions. There is a lot of unconscious bias going on, and a lot of training needed in the clinical workforce to make sure that those things are at least recognised, and the right questions are asked, because we probably will not know. We have to assume that we do not know.



Professor Dame Lesley Regan: We could give you quite a few examples of where a particular faith group or community does not have actual words to describe something. There are some south Asian countries in which there is no word for “breast”, and in others, the word “menopause” does not exist. It is then very difficult to understand that if you have not been used to it.

That is one of the reasons why, 18 months ago, we set up the women’s health collective, based at Wellbeing of Women, which is the women’s health charity that I chair. I set it up with Nighat Arif, the Muslim GP, and the proposal was that we would invite a representative from every disadvantaged or marginalised group that we could identify—so as well as ethnicity and religious groups, we have also got neurodiversity, physical disabilities and hearing or sensory disabilities as well. I have to say, I have learned an enormous amount from listening to them.

The first thing I would say is that before you can do anything about providing better help or care, you should become, as you say, more aware as a white Caucasian well-educated woman of what these people need and what they want, as opposed to what people who look like me think or have been taught that they need or want. In order to have that conversation, a lot of work has been done on building up trust. So 18 months down the line I think we now have a group who are very responsive when I ask them for their feedback on things, because they know that I am not just getting them to tick a box but actually want to know what they think.

Q3 Kirith Entwistle: That is great; that is really good to hear. Thank you so much for sharing some of the work that you have been doing on this issue. I also want to find out what work is being done to prevent some of the racial biases that we have seen, particularly around women’s pain thresholds.

Professor Dame Lesley Regan: I just do not understand how that has come about, really. It is not that I am naive or have my head in the sand; I just find it so extraordinary that if someone is in pain, particularly when they are in labour, you do not do everything you possibly can to alleviate it. There is also an issue about procedures such as hysteroscopies and insertion of Mirena devices and things like that in clinics.

It has been a bit of a Catch-22, really. I can remember that 15 or 20 years ago, we were all being told that it was a really bad thing to give a woman a light general anaesthetic to do a hysteroscopy or insert a coil, particularly if she was a nulliparous woman—that is, she had never been pregnant, so the cervix had never dilated and it was likely to be more difficult—or perhaps if she was very overweight or had uterine fibroids that changed the shape of the uterine cavity so that it was more difficult. We were all encouraged to do that in out-patients, and now of course we have people who feel that they have been really quite physically abused by the pain that they have experienced during a procedure. It is not necessary to have a painful out-patient procedure if you use enough local anaesthetic and actually talk the woman through it and explain what you are doing at every stage along the pathway.



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Dr Mann: It is really important to think about pathways, because those differences happen all the way along, and to start thinking about how women get their information about the procedures that they are going to have. For example, there is some really good information on the NHS website about procedures, but it is about ensuring that the right people have access to it and that people get their information early and understand what choices they have. Of course, that information may not be accessible; for example, we have heard a lot about the issues, in particular, for women who do not speak English. How are we going to cater for them? Again, that will be down to really understanding local populations and making sure that local areas know their local population, so that they can ensure that they have the resources in the right languages. That is at an ICB level, but making sure that we support them to do that kind of work is essential.

Moving on to the next phase, it is about, when someone actually comes into care, how they can have a meaningful conversation that does not inject any biases into it. That is a very difficult thing to ask, because we are all biased on some level, and it is about trying to have proper, shared decision making, because a range of options are open for procedures. The majority of people do not necessarily find them painful. If we select people appropriately, with them, to have the right level of support in preventing pain, hopefully fewer people will experience pain. But it is really important to give people choice and make sure that they have the thing that is right for them—they will not know that unless you have a proper discussion—and the system then needs to be ready to do that.

We can think about, for example, IUD insertion. We are doing a lot of work—I am sure we will come on to women's health hubs—to try to widen access to things like IUD insertion, and we have a really skilled workforce. That helps with pain, but it also helps with that kind of selection. Things like community diagnostic centres that have been opened, which are diagnostic centres in the community, are also well placed to do things like diagnostic hysteroscopy, ultimately, if that is what the local area decides. It is about having the places set up well, because not everybody who does these procedures will have the full range of local anaesthetic available, so we need to make sure that people go appropriately.

Professor Dame Lesley Regan: It is also about making women aware of what they can and should ask for, because I don't think many men would go to see a urologist and have a cystoscopy without anaesthetic. I think we have to make the narrative a bit different—that you do not need to have this discomfort, and you need to explain that. I am sure Sue would agree that one of the most useful things you can do, if you are doing something to a woman in gynaecological out-patients, is to tell her, "If you're uncomfortable and you want me to stop, tell me immediately." Just that very knowledge that she has some control over the situation usually calms people down quite considerably. At the end of the day, it is not a pleasant thing to do—I don't like having my coil changed that much either.

Chair: Before we move on, I want to dig down on a specific point around



ethnicity and culture and women's pain. I am a big fan of Nighat's work as well, and if anybody watching does not know Nighat, please follow her on social media—she has a wealth of knowledge. Dame Lesley, you talked about trust, and that is really important, particularly when it comes to FGM. This is something that I am seeing increasingly in my inbox, and I know this is still happening in the UK, as well as women being taken to other countries for that to happen. The trust element is so important. How are you able to gain that trust, particularly with women of childbearing age of 25 to 32 who have been subjected to FGM, usually by a family member?

Professor Dame Lesley Regan: I remember when I was a very junior consultant and I first went to St Mary's, part of the Imperial group. I was the only woman consultant obstetrician and gynaecologist—which, in itself, is a bit of an oxymoron these days, isn't it?—and the reality was that I could not understand why I kept seeing all these young women from the east and middle east who had never been able to disclose that they had had FGM. The very striking thing, coming back to your point about trust, was that it was not the physical act that distressed them so much, and it was not even the fact that this was part of a male cultural imposition; it was the fact that their mum, auntie or big sister had been complicit in it. They told me—I had no reason to disbelieve them—that that was the thing that haunted them most, and that they could not understand why another woman would do this willingly to somebody. I think most of the solution to this is recognising that I do not understand all the cultural mores, if you like, and asking people to please help to inform me of what I need to know about what they feel about something, or where they are coming from, so that I can appreciate their position.

Q4 **Chair:** On a more patient-facing level, what do you think needs to be done, Dr Mann? Does more work need to be done particularly in this area? We heard a lot about FGM, say, five or 10 years ago, but it seems as though people have stopped talking about it quite so much. Actually, what I am seeing in reflections from communities is that the problem is very much still there, and it is a problem when they disclose, even if they speak to their GP. One woman was even told that it was just cosmetic work and to see a plastic surgeon. I am wondering whether more work needs to be done on that level.

Dr Mann: Absolutely, and I think the trust has been eroded. Part of it is understanding what we need to do from the communities we are serving and working closely with the voluntary sector to know what that might be. But I think we have a responsibility as clinicians as well when we see people in clinics. Often, we will do a gynaecological examination, and it is the one opportunity to recognise FGM and then initiate a conversation, so we have an opportunistic duty to do that. Women experience awful things apart from the trauma of the actual procedure—they have urinary problems, sexual difficulties, all sorts of pain and infections. It is about giving people the opportunity to have that conversation and to decide for themselves—it is a choice. I have seen quite a few people who have said, "No, thank you. I'm absolutely fine." I might examine them and think, "That surprises me", but it is even having that first conversation and

following it up, because after that, we have specialist clinics—but if people are not using them, we are not getting it right, so I think that is really our duty.

- Q5 **Rachel Taylor:** You have touched on some of the areas that I was going to ask about in respect of painful procedures. Women have described feeling pressurised into enduring severe pain during routine procedures like hysteroscopy and being ignored or belittled when they cannot endure it. That might be because of a lack of availability of anaesthetists on the day that they are in the out-patients department, but what is being done to challenge those behaviours, with people feeling belittled and so on?

Professor Dame Lesley Regan: By talking to women, by demonstrating that we now have a women's health strategy—we have not just an ambassador, but a national clinical director, and they are leading it and have a bit of expertise in this field. That is not a very satisfactory answer to "What can we do?", so a lot of this is about education. I find it strange that you have to educate a nurse, a doctor or any form of healthcare professional to recognise that they must be sympathetic about pain, because that is something that is probably inherent to your training if you go into the health world, but obviously we do, because they are feeling belittled. A lot of it is talking people through it and explaining to them that they are in control and that if they find it too overwhelming, you will stop.

Rachel Taylor: Do you want to add anything to that, Dr Mann?

Dr Mann: Yes. I agree that there is a real effect of having someone who is confident and professional doing the procedure to help someone through the procedure. No one should ever be pressurised into enduring something that is painful without, as Lesley says, stopping. The idea that people are pressurised is very uncomfortable.

Thinking about a couple of things, obviously we work closely with professional organisations, and the RCOG and the Faculty of Sexual and Reproductive Healthcare have produced a guideline on procedural pain. It is one thing having a guideline, but—really important—the next thing is making sure that people adhere to it. Sometimes difficulty adhering to a guideline is about what is available in the system to provide.

We need to make sure that we have that tiered system, so if you are someone who, for example, has had a lot of vaginal deliveries and had procedures before, you are likely to tolerate it very well, so that could be done in a relatively low-key setting, or as an out-patient, but we must also look further, going towards where someone gets general or local anaesthetic if they need it. It is understanding that to begin with and making sure that the procedure starts in a place where that will not happen—but we can always stop a procedure. Doing that is a professional education thing.

- Q6 **Rachel Taylor:** Often, however, women begin the diagnostic process for reproductive health issues when they are girls. They may never have had penetrative sex and the idea of a painful, invasive procedure can be



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intimidating. How do we make sure that young women, girls, victims of domestic violence and rape, and lesbians who are not used to having penetrative sex are able to be looked after in that sort of setting? I think most of us appreciate that, as women, we are able to have a voice and say that we can stop these things, but if you are in one of those groups, it is so much more difficult. What can we be doing more to help those groups?

Professor Dame Lesley Regan: A very practical point is that if I were a paediatrician—I am not—and I were ordering some blood tests to be performed on, for example, you, Samantha, I would, in addition to ordering the blood tests, give you a prescription for some Emla cream to put on your arm so that it anaesthetised the arm before you had the needle put in. If you are going to send a young girl and you want to make sure that in the future she doesn't fear going to see a gynaecologist, that she is going to turn up for her cervical smear and that she is going to use the very best form of long-acting, reversible contraception that will suit her, so that she gets pregnant only if, when, with whom and how many times she wants to, why not just order the blood tests and also give her a prescription for some Instillagel? I think it costs £4.50 or a fiver. You give them the prescription, and then they take it along with them.

They are just practical things that I have learned on the hoof, but you are right, in that nobody puts that into the pathway. That is what Sue and I have to work out and what we want to try to establish in the women's health hubs that we are both championing. We want very senior people to be doing the triage of the referrals, so that there is that added layer of expertise and knowledge to think, "Well, Rachel will probably be okay there, but Catherine wouldn't be, because she has that particular history or she has had that problem in the past or her children were delivered by Caesarean section, or whatever."

Q7 **Rachel Taylor:** Do you think that is something that can be put into guidelines?

Professor Dame Lesley Regan: Yes, I think it can be. We also need to work with the curricula and to get the training programmes—at the RCGP, the RCOG and the Royal College of Midwives—all to understand that personalised care. I don't think that is difficult, but it seems that there has been a void, given all the people who have complained and said differently. It needs to become a part of everyday work.

Dr Mann: We really need to think carefully about trauma-informed principles guiding what we do in reproductive health. That should become more universal. We often think about it in particular settings, but actually it needs to shape everything we do. The young women, I would hope, mostly don't have internal examinations without a very good reason to do that. For people who have never been sexually active, that should be standard practice. To examine someone internally, there should be a very good reason, and a very big conversation about how that might happen. But there are plenty of other women for whom examination is really difficult. That may or may not be because they have had previous sexual

trauma. It might be because they are post-menopausal and it's very uncomfortable.

There are all sorts of reasons, so it goes back to the same principles about good consultation skills, but also having the facilities. I think we are going to keep mentioning hubs, aren't we? But there is a case to say this needs to be done in a setting where there is someone who is very familiar with doing intimate examinations, so they are very expert and thinking about what preparation might be needed. This is also about making sure that we do only the things that are absolutely necessary. Patient choice comes at the front of that, because actually all women can choose, given the right information, so that's about shared decision making: "These are the consequences of not having and these are the consequences of having the examination. Would you like it or not?" I think that's important, too.

- Q8 **Rachel Taylor:** Thank you. I want to move on to a slightly different topic, about different reproductive health conditions. Do you think there is sufficient guidance on the different health conditions? For example, should there be a NICE guideline for each reproductive health condition? That question is to you, Dr Mann.

Dr Mann: We are really glad that NICE now has a suite of reproductive health guidelines. We have had two new guidelines—one updated and one published—in the last week. Those are a menopause one and an endometriosis update. We really welcome that. Of course, NICE guidance is always useful in shaping and setting standards for what care gets provided. Obviously, it is only guidance, but it does really drive what should happen and how we set standards for delivery of care.

You say, "for every condition". Lesley and I talk a lot about conditions being a continuum. Endometriosis is a good example: you have endometriosis, but then you have pain, so you have a whole continuum. What conditions actually need a guideline? We need to look where the gaps are, and we work very closely with NICE to start thinking about how to shape that and then how to provide decision-making tools alongside those. It is difficult to say there should be guidelines on everything. I think there should be on the conditions where we do not have enough guidance to shape good care. That is an ongoing conversation about where the gaps are and what we need most urgently, and then supporting the development and the delivery of that.

- Q9 **Rachel Taylor:** Do you think it matters that the guidelines are, in effect, being produced by different organisations? Or do you think that helps to inform them, because they are being developed by groups and organisations that know the specific condition better?

Professor Dame Lesley Regan: NICE have done a lot of work recently on collaborating and utilising other people. For example, they have been asked to produce a guideline on polycystic ovarian syndrome. Jonathan Benger, who is heading up the suite on reproductive health and women's health issues, felt that the Australian one published last year or 18 months ago was very comprehensive, so why didn't they refer to that? I would



encourage that, because the more collaboration we get, the more uniform the understanding will be, and that means we can also then have resource to tackle other topics that do not have guidelines. I think it is the bane of both our lives. Somebody else reinvents the wheel and calls it something different. We just need to collaborate a lot more.

Q10 **Chair:** I want to come back on the last two points you both made. You talked about gaps in guidelines, and illnesses or conditions that do not have guidelines; which are the ones that do not have guidelines that you believe should be a priority?

Professor Dame Lesley Regan: We have done quite a lot of work in the last two years on improving the NHS website, and there are now 100 topics grouped together under a women's health section. I think everybody knows that Naga Munchetty asked me on BBC Radio 5 Live, "Why is there nothing about adenomyosis?" My commitment to her was to get adenomyosis on the map, and it was done within two months. You know, it takes a lot of pushing, and there are all sorts of competing pressures on NHS Digital's time, but we have managed to do that.

I sometimes say to my patients when I suggest they look on the website, "It's not a very dramatic website, is it? It's very blue and very monochrome, it has to be done in a certain way and it's got to be in alphabetical order." But they do now have some really helpful links to videos and animations, and there are all sorts of other ethnically diverse—if you like—ramifications of it, so I think it is a lot more interactive. Well, no, the website is not more interactive, but it really does signpost. You are not just told to go off and find something; you can press on the link and get there.

Dr Mann: Often, the guidance is out there; the point of having it at NICE is that it becomes very accessible to people, so it is always good to get NICE guidance to shape what we do. Much like Leslie said about adenomyosis, we need to listen to what is not there. Polycystic ovarian syndrome is another one that is coming through the pipeline in terms of what we should do. We already have an international guideline, and the authors of that are going to be very much instrumental in the NICE guidance, as Lesley pointed to. We hear and then we work with NICE to try to help to prioritise the topics that come through, but there are a lot of competing pressures.

Q11 **Catherine Fookes:** I am a Welsh MP, which sets the context of my question. I understand that NICE guidelines officially only cover England, but then the decisions on how they apply to Wales are made by the devolved Government. It seems that they could sometimes cover Wales as well, so how does that work in practice? I hope it is okay to ask that question, Chair; it is important that people in Wales know how this works for them.

Professor Dame Lesley Regan: I would respond by saying that it is on a website, so you can just go and get it. We need to ensure that we provide



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women—and the healthcare professionals who are looking after them—with the signposting they need to access the information they need.

Dr Mann: In terms of topics, we do work closely with, and we both know, the leaders in Scotland, Wales and Northern Ireland, so we are in constant conversation. Often, the health problems are pretty similar and the need for guidelines is pretty similar. That would influence the direction of travel as well, but obviously not directly, because I am in NHS England.

Catherine Fookes: I get that. Thank you.

Q12 **Chair:** I want to ask a follow-up question on that, as someone who was recently diagnosed with adenomyosis—it took a while. The information that you have said is out there is not always easily accessible, even for someone as well briefed as me. We do not always use websites, and in particular we tend not to use websites that are not accessible or interactive. I wonder how you measure the success of the guidelines, in terms of how often and how well practitioners are using them, but also how patients are accessing them.

Professor Dame Lesley Regan: Wearing my Wellbeing of Women charity hat, we have a very interactive website, and I run an extremely well-attended monthly webinar on stigmatised or difficult topics, or things that people do not normally discuss over dinner. I can talk to the data people there and they can tell you about the clicks and whatever, and I am sure that whoever runs the NICE website could provide that information too, but I think it is much more about raising public awareness. There have been several campaigns. The Department of Health ran one earlier this year about not suffering in silence with period problems, and Wellbeing of Women have just won a prize in the third sector for their Just a Period campaign, which is a film campaign featuring women from a wide variety of ethnic minorities talking about their experiences and encouraging women not to have pain or heavy bleeding that they cannot manage.

I come back to my earlier point that if your period stops you getting on with the rest of your life, that is not normal, and you need help. We talk about the fact that women are waiting seven or eight years to be diagnosed with adenomyosis and endometriosis. If every healthcare professional you went to had asked you about your periods, you would not have developed endometriosis, certainly—adenomyosis is a little more complex in the way it is formed, but you would not have developed endometriosis. You do not wake up one morning saying, “I’ve got endometriosis” or “I’ve got polycystic ovaries.” It is a progression. If we prioritise the common things that women experience from very early in their reproductive lives, then I think we will massively reduce the morbidity and the suffering that they experience.

Dr Mann: I think it is also important to think about where people get their information from. I am plugging the NHS website, but I do think it is very good for these kinds of conditions. There is a page on adenomyosis. That is monitored for clicks, but the proof is in the pudding: did people feel that



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they got the information they needed? We need to keep asking people whether they are informed and know what to do. The basis of any information strategy is people feeling that they have enough information to know when they need to do something about it, and then to understand what they have been told. If we are not getting that right, we need to listen to that and hear it.

Chair: Thank you. I will bring in David, and we will move on to medical training.

Q13 David Burton-Sampson: Thank you both for coming in today. This question is to you initially, Dr Mann. I know from a family member with an experience similar to Sarah's that it can take a very long time to get to a diagnosis of endometriosis. We have heard similar concerns about the test procedures and then the actual treatment, with people often just saying, "Okay, the treatment is that you're going to go on to the contraceptive pill," or whatever. Do you think the training for medical professionals is up to standard? Is it sufficient for them to diagnose and then move on to the treatment of individuals once they are diagnosed?

Dr Mann: I am sorry to hear about your family member. I think that is the experience of a lot of people. That has come up our agenda, and it is really important to know and understand. A lot of people have waited a very long time for their diagnosis of endometriosis. That was highlighted in the recent NCEPOD report, but the updated NICE guideline is really trying to shift towards improving earlier diagnosis.

Let me take it back a bit. Training is really important, but it needs to happen at every stage. First of all, we talked about women being taken seriously. Women very often have awful period pains that keep them off work, and they will say to me, "Well that's just my periods. It's normal. I don't go to school or work for a couple of days every month." I have to say to them, "No, that is not normal. That is not as it should be." So that is the first thing—trying to help empower women to not feel like they are being a bother if they come and say that they are having pain.

The second thing is that we need to treat every person with pain the same to start with. A diagnosis of endometriosis is a process. Often the way that we treat pain for periods is the same as the way we treat endometriosis. The difference is that if it does not get better, we need to go to the next stage. What is really important is getting people on the frontline to be good at listening to people's complaints of pain and taking early steps. Sometimes that is just good pain relief, but in the actual treatment for endometriosis, the first line tends to be hormonal. We recognise that in the community there has been a lot of worry about hormones. Whatever we say, there are some people who do not want to use hormones. Rather than say, "Well, that is the best thing for you," we need to get good at listening and saying, "Okay. That would be the best treatment at this stage for you, but it is your choice." It is about having those initial conversations in a sympathetic way and saying, "Here is a range of treatments. These are the kind of things that may happen, and this is what won't. What would you like to do?"



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We must be making sure that people get early diagnostic tests. We know that ultrasounds are really important early on, and we want people to know that. That is in the guidance, so people should be following it. That is what I would say about the general level, when people come to their first port of call.

In terms of the training, we are really talking about primary care. There are lots of resources around that. The RCGP has some very good resources, including a library of women's health resources that can be used and that is regularly updated. There is also the Primary Care Women's Health Forum. A lot of work is going on. We know that there is still variation; GPs have to do an awful lot of different things. Understandably, some of them are more expert in women's health than others, and the others may be more expert in something different. It means that women will get some variable experiences, but we want to make sure that if people do not get help at the first port of call things do not just stay as they are. We will reduce these 10-year lags to a diagnosis if we just ensure that the "Are you getting better?" question is asked or people are told, "I cannot help you, so I am going to refer you somewhere else."

The next stage would be that intermediate layer of care—hopefully in the community—with slightly more specialisation, and then potentially on to specialist services. We know that NHS England is developing a service spec for severe endometriosis to make sure that that end of things gets managed much better. So it is about diagnosis, effective treatment and then being linked in with pain specialists and the other important members of the team.

The last thing to say is that we know that endometriosis is important for fertility. When we see younger women who have an intention to become pregnant at some point in their life, we need to think about making sure that we act as quickly as we can.

Q14 David Burton-Sampson: This might be a question for both of you. What needs to be done to improve current practitioners' access to professional development on women's reproductive health conditions? Is there more that can be done?

Professor Dame Lesley Regan: It is in prioritising training, both medical and nursing training, the importance of the 51% of the population and the fact that so many of the problems women experience and have had a bad deal with in the past, if you like, are very common day-to-day issues. We have to make sure that they are catered for. I often find when I am talking to women that on most of the occasions, they go to see healthcare professionals they are not sick; they are trying to do something to maintain their health or prevent a problem happening later. We have to ensure that all the clinicians we train appreciate how common these things are.

I have given you several examples, and I will not repeat myself, but 51% is a large percentage of the population, isn't it? There is also an



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inevitability about becoming menopausal if you have had periods. There are 400,000 women who enter the menopause each year. So instead of this being a great big surprise and us having to have a celebrity campaign over the last two to three years to make it something that is talked about, we need to recognise that although so much of life is unpredictable, for the things that are predictable let's get upstream and make sure we have catered for them in good time.

On things like period problems, contraception and menopause, women should not have to go to secondary care—to a hospital—in the first instance to have those sorted out. It should be a very routine thing, close to home and in the neighbourhood. As Sue said, if in the follow-up, when they are asked, "Are you feeling better?", "Are you going back to work?" or, "Can you go to school now?", the answer is no, that is when you need to refer into specialist services.

- Q15 **David Burton-Sampson:** When we look at the diagnostic figures, we see how long it is taking women to get diagnosed and how many times they have to visit a GP before somebody eventually says, "Right, okay, we've got to now start doing something about this." Can we look at a way to perhaps start incentivising medical practitioners to take up training? There is clearly a gap across the industry, and we have to do something to close that gap.

Professor Dame Lesley Regan: One of the things that Sue and I feel very passionate about is establishing women's health hubs and ramping them up, or scaling them up, not just because they provide good care provided by people who are interested in women's health, and will therefore invariably, I think, do a better job—if it is something they find interesting and rewarding—but also because there are fantastic training opportunities.

I would like to take the GPs who have not done much obstetrics and gynaecology during their training—I believe you do not now have to have done an O&G rotation when you do your GP training course—and we could rotate them through and we could rotate our trainees through. It would be fantastic. I have young trainees who are perhaps a year or two off becoming a consultant, and when they are with me in an operating theatre, they do not know what something is, because they have not done those common or garden things. They may be very specialist in other things—they may have very specialised skills—but sometimes we forget, and we need to keep reminding people, that what is common needs to be sorted out easily and quickly, close to home.

David Burton-Sampson: Dr Mann, do you have any thoughts?

Dr Mann: Yes. It is important to make sure that you have the right skill mix. I would like to see women's health hubs as looking after a population and saying, "We need the right people to provide care for that population." So there will be some people who will be able to make an initial diagnosis, do the right diagnostic tests and make a sensible referral, and then, as Lesley was talking about, there will be the more specialised tier, who want



to do more. I have some really excellent GPs who work with me in the hub where I work, and it is a really important career development pathway for some. It improves retention. It diversifies portfolios.

Also, as Leslie was saying, we can start to rotate people through so that they get some exposure, but they might just go back to general practice, which is also really important because we still have to have that general layer. But we do need to find ways to help people to get the experience, and we are looking into that. We are looking at what kind of workforce and what skills are needed, and thinking about that being aligned to the 10-year plan, because there will be a workforce element to that.

It is about thinking about how we can ensure that we have got training right in women's health to provide all the tiers, because it is not just about doctors. It is a multi-professional workforce, so we also need pelvic physios, for example. It is about thinking about who those people are and then whether we have the right skills there. We probably have a lot of the things that are needed for training; we just need to pull them all together.

- Q16 **Catherine Fookes:** I have a quick follow-up question. I wanted to check that I had heard right that people who train to be a GP do not have to do obs and gynae rotation.

Professor Dame Lesley Regan: No, they don't. When they choose their rotations in their vocational training scheme, I believe that they do not have to do obs and gynae now, whereas it used to be mandatory.

- Q17 **Catherine Fookes:** That seems absolutely mad to me. I am in a very rural constituency in Monmouthshire, and at the very least, in my opinion, you need to have at least one person in your GP practice. In fact, when I was CEO of a women's equality charity, before I came here, we were campaigning very strongly across Wales, and across the UK, to have at least one specialist on women's gynaecological conditions in each GP practice.

I have a group of 80-plus-year-old women who cannot get their pessary changed. They have been told that they cannot have their pessary changed—that is about a prolapse issue—at the local surgery. A couple of them cannot drive, but they have been told that they have to go to a hospital half an hour away, and there is no public transport.

Professor Dame Lesley Regan: On Monday morning, I was in the operating theatre. I was looking out of the window and I saw an elderly lady come out of an ambulance accompanied by two ambulance drivers and a carer. They went into the gynaecology out-patients and I was thinking to myself, "I bet she's gone to have a pessary changed." Quite often, I have elderly women saying, "Well, this is the third time I've been. The ambulance was late so I missed the appointment last time." Can you imagine the resource that is wasted on something that could be done in five minutes in their own home? As long as they do not have arthritis and they are not too squeamish about it, we could teach those women how to change their own pessary. It is not difficult.



Q18 Chair: You have both alluded to the need for women's hubs. I wanted to ask some questions about them. Do you think that the funding for women's hubs has been effective? Are there enough hubs across the country to ensure that all women and girls have access to the sorts of services that you have just talked about?

Professor Dame Lesley Regan: No, and I don't think that anyone is pretending that there are enough yet. It is a pilot. It was decided for the pilot that the finance—the £25 million—would be split up between the 42 ICBs equally, not because it covered the population in a fair way, but because that would give every ICB an opportunity to set up a pilot, and we would not then be effectively endorsing the ones that were performing well to do even better and the ones that were performing poorly to do even worse.

I am an incurable optimist, which is fortunate really, but the enthusiasm that we have met in the various ICBs—I have visited all of them—has been absolutely enormous. Individuals have told me that they have stopped doing something and have decided to go and work in this. As Sue mentioned earlier, it is not just about providing good care.

We have a big problem with our workforce in the NHS. We are the largest employer of people in Europe and 80% of them are women. If a lot of those women are having period or menopause problems, and we are not sorting them out and easily getting them back to work, we have a workforce problem. The reward comes from working in a service where you feel as though you are doing a good job and you are not having to say, "No, you can't have that, because I'm not commissioned to do your smear," or, "No, you can't have that, because I'm only allowed to give you contraception, not sort out your heavy menstrual bleeding"—that is demoralising. It is going to be not only a recruitment tool for staff, but a workforce retention tool, which we badly need.

Q19 Chair: Has that enthusiasm from ICBs been matched by need? Are the enthusiastic ICBs the places where you are seeing the greatest need?

Professor Dame Lesley Regan: I would say yes, because I think of North East and North Cumbria, which have some of the highest levels of deprivation. They have embraced this wholeheartedly and were the first ICB, I believe, to set up three hubs. They decided that they were going to prioritise that because they thought it would be so valuable.

Q20 Chair: Have the ICBs ringfenced the funding?

Professor Dame Lesley Regan: No. To go back a moment, if I may, when we decided to ask every ICB to set up a hub, we also set up a group called the network of women's health champions and asked every ICB to send someone to a meeting. We have had nine or 10 meetings now—they are usually monthly, with a break over the summer—so it has been going for over a year. It is not 36 or 42 people who turn up; it is usually more like 90, so there is a lot of enthusiasm for it. What some of them were telling me sotto voce was that, no, they did not think that the money was being used in the right way, because it had not been ringfenced. At that



time, I think there had been a political decision, which I cannot influence, to not ringfence anything apart from maternity funding.

- Q21 **Chair:** Dr Mann, you talked earlier about the importance of providing care that is sensitive to the local area. Are women's hubs a way of doing that, particularly around cultural and religious sensitivities? Have you seen any good examples of that?

Dr Mann: There are lots of emerging pockets of good practice. First, to say something a bit more general, we have to remember that this is a transformation, and some ICBs were further down the line than others, so a lot of the emerging good practice around these kinds of things is from the ones that were already starting to set up. We can expect that there will be different paces of change.

We are encouraging areas to look at their local populations and understand how they shape services around them. In more rural populations, for example, there is more of a mobile or virtual approach. We know that in any development the important thing is leadership, so we need to make sure that that is there, and then we need to understand health needs and—this is key—inequalities. We need to demonstrate that we are impacting inequalities as well as overall health; at the end of the day, we need to be able to measure that. We have done some initial work on, for example, HRT prescribing, where there are massive inequalities. That is a good way of enabling local areas to shape their services according to the differences that they are seeing.

So it is about use of data, leadership, having an inequalities strategy, and then having the workforce and the structures within that to make it work. We have seen other programmes—the teenage pregnancy strategy, for example—that took that kind of approach, so we have learned, and I think those are the ways that we need to think about it.

- Q22 **Chair:** An evaluation of the hub model found some shortcomings, as we expect with any pilot; we always want to see things to improve. One finding was that it was rare for women's hubs to offer multiple services. What are the barriers to that, and how do you think we could overcome them?

Professor Dame Lesley Regan: Resource, probably. As Sue was saying earlier, we did not have a strict pro forma setting out, "This is what you've got to do," because you are going to have different needs whether you are rural or urban or seaside deprived or whatever. So it was not going to be prescriptive: "You've got to have this." But I don't think any woman should be going to secondary care—a hospital—for anything to do with her smear or a colposcopy, her periods, her contraception, her menopause or, I would say, her urinary problems, at least in the first instance. So much can be done out in the community.

We could give you some examples of really innovative hub models that have done things very differently. There is one in Croydon, which I visited with Gillian Merron a couple of weeks ago, that has reduced the number of women waiting for urogynaecological incontinence surgery by 50%, by



providing physiotherapy and self-taught exercises in the community. There is a fantastic example in Tower Hamlets, where they have designed a single point of access—a virtual triage centre. Senior people went through the referrals and, by signposting them to the correct place—a hub or a diagnostic centre or secondary care—they got the number of referrals going into Whitechapel and Mile End hospitals down from 86% to 26%, which is a massive difference when you think about the overall costs of sending someone for a procedure in the community and sending someone to secondary care. The economists will tell you what figures they put on those things, and they are very different.

Q23 Chair: Dr Mann, problems with the existing commissioning structure in the NHS have been highlighted as a barrier to the women's health hub model. What do you think needs to change to improve that?

Dr Mann: That is interesting, because I was talking about that yesterday. We have a policy research unit doing a study on what is currently happening in commissioning and how we can do it better. I am really looking forward to hearing the output of that to make some recommendations. In NHS England, we have been developing some commissioning support guidance for the system. We are hoping to help the system make decisions that will foster the development of this kind of service and do it well.

The problem with commissioning, as I am sure you are aware, is that different bodies commission different things. If we think about IUD and IUS insertion, the local authorities commission IUDs for contraception and the ICBs commission IUDs for heavy bleeding, for example. If you are not having your IUS for contraception, you are not eligible to be fitted by that service and you have to go to a secondary care service and sit on a waiting list. Hubs will facilitate the process, but the commissioning structures need to make sure that they follow.

That is just one example. There are other commissioning bottlenecks that we know about and, in the end, it is all about collaboration. It is about collaboration between all the different players to deliver the same ends. We need to help ICBs to do that collaboratively.

While I am on the topic of collaboration, none of this will happen unless primary and secondary care work together. You need collaboration in how you commission and contract services and to get the system to work effectively together to plan that pathway approach, rather than all of us sitting in our ivory towers going, "Well, I do this." That is new; that is a change in culture.

It takes time, and that is why it has been difficult for the system to even have the conversations. That is where I go back to leadership being absolutely essential, with some kind of driver in outcomes to say, "How are you doing?" and support the system. We will be going out to ICBs and working with them to look at how they are doing, what the barriers are and how we can support them as well as we can.



Q24 **Chair:** Talking about collaborative approaches, on the mental and physical side of this, we have already touched on the trauma that many women have faced. Do you think the hubs sufficiently provide mental health services or work with mental health providers in their areas?

Dr Mann: We know that there has been an injection of more support for the mental health system, with 8,500 extra mental health workers. We need to connect the dots better. There are different areas of mental health that are being reasonably well addressed. We have self-referral to talking therapies, perinatal mental health services and maternal mental health services, so there are a number of things there. As for how you ensure that all these things work together, it is not just about mental health—it is about things like pain specialists and physios. There should be a multidisciplinary team, so the women aren't just seen as having one condition but are addressed as a person. Weight management is another really important one.

Learning how to incentivise that connection is really difficult, and at the moment the system does not do that. Those commissioning levers are important, as is helping ICBs to determine how that pays and how it is more efficient. That is complex, obviously, and it is locally determined.

Professor Dame Lesley Regan: I think it is a mindset change as well. Instead of thinking, "I am commissioning contraception," or "I am commissioning cervical smear uptake," you are thinking, "What does this woman need?" and wrapping the services around her. That will require secondary care and primary care to get out of their territory and to think about what they need for that woman and how to make sure that she can access those things. To go back to my first point, she is usually not ill when she is having these things go on, so to get her swift preventive treatment so that she can get on with her life again—her work, her unpaid caring or whatever—we need to pool the work and to understand what she needs. Rather than going five different times to see me or one of my colleagues, you need to be able to go to one place and get it all done.

Sue made the comment about the IUS for contraception and the IUS for maternity, but while I am putting in her IUS, have a speculum in and can see the cervix, I am not meant to be doing her smear. I am in secondary care and we don't do smears there, because somebody else is commissioning those. That is not sensible.

Q25 **Samantha Niblett:** Thank you so much. I am finding all this enlightening, fascinating and horrifying in equal measure. I want to change the topic a little and move into research on women's reproductive health. Dame Lesley, to what extent is investment into women's reproductive health research sufficiently prioritised and funded?

Professor Dame Lesley Regan: Well, it isn't. If you read the McKinsey report, the Deloitte report or the report that came out from the NHS Confederation just two or three weeks ago, you will see some very stark figures about how little money goes into reproductive health research. There are all sorts of reasons for that—gender biases and a lack of



recognition of what is needed, as well as fear from pharma, industry and tech that if they include women's reproductive age in drug trials or procedural trials they will be litigated against if something happens. There is a long history that has to be unpicked. The most interesting thing about the McKinsey report was the analysis it did with a lot of pharma companies. On exploring new research tools, they talk about assets. An asset is a molecule that is under investigation to see whether it can solve a problem. The example the report used, which is very hard-hitting, is that one in 10 women have endometriosis and there are 25 molecule assets in the pipeline being investigated. One in 10 people globally have diabetes, and there are 584 assets. Those problems have exactly the same prevalence, but women's health has been thought to be a "niche market". That is the other narrative that has to change. There is nothing niche about 51%; it is the majority. So we have to change that.

Q26 Samantha Niblett: That leads me to an extension to that question. It is incredibly broad, but I would be fascinated by both of your responses. Actually, let me go back a step. I will ask the question separately because it is so broad.

I feel like I am asking a rhetorical question here, frankly, with the answer to the first question being, "No, there is not enough," but is enough research taking place to understand how different groups of women are affected by reproductive health conditions? If we take "not a lot," how much of that "not a lot" is done to understand how different women are affected by reproductive health conditions?

Professor Dame Lesley Regan: There are disorders that affect women disproportionately. If you add up all the things that affect women disproportionately, such as rheumatoid arthritis and migraine, you will find that over 50% of the research spend is not getting anywhere near them. We have to reset that dial completely because it is really important. The McKinsey report—Deloitte has also done one recently—has shown that you have to bust a few myths. No. 1 is that women live longer than men so they must be healthier—wrong. They live longer than men, but they spend a disproportionately lengthier period in the later years in poor health.

The next myth is that women using up health services are at the end of life. That is not the case. It is not just menopausal women between the ages of 45 and 65 who, when they leave the workforce, create an economic problem. That has now been recognised and employers are trying to do something about it. The reality, if you look at the numbers, is that a vast majority of those DALYs, or disability-adjusted life years, are in women between the ages of 20 and 45. I can happily send you the report. It is very interesting and beautifully produced, with fabulous infographics. You remember the numbers because they have done it very cleverly.

Q27 Samantha Niblett: The broad question is for both of you, but I will come to you first, Dr Mann. What would be your priority research area for women's reproductive health?

Dr Mann: The role of the NHS in research is not commissioning the research; it is trying to identify areas, as you talked about, and equally



importantly, trying to support the uptake of research and influencing its shape as it goes forward. I am very keen to see us do more research around women's experiences. We have the reproductive health survey. Alluding to your point from before, the sample we got had more educated women and more white women, and did not include many older women. So we know that we have some information, but we have not got enough information on those particular groups. So doing something very user-focused in terms of experience would be important. Narrowing it down to conditions is really difficult because there is a wealth of conditions. We can influence the areas of calls for research, but often the decisions on the things that come up get made elsewhere.

The other side of things is ensuring implementation. I alluded to that when talking about using research, but there is a lot of implementation research. Implementation is a science. How do we best get research taken up in practice so that it can be most useful? The science is really important—new developments, innovation and all those things—but actually getting things into practice is really difficult, and we do not always do it as effectively. It is about conducting research on implementation, and there is a whole big science around health services research that I think is also really important and under-addressed.

Professor Dame Lesley Regan: I cannot really add much to that—I think that is absolutely it. Everyone has their niche area, haven't they? I have always been interested in repeated miscarriages and the immunology of pregnancy. That, compared with some of the other issues that we have been discussing today, such as menstrual health problems or pelvic pain, is tiny. We have to think about what problems really trouble women and stop them getting on with their day-to-day lives—stop them being able to go to work, finish their education or look after families. We have to focus it on that.

I would say that we need a lot more work on controlling menstrual problems because they are so common and there are only one or two groups in the UK doing meaningful work on that. On the other hand, lots of organisations and universities want to look at the next drug for ovarian cancer, for example. Of course that is very important, and if you know someone who has had ovarian cancer you would be championing that. However, the percentage of women that affects is very small. I am not in any way decrying work into cancers, but that is also driven by research and spending. There is an enormous amount of money to be made by pharma out of cancer drugs, so it tends to focus on those but not on the research that will improve women's menstrual lives or provide them with a much better form of contraception.

Q28 Samantha Niblett: It feels like a massive, huge thing to unpick and your expertise has kind of blown my mind, so thank you again. I want to come back to what you said about using period tracking tools. That has caused some fear, particularly when we have seen what has happened in America with *Roe v. Wade* and people being concerned about their data being sold so that they can be identified for having had a termination. I



premise this by saying that I am the founder of Labour Women in Tech and I have done work with organisations, and women in particular, who have founded FemTech companies that want to help women. The demand for it has been born from the lack of services for women, such as the fact that it takes up to eight years for an endometriosis diagnosis. I have heard some people say that actually, from using a particular FemTech product to monitor whatever it might be, they have gone to the doctors and insisted that there is something wrong. That is a slight problem in itself because you have to be both digitally included—so you cannot be from a poorer background where you cannot afford these products, which cost money—and you have to know that they are out there. With that in mind—that it has empowered some women but excluded others—what potential is there for the NHS to use FemTech to improve awareness, diagnosis and treatment of reproductive health conditions in particular?

Professor Dame Lesley Regan: Well, somehow we have to be able to sort through these FemTech companies and only commission the ones that are altruistic. For example, with the founders of the Flo app, those two men are billionaires because they are selling their data—I don't know how they have got away with it. On the other hand—I am interested in this, again wearing my charity hat—other organisations that I have spoken to recently are trying to do things for absolutely zero gain because they actually want to improve lives. My daughters would say to me, "Mum, that isn't realistic. People don't do that."

Dr Mann: But it is a minefield out there, isn't it? There has been an absolute explosion of FemTech apps and I think it is our job to help people navigate through them. We should not put off innovators—I think innovation is really good—but there are some amazing apps and some lower-quality apps, and trying to keep pace with that is really difficult. How do you help women to reach good, accurate information and make decisions that are helpful for them, and also find their way through the stuff that looks glossy but maybe is not so good?

We have been supporting a funding call recently to try to get innovators to come forward with their FemTech proposals, which is called the Small Business Research Initiative. It has put out a call and we have had 200 applications, so we are about to decide which of them is the most promising, so that is really good. There are things that NICE do. I did not realise until I came to NHS England that they do something called early value assessments. They have been looking at all the menopause apps, of which there are very many, and trying to trawl their way through and evaluate their usefulness, accuracy and so forth. The findings will be published. It is difficult to keep pace with that because there is constant innovation, but it's a start. Also, we need to get better at producing our own information, digital information, and we need to start keeping pace. We have online things. We could use the NHS app better and YouTube, but we need to get out into the space to understand that a little bit better.

Q29 **Samantha Niblett:** A slightly extended question on this: when it comes to coming up with innovative products for use by the NHS, you have the greatest expertise in the NHS. You have your clinicians and experts who



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could be encouraged to be entrepreneurial about this. I know that there has been some resistance and some encouragement, depending on who I have spoken to. Do you think it would be a good thing for the NHS to leverage the expertise of people who understand these conditions and treat women, and who perhaps have an interest in technology and could almost be an entrepreneur who is a doctor as well?

Dr Mann: Keeping pace is really difficult, as is maintaining no conflict of interest. It is really important to be balanced, have a view, look at things objectively and make sure that the decisions that get taken are purely on the basis of improving health and care and information, and that is difficult. We have people on the case. The health innovation networks have been doing a scan and looking at all the apps that are out there and trying to map them and look at the usefulness. It is obviously a big job, so we cannot do it alone. It is just trying to find a process to look at the best ones coming forward and try and be aware of them, but have a way of identifying the ones that are good and the ones that are less good. I don't think we have quite cracked it.

There are some things in place and a whole part of NHS England that looks at what is in the pipeline, where the gaps are, what needs to be developed and where we should support innovation. That is part of our transformation directorate, which is doing a lot of work on trying to understand the landscape of what is going on and what is not going on, because you are only as good as the things that are produced. We don't produce things that people are not interested in but might be useful, so that is important to recognise as well.

Q30 **Alex Brewer:** Waiting times are particularly problematic. Waiting times for gynaecological treatment have grown faster than any other speciality. Why is that and what is being done to bring them down?

Professor Dame Lesley Regan: Looking at the waiting lists is controlling our lives at the moment. There are lots of different drivers. One is that women are more aware—which is a good thing—that they need to go and ask for help. The commissioning and reduced resourcing has meant that they are no longer able to access many of the things that I have talked about. I don't think you should need to go to secondary care for those. They have not been able to get that locally. That is why I think the hub model that we are both pushing will resolve a lot of that.

Many of the women on the gynaecology waiting list, which is very large, are not going to have a procedure or an admission to a hospital, so my question is: why are they on the waiting list and why can't they be sorted out nearer home? It is the pre-referral pathway that we have to put the energy into. That is the left shift. It is not quite going back to prevention, but it is making sure that when they have a problem, the problem does not get worse and they are sorted out locally in the community, and they leave the people who need admission, invasive procedures or surgery on that waiting list.



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Dr Mann: Yes, it has been occupying us and they are very large. There are 600,000 and they do not shift, but we have seen quite a lot of improved efficiencies within secondary care. There has been a lot of work with the Getting It Right First Time programme to look at how we can reduce the length of hospital stays or do less invasive procedures. There has been a lot of support to the system from that team, going out to work out how to address the waiting list. The rate of referral in, however, is out of keeping with the pace that we can keep up with. As Lesley said, it is important to think about how we can manage that bit of the pathway better, so that is the demand, rather than the product—for want of a better word.

As Lesley also said, understanding the drivers is important. One thing that is key to that is that, first, people are waiting for diagnostic tests in secondary care—they might see someone, wait for a diagnostic test, come back for another appointment, and then never require anything in hospital. We have got the community diagnostic centres—I think there are about 167 now—so we are thinking about how we use those most effectively and join them up with the pathway, so that they are not just diagnosis, but diagnosis and treatment.

Quite a lot of work is going on there, because one reason why the waiting lists have gone up is the massive increase in HRT. When we start prescribing HRT, we start getting irregular bleeding and when we start getting irregular bleeding, we start getting more investigations, and then we put people on waiting lists and they need to have a hysteroscopy. There is therefore a new pathway for bleeding on HRT—to be a little less anxious about it and more able to get the right diagnoses, managing that, and only taking someone to investigation if they really need it. That is one simple approach that is happening.

Another thing that is happening is developing some advice and guidance for GPs and, as Lesley mentioned, something like a single point of access, which will not only support appointments in the community, but help GPs to manage people—with people there who provide good, detailed advice. We have had advice and guidance for a long time, but it is making it more a total triage, where we can advise GPs and direct. We talked about pessaries, and incontinence is another thing. Those things are massive problems, which affect loads and loads of people. They do not need to be in hospitals, but they are in hospitals at the moment. We need pelvic physiotherapists and people in the community who can change specialities, so elderly women do not have to travel for miles. Those are some other simple things that we can do. We could go on for a long time on waiting lists.

Q31 **Kirith Entwistle:** We have touched on this already, but I want to ask specifically about endometriosis. I have a constituent who came to me very distressed. She has been waiting over 18 months for treatment. I have friends and family who have had to wait—I think they have been given about 70 weeks' waiting time to get a laparoscopy to confirm the diagnosis. I wanted to know what specifically is being done on those two



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areas. Apologies if I have to leave before you finish your answers, but I wanted to ask that question.

Professor Dame Lesley Regan: I go back to what I started with: if her painful, heavy periods had been sorted out a long time ago, she probably would not have progressed to get endometriosis. I would also say that you do not really need to have a diagnostic laparoscopy, because fitting this individual with a Mirena coil and providing her with relief for the pain and the heavy bleeding might be what she needs, and she could have that done in the community. If it were not resolved by that, she might need to go on to have a laparoscopy.

It comes back to the education points that you were making and to training. We have to get healthcare professionals to talk to women about it and say, "We are going to start this. It's not that I am palming you off with a pill or a Mirena device, but let's see whether this gives you a bit of relief, and if it does not, then we will go on to the next step." There, patient-initiated follow-up is really important, because if I tell them, "Okay, I think we finished this. You tell me that your symptoms are sorted out, so I am going to discharge you, but if you need me again, you can contact this number or this email address.", they probably will not need it, but many of the women who are sitting on waiting lists or follow-up lists at the moment are there because they are so scared, because it has taken them so long to get in there to be seen, that they do not want to be discharged and have to go through that waiting again.

Q32 **Kirith Entwistle:** What if they do not need a laparoscopy, as you said, but that is what they have been referred for? Is that because there might be a missing link in terms of the awareness, training or pathways, as you suggested earlier, on the healthcare professional side?

Professor Dame Lesley Regan: Yes, I think that must be the case—well, that must account for some of them, but not all. I would have to ask your friend or family member what has been tried. If those things have not been tried, I would say that those were options that she needs to pursue now.

Dr Mann: Just a couple of points on that. In general, if you release the logjam of the system, those people who need laparoscopies will not be waiting so long. That is a general point about how we free up and reduce those waiting times. The second thing to say is that the longer people wait, the more complicated the surgery gets, and therefore the longer it takes and the longer people need to stay in. If you start moving people upstream—that is very much the direction of travel, certainly with the 10-year plan, with treatment to prevention and secondary care to primary care and community—that is what we need to do in women's health. That is the other important thing.

Q33 **Alex Brewer:** You have answered most of my next question, but do you think there is anything else that should be done to tackle waiting lists that you have not already mentioned? Also, should there be a target for diagnosing certain conditions, such as endometriosis, to drive



improvements? Is that something that would work in your view?

Professor Dame Lesley Regan: One of the things that I have a concern about in the data is that when the clock starts and when the clock stops is when you have a procedure. My metric is: is she better and has she got back to day-to-day life? That is what the metric should be. That is what we should really be pushing for.

I am sorry that the one thing that seems to make people sit up and listen is not doing the right thing by women, but the fact that there is a financial drain on society if we do not—but if that is the game, we are going to have to play it very well. The McKinsey report and the NHS Confederation report that came out a couple of weeks ago have demonstrated that there is a massive loss to society and to people's wellbeing—both their physical and mental health—from not looking after women with these very common things during their reproductive and post-reproductive years. It is also about instilling in people, "I am the first generation of woman who is going to live probably longer post-reproductive than I was reproductive." That was not the case for my granny; she was going to die relatively early. And as I said earlier, we live longer, but we have a very much longer period of ill health.

It is also about getting women to understand that the things that are going to really be troublesome for them later are not cancer. They are cardiovascular disease, the complications of osteoporosis and frailty, and dementia. Those are the three big killers, and yet we tend not to do very much about preventing them during their reproductive years and in explaining to them how they can, if not avoid them, postpone them until the later stage in life so that they can remain independent and not disabled by their problems.

Q34 **Rachel Taylor:** I wanted to come back on the PIFU pathways, and whether you feel that sufficient research has been done into how women access those. Are the timescales that have been set correct? There is a lot that we know about women not wanting to be a bother. They have eventually got the treatment that they have been waiting so long for and then they are told, "Don't come back; we are discharging you now, unless you tell us." That may have an impact on different classes and different ethnicities in a different way. You or I may be well able to phone up and say, "I don't think it is quite sorted out.", but other people may not be. Has any research been done on that? Do you think those PIFU pathways will work for women?

Professor Dame Lesley Regan: It has not been my experience. My experience has been the opposite and that women have really welcomed it. You do not want to sit in an out-patient clinic in the waiting room for hours and hours and hours because you have nothing better to do, do you? I am sure you have much better things to do. My experience has not been that. Women have welcomed it and have been delighted that they have been pointed towards sources so that they can get access back into the system if they need it.



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Dr Mann: I would agree with that. I do think it needs to be offered. It is a good option—it is empowering for people—but it needs to be for the right person, as you say. You might be speaking to someone who is unlikely to be able to activate it. One of the issues with this is giving the right information about how to come back through the system.

In answer to your question on whether it has been evaluated, it has not, in terms of satisfaction. Maybe that is something that we need to look at. It has a lot of potential as a good option—not only could it be empowering, but we also do not really know who needs follow-up and who does not. That has never been systematic. Who better than the person themselves to decide, provided it actually happens?

Putting it back in people's hands is, I think, welcome, but I absolutely take the caveat that you have to be quite confident to do that. How it is delivered and how that communication pathway works is important.

Q35 **Natalie Fleet:** Since the strategy was implemented in 2002, where have you seen the most progress and where is progress lacking?

Professor Dame Lesley Regan: I think it came in in August 2022, not 2002. The progress has been that women are much more aware about women's health. I often say when I am introducing a session, "If I had invited you to come to this three years ago, you would have said, 'What is that about—women's health?'" Now I think people are aware of it.

It has been a great step forward that Sue Mann has been appointed. I see NHS England as the implementation arm for the policy, and we can work together collaboratively to improve it. Progress is slow, but then changing hearts and minds is a slow business, isn't it? But it needs to be done, and it needs to be done well.

The biggest likelihood of getting a success story and speeding things up is to scale up the women's health hubs, because they will be good for the workforce and good for women. They will be good economically as well, in terms of the returns on investment that one can make by organising, as I said earlier—wrapping services around women, not making women run around all the different services, which is always the most expensive way to do it.

Q36 **Natalie Fleet:** Was the women's health strategy for England suitably ambitious? What are the performance indicators that we can use to judge its impact so far?

Professor Dame Lesley Regan: Well, it was a very aspirational document. It did not have an implementation plan, and that is what we are trying to do now—to implement it. I think it was ambitious to say that no woman is going to experience these problems and not be able to access information. That is very different from where we started off.

We have made quite a lot of progress, but, as I often say to people I am working with, I am one of the most impatient people I know, so I would like it to be a bit faster. I understand that things take their time. There is



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definitely a general move towards understanding that this is something that we have to do as a society—we have to improve it—and that when we get it right for women, everybody benefits.

- Q37 **Natalie Fleet:** Thank you. Dr Mann, a blood test has been authorised to help diagnose PCOS, but we understand it is not available via the NHS for that purpose. Should it be?

Dr Mann: I think the test you are referring to is something called the AMH test. To begin a bit more generally, PCOS is a really important condition and it is probably very under-recognised in the community. It can cause a lot of distress; it causes irregular periods, it can cause unwanted hair growth and it can cause fertility issues, so we do need to get better at diagnosing it.

I suppose the question is whether this test offers additional benefits to diagnose and get people the treatment they need. Just having a diagnostic test does not necessarily make it the right thing to do. We need to really understand in what circumstances it is best used and how it can be helpful in terms of shaping treatment.

For example, someone may go to their doctor with irregular periods, because they want to be pregnant, or unwanted hair growth, but lots of different things can cause those conditions, so we do not just want to go straight to a diagnostic test. When we look for polycystic ovaries, it is a combination—it is a syndrome—so we look at an ultrasound scan, a blood test and what people are actually complaining about.

Does this test add value to what we already have? Probably. It is potentially a good test, and it may be that it could be used as an alternative to ultrasound. We still have the other things that we need to look at to make a proper diagnosis of the syndrome, but would it be useful as an adjunct? It is not completely clear. I am not quite sure what difference it would make in my clinical practice, to be honest. That is a very anecdotal thing to say, but the point I am getting at is that all tests need to be evaluated. Here we are, we have a test: when would we use it, who for, how, and how often?

The test is already available, so it is not a question of making it available. It is often used in a fertility setting, so it is not a new test; it is just using it in a different situation. It could be used, but I would not say at this stage that that is the right thing to do. There is certainly evidence that it does have a link with the diagnosis of polycystic ovarian syndrome.

Professor Dame Lesley Regan: Let me just take it one step further. AMH is a measure of your egg reserve—your ovarian reserve—and there is a normal range. When you become menopausal, your egg reserve goes down to about zero, or a very low figure. It is not really a diagnostic test for polycystic ovaries; it is just that women with polycystic ovaries tend to have very high levels, because what is being measured in their blood is the signals that the multiple follicles in their ovaries are sending out. It is not saying, "This woman has PCOS." It is saying, "She has a high AMH,



and the explanation is either that she has a massive egg reserve or, more likely, polycystic ovaries." I am not sure it is particularly helpful, and it certainly does not diagnose the problem. The diagnostic criteria are based on ultrasound and biochemical parameters, of which AMH is not one.

But AMH is useful when you are measuring, for example, some of the women I see who have had repeated pregnancy losses and have got older as they have done so. It is important to know then what their AMH is, because there will be occasions when, if it is starting to drop, you need to warn that woman that she needs to think about getting on with fertility straightaway, as opposed to waiting a couple of years. It is a useful diagnostic test, but the idea that it is there for polycystic ovaries is rather fictional.

Q38 Natalie Fleet: Does the Government need to change its approach to women's health?

Professor Dame Lesley Regan: I think they have, haven't they? Well, I am working under the illusion that they have. I shall stick with my illusion, because it is the only way I can get up in the morning and carry on.

Q39 Natalie Fleet: Wonderful. I am absolutely thrilled that we are talking about women's reproductive health. I really liked it when you said that we need to think about what a woman needs and wrap our care around her—I absolutely love that.

It feels like there is a huge omission, because I cannot see anywhere a mention of conceptions from rape. We have no idea how many conceptions there are, but up to 10 births every day happen in those circumstances. I cannot see anything anywhere on the internet about this happening in the UK, and I specifically cannot see it on the NHS. There is nothing on the trauma of giving birth in those circumstances, and the effect on the physical and mental health of the child and the mother. There is no guidance or acknowledgment that it happens. As far as I am aware, there is no training for NHS professionals looking after these women, and delivering and supporting these children when the mother has given birth in the most horrendous circumstances. That will have lifelong impacts on both the mother and the child. Should conceptions from rape be included as part of the women's health strategy?

Professor Dame Lesley Regan: Well, violence against women and girls is one of the seven key themes, but I often say that that is one of the things that worries me most about the strategy, because this is such a ubiquitous problem. I have never met any other disorder affecting women's health that has no socioeconomic, educational or class boundaries. It is highly prevalent, and the incidence is the same in every country in the world. I think that sometimes the enormity of the problem makes people feel quite paralysed—"Well, what can I do?" So we have to again change hearts and minds by explaining to, say, every person in this room today that if you did one thing this week to call out some bad behaviour or said, "Oh, I don't think that's on. It's really not appropriate to be saying that", or whatever, we would all be—well, putting a drop in the ocean, but it is a massive problem. It is not resolved by health and it is



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not resolved by training people. I think most people who work in our field, obstetrics and gynaecology, are trained in trauma. They have trauma-informed training in how to look after women.

We talked earlier about sensitive vaginal examinations. I have certainly been trained in how to look after women who are going through labour and who have suffered this particular problem. But we have to make sure also that every other part of the Government, including Departments like the Home Office and the DWP, the education sector—everyone has to contribute to tackling this problem because it is a massive societal issue. I don't think the answer is just in health. It's important because, second only to accident and emergency doctors, obstetricians and gynaecologists see more and have more disclosures made to them than any other group. If you are the survivor of an attack and you are injured, you will either go to A&E or go and see an obstetrician or gynaecologist, because you are pregnant, you are bleeding, you are frightened that you got an infection, or whatever. So we see a lot of it, but that is not the whole answer. We have to do an awful lot more about training and educating, particularly of young people.

- Q40 **Natalie Fleet:** You mentioned earlier that Naga Munchetty had asked you for something on the website and you had delivered it. If you could consider also delivering some advice about this on the NHS website, that would be really appreciated.

Professor Dame Lesley Regan: Do you think that most women would want to volunteer that information? I would say, as a clinician who has talked to a lot of women who have been victims of sexual assault, many of them would not want to disclose that information.

- Q41 **Natalie Fleet:** My question is whether there could be guidance available to women who seek it. Right now, if you googled, "How do I tell my child that they were born as a result of rape?", you would get results relating to countries very far away. There would be no acknowledgment anywhere on the internet—on the NHS website or beyond—that there are conceptions and births from rape in this country. So if you are a woman who has accepted that this happened to you, and you are actively working out how you can square the circle of wishing your child did not exist and having to raise them—if you have struggled in many, many ways or if you are a child who realises that you were born as a result of your mother being hurt, there is nowhere in this country for you to go. I'm thinking of the NHS website. I understand what you are saying about that not being the full solution. Of course there is more in other areas. But if we could provide some information for people searching for this advice when they are ready—in their own time and in their own home—that would be really beneficial.

Professor Dame Lesley Regan: Okay. If you would like to email me, we could talk about how we could go about that.

Chair: And if there is any additional information that you could send to us on that specific point, that would be really useful. Thank you, Natalie.



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Before I hand over to Christine, I want to say that I am aware that we have now gone slightly over our time. We have only two sections of questions left. This session has been really fascinating and very, very useful, particularly because we have come to this report halfway through. So this evidence is very useful for all of us on this Committee, and I thank you very much for your time. I am going to hand over to Christine and then quickly to Catherine.

- Q42 **Christine Jardine:** With regard to a previous answer, do the Government need to change their approach to women's health? I cannot speak for the Government, but I think I can say quite conclusively that since we have had more women in Parliament, we have been more aware, and we have seen some very high-profile campaigns—Carolyn Harris's campaign on the menopause, for example. But I wonder: are these coming too late in life? We are coming to them as adults—fully formed adults. What is your assessment of the quality of education on women's reproductive health in schools and what, if anything, needs to change to improve education there?

Professor Dame Lesley Regan: You have probably been informed that I chaired a committee for the Department for Education last year that looked at the age-appropriateness of sex education in schools. And I learned a lot about it; I thought I knew quite a bit, but you can always learn more.

Historically, although this was mandated in 2020 as being part of the curriculum, what has not been mandated is the training for the staff to deliver it. I talked to a lot of teachers about this, and many teachers told me that the teacher who was not in the staffroom on the day the decision was made was the one who was given the sex part—the RHSE part—of the portfolio. They may have no experience or very little training.

Nevertheless, I passionately believe that if we were to teach girls and boys about periods and sex and space and privacy from a very early age, we would resolve many of these problems. If every girl came out of school understanding that she was probably going to have 12 periods a year for 40 years of her life, she would know that her fertility was limited and she would not then be surprised when she could not get pregnant. She would also know that she was going to have a menopause, and that it would be much better for her if she did not have an unplanned pregnancy. I am sure you are aware that 45% of the 800,000 maternities in this country are unplanned. I am not saying that all those pregnancies are unwanted, but they are unplanned.

The abortion rate has gone up significantly in older women. Those are women who have finished their families and they tell me, because I have a big abortion clinic at St Mary's, that they are there because they cannot access long-acting reversible contraception.

So, I think we have a massive need to put sex education in schools right front and centre. The average age of menarche—of periods starting—has gone down to 10 years of age. Therefore, if you are not teaching the eight



and nine-year-olds—and you need to teach the boys and the girls about it—you're going to miss it.

Again, wearing my charity hat I have done quite a lot of school period workshops. Invariably, there will be one young girl who will come up at the end of it and say, "Oh, Miss, could I ask you something?" Then she tells you a story about her friend who woke up in the middle of the night saying that she thought she had died because she was in pain and there was blood all over the bed. That is an 11 or 12-year-old who does not know what is happening to her.

We must ensure that we have actually taught children this at school, because they are not getting it from their parents and they are getting stuff from social media that is inaccurate. We really have an obligation to do this well, because they are our future, and if they are not prepared for what is going on, that is really very sad.

Dr Mann: I cannot emphasise how strongly I feel that it starts at school, to add to what Leslie said, all of which I agree with. However, we also need to arm our young people with critical thinking skills because, as Leslie was saying, there is so much information out there, and if they are unable to understand their bodies and how to name the parts of their bodies and how to talk about things without feeling embarrassed, we will not start tackling the stigma that comes later in life and the difficulty with finding the things that they need.

They also need to know where to go and when to go there, so we need to give them routes in to getting the help they need, but we need to know when that is. That is really important.

Q43 **Christine Jardine:** Just to drill down on that a wee bit, we have specifically talked a lot about misunderstanding endometriosis and how period pain can lead to endometriosis, and getting that information quickly. At what age do you think children should start to be taught about the health conditions that can affect girls and women, as opposed to reproduction itself?

Professor Dame Lesley Regan: Again, I go back to the point that if we instilled in every young person the fact that women will have these periods, and that it is not normal to be in a lot of pain and to need a hot water bottle all the time or take days off school, we would not have such a problem. I am not trying to be simplistic. However, it is about understanding that this is a normal thing but you don't have to suffer in silence. I think that is a really important step forward.

I have been to some schools where they have had the most amazing education and they talk to five-year-olds not about sex or, as you were saying, rape, but they say, "Well, hang on, why have you taken Matthew's teddy away from him? Matthew's upset now. Can you see he is crying? Why have you done that? Because you have invaded his space and you have taken his—?"



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There are lots of ways in which one can instil in very young children the sort of ethos and morals that we are talking about. There was great concern in Parliament that we were going to be sexually explicit to five-year-olds and six-year-olds, but that is not the point at all. It is about the age-appropriateness of the information that they are given, so that they are not shocked and frightened by things that are happening to them and are prepared for them.

Q44 Christine Jardine: Is it fair to say, from everything you have said, that you feel it is just as important that boys are part of these lessons as girls?

Professor Dame Lesley Regan: Absolutely. There is no point if you have them separately. As I say, with Wellbeing of Women we have gone to several schools, and they said, "Oh, we haven't got any boys in our school." I said, "Well, find some. Bring some in." They need to be part of it. What we usually do is have a workshop on what the reproductive cycle is, what is happening and why, then we bring in the boys for the myth-busting session at the end. The young men tell us that they want to know because they have mums and sisters, and most of them want to be caring about it. The young girls also tell us that they want the boys to be there, because otherwise it is still a taboo subject.

Q45 David Burton-Sampson: Very quickly, on taboo, I was reading that many women would not tell their employer the real reason why they are not able to come in to work when they are suffering from a particularly challenging period. As an employer—I still have a business that somebody else is running for me now, but I am an employer here in Parliament—that makes me feel incredibly uncomfortable. What more can we do to raise awareness of women's health issues with employers, so that they are maybe more sympathetic? Clearly, this reluctance to talk to the employer comes from experience of employers going, "Well, it is just your period. Why do you need time off work?" Is there more that we can do here to educate and raise the awareness of employers?

Professor Dame Lesley Regan: Yes. The DWP have had a whole programme of work going on about providing information for employers to do this in a much more sensitive and understanding way. Again, the only way that it will get real traction is by emphasising the loss economically if we have women who cannot go to work or get on with their caring roles. That needs to be emphasised. I will forward you this report, which I think is really helpful, as is the NHS Confederation one. They demonstrate that as an employer, you will benefit enormously from investing in some sympathetic counselling or getting the HR people, occupational health or someone else to talk to this woman and help her feel supported, so that she does not quit her job or start to do just two days a week—which will benefit you as well. I suppose the only other thing I could say is that you have women in your lives, and you just want them to have the best opportunities, don't you? I am sure that most of the men in the room here today or in this Parliament would feel the same way. Sometimes, personalising it into, "What would you do if this was your daughter or your wife?" is the only way to get the message over.



Chair: Thank you, Dame Lesley. I would probably push back on that and say that they should not care just because they have a daughter or a wife: they should care because this is part of society.

Professor Dame Lesley Regan: Oh yes.

Chair: But by any means, I guess we will take it if it means progress. Thank you.

Q46 **Catherine Fookes:** Thank you so much—this has been so fascinating. I am sure that we could all go on for hours longer, but I will try not to keep you both too long. You have been absolutely brilliant witnesses.

Women’s reproductive health is a taboo subject for many, isn’t it? It is at every life stage. I am a middle-class privileged woman, but I came to need a total hysterectomy a few years ago, and I found people saying to me, “Are you going to tell people what you have been in hospital for?”, and I said, “Well, yeah. It is my womb; it is nothing to be ashamed of. I am having it removed.” I have to say that as I was leaving the hospital, one of the nurses said, “Do you want a patch?” I said, “What for?” She said, “Because now you are probably going to experience the menopause straight away.” Even though I am an intelligent woman and I have been to university and was the CEO of a women’s equality charity at the time, I went, “Oh, I will be okay.” I did not really understand that the menopause would most definitely impact me, and I certainly did hit a brick wall a few weeks later. Obviously I now have the right treatment and everything, but in terms of the apps and the FemTech, my apps were my friends. I happen to have some friends a bit older than me who were going through the menopause, who were like, “Oh my God. I can’t believe you left hospital without anything. You need support and help.” They helped me through it massively. Without my girlfriends, I don’t know where I would be right now. I probably wouldn’t be sitting here, that’s for sure. Like many women, I would have given up work because I was really struggling.

Anyway, how can we challenge the stigma that prevents many women and girls from seeking support? I will start with you, Dr Mann.

Dr Mann: That experience absolutely should not happen and is shameful. Obviously, the menopause has had a lot of traction over recent years and we all know much more about it, but a particular group of women experience very sudden menopause, like you did. You had a surgical cause, but also some women go through it earlier, and that group of women need to have particular care and particular information to recognise that. That relates to the kind of care you had, and the warning and the explanation—that should be different.

You are right. It starts much earlier on, and people are talking much more about menopause. We have a lot of influencers out in the system and we are talking a lot more about it, so that is a good thing. Going back to the conversation we just had about RSHE, stigma is about what you grow up with and culture, and what boys know and think. There is a long time to do that work, but we really do need to continue those conversations



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about, "There's a reproductive life course. You start your periods. You have a reproductive life. You make choices in that time, and then you have a menopause." These are normal things, and boys and girls need to understand that.

As Lesley said, women are living roughly half their lives in the menopause, so it is not a fringe area; it is essential. Tackling stigma at every level and having the conversations—you alluded to the workplace—makes it easier for women to come forward. I am glad you said what you said, because it is not always straightforward for people to share those things. The more we do it when we are in those positions, the more it will encourage people. People need to stand up and be counted, and it is helpful if they see that around them. They feel more comfortable with it.

Catherine Fookes: Would you like to add anything to that?

Professor Dame Lesley Regan: No, I don't think so. That sums it up beautifully.

Q47 **Catherine Fookes:** What action should the new Government take to ensure that women with reproductive health conditions get the support and understanding they need to stay at work? We have already covered that to some degree. It's about the economy, stupid, isn't it? It is about showing what we are losing.

Professor Dame Lesley Regan: Well, prioritise women's health hubs and you will fast-track it.

Q48 **Catherine Fookes:** Great. Do either of you think there should be a public health awareness campaign on women's reproductive health?

Professor Dame Lesley Regan: I think we've got one, haven't we? I do not wish to sound complacent about it, but I think people are a lot more aware of it. That doesn't mean we should stop trying; I think we need to carry on with that.

Going back to a point earlier—you were talking about influencers, Sue, and someone mentioned social media—we have to make sure that we are communicating information in the right way for the recipients we want to reach to access it. There is not much point sending out sheets of A4 or long, turgid documents in PDF to people who are only going to access information on social media—perhaps not LinkedIn, but Instagram or whatever.

One of my new year resolutions for next year will be, "I must get rid of my fear of social media." I think people of my generation are a bit wary of it, and then you hear about people who have been bullied or cancelled or whatever when they have used it. But we have to recognise that if we want the next couple of generations of young girls and boys to understand what these things are, then we have to communicate with them in the way they receive and absorb their information, and it ain't on pieces of paper.

Catherine Fookes: There are some incredible campaigners out there. May I abuse the Chair for one moment, Sarah? There is an amazing group



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in Wales. Two young women run an Instagram called @loveyourperiod, and they are absolutely brilliant. They have spread the word so much in schools and become ambassadors. It is incredible what they have done.

Professor Dame Lesley Regan: Well, Nighat Arif posts something every day. She has three sons, and they do all the video footage for her and then they post it.

Chair: Thank you very much, Catherine, and thank you very much to our witnesses. Dame Lesley, may I make one recommendation to you? Don't go on X as your first choice of social media. There are other providers available.

Professor Dame Lesley Regan: I do have an account, but it is very badly used.

Chair: I just want to say thank you very much, on behalf of the whole Committee, for the time that both of you have given today. We are very grateful for your experience and your in-depth answers. Thank you, everybody. That brings proceedings to a close.