

Women and Equalities Committee

Oral evidence: [Reproductive health conditions: girls and young women](#), HC 1265

Wednesday 3 December 2025

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Members present: Sarah Owens (Chair); Alex Brewer; Christine Jardine; Kim Leadbeater; Kevin McKenna; Rebecca Paul; Rachel Taylor; Nadia Whittome.

Questions 42 - 78

Witnesses

I: Dr Aziza Sesay, GP and women's health advocate; Dr Tori Ford, Founder and Executive Director, Medical Herstory; Chella Quint OBE, Founder, Period Positive and author; Kerry Wolstenholme, RSHE specialist and author; Dr Nighat Arif, GP and women's health broadcaster.

Written evidence from witnesses:

Dr Tori Ford, Founder and Executive Director, Medical Herstory ([RHW0063](#))

Chella Quint OBE, Founder, Period Positive and author ([RHW0082](#))

Kerry Wolstenholme, RSHE specialist and author ([RHW0048](#))

Examination of witnesses

Witnesses: Dr Aziza Sesay, Dr Tori Ford, Chella Quint OBE, Kerry Wolstenholme and Dr Nighat Arif.

Q42 Chair: Good afternoon and welcome to the Women and Equalities Committee. Today we are holding our second evidence session on menstrual and reproductive health conditions among girls and young women. It is part of our set of inquiries looking at young women and girls' menstrual health. We have a fantastic panel in front of us. We have Dr Aziza Sesay, GP and women's health advocate; Dr Tori Ford, founder and executive director of Medical Herstory; Chella Quint OBE, founder of Period Positive and author; Kerry Wolstenholme, RSHE specialist and author; and Dr Nighat Arif, GP and women's health broadcaster. Welcome to you all, and it is fantastic that our Committee is going to be gaining from your experience and expertise today.

Aziza and Nighat, to what extent is challenging stigma and taboos around periods key to improving girls' and young women's menstrual health and wellbeing? I know that you both do this in a multitude of different ways using different platforms from television to online, but how important is it that we challenge that stigma? Aziza, I will come to you first.

Dr Sesay: Hello everyone. Before I start—just to test the waters here—I have a little prop with me. Can I ask all of you if you wouldn't mind saying this out loud?

Chair: Vagina.

Kevin McKenna: Vulva.

Chella Quint: Vulva.

Dr Sesay: Vulva. You said vagina, and that's the thing. A lot of us were brought up to believe that it was vagina and I think it was only in July this year that they have included vulva in the document. And that is the reason; we did not have vulva there. This is actually a vulva, and this is the external female genital anatomy. The reason I always start with that, and I have everyone saying it, is because there is so much shame and stigma around it to this day. I am wearing a T-shirt. I got you one actually.

Chair: I can't see it. What does it say?

Dr Sesay: I'm wearing a T-shirt that says?

Chair: "They are not bad words".

Dr Sesay: Yes, and at the back it says?

Chair: "Vagina, vulva, clitoris."

Dr Sesay: Clitoris. There's a song that we're campaigning for.



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Chella Quint: That sounds catchy. It sounds like it could be a song.

Dr Sesay: It is a song.

Chella Quint: Wow. You don't say.

Dr Sesay: It literally is a song. I promise.

Chella Quint: I bet it will get to Christmas number one.

Dr Sesay: There is a song out right now, and we are campaigning for it to be Christmas number one. The whole point is that even when I walked in today wearing this T-shirt, the guard said, "Please make sure that you keep your blazer on." Why? Because they still deem it as inappropriate, as bad words, as something that we should be hush-hush about, as taboo. Unfortunately, that is the reason why I often say that there are many women suffering in silence and who are literally dying of embarrassment. They do not come forward about their problems because they are embarrassed. I had an elderly patient who was ashamed. She had a massive vulval lump; you could not miss it; and she did not come forward because she was embarrassed. The only reason she came forward was because she was in excruciating pain. I took one look; I knew it was cancer. She had stage 4 vulval cancer. That is not an isolated story; it is something that happens quite often.

We need to break the taboo quite young because it is passed on intergenerationally. We are not born with the shame; we learn it: "Head, shoulders, knees and toes, knees and toes," and vagina, vulva and clitoris, yes, those. They are not bad words. We often say head and shoulder and when we use euphemisms, that perpetuates the negative narrative. I had someone say to me, "Oh, you know what? You've empowered me to teach my son to say penis instead of ding-dong." I was waiting for you guys to laugh; I'm joking. He immediately said, "Thanks, Mum. What is the real name for my elbow?" Why do we not normalise the words? It is similar with periods.

I do not want to steal all the conversation, as I know Nighat has a lot to say as well, so my last point is: when we teach our children the correct terminology, we are protecting them. We give them body confidence, we remove the shame, and then they are able to describe the areas in which they are experiencing symptoms. My daughter is seven, and we are selling little crochet pocket vulvas. I have a vulva anatomy card. I printed it out, and I was so excited. I showed it to her and she was like, "Mommy, why didn't you label the perineum?" She can say to me, "Mommy, I am having pain in my left outer labia." I have patients saying to me, "Doctor, I have a lump in my vagina when they mean vulva." Finally, it is to protect them from sexual predators. Evidence shows that sexual predators often avoid children who use the correct terminology because they know that this child has been taught about body safety, autonomy and anatomy, and that they will say if someone is touching them. There was a young girl who was being molested by her uncle, and



her mum taught her to say cookie. She tried to tell her mum, "He keeps playing with my cookie. He keeps touching my cookie." It took a long time for her mum to understand what she meant. There is no confusion when they use the correct terminology. That is why we need to remove the taboo from the genital anatomical names.

Chair: Thank you. Nighat, I should declare that we have worked together before.

Dr Arif: We have, on some incredible campaigns. Can I just say that for the record?

Q43 **Chair:** I am a big fan of your work, but I want to ask how important it is for really young girls, and how you break that stigma at a young age.

Dr Arif: Aziza has just said all the key points. The first thing we need to come back to is that 50% of the population has external female genitalia, and it leaves you at a huge disadvantage if you do not know the words for that. The shame and the stigma run deep. It runs across gender—even with females—language, health, faith groups, and marginalised communities. In the Punjabi language, we do not have a word for vagina, vulva, posterior fourchette, the clitoris, or the labia. How do these communities actually speak to a healthcare professional? We know there is birth trauma. Birth trauma is a natural process that happens but currently, as it stands in the UK, black and Asian women are six times more likely to have perineal tears and seek help later. I am part of that statistic; I have had a third-degree tear; I have had three children. You are left with these long-term birth injuries. We are very open to talking about things such as caesarean section being a birth injury, but when it comes to the perineum there is not really that much support available, and lots of education needs to be done around that.

It then translates into how that topic of conversation is discussed on social media and it becoming more widened. Healthcare professionals like myself and Dr Aziza are actually censored a lot because we use medical terminology, but the word penis is not censored. That is also something that needs to be worked on, and it is. Like Dr Aziza, I also use a vulva model. First, I am told that I am besharam. "Besharam" is translated as shameful in my community. A long time ago, I realised that the single thing that stops any advancement is to say, "But we have always called it a cookie, a flower, a down-there," so progress is not able to happen. Vulval and vaginal cancer happen; cervical cancer takes lives and has taken lives. But if you think about it, a lot of women do not realise that vulval cancer happens, and that they need to look out for the signs and symptoms. We even understand the red flags. If you know your anatomy, you are empowered to access services. Access to the NHS gets harder and harder; we have forms that you have to fill out in order to get access to a GP. If you are able to say what bit of the anatomy is affecting you, then we know that we can navigate healthcare within the system much faster and easier.



My final point would be that when it comes to understanding anatomy and the stigma and taboo, it needs to become part of our lexicon and widened out, so you can use the right anatomy. Men need to be part of it. Being able to say "vulva" is not something that is only for women. I am a mother to three boys, so my boys know their anatomy. In my immediate family, I am the only woman in the house, so they need to know what has happened to mum. Inevitably, and I joke sometimes that when they put me in a home, that mum's vaginal oestrogen goes with her because they know exactly what that does with regard to helping with, say, vaginal atrophy and genitourinary syndrome of the menopause, because our genital anatomy follows our whole lifecycle. It is not just for the young. It is so important to educate the young, and there is work being done, but it is throughout our fertility years, perimenopausal and menopausal years, postmenopausal years and beyond.

Q44 Chair: Thank you. Nighat, you talked about being shadow-banned or cancelled on social media. What does that do? Can you talk through how that happens? Have you had any contact with social media companies about how we tackle that and stop it happening?

Dr Arif: It comes in different forms. It could be the fact that my content will be taken down if I have a model. Visibly, I am a Muslim woman who wears a hijab. There are users on the platform who will say, "This is something that is against our faith group; it is forbidden, haram; this shouldn't be seen," and they will report me for breaking community guidelines. That is one way that the platforms will take down my content. Or, if I write the word vagina, it will be screened by the content algorithm and it will take down my content. So, it is often users as well as the algorithm itself. That means that I will get a notification. I have had my TikTok account taken down three times. My YouTube account has been blocked twice, and I have had to take that up. LinkedIn has taken down a video of mine where I was explaining the role of low-dose topical vaginal oestrogen with a model saying that I was promoting a product. I made it very clear that it was not product promotion; it was an educational post. I am talking about something that is available in the NHS on prescription. It is the same with Meta and Instagram.

Dr Aziza and I are YouTube Health content creators as well as part of the TikTok Creator Academy, and there is lots of dialogue happening. I have been able to reinstate my personal account, but that means that if I look at other accounts that are not making that content, the growth is not there. I would say that that is not getting to the wider audience; it is still hampering a lot of our content. If I look at male content creators who are probably making exactly the same content as me, I realise they are probably self-censoring. As a creator, it then comes to the point: do you self-censor those words? Again, this makes it more shameful and taboo. I find that their content is growing even though they have said exactly the same thing as I have without using the word vagina or vulva. That is not what I want as an educator, a clinician, as someone who works in the



NHS because I do not want to self-censor because these are medically accurate terminologies.

- Q45 **Chair:** Absolutely. I cannot get my head around the idea that TikTok and YouTube already know that you are doctors and this is the message that you are trying to get out, so why is it that they would take down any of your content or any of your personal sites? Why would they do that, especially since they know you are working with them to create this? Aziza, have you had any negative experiences? Has there been any positive change in how they are actually going to help with this? As we have seen, particularly for certain words—such as vulva and clitoris—they just take it down or it is banned. It is not even always just taken down; it is pushed down further so you are not going to get the growth and spread the message.

Dr Sesay: I have had loads of people say to me, “Aziza, have you posted anything lately? I don’t see your content.” That is what shadow-banning is. They just make it so that it is not visible. Even if people are sharing it as often as possible, it will not be visible. Recently, I did a post with The Eve Appeal where we were showing how to check your vulva because many women do not know how to check it, and I used this model. I did not know, but someone flagged to me that on my page, when this video is clicked on, it has a sensitivity cover on it. When you click on the sensitivity cover and ask why, it says it is because people will find it upsetting.

- Q46 **Chair:** Did it show a vulva?

Dr Sesay: It just showed this model of a vulva. It was because of this image, and because I said the word vulva and I spelled it correctly. Again, we do not want to self-censor because that just perpetuates the narrative. I have worked with YouTube and I have had the discussion with it about this. Unless it is an individual person who is looking at it, it automatically assumes that if you are going to be talking around these areas—there is a hyper-sexualisation of women’s bodies—it is automatically deemed as pornographic and inappropriate content. However, if it is sexy—and I have to admit this—if you are being provocative, that does not seem to get censored. It is almost like a pick-and-choose thing; this is genuinely how it feels. I have spoken with and worked with YouTube.

There is also a campaign called CensHERship looking into all this banning. It has gathered evidence and I believe it put a white paper together. I think there was a talk in Parliament with Essity recently. Again, a lot of us are seeing it. It is not because we are trying to make money; a lot of us healthcare professionals are putting this out there. I am going to share a story. I used a brown model of a vulva because you do not usually see the representation. My vulva is brown. A patient saw one of my videos and she realised, “Oh, I need to pay attention to this.” She checked her vulva and has now been diagnosed with lichen sclerosus. We know that if it is not treated properly, there is a low chance that it could progress to



vulval cancer. Hopefully that will not be the case for her. That is the story about these videos. These videos are lifesaving, but we cannot show them.

It is the same if we try to show what happens during cervical screening. It is all seen as too much, explicit or inappropriate. We are having to fight; it is like an awkward struggle. It does not make any sense to me. It boggles the mind that they are able to create all this incredible AI, yet they cannot get the tech that can differentiate between pornographic, inappropriate content and accurate, scientific, lifesaving content.

Q47 Chair: Clearly. But surely that should be pretty simple to do with content creators that they already work with. I am not a tech wizard but if Nighat or Aziza is going to be posting something, I am going to go, "This is not pornographic. You don't have to take this down." It is common sense.

You have both mentioned vulval cancer a couple of times now and you have said that there are some simple red flags. It would be a missed opportunity if we did not say what those red flags are. Can you do that for us?

Dr Arif: Of course. First, I would say know your normal. Really importantly, look at the skin for any red patches that are new or different to you; look for any lumps or bumps that have changed, particularly if they have evolved pretty quickly within the last two weeks; any lymph nodes in the groin; any lesion that is bleeding; any heavy discharge from the vagina. The vagina is the canal, but look at the vaginal opening for any sores that have not got better over time and you have tried different ways to manage that. Also, look for any loss of architecture; that is the other sign that we are looking for. It could be the clitoral hood, loss of the labia minora—the inner lips—or labia majora as well. Look for any sort of growth or ingrown bumps within the actual pubic area that are persistent and not going away. We always think about pain, irritation, and if there is any pain at night. Night pain or itching is sometimes a red flag as well because that is disturbing your sleep and needs to be checked out.

Dr Sesay: Some people literally do not even know how to check: make sure you wash your hands and get a mirror, put it between your legs. You either lie in bed and get your legs wide, squat down, or perch one leg up on a toilet. People do not even know this basic thing because we are not taught it and it is seen as inappropriate. Just really quickly, because we keep saying vulva: I also want to mention vaginal cancer. The hashtag vaginal cancer was hidden because it was deemed inappropriate. There was a woman who was sharing her story about vaginal cancer. How is she supposed to feel if her cancer is being censored and being told it is inappropriate? It almost feels like shame on you for having that.

Dr Arif: One thing I am really trying to get women, girls and clinicians to do is to please examine standing up. I get women post-birth going, "I feel like the world is between my legs." What they are talking about is a



prolapse, but they do not have the word for prolapse. Actually, if you examine a woman lying down, you will not see it because gravity has pushed it back up again. For men who have hernias, we examine them lying down and standing up. Why? Because when they cough and against gravity, their hernia comes out. It is the same with women as well. Aziza said it really well: squat. That is really important. Put a mirror between your legs, cough, and see if anything comes through the vaginal opening or the back passage because rectal prolapses happen to women as well.

Q48 Chair: Thank you. I did not want to miss the opportunity since we had talked about it quite a few times. You said there were clear red flags; we should know what they are.

Chella Quint: I have something to add because we look at stigma in a slightly unique way. Do you mind if I share that quickly before we move on? We know stigma is harmful, and we see tackling stigma and taboo as an essential first step because, in our experience, it opens the door to learning. But sometimes people see it as the end point—not anybody on this panel—but sometimes we see situations where if you do not pair taboo-breaking with menstrual literacy to back it up, the information has nowhere to go. People might learn something, but it will stay with them. Creating a culture of taboo-breaking to avoid leaving a vacuum is one of our aims because we have already seen that vacuum sometimes filled by opportunistic companies, maybe selling products that are not necessarily regulated or tools that have not been vetted, which has happened before, and ignorance and shame were used to benefit from that shame.

It is heartening that the new openness around menstruation has reached the highest level of Government, and I am really grateful to be in excellent company today. I want to share that we are starting to use the term institutional menstrual shame. By this, we mean that menstrual stigma is so baked into the institutions that make-up our society and everyday routines that even when an enthusiastic leader, youth group or external project makes progress, that progress can vanish when the staff move on or the funding ends. We have been designing and testing frameworks that I will talk about in a bit that address that, but I wanted to share this idea that all this great work individually needs support holistically so that it is not the final step, but it is wonderful that this session started with asking about stigma.

Chair: Thank you very much, Chella. Rachel will have more questions about that and the Period Positive pledge.

Q49 Kevin McKenna: Before I was doing this job, I was a nurse, so I am very tuned in to the fact that lots of euphemisms are used even within the clinical professions, and we have had lots of battles down the years trying to de-euphemise what we do. Cutesy euphemisms such as passing water instead of urination are used, but sometimes it is dressing things up to sound very scientific, such as micturition, which frankly most of the public have no idea what that means, but it helps clinicians somehow distance themselves. While you have been doing this work, have you



encountered cultural resistance in the clinical professions? Is that a problem? How do you determine which are the right words or most useful words to have a common understanding of? For instance, many people still use vagina instead of vulva. I can see the technical reason for that, but how do you ensure that we are not over-medicalising and are using language that everyone can use?

Dr Arif: For me, when it comes to producing my online content, there is a cultural barrier because I am trying to break that taboo within my own community. I am actually addressing all my patients where I practise, and a lot of my patients are from black and Asian communities. I am Pakistani; I speak Punjabi and different languages. Because we do not have those words, I see the limitations and the problems that could have been prevented had they just been picked up early enough. I go back to the common medical terms that patients would understand quite well, and you have highlighted that really well. We know that some medical words such as micturition do not actually mean that much—the same as a patella would mean nothing, but a knee is still medically accurate.

When it comes to female genitalia, as clinicians who are working with patients, we see that the general public have started using these terminology words within their lexicon anyway. I am really pleased that a lot of my Pakistani ladies come in and say urethra. I'm like, "That's amazing." That is because they have seen me say it. It is almost that pattern of, "Well, this is the actual word for where I pass urine from. Ah, okay, so my urethral opening is sore. Actually, my vaginal opening is sore," because the vagina is the canal itself. Making those sorts of distinctions comes because we are trying to be as clear as possible to make sure that pattern of language goes through.

The pushback is that I get a lot of trolling and a lot of my content taken down. It is sometimes seen within my community as not the done thing, but I am slightly maverick in that respect. As a clinician who works very closely with and has a lot of respect for my community, I understand why the cultural barriers are there. They are always grateful when those barriers are broken down because the education gets through. Now I get a lot of men from my communities, fathers and brothers, who say, "My wife went for the treatment because she saw your content." I would say it is just knuckling down, ploughing on, being present and consistent.

Q50 **Kevin McKenna:** Are you getting any pushback from clinical colleagues?

Dr Arif: At the start, there was a lot of cynicism within healthcare professionals. I have been on the social media platform for three years. Before that, I was your average GP—I like to say just a GP—not doing anything fancy or clever. Then I just thought, actually, this is something that my colleagues could learn from. The pandemic was a turning point for me for using social media. There was some cynicism from colleagues, but now they are seeing that their patients are on these social media platforms, so their patients are coming in knowing the information. As healthcare professionals, it is a missed opportunity if you are not on that



platform because you are missing a lot of the information that the patient is getting, whether that is the accurate information from healthcare content creators like us or whether it is misinformation. I know we are going to come on to misinformation later, but that is rife. As healthcare professionals who are meant to be leaders in healthcare, we have to do our due diligence and know what our patient is consuming because they are going to come through the door asking for that. Finally, for healthcare professionals, it is so busy; it is an ever-changing world and we all have our own areas of expertise. I am not the best at everything, so the way I learn is following excellent clinicians. We are like magpies; we are learning from each other when it is difficult to keep updated all the time. That is where healthcare professionals are grateful for my content because they are like, "Oh, I didn't know the guidelines had been updated for this."

Q51 Rachel Taylor: My first question is to you, Tori. Your approach includes publishing lived experience narratives, holding storytelling events and those sorts of things. Why did you choose that approach? Is there evidence that it is effective in normalising those conversations about menstrual wellbeing?

Dr Ford: First, just to say I have never been in a room where we have said vulva so much. I am the first to say it usually, so I am among royalty. Medical Herstory began with my own story. I have lived with chronic vulval pain for over 10 years, starting when I was a teenager. I tried to go to different medical professionals and share what was going on in my life, and tried to make sense of it. Of course, at that age, coming into your body, coming into what it means to be a young woman, a young person, there is a lot of complexity in that. I faced a lot of the dismissal that we have been reading about in a lot of these reports of saying things like, "Oh, well, just change the colour of your underwear; wear white underwear; that'll change all of your pain." Or, "Maybe take some time off school. Have you ever tried having a glass of wine and relaxing?" Really dismissive advice that really sticks with you. I remember one of my healthcare professionals saying, "Oh, well, some people get coughs repetitively; some people are just more prone to chronic vulval pain." It was that kind of equation of something that, for me, was rooted in a lot of shame and stigma like we have been talking about today. At that time, I did not really understand words such as vulva. There was so much embarrassment that made it really hard to speak out. This was not really something that was talked about a lot online 10-plus years ago.

I actually started sharing my own story with some friends and community members and they said, "Tori, you've been through so much. It sounds like fiction; you should write it." I thought, "Who wants to be the face of vulval pain? That's taboo, embarrassing, and shameful," and here I am. I ended up writing this story for my school newspaper and it went on to make the front page. I was really horrified. "What have I done? I'm talking here about my body, my pain, the complexity of what it's like to



be navigating a health system and feeling not listened to. Are people going to say, 'This is gross, shameful, unladylike or unprofessional?'" Instead, I heard so many people saying, "I have a story to share." Friends that had ovarian cancer at 18 years old being told, "Don't worry, you're going to get through it. It's the female equivalent of testicular cancer." This is the phrasing and subtleties in the way that people are talking about their bodies, or going to doctors repeatedly with chronic menstrual pain and just being told, "That's normal, that's natural. We all deal with that." People said, "We have these stories; we want to share them. What can we do?" That is how Medical Herstory was born.

Today, we have shared over 40 different stories internationally relating to different topics, and we are working to eliminate sexism, shame, and stigma through those stories. We have a lot of evidence that shows how impactful stories are, especially when they are used alongside statistics. We hear from individuals who share their stories about the impact on them. Often, it is their first time speaking about these issues, and putting them in writing. A lot of times we have people who start off with a process wanting to be anonymous in their story and by the time they have written it they say, "Actually, I want to put my name on that," and that is really powerful. We also know that there is a need for these stories to be shared. In addition to having our written evidence, we have held over 50 storytelling events, and we have had over 2,500 participants, so there is a real need and desire to hear these stories. We have done those on vulval health, trans health, trans joy, indigenous health, and refugee and migrant health. Bringing people together in these spaces to share their stories is really impactful.

Then, some of our own internal data: from these events, over 80% of participants reported decreased feelings of isolation in navigating their own health experiences. As we have talked about, one of the main things that shame and stigma do is isolate you and make you feel alone. Some 90% reported feeling more educated, empowered, and aware of patient experiences, and we have similar data from storytellers and the audience. We have seen this in many different areas of how hearing these stories sticks with you, and as we have been hearing today, when you are able to illustrate something with a real case, it has power to it.

Q52 Rachel Taylor: Do you think our NHS could learn some lessons from your approach?

Dr Ford: Yes. I actually had a quick look today at the NHS web pages, and I reached out to some colleagues and said, "I have an idea." It would be amazing if, when you went to the NHS sites, there were stories of experiences. What does ideal care look like? What is it like at the end of my 10-year journey? I now have an absolutely amazing sexual health doctor and all the details that have made the care so wonderful, helpful and empowering versus all those experiences where maybe a doctor at the time is not thinking through a comment like, "Oh, I'm going to



reassure them it's normal, natural, common. It's just like having a cold," and take those seconds to pause and think about it.

Something Medical Herstory does well and that we could see more of in the NHS is co-production, really bringing patients in and having seats at the table. In addition to the work that we do within storytelling, we teach in medical schools, and we do patient advocacy workshops, recognising that you were never taught how to go to the doctor. We thought that was quite odd. We do a lot of that work now and would love to collaborate more with the NHS. But yes, co-design and co-production in websites and public-facing materials could be extremely impactful. There are so many patients and patient groups, many on this panel, who would be happy to do some of that work.

Q53 Rachel Taylor: Chella, I want to talk about your Period Positive pledge. What aspects of the pledge do you think are most important in challenging stigma and taboos?

Chella Quint: I should start by saying the Period Positive pledge is based on the phrase "period positive". When I coined it, it did not mean that all periods are wonderful—many periods are a pain in the uterus—but it means that talking openly about periods and the whole menstrual span is a positive act. The definition has become more and more detailed over time. Over the years, as individuals and organisations have contributed to the project through co-design and participatory partnerships, it has remained a grassroots idea that has become more and more tangible. The key negative message that we challenge is the idea that a good menstruator is an invisible one, someone who never leaks, and maybe never even mentions their period. Advertising has, for the whole history of menstrual product advertising, almost entirely portrayed leaks as catastrophic and implied that buying the right product, especially their product, would improve everything. Menstrual researchers have started calling this the menstrual concealment imperative and pointing out that that means people sometimes—borrowing language from critical race theory—pass as a non-menstruator, saying that the norm is not having periods, even though obviously we know that is not the case.

The Period Positive pledge is designed to look memorable. There is a kids' version that the editors of my children's book helped me develop so that it is in child-friendly language and is available online for people to use freely. It came out of my master's research. My students were testing taboo-breaking lesson resources in an action research learning lab when I was teaching drama and head of PSHE. In my spare time, I was doing stand-up comedy about periods. I know it is very stereotypical—"Oh, female comedians, they just talk about periods." That is absolutely not true. We are all very funny, but I happened to be talking about periods, which was a bit awkward when it came to the stereotype, but really fun. When I started talking about it in 2005, not a lot of people were doing the whole thing; people talked about other stuff, too. Turning those into lesson plans was a lot of fun for me, but it did not really matter if it was



fun for me. I was not doing six shows a day in the classroom. It mattered that kids needed something better than a leaflet with very sad girls worried about puberty.

One thing we did was look at Stains TM, a removable stain you can wear on your clothing, to create something that, as a joke, we called Leak Chic. When I brought it into the classroom, young people just took it away. They became executives in media and marketing firms, and they created a product using media language. They created an ad spread for "Vogue". One of the kids said Le Stain because she knew that fashion was French. The joke that we decided was too naughty was Clot Couture. However, clots are a part of menstruation, and we should not censor ourselves. In the spirit of not censoring, we decided to tone it down to Leak Chic. The kids learned advertising language that they had been influenced by and said they no longer wanted to be influenced; they wanted to be informed. They wanted unbranded products in the classroom.

They had three demands. It was a co-design project. They had outputs that they were recommending: tell us everything; show us who we can trust; and include everyone. That led to three things: the Period Positive pledge and two other framework tools. One of the tools was an award symbol so they could see which teachers, and eventually schools and cities, they could trust. The symbol is just like an open-mouthed, smiling blood droplet. The open mouth moved on from being a little, simple smile because they said it was not always happy; it was about talking and laughing, using joy to challenge shame; and sometimes even shouting when they were angry. The other tool was a curriculum guide, a programme of study just like any national curriculum subject has a programme of study.

The pledge is meant to be taken as a whole. It helps people join the conversation if they are new. It is as if you are starting a new TV show, but you are jumping in at the middle and the episode starts with "Previously on." This is like a "Previously on" for menstrual activism and advocacy. The lessons we have learned from working with partners over the years focus on challenging the things that have become so normalised that we do not often question them—the "We've always done it this way" problem that you mentioned earlier, such as only teaching girls or relying on corporate lesson packs. Some key pledges focus on language, avoiding euphemisms and outdated industry terms such as sanitary protection or feminine hygiene, and instead use accurate words such as menstruation, menarche and menopause that everyone is allowed to use. Sometimes people do not feel they are allowed to use those medical or scientific terms, but medical professionals and scientists have periods and those terms should be for everyone.

Q54 Rachel Taylor: What progress have you seen in the adoption of the pledge?



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Chella Quint: I have bullet points. I appreciate you asking that. We have now seen the pledge used at every level from individual homes to towns and cities. Some pledges focus on avoiding corporate over-influence. Places where people have wanted to make their own resources or challenge that sort of, "You've got to use this product from this company at this expensive price that's advertised at this level, and here are some bits and pieces for you." They rejected that; they reached out.

In schools where we piloted it, pupils and staff have used the pledge really creatively. One school had pupil champions use it as the basis for a youth voice project to redesign the toilet block that was about to be renovated. They requested individual cubicles with floor-to-ceiling doors and sinks and bins inside. One of the reasons they cited was, "So you could wash your hands if you had blood on them." Another reason was they want to be able to rinse a menstrual cup without having to leave the stall, or use an internal menstrual product without worrying about tracking blood on to the doors and things. A different school used the pledge in a whole-school conversation about toilet access which led to an audit. The audit was based on work originally developed by Shirley Prendergast, a researcher at Cambridge who published the audit in 1994. We got the same result when we tried it again as part of the master's research in 2013. That led to a new policy where the headteachers made it explicit that toilet access was allowed at all times and that it should not be linked to discipline. It seemed to have become this tacit rule even though it was never official policy and this was easily undone. Two more schools adopted it later, and the pledge became something that they used as a planning tool for designing cross-curricular education materials. Kids and teachers were working together to create their own lesson ideas that were as creative as the period stain one, but from their own ideas and using lots of different school subjects to support it which meant that more topics could be covered from the curricular model and more staff training could be justified.

I can talk about that afterwards but I want to mention that, beyond schools, one primary care trust has used the pledge to change language in posters and policy documents that are displayed around and used for their own staff. Staff involved in the free products Bill guidance told me that their advice on avoiding euphemisms in the free product guidance came directly from the pledge. Two parents in different parts of the country got in touch by email at completely different times to say that they wanted to put the pledge up at home and could I send them a copy because they wanted to show their own kids that they wanted to be an open, period-positive household. Finally, at city level, councils in Sheffield, Brighton, Swansea, and most recently Frome, have all drawn on the pledge and the period positive award to build in strategies that are ongoing.

Rachel Taylor: I'm loving the Le Stain.

Chella Quint: Le Stain TM.



Rachel Taylor: If I was a purist, I might call it La Stain.

Chella Quint: But it is le vagin. I'm sorry; it all went into French for a minute.

Q55 **Rachel Taylor:** Using the Leak Chic is obviously one of the negative media messages you are trying to combat: that a good period is only an invisible one. Are there any other negative media messages that you have been trying to combat?

Chella Quint: There are so many. I have a TED Talk; you should watch it. It is old, but the second half is very accurate. Periods being commodified is a problem. Periods being something that happens to you is a problem. Periods should not be portrayed as something that happens to you; they should be portrayed as just one small part of something very interesting that bodies can do.

On other pubertal stories, there was a great piece of research from New Zealand in 2012 that talks about how all the male puberty changes are talked about as being really positive and additive, and all the female-bodied ones are portrayed as negative. Even the pre-2019 RSHE guidance document talked about coping with periods. I was one of the people who requested that it be changed and that three sentences be moved to six sentences. In terms of menstrual product advertising, there are four types of menstrual literacy and I think we only learn about two. The other two are really essential for dealing with those negative messages from corporate media: body literacy and product literacy. Lots of us already do that, know that, and could teach it at a pinch based on what we have learned. But media literacy and cultural literacy are equally important, and they are completely missed most of the time. Kids need to know that, in all cultures, all over history, all through time, people have thought blood was powerful—menstrual blood most powerful—and power does not have to be good or bad. It depends on how it is interpreted, sometimes after the fact.

Another issue is media literacy. My favourite ad to hate about menstrual product advertising in 1926 talks about a great hygienic handicap and the women of tomorrow, and posits disposable menstrual products as this aspirational concept. It helped a lot of people to not be tied to using reusables at a time when we did not have washer-dryer combos in our kitchens. The result is that we have 100-plus years of this echo of media negativity, and if we do not challenge those messages or instil in people the ability to be literate about those messages, specifically the words whisper, secret, discreet, accident, and panic. A menstrual product leaks, okay, you have to wash that pair of jeans, but it should not be a social shame that you remember from school onward.

Rachel Taylor: That link between comedy and challenging those misconceptions is interesting, and that is often the case. Thank you.

Q56 **Chair:** We are still on our first section. We probably have another six



sections to go, so can we try to keep answers a little shorter? If there is anything that you think is worth us looking at in more detail, please send in written evidence as well. This is partly our fault because we are finding this so fascinating; and, yes, Tori, it is lovely to be in a room where we can actually talk freely, and it is a special part of this Committee, so thank you. Kerry, we have not heard from you yet. We are going to go on to a section about RSHE, specifically the curriculum, but I noticed that you were nodding at quite a lot of the storytelling and the other ways of communicating information. Is there anything you want to add?

Kerry Wolstenholme: Around stigma, you also have to remember that the people who are being tasked to challenge the stigma carry that stigma themselves and we need to go back and really change that. As much as things like the guidance are helpful, and especially the new guidance because it says vulva, there is still an apprehension about the word age-appropriate. There is nothing that confirms age-appropriateness. If we have media taking down crochet vulvas, then teachers are saying, "Is a crochet vulva okay in the classroom? Is it not okay in the classroom?" Explicit, honest, direct, and clear information to those people reduces stigma. I really love to see people own it and go, "This is what we think is age appropriate. There's your answer, your confidence, your clarity." I liken a lot of support and guidance in challenging the stigma to the technical challenge on the "Great British Bake Off", where it gives you some information, and then you have to piece the rest together yourself. For people who are great at this, we would just be like, "Yes, that's fantastic; we could do this and that." But for somebody who is new, they would be looking at it like, "What exactly does it mean? How far can we go? What is too far? What is not?" For me, if you want to challenge that stigma, it really is just to make everything clear, direct, and obvious. Clarify it, confirm it, stand behind it, and give it to them.

Chair: Thank you. I am going to move on to Kim, but this conversation will still continue as a bit of a thread.

Q57 **Kim Leadbeater:** Goodness me; thank you so much. This has already been amazing. What a fantastic panel of brilliant, wonderful experts. I will confess, I am part of the problem because I am generally a very open person, but I am not very good when it comes to these issues. I am guilty of talking about my bits. I am embarrassed that that is what I do, but I have to be honest that that is the case, so this is so refreshing. I am going to talk about communication. You are all amazing communicators, which is wonderful to hear. How well is the NHS communicating in this regard? What does that look like in terms of content on NHS social media and the NHS website? Could you all maybe share a couple of fairly concise thoughts on that? I am also quite interested in the accents on the panel. I am a northern woman, a Yorkshire woman, and I get a northern vibe from you, Kerry, but I am also getting other accents, and I wonder if there is anything about being British that is part of this problem around having these conversations, or



are there similar issues in other countries? Are we not unique in that?

Chella Quint: We are definitely not unique.

Kerry Wolstenholme: I have taught RSHE for 28 years, and in the classroom teachers are very keen to do this lesson, but when it comes to saying the word they say, "We're going to talk about sex education, body education, and vaginas," and vaginas is whispered. It is because it happened in our households; it is still there. As much as you can go on TikTok and scroll, it is not on TikTok because people are saying all this information and words and explicit stuff online; we have still not become comfortable with the health aspect of that. We just need some support in differentiating the two of inappropriateness and what it is okay to say, to do, and to be. In terms of the NHS stuff, there is a real battle. A lot of NHS materials still look like a 1985 Word document. When you are challenging that against the content that people can create so easily online now that looks great and looks like they have a production team behind it, if you are a young person, where are you going to go? We need to step up and get better at creating stuff that is quality; we want to see some quality.

Kim Leadbetter: And modern.

Kerry Wolstenholme: Yes.

Dr Arif: I am hoping I will give you solutions on some things that we have been doing. I am a trustee at Wellbeing of Women. Aziza is also an ambassador for Wellbeing of Women. We have been doing lots of work around just knowing what your normal is because we have moved quite far away. It was really refreshing when you said your bits because actually that is really common, and it is because we do not know what is normal. How do you know that this period or a silent period is okay, or this heavy period is okay? We have done some really hard-hitting campaigns where we have worked with grassroots organisations. I co-founded the Health Collective with Professor Dame Lesley Regan, the ambassador for the Women's Health Strategy. We have done Just a Period and Know Your Period. So, knowing that clots are not normal, pain, changing your period product every hour to half an hour is not normal. We have done a period symptom tracker as well. Some 60,000 period symptom trackers have been downloaded and used. At the end of it, you answer some questions and you get a form that says, "This is not normal. Please go and see your GP." I have actually had one of my patients brandishing this letter in my practice saying, "My periods are very heavy. I'm passing clots that are the size of my fist. My period doubles over so much into my life that I'm missing school and education. What are you going to do about it?" I was so happy that she had used this and brought it along because it assisted our conversation on what we can do further. Patients might not know the diagnosis of fibroids, endometriosis, adenomyosis, PCOS, PMDD, or perimenopause, but knowing that their body is changing at certain points is really great. Out of that, we found that 62% of respondents sought help and got a



management plan. There are simple things that we could do for the NHS; I look at the NHS website profusely as a GP and it is very much outdated.

I have been having discussions with the NHS communications team and those lived experiences of patients are really great. When it comes to menstrual health, having the free symptom checker from Wellbeing of Women would be a brilliant addition to the NHS website and would modernise it. It would also be great to have links with content creators so it can go to a video. It does not have to be mine, it could be by all the brilliant, excellent content creators out there, that says, "This is what a normal period is," or "This is what endometriosis is," because otherwise you are looking at these stock websites which do not actually mean anything. We know that the biggest trust that all age groups have is still within the NHS, thankfully. We know there is already a buy-in because people trust the NHS and they will bring that to the GP surgery. For the educational bit, we do not have to reinvent the wheel; we can just use what is already out there. The other really quick win—which would be great and I know we are going to come on to—is free menstrual products being available at the GP surgery, at sexual health centres, and at schools so that we are not thinking that having periods is a problem. We know that women bleed; men know women bleed; boys and girls know women and girls bleed. Yet the shame of it and keeping it very quiet perpetuates the fact that help is not sought.

Q58 Kim Leadbetter: Brilliant. Does anyone want to add anything to that?

Chella Quint: Resources need to be accurate and engaging in equal measure. I worked with the teams from BBC "Bitesize" and "Newsround" in 2020 and 2021, supporting their period-related content. The most popular segments were a quiz on the "Bitesize" resources and an animated bit, but the "Newsround" special was nominated for an International Emmy. The whole thing was engaging, and it had lots of different magazine-style segments. We also recommend that people talk about ranges. We have banned the word normal. This is my kids' book called "Own Your Period"—it is in lots of libraries; I am not selling. We talk about average ranges. We talk about an average menstrual cycle range of 21 to 45 days for kids who are starting their periods. As an adult, 21 to 35 is average. When I was growing up, we had the 14 days for this half, 14 days for this half, ovulation bang in the middle, and that is not true. The first part of the cycle is not the first half. What is normal for you is your normal, so giving people ranges of averages is really helpful, and that builds on knowing when to get help.

Also, asking for sentence starters has been really practical for kids. In author talks I have done with the Girls' Day School Trust, the feedback they received was they were particularly excited to give their pupils conversation-starting sentences to talk to doctors, parents, teachers, and friends about menstrual health. That is an interactive thing that is very easy to do. Literally, it is just sentences on a web page and maybe a couple of cartoons. Representation is important though. The other thing



that I asked for with the “Bitesize” resource was could all the people not look like a cookie-cutter cutout silhouette of a lady. Different body shapes and sizes, gender representation, race and ethnicity, and ability should be shown. There are lots of visibly disabled people in my book, even though the book is not about disability. Those are just little titbits you can sprinkle in.

Kim Leadbeater: It seems there is consensus that the NHS resources probably need a bit of a revamp.

Dr Sesay: I want to mention really quickly that some of us have worked with NHS England and we have created content with them, and what makes it difficult sometimes is time. I can film a video right now, edit it, post it, boom, done. If I do it through the NHS, I have to show them the script; we have to edit the script together; then film the video; make sure the content is fine; check copyright; this and that. It makes it so complicated. We, as colleagues, including Nighat, created a video for bowel cancer, bowel screening, cervical screening, and breast cancer screening. We did a multilingual video, and we had multiple GPs and other healthcare professionals invite and encourage women and people to do their screening. We shared it with the NHS. It said, “We can’t show this because there are so many hoops to jump through.” That video is in 25 different languages. This is so simple, but that is what complicates things.

Dr Arif: Can I just add that we did one for breast cancer and cervical screening as well?

Dr Sesay: Yes, that’s what I said.

Dr Arif: I’m sorry.

Dr Sesay: We did it for all three, and we had so many amazing people who volunteered their time. This is the other issue: most of the time they want us to create videos without any remuneration. That is a problem because when we work as doctors, we get paid. A lot of the things that we are doing is goodwill, freewill, but this is what makes it a bit difficult for us because sometimes it just does not feel like it is level. Some people will get paid; others will not and that definitely plays a part.

Q59 **Kim Leadbeater:** Tori, do you want to finish off with my final bit about whether we have a particularly British problem with talking about these things or not?

Dr Ford: My Canadian accent has maybe been clocked; I do not have an awesome British one. Medical Herstory has had more than 300 volunteers over the past five years across 12 different countries, from the UK to Dubai, Japan, Sudan, everywhere, bringing their own experiences. We have been really shocked to see that these issues are not an NHS issue; they are not a Canadian Medicare issue. Sexism, shame, and stigma are so deeply embedded in healthcare as a concept, as an institution, and as



a historical legacy. The threads are eerily similar, the feeling dismissed. Looking for good examples, we can also expand our circles there.

Q60 **Kim Leadbeater:** Are there any countries that do it better?

Chella Quint: No. I say we are all going through puberty at the same time. I am from the US, but if people want to pretend I am Canadian, apparently that is a compliment; that is the right way around. Hello, neighbour. I am from Sheffield in my post-American life.

Kim Leadbetter: Yes, Yorkshire. I am just a bit further north.

Chella Quint: Every country has a north. There was good sex education in New York and New Jersey, but terrible period education, and that was actually the way I noticed the difference. As a globe, we are all finding ourselves in this same position and sharing knowledge. The Society for Menstrual Cycle Research is a brilliant global resource that brings people together at conferences. We wish more people would receive funding from their Governments to attend because the global scholarship helps to move the conversation on. It is not just researchers; it is also clinicians, artists, and activists. It is an amazing resource, and you are not alone. Sometimes, though, if you are already experiencing stigma because some other aspect of your identity is stigmatised or marginalised, it can sometimes be easier to have an objective view of something that people do not want to mention and you feel more comfortable mentioning unmentionables; at least I do. But maybe that is what you are seeing as Britishness. I do not think it is, and I am from somewhere else and I feel comfortable talking about this and challenging it here.

Kim Leadbetter: That is brilliant. Thank you so much.

Kerry Wolstenholme: Can I just add to that? With the Britishness thing, periods have sat under hygiene for so long. If you think about how we behave with anyone going to the toilet, even sneezing can be uncomfortable or if you have an itch in your throat and you want to cough and you are on a train, we just do not like to upset other people. We have put periods in that kind of place, and we are trying really hard to move it into something else, but we then put it under sex, which also makes people then go, "Ooh." Body and health: people are not offended by that. I am not offended by body and health. Even just choosing the terminology of this as body and health education—not sex or hygiene—really helps us just to say what it is. I wish we were not so British in those ways, but we are being considerate. I suppose good manners is what we are trying to do. It is just finding where to sit it. Body and health education, or information, is much easier than hygiene and sex.

Dr Arif: On Britishness, though, every single time you go to a dinner party and you start talking about periods, it is the most favourite topic that you will always have. So, we are not that British.

Chella Quint: People are just waiting for an invitation.



Dr Arif: It's like, "Let me just talk about this."

Q61 **Chair:** Aziza and Nighat, I can guarantee that you and doctors generally would get lots of questions. As soon as you say you are a doctor, you are going to get loads of questions. It is similar if you say you are an MP. Thanks, Kim. I fall into the opposite category of Kim. I probably overshare, and long may that continue. There is something happening in social and traditional media around misinformation. Kerry and Aziza, what do you think the NHS and the Government could be doing more of to tackle misinformation? In some cases, I am going to say it is disinformation because it is deliberate.

Kerry Wolstenholme: We could have a verified badge for people to prove who they are, some kind of badge system which gives somebody a stamp of approval to be able to give health advice, information, and knowledge. The doctors who are posting on social media, if their badge is a red badge instead of a blue one, that shows that they have proved their qualifications and their stance to be able to share that knowledge. I spotted and challenged two things just two weeks ago and then got lots of really nasty comments. There were two girls in a gym filming a beautiful video of themselves working out in their gym gear. One complains about her stomach bloating and a large stomach area, and the other one says, "It's actually not your belly; it's your uterus. That is your uterus." It was not her uterus and so I said this was misinformation. "I love that you're being really supportive, but it's really important that young people don't think that's their uterus." Lots of people wanted to argue with me about that. They are not arguing with me because they think it is not true; they are arguing with me because people then click on their account. The online world is not really about informing; it is rage-baiting. It's like, "I'm going to say something that I don't even think is true just to cause arguments and ideas." For me, as much as I love social media and love the videos, it is not a place that I am going to use to resource my education in the classroom because it is not being verified and given the tick box of this is safe information. If you deliver RSHE, a chunk of that is about online safety, data sharing and verifying good sources. I cannot promote and say, "Watch this YouTuber," and in another classroom say, "Watch who you watch; make sure it's from a good source," because it conflicts the two. Give us the resource that is clarified and verified.

Dr Sesay: Actually, there is something like that on YouTube. YouTube created this YouTube Health shelf where, in order for you to be on this health shelf as a healthcare professional, you have to prove that you have a medical licence, are with the GMC, and that you have had a certain number of views. You have to jump a few hurdles to get on to it. Then, you get the badge and the tick, which I guess is a good thing, but sadly, in some ways with some people, there is still the negative narrative associated with doctors. Some people just do not trust doctors. They see the tick and they are like, "Well, I don't want to listen to them. They just want to sell me vaccines," and all the negative narratives that



are associated with it. But YouTube has tried to do that. I definitely agree that there should be some sort of verification to ensure that the content is scientific and evidence-based because you absolutely have a lot of people—rodeos—out there selling supplements, especially. When we talk about women's health, we know that research is only 1% to 2%. For a lot of the conditions, we do not know why they happen and we do not have cures. Women are left vulnerable, and they are being exploited by all this misinformation. They are being sold these supplements or remedies and being told that they are cures. There need to be sanctions and repercussions for individuals selling things that are not factual and that actually may be dangerous in the long term. Even if it is not necessarily dangerous, you are taking a lot of people's money because they are so desperate. There should be something to say that it is not right. As I say, a lot of the time if you share the most absurd thing, that is the one that seems to be pushed. If there is any way for shadow banned content like ours to be reversed, that could be the difference between life and death for someone because that is the information that is life-saving and can really make a difference.

Chair: I am going to hand over to Alex now. I am told that we are moving quite quickly through that debate, so we may end up with four votes at some stage as well.

Q62 **Alex Brewer:** This is absolutely fascinating. In the interest of time, I am just going to ask different questions to one person only. To start, Nighat, can I just ask you, do you think that girls and young women using period trackers—as a group we have mentioned period trackers already—have enough information to effectively choose one?

Dr Arif: No. That is not the case at the moment. A lot of it is awareness out there. I also always worry about data protection and the selling of your data to individuals. Femtech companies have a huge responsibility. There is a mistrust already because now young girls have become aware that tracking online or on a tracker means that they might be sold products that they do not want. That monetisation really concerns me.

I have moved away from some big period trackers, apart from ones I would say are linked with charities, which I know are not for profit. That is why it needs to sit on the NHS. How I feel about data protection in the NHS is a whole other conversation. But it needs to sit somewhere where there is that level of trust, that level of security, and fundamentally that safety for young girls and women and my patients with their data.

Q63 **Alex Brewer:** To follow on from that, would you share concerns that the femtech sector is not drawing sufficiently on racially diverse data? Does that then have an impact on exacerbating health inequalities, for instance?

Dr Arif: Yes. I would say more than inequalities, equity. Health equity is massively disparaging at the moment in the NHS. I see that time and time again with my health collective that I am working with. We have



mapped grassroots organisations. I am not just talking about black and white. I am talking about those with a hearing impairment, disabilities or visual impairment, traveller communities, Tori mentioned refugee communities, poverty also plays a huge part, and access to online information. We know that health equity is actually the biggest barrier for appropriate care when it comes to women's health already in the NHS.

When it comes to femtech, those who have the means and the financial means to buy that tech, yes, their data will be pulled. It is skewed towards that. AI is already skewed towards—dare I say it—the white middle-class narrative. I would say there is a north-south divide as well. If you live in the north of the country, you will find there is a huge disparity compared with if you are London-centric. That plays a huge part with regard to what is accessible when it comes to femtech. That concerns me because the barriers are getting worse and more entrenched. The distance between those who can afford it and those who cannot, the worried well and those who are actually genuinely sick, is getting wider and wider in the NHS.

Kerry Wolstenholme: Can I add to that? It is just something we spoke about in preparation for this meeting. I meet lots of young people, particularly black and ethnic minority young women, who do not have access to phones and computers. Their parents are much stricter with allowing them a mobile phone at the ages of 11, 12, 13 or 14. They are not engaging with this online news, information and femtech stuff.

I always look for a solution. I know the problem, so what is the solution? Every young person, when they go to a secondary school, gets a homework diary. We had them when we went to school. They have a timetable in them, they write their homework in them, and they get it signed. We can put things like these period trackers inside those, so they are not costing families, are normalised and every student gets one every year. It is old-fashioned and paper-based, but we sometimes need that, especially when we are looking at people who do not have data or wi-fi.

Dr Arif: I get those diaries in my surgery.

Kerry Wolstenholme: Yes. Just simple things like adding a couple of pages to that would reach lots and lots of young people.

Q64 **Alex Brewer:** That is really interesting. Thank you. Sometimes the old-fashioned analogue way is the best way to go. Tori, I wonder if I can come to you at this point and ask about the potential for young people using femtech trackers as contraception and that then potentially leading to unwanted pregnancies. Is that something that you have noticed? Is this happening? If so, what can we do about it?

Dr Ford: Yes, that question fits really nicely into some things we have been seeing around misinformation or concerns around contraception in young people. In addition to all the work we do at Medical Herstory, we also partner a lot with researchers. We have been developing a project



looking at young people's sexual health at ages 16 to 18. In doing this, we have been hearing a lot of concern around, I do not know if I want to say, "traditional," but maybe more medical forms of contraception, specifically the birth control pill.

A lot of people are worried that if they go to the doctor and the birth control pill is given as first-line treatment that that is a form of dismissal. There is a lot of concern and misinformation around the idea that if you have been on the birth control pill for x long, you do not know yourself. You do not even know if you like your partner. You have to go off it and find yourself. We have to be really concerned about how those narratives fit within a larger push of conservatism, traditional housewives and reproductive rights, maybe encouraging people to take on more reproductive roles without reproductive rights.

Where those femtech apps come in is in addressing that gap. Others on the panel might have more expertise than me about how reliable those are, but the more interesting question is around why they are showing up and why people are turning to them, which we can be thinking about and addressing.

Dr Sesay: First, the best way to not get pregnant is to not have sex, which is not realistic, obviously. The natural contraception method is something that has been used for a long time, before contraceptive pills and hormonal contraceptives came into play and made such a massive difference in a lot of our lives. There is a lot of misinformation—a lot of disinformation, as you say—around hormones. In fact, there is hormonophobia at the moment. Loads of people just do not want to take it, whether it is HRT or the contraceptive pill. They have been demonised.

In order for people to use those sorts of systems, they really need to understand their periods and cycles. In order for them to understand their cycles, they need to have great education from the early days. I do school education, and I said to the girls, "Your menstrual cycle typically lasts between two and seven days." Guess what their response was? "Yes." And I said, "No, because your menstrual cycle is your whole cycle." They did not even have that background knowledge.

These were girls between the ages of 15 and 17. If they are turning to use the natural contraceptive methods, then if they do not quite understand what exactly the menstrual cycle is—what happens, what the changes are that happen at each part—how can they reliably utilise that? These things can be helpful, but they are so strict and rigid. Even I, as a 38-year-old woman, would not rely on it myself because it takes a lot. You really have to be regimented to use those methods and for them to be accurate. Nothing is 100%. There is something called perfect use—and nobody is perfect—and perfect use is 98%. Then you have the typical use, which is more realistic, and that is approximately 70%. That is what I have to say about that.

Q65 **Alex Brewer:** That is interesting. Tori, if I could just come back to you



for my last question briefly. What do you think the role of the NHS and/or Government should be in the femtech space so that we can start ensuring efficacy, data privacy and this inclusive approach, this health equity approach?

Dr Ford: Yes, echoing what has been said about health equity is super important. Technology often has the ability to re-entrench and re-ascribe inequities within the technology. For example, there is the inverse care law, which states that people most in need of care are the least likely to get it. We see things like that within that. It is also interesting because Medical Herstory—I do not know for what reason—often gets put on a lot of femtech panels. It is quite interesting because the work that we do technically is online, right? The stories are online, social media is online, you can watch our events on YouTube. It is all accessible.

The way that femtech companies sometimes talk about these issues as a billion-dollar opportunity instead of a billion-dollar problem is something the NHS should be aware of and cognisant of. Leading by example is also important. We have heard some great examples today about charities that are doing amazing work that the NHS could be adopting. We have talked, too, about NHS websites. I do not think the NHS needs to be the expert in storytelling, but I know that on every NHS page there is an other links resource at the bottom. Creating pathways there that make it easier and more accessible for companies or organisations that are not for-profit to be raising awareness and destigmatise, like we have been saying, would maybe be some easy wins. But there is a lot of bureaucracy; it is a complex problem.

Dr Arif: I was just going to say, it would be really amazing if we had femtech companies come and give evidence about how they are going to do it because the role of AI is going to become wider and wider. The ownership of women, girls and boys understanding their bodies is going to get more and more in the palm of their hands as we go forward. Where does that responsibility lie at the moment? We are saying it is the individual and their parent if it is a young person, or if it is an older person, then it lies with them.

I feel like femtech companies have a role to play, and it is a good role. I have seen some great outcomes, even in clinical practices, where a patient has come in and because she is tracking so well, she has realised that actually the symptoms she was experiencing could be signs of PCOS. She had no idea until she started tracking. It would be great to get the femtech companies to work collaboratively.

Q66 **Nadia Whittome:** First, I just wanted to say thank you so much. It has been particularly healing hearing Asian and black women, in particular, talking about this stuff. I feel like it undoes a lot of generational stigma, which obviously exists across all communities, but I am 29, and I still have not had my smear test, which I was obviously meant to have four years ago, because I am absolutely terrified. I am going to book my smear test after this.



Dr Arif: We are more than happy to guide you through it.

Nadia Whittome: Thank you. Yes, is that okay?

Dr Arif: Yes, absolutely. Because first, you are not in the minority with that. Please do not feel that there is shame or stigma, but secondly, you are definitely not in the minority. Yes, we've got you.

Q67 **Nadia Whittome:** It is on my 30 before 30 list, so that is how I know it is going to get done. First to Chella, you mentioned previously that the Department for Education's period product scheme for state schools and FE colleges has improved. Does it ensure that appropriate and sufficient period products are available? Is that the case for girls and young people who experience very heavy menstrual bleeding?

Chella Quint: Yes and no. I want to say that the scheme review and update two years ago was excellent. It was conducted by outstanding people at the DFE who held roundtables; they were very thorough, tracked their changes, and did a lot of work around reviewing what had happened before and what did not work. Some young people said they wanted nighttime pads but it was not part of the scheme. This was immediately changed, and the next time I spoke to one of the researchers there, she said that this was immediately taken up.

Where the scheme falls down genuinely goes back to Shirley Prendergast's research from 1994. She said that there was no joining up of provision of education and stuff in schools. Now, we know this also should be in non-state schools and other settings. That is one of the other flaws. But the people who are in charge of procurement do not necessarily know enough about periods; maybe the cleaners and caretakers have not had training. What we always say is a period-positive school should be one where the lollipop lady, the headteacher, the chair of governors, anybody, could address a teachable moment around periods, whether that is a leak, a question, or providing the right product.

Now that change has been made, young people who experience heavy bleeding are more provided for, but period underwear was not covered on the scheme in the early days. That is still difficult to access depending on the brand and depending on how you do your procurement, because the reusable product companies are not as well-established or are small companies that have been bought out by multinationals, which have different agendas. Holistic menstruation education that goes from staff, to pupil, to person at the council who is in charge of helping lead the procurement, has to be really good, and it is not. For all the wonderful roundtables and all the excellent updates, they are not being met halfway yet. That is something that needs to happen.

The future of education should be tied into the provision of products in that they link to each other, and the product provision scheme must refer back to a curriculum in a cross-curricular way. It should all tie into the tracking of cycles as well, whether that is some pages in a planner, or a



computer lesson on how to use apps safely based on protecting your personal data, or a maths lesson teaching the mode, median, mean and averages by looking at an average menstrual cycle, or media studies teaching persuasive language in advertising not using a car ad, because what year 6 people can drive a car, but what year 6 people might get their period?

All these things have to be in place to support the free product scheme because products are providing a short-term, immediate need for those experiencing period poverty, but it is also a poverty of knowledge, of confidence and of access, and those things are essential.

Q68 Nadia Whittome: Kerry, you and Chella touched on this previously, but we have heard of schools locking toilets, which obviously prevents girls from accessing period products. Is that an issue? How common do you think that is? Is it something that you are aware of happening on a large scale? Do you think we need stronger DFE guidance to stop that from happening?

Kerry Wolstenholme: I recognise that there has to be some kind of regulation. Pupils cannot just be leaving the classroom as and when for any different reason, but we just need to have a human approach. Last week I worked in three schools. I am 46, perimenopausal, on my period, and I had to follow the school day like any other pupil. I leave my house at 7.30 am, I arrive at school at 8.30 am, and I am straight into two lessons back-to-back. I have not been to the bathroom since I left home that morning. At break time, it is crucial that I get to a bathroom alongside 1,500 other students who have their break at the same time. How many toilets are there? There are not enough for everybody. You have to make a choice. Do you really need to go? Are you going to queue?

This is happening. It is just not set up correctly. Schools try with staggered break times and toilet passes. There are lots of different things that they have done. There is no really easy fix. We cannot just have anyone going to the bathroom at any time, but we need to recognise that women are on their periods. Some of those women are having heavy periods, and if you are on a heavy period in a classroom that you have been in for two to three hours, you will start panicking. Are you flooding? Is this on your seat? Is this on your clothes? You are then not learning. You are not concentrating on information.

I would like to think that most teachers I work with are very lovely, and if a young person said, "Miss, I really need to go. Sir, I really need to go," they would be allowed to go, because there is a relationship where you know when your student is asking because they really need to. Most of the time that happens. We need to reassure schools that that is okay and that their policy should reflect that we are people with bodies, and we might need the toilet sometimes, and it is not on their timetable.



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Dr Arif: Kerry, you are reflecting what we experience as NHS GPs, where every 10 to 15 minutes we get a patient. We cannot just go to the toilet. I remember I put a coil in a patient, and I stood up. I have a coil myself, but I have PCOS, so I never know when I am going to flood through my underwear. Lo and behold, I had gone and bled through my scrubs. My patient was more worried about me, even though I had just sorted her out. I went upstairs—as it always is—to look for period products. There was nothing in our GP surgery. I had to then use toilet paper in my surgery, and then when I got a lunch break, try to head into the village to try to buy some period products.

At Wellbeing of Women, we have worked very closely with grassroots organisations, and we are trying to move away from period poverty being a term. Our grassroots organisations find that and menstrual poverty very demeaning because period poverty says that to have access to period products, there is a level of privilege that you need to have. What they have constantly said to us is it is better to use things like period equity, because not everybody needs the same tampon or has the same flow; some need heavier flow, some need light flow.

As we know with the cost of living crisis, food bank access is more and more in demand. In fact, there was something this morning about that. The London School of Economics has said that the most sought-after item at all food banks is actually period products before food. That just shows two things: first, access to period products is getting harder and harder. The cost of it—the pink tax—plays a role as well. If we could have free period products, I would love you forever if you did that. Secondly, people do not think of it to put into their trolleys when it comes to food banks because they think of food, but actually period products are just as important. They go very, very quickly, and they are the most sought-after item.

Chella Quint: I am so sorry, I need to bravely disagree about not letting kids out at all times. I work with about six different period organisations that are youth-led, and the young people are absolutely desperate to be able to go to the toilet whenever they want. I trained to teach in 1999. Over the years, I have seen a slow and worrying corporatisation of primary and secondary education and an academisation, which has led to academy chains choosing zero-tolerance policies, where behaviour and toilet access are inextricably linked. This is a sign that we are not living cyclically.

I need to be the radical who is not in the classroom every day any more, and not a doctor, and say we need to treat ourselves more humanely as a society. We must consider a blanket toilet access policy as a national education policy recommendation because we should not be put in the position where we are all fighting for the loo, or holding it in, or our own coil is falling out as somebody else's is going in, or whatever. Not to be extreme, but we must consider this because young people across a number of different organisations have said this is the youth-led view. It



may be inconvenient for teachers, but we simply cannot do this. We should be treating doctors more humanely as well.

Q69 Nadia Whittome: Please feel free to add to the previous question, but I have a further question to Aziza and Nighat. Are there circumstances in which young women, particularly those who experience very heavy bleeding, can get period products free on the NHS with a prescription? Would you support legislation to provide some or all women with access to free period products?

Dr Sesay: Yes. First, I just wanted to say that there definitely needs to be some sort of rule against allowing brands to charge £1 per one period product. When you are really desperate and you go to the bathrooms and they have them in the stalls, and you do not even have coins—I do not carry cash—and it is £1 for one pad or one tampon, that should not be allowed. That should not be legal. You go to a hotel, and they do not have period products in hotels—not the ones that I have been to, anyway. Even the poshest hotels—

Nadia Whittome: They have a needle and thread.

Dr Sesay: They have everything else. They have shower caps and toothbrushes, but they will not have period products. Does that make any sense when 51% of the population will menstruate at some point? In terms of heavy periods—I am always going back to education, and this is why we run our platforms—many people do not even know what a heavy period consists of. I am just going to say it now in case anyone is watching. A heavy period is if you are having to change your period products every hour, or double up on period products, or having to put a towel on your bedsheet because you know you are going to leak through at night, or if you are bleeding so much that you cannot go to school or do your day-to-day activities. You said not to say, “Normal,” but that is not something that you should just put up with.

If you are having heavy periods to the point where you are becoming anaemic because you are losing so much blood, and so you are having symptoms of shortness of breath, chest pain, dizziness, difficulty just going up and down the stairs, then that is not something that you should put up with. But there are so many women who think that that is normal, and this is because they do not have the education. It is also passed down intergenerationally. I am a black woman. I am two to three times more likely to have fibroids, and actually I have a fibroid. Luckily, my fibroid does not mean that I have heavy periods, but that runs in the family.

I have been to schools where a young girl came to me, and I told her what is something that she should not be putting up with, and she said, “Oh, but my mum said that’s normal and that runs in our family.” Then we have had patients who say, for instance, “Oh, I can’t let my daughter suffer like me,” and their daughters have endometriosis. Then they say,



"Oh, maybe I do," and then they get checked, and they had endometriosis all that time.

I absolutely agree that we should definitely put something in place: period products for all. It does not need to be prescribed. Why do we not just give it to everybody? We know this is something that typically 51% of the population will have and experience at some point. I do not know that there are prescriptions. One of the issues is nothing all over the UK seems to be standardised. It really depends on who knows what is available, where they are located, and that privilege. There is a lot of work that needs to be done in that area.

Dr Arif: With regard to a prescription being given by a GP for period products, as far as I am aware, that is definitely not something we do in our practice. With regard to managing heavy periods, we still have education for colleagues to do. We use haemoglobin for women, but haemoglobin is not the best marker. Actually, you need to look at iron stores, which is ferritin, but the ferritin ranges so much; it could be 15 to 150. With menstruating women and girls, if you are bleeding every month, then actually you are told if it is 15, it is normal. It is not normal. I have now started calibrating it to women and girls, saying, "Your ferritin needs to be 70 and above to make sure that you're getting the replenishment of the stores." This means that a lot of women are misdiagnosed for their iron deficiency anaemia, as it stands, because of the lab ranges that we have.

The generic products that we give for iron supplementation are also not tolerated. Iron tablets can make you feel constipated, bloated, and you could get black stools, which means compliance is not great. This means that if you have an underlying problem that means you have heavy periods, on top of that you are using lots and lots of products which are costing you. It means that we are seeing more women and girls ending up in A&E needing a blood transfusion. The latest data that came out recently from my colleagues showed that the NHS is spending up to £13 million managing iron deficiency anaemia for menstruating women. That is a preventable cost if we just managed looking at iron stores, blood tests, and heavy menstrual periods in the NHS. That could be easily done.

A month ago in October 2025, we updated the NICE guidelines to manage iron deficiency anaemia for menstruating women and girls, to say, "Look at ferritin in particular." Because at the moment, the way that the ferritin levels are done is that we equate men in that data. Men do not bleed out of their penis every month. If they did, we would have a different conversation.

Chair: They would be free. Period products would probably be free. Thanks, Nadia. Sorry, I dropped my Chair hat there and just went for it.

Q70 **Kevin McKenna:** Moving on to RSE and health education, and the curriculum in particular, Kerry, what is your assessment of the latest



updates to the RSHE curriculum on menstrual health?

Kerry Wolstenholme: It is very small. There is not much detail. It says to teach it, and that is pretty much it—"Teach it. It's in there." There is not enough of what to teach and when. It is not standardised in every school across the country. It is up to each individual RSHE teacher to go and find out, "Well, what actually do we need to teach?" If you look at any of the workbooks that are currently used in education through schools, they teach the 28-day cycle and the parts of the body, often not including the outside of the body; it will just be the uterus, the fallopian tubes and the vagina. Sometimes not even the cervix is mentioned. There is no minimum standard of what that actually means.

What I also see, which is a positive, is that it is taught much younger because we have lots of girls who start their periods in primary school, but then you teach it age appropriately for a seven, eight, or nine-year-old. That is not the same education that a 13, 14, or 15-year-old would require. What I see is we get a one-hour lesson in primary school for primary school children. That is all very much a reassuring lesson, saying, "Puberty. This will happen. You can ask us any questions." It is a lovely lesson. Most schools are doing a fantastic job.

Then it is touched upon in biology in year 7, and a lot of schools are going, "Well, that's our puberty education, period education done, because science covers that," and they are stretched, and there is not enough time to do everything, so that can tick that off. Then that is it. That is period education. If you are now 14 or 15, you have started your periods and had your periods for a few years, where do you ask the questions that you want to ask now that you are old enough, mature enough, and have some lived experience?

I teach a Know Your Body workshop to year 9s and year 10s which is quite popular, and schools pay for me to go in and deliver it. I have worked with 1,000 young people over the last two weeks—young people did not know that they bled from a different part of their body from where they pee from. These were year 10 students. They were very mature, wonderful, amazing young people with great questions who did not know that information at 15. They have had RSHE since 2020. They have had it for five years, and they still did not know.

Something is not hitting, and I would say it is because it lacks detail. I would 100% ask for what I referred to as guided learning hours. That is because I am teaching higher education, further education. Schools came back to me and said, "There's another way of giving subject-specific hours." I would put that to RSHE, so that it is not 20 minutes in tutorial time. Some schools are delivering it one hour a week for years 7, 8 and 9. Nothing for years 10 and 11 and nothing for college students. If I could, I would have a minimum standard of hours and more detail. But be clear: this is what period education is. It is not 28 days.



Dr Arif: I have always wondered, Kerry, whether the right people are delivering the education in schools. Is the teacher educated about all the anatomy and the biology?

Kerry Wolstenholme: Personally, young people said they want period education. RSHE is in schools because young people want it. We listened, and it is there. School is the starting point for that because young people said, "We want it with our friends, in our schools." They are used to learning in that space. That comes with all teachers then being educated. I have mentioned this before. Can we not go to newly qualified teacher training and teach RSHE as a module? Every single qualified teacher will then come through having been trained in RSHE.

We have dealt with what is coming up, and then we just have the now to deal with, which is then a smaller task for local authorities. A rise in confidence is all that teachers need. They are equipped enough and experienced enough to go and devise a lesson. They just need to know that what they are saying is right, is not going to be shunned, and they are not going to see a backlash for it.

I have been around quite a while doing sex education in schools. I worked under SRB funding back in the early 2000s, and we were given really lovely budgets to do health and wellbeing work with young people in partnerships with local authorities and schools. My job back then was that I would go in a school alongside teachers, deliver workshops, but then say to young people, "If you need any more information, we're at the health and wellbeing drop-in." They could come once a fortnight on a Tuesday. There would be me and a school nurse or a sexual health nurse there for three hours.

We had a universal offer of education for the basics, but then we had a community local space where young people could say, "Well, actually, you said something about this. I need some more information." Then from there we could refer the ones who needed a referral. It worked and was not extremely expensive. It needs to have both a classroom and community approach, not just teachers, teachers, teachers. There is just not enough space to keep adding and keep doing more.

Q71 **Kevin McKenna:** There are two things that arise from it being built into teacher training. How much extra would that be adding on to the teacher training course to really build this in? And then what do we do about the older cohort of teachers who have already been trained? How do we get retraining into the system?

Kerry Wolstenholme: Thinking back to when I went to university, a lot of what we did was self-directed learning. It does not have to take that much time if we put it on the initial teacher training. We could put a module on there, tasking people to know the guidance. That is the first thing. We could do a micro-teach of a lesson from the guidance or plan a resource. There are lots of different things that could be done. A lot of that would involve just reading, I suppose, giving them a book list of



relevant materials, because they are in that space of learning and absorbing that information anyway to become an educator. It is just asking them to do something else on top of an already existing job.

With our teachers now, I am not a fan of online modules. I do not know if you have done them yourself. I just have a cup of tea and click through, and I do not really absorb the information. I am a fan of face-to-face training. I have done lots of training in schools, for example, 200 people, from the caretaker to teachers. In 20 minutes, you can change their mindset. That is all we need to do to teachers. They are teachers. They know how to plan a lesson. They know what to do. We just need to change their passion and understanding of why they should do it.

That is all we need. Although I should say we also need money. More money for funding for the training will be needed to do this because right now, the RSHE guidance is there, the extra lessons, but there is no money to deliver it.

Q72 Kevin McKenna: How much money do we think they need, roughly?

Kerry Wolstenholme: It depends on how you want to do it. Do you want to give it to each individual school, or do you want to create a space, maybe with the NHS, where all that stuff is there and then they can access it, if that makes sense?

Dr Arif: Some feedback that I have had, when I have done videos of how to explain to a Gen Alpha about what a period is or what a vulva looks like, is lots of teachers saying, "That's actually helped me lesson plan, and thank you for the education because now I know how to speak about it." I always worry about how much the teachers are learning because when I go into schools, or Aziza goes into schools, we get boys and girls together in one room, and 100% of the time, the teacher at the end would say, "I've learned so much from you."

Dr Sesay: It is just a different vibe as well. I have recently gone to a school and the biggest thing for them was, "Oh, a doctor is like this? I can approach them, and they're fun and they explain things?" I feel like we definitely need the PSHE, and actually it was a PSHE teacher who reached out to me. But it gave the students that confidence to know that doctors are not that scary, they are not that bad, and have the knowledge. The teachers learned from the way that I taught them. It now means that, hopefully, it changes that narrative, and they have the confidence to learn. Some feedback was that, for instance, a teacher learned more about adenomyosis from that talk. There is definitely room to add doctors and PSHE teachers into one.

Q73 Kevin McKenna: I am sure that, as GPs and doctors, you should be recharging academy chains anyway for that training. Chella?

Chella Quint: We have solutions. I agree with everything. In 2018, I was invited to be on a panel by the APPG on Women's Health. I was really nervous because it was my first time here. I presented the first draft of a



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curriculum model that includes by key stage topics that are drawn from skills, knowledge, and understanding that match other types of skills, knowledge, and understanding for that key stage. Learning about the water cycle in year 3 and learning about the digestive system in year 4 means you can absolutely learn about the reproductive system in year 4. It is the same type of learning. I mentioned maths, computing, and graphics.

All this comes together to show that this curriculum model exists. Every other school subject did not plop from the ether, but unfortunately, menstrual literacy has to because the history of cultural stigma meant that it did not develop naturally, like teaching modern foreign languages, or history or maths. The programme of study exists. It is even called the Period Positive National Curriculum because I thought I could sneak it in by calling it that, but it deserves to be there. The way we roll it out is the way Healthy Schools operates, or the way the Gatsby benchmarks help schools to chronicle their delivery of careers education. Just like every teacher is a teacher of literacy, numeracy, or IT, every teacher is a teacher of menstruation.

We did a piece of work on this in 2023 called Menstrual Literacy for All. We did a pilot with two schools, an LGBT youth charity, and a youth homelessness charity. It was not just a design sprint creating lessons, it was bigger. It was surveys with adults. We have since replicated that survey with young people this year, "Would you want to learn about menstruation from any teacher?" The answers were a resounding yes. But the answer to "Do you have enough menstruation education?" was a resounding no. "Would it be okay to learn more about periods and get more training to teachers?" Out of 314 teachers, I think 78% said, "Absolutely." Over 90% said they do not have enough, or none at all. There is an enormous appetite for this.

The Period Positive award helps you track it the way that the Healthy Schools award does. The curriculum model works like the Gatsby benchmarks. Yes, I say give me an hour, and I will have them eating out of the palm of my hand, being free, being open; 20 minutes is amazing, and I need to learn from you, Kerry. This is incredible. But I completely agree. Maybe in 2018, people were not ready for this. But this is legit and real, in black and white and on a video.

On behalf of the young people who want this, the teachers who are willing to do this, the parents who are really supportive and keen, and the home school kids who are absolutely chiming in in the same way as everybody working in the formal education sector, let us do this. You can have it. It is free, and it is open access. That is the point. It goes outward; it ripples. One school becomes a gold standard school only if they are working with other schools and community services in its sector, and other cities support each other. Nationally, it could work.



It would probably cost about as much as Healthy Schools, which is not a lot a year, but we should probably ask for more. We would like a blank check please, because it is invaluable really. Menstruation education is fundamental. Everybody had a room that was a womb. That is what I always say. Boys should be in the room and people who never had a period and never will should be in the room, whether they are a doctor or not, or have daughters or not. It does not matter. We all lived inside a uterus. That was our first apartment, if you like. We all have a right to understand how they work and a responsibility to make sure that everybody can use theirs the way they wish to.

Q74 Kevin Mckenna: I have just one more thing. I will probably go back to you, Kerry, in the first instance. Obviously, there have been calls for education to address racial equality around menstrual education. What are your thoughts on that? Are we meeting that yet or not?

Kerry Wolstenholme: No, absolutely not. I am a white, cisgender woman, so it is difficult for me to answer this question. I do not know enough of what is said in your household, Nighat, and what was said to you. Where do I get that information so that I am equipped when I am designing my lessons to meet the diverse classrooms that I now teach in? But again, when you are telling a school to teach period education, you can then give them what that means, the resources, links and websites that will help you so if you are in a diverse school, you have that there and can use it. If you are a faith school, you have access to faith materials and so on.

Schools are very worried because of the media backlash of teaching anything to do with sex, relationships and gender. They are scared, but if you say, "You can use this. We okay this," then they will use it.

Q75 Kevin Mckenna: Do other people on the panel think that is the right approach, or do we need to do something else or more?

Dr Ford: Cultural competency training is really important. You do not quite understand things unless you have experienced them before. We mentioned where people are from. I am actually originally from Sierra Leone, I was born and raised in Saudi Arabia, and then I came to the UK, so I got used to the system in the UK. However, we need to understand what happens at home, how things are viewed, and how they approach different topics. Some students may be struggling because at home, they just do not talk about periods at all. You need to have cultural competency training. If we are able to have that widespread throughout the UK, because the UK is multi-ethnic, it would make a massive difference.

Dr Arif: One of the places where that has been really great has been grassroots organisations. There is Cysters, which is run by Neelam Heera in Birmingham. It works with south Asian communities, black communities and trans communities. It is trying to look at the language barrier for periods. In Punjabi, we do not have a word for period, but it



has become an acceptable term because the Punjabi word is actually kapare, which harks back to the Punjabi days in India and Pakistan where you would use rags. Being on your period is, "I'm on my rags." Young girls, 15 and 16-year-olds, hate using that. Obviously, now they are bilingual, so like me, even though I speak Punjabi when I am speaking to my mum, I will say, "Period." She will squint and say, "No, it is kapare." That comes within communities.

Again, we have worked with other communities. Inherent Birth is also looking at the lexicon that is used around periods, and different dialects and the way that they say it, such as Bangladeshi communities and Sri Lankan communities. This is why the collective is trying to do a lot of education work. We feed into schools because our charity members go into schools and teach in their local locality.

Chella Quint: From a language point of view, British Sign Language is the same actually. The term for a period is different for different people. I have spoken to older British deaf people who use BSL signs that are more secretive and private-looking, and young people or people using home signs would use something more expressive. Even in the US, the sign is very close to the face, where it almost looks like the sign for bashful.

That leads into disability inclusion. There is not a lot of awareness about teaching around sensory needs for neurodivergent menstruators, because different products feel different to different people. People with limb differences or fewer fine motor skills might not be able to use menstrual products in the way that the little leaflet explains. No matter how you contort yourself, if you do not have the dexterity to insert a tampon or menstrual cup, you cannot do it. There are styles that are designed to be used one-handed, but most people do not know about them. As part of the four types of menstrual literacy, there is geographical, queer, and disabled culture. All these aspects of people's lives coming out, which may remain unseen in wider menstrual conversations, are really valuable.

Dr Arif: That reminds me that the use of period products such as tampons or moon cups are really frowned upon because it is going to break your hymen, so you are not a virgin anymore, which is steeped in stigma, taboo, and patriarchy. Again, in that cultural competency at schools, some girls will find that that is definitely not an option. If you are talking about only tampons or moon cups in that lesson, you are not talking to that cultural group.

We work with a lot of Roma Gypsy families, who say girls cannot use period products. This happens in some Muslim groups as well, where the hymen is their way of showing that the girl is a virgin for arranged marriages. That is their cultural practice, and it is very hard for schools to keep on top of that. It only comes from educating those groups, which we are hoping to do because we think that should be part of the women's health strategy.



Kerry Wolstenholme: I was just going to say that for a lot of the puberty and period education in the schools that I work in, they are now showing all types of products. There are period pants, moon cups, discs—the discs that are now out—lots of different things. Lots of schools have that already embedded.

Chella Quint: We teach that through a dance. It goes internal, external, disposable, reusable. It is a faster way to teach it.

Chair: This bit is fascinating. I know that we could talk about it for a long time, and we should, but I am conscious of votes, and I do not want to finish before we have actually finished. I am going to hand over to Christine now.

Q76 **Christine Jardine:** Can I thank you all? It has been absolutely fascinating and in some ways reassuring. I wonder if I could ask Nighat and Aziza, our 2024 report found dismissive attitudes and gaps in GPs' awareness and knowledge about menstrual and reproductive health: present company excepted, obviously. Do you think things are starting to improve? For example, do all GPs receive adequate training on women's menstrual and reproductive health?

Dr Arif: I will start with the fact that GPs are generalists. Not all GPs are going to have an education that is steeped in women's health. We are all asked to choose a speciality, and then we go into an area of specialism. I believe that was started under Tony Blair, where you could be what is known as a GPwSI, a GP with a specialist interest. Unfortunately, that training fell by the wayside, so it fell to self-directed learning for GPs in the area they would like to go and do. The funding fell away, and if you are already working, and paying for so many other courses and so on, which are very expensive, then some GPs may not have prioritised women's health, although it concerns 50% of your population.

The RCGP will say that it is trying its best. We now have a women's health education, which is led by our colleague, Dr Itunu, who is doing some incredible work in that area. We are both working with the Royal College in order to improve that because it is part of self-directed learning. People do not have time to do modules, and a lot of health content creators are learning from each other on social media platforms. But even GPs will say that it needs to get better.

Dr Sesay: It is not just GPs. We need to look at the whole system because it is also within secondary care. I am glad that paper came out. Loads of people were really surprised, but it is true. Medical misogyny exists, and we get a lot of messages: "Oh, I had no idea that these symptoms were abnormal, and I need to get checked," and, "I've been to my doctor so many times, and I've been told actually there's nothing wrong with me," dismissals, and so on.

There needs to be education in the patient population and within the GP practice. Nighat was just saying that technically they will say that



women's health is mandatory in the training, but actually, having an hour on menopause is not enough training. You are going to forget. We all have specialisms and what we are best at, so not everybody will be a specialist.

Dr Arif: I just have a very quick point. Women's health does not fit into a neat specialism because even if I have a cardiovascular health issue, I want my cardiologist to understand about hormones and the menstrual cycle because that will affect cardiovascular health. I also want my endocrinology colleagues to understand PCOS. But that does not really sit anywhere because secondary care colleagues in gynaecology will want to be involved if there is a procedure, or a treatment or fertility issue. We are more than just fertile beings. There are more aspects to that. It will then come back into general practice. That is where the biggest disjoint is because women do not fall into a neat specialism. I would say it is like the desert at the moment when it comes to women's health because no one has really taken ownership, apart from general practice, or individuals who have a specialist interest in that area.

Dr Sesay: It involves the whole body. Mental health is also a big thing that a lot of people talk about. Everything is intertwined, so everyone should be a women's health specialist, technically.

Christine Jardine: That would be a very good idea.

Q77 **Chair:** Before we move on to our last section, I just want to ask Kerry a quick question that related to the previous section. I am quite honest with my five-year-old. When she asks me why I am bleeding, I tell her—not everything—and I also say, "You can only chat about this inside the house because not everybody will want to know at this stage, at five." What do you say? And how would you advise schools that are seeing pushback from parents for learning, even if it is age-appropriate, around menstruation?

Kerry Wolstenholme: Around menstruation?

Chair: And around anything to do with young girls' health and their bodies.

Kerry Wolstenholme: Menstruation should not fit under sex education and then be something that can be withdrawn from. I would argue that that is not sex education, it is body education, it is health education, and every person needs to know that information. What I would say to schools that have parental backlash is first, to understand. Even with me doing this job all my life, my mum would go to the shop and put pads in a brown paper bag. Even she was embarrassed about this stuff. You need to understand where they are coming from, why that shame exists, and why they are apprehensive and frightened about their children being taught.



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A lot of the good practice is the community work because this is not just delivered by a school but delivered in the community. For example, the groups in the morning that parents go to such as the singing groups. It is important that everybody is on the same page, singing songs about body parts, and that it is mentioned not just in the classroom in school but everywhere else.

I am very old school, and I love books, so that is probably why. When I had my children, who are 27 and 18 now, I received a book when I was pregnant. It was from conception to birth. The NHS gave everybody who had a baby one of these, and it became my go-to. We did not have the internet then. When the baby was born, you would get one which covered nought to five-years-old, but then from five it felt like, "Go on, crack on. Figure it out for yourself."

I would love to see one for primary school parents that has that information and that has puberty and period education in there. It is all right to say, "It's online," but there is so much online. Let us just have it so that that is the book. Health visitors could give it to them. Then again, for secondary school, you could have another one, which would include pornography, harmful sexual material, drugs, alcohol, so much stuff, and very simply done. I loved that, and I valued that information. It felt very trusted, and it did not feel like I had to search for it. Something like that would help reassure parents and teachers.

Dr Arif: Can I just say, mum to mum, it has really saddened me that you said to your five-year-old to keep that in the house, because that is self-censorship? I am a mum to a seven-year-old son, and he was five at the time—so exactly the same—and he found one of my unused tampons in the bathroom and thought it was a sweet wrapper. I spoke to him about it in the appropriate language and said, "Mummy has a bleed. She's not in pain, it's nothing to be worried about, and I use this because women and Mummy also have bleeds. In Ramadan, that's why you don't see me fasting, because I am actually on my period at the time."

I do not know how much he took in or understood but he shared that at school with his friends. One of the mums spoke to me about it, and she said, "Actually, I'm really grateful. Thank you, because that's made my conversation with my daughter a lot easier." Maybe it should not always be the responsibility of educators, but as parents.

Chair: I understand. It feels like self-censorship, but at that stage, it did not feel like that because she will just talk. I know it is the right thing, but—

Dr Arif: As mums and dads, removed from me as a doctor, I would just say that that is life-saving information that you have probably shared. Actually, it is just part of life because bleeding is part of life. We would not be here without a period.



Dr Sesay: I hear what you are saying as well, in argument, because I taught my daughter vulva from the very beginning. She went to nursery, and she said vulva to her friends, and then the nursery teachers were really taken aback. They came to me and said, "Ooh, do you know what? The parents are going to be really upset if she uses that language. We have taught them, 'Private parts.'"

Similarly, when she was at school—this is when she was six years old—she was telling her friends about something to do with vulva, and then her friends also said, "No, it's private parts. That's not right." Then the teachers eventually said, "Oh, it's okay, we'll teach them in year 2, when they're seven, that the word is vulva." There needs to be a balance where we normalise it for parents, so then there is not that shame and stigma, so you do not feel that you have to because you are worried that she might say it. But it is good because we should all know this.

Chair: On a personal level, I just feel like there is possibly enough to be angry at MPs about already without adding my child—

Rachel Taylor: Without that being in the paper.

Chair: Yes, without that being in it. But I take your point. It takes a village, and I agree with Kerry's point about how once we have that community education, actually it is not an issue. I will take it back, and I will reflect on it. I am going to be honest; she has probably already talked about it.

Chella Quint: I am sorry, I am butting in, and you are the Chair. My mum is going to be very angry with me because she is watching. But we all have to hold each other and support each other in this space. We are the risk-takers and the outliers now. Based on 10 years ago or 20 years ago, when I started, there are many more of us now, and we are working toward this. There are going to be difficult conversations, but isn't it wonderful that you could respectfully challenge and support each other?

Dr Sesay: And we can nip it in the bud.

Christine Jardine: Can I just join your butting in for a moment? The thing that you all have in common, which is good progress, is that regardless of the terms you are using, you are talking to your children about it, which a previous generation would not have done at all.

Chair: We probably would not have had an entire Committee session about this. I am going to hand over to Rachel for the last section of our panel.

Q78 **Rachel Taylor:** I will try to make this quick because you have all actually already given us some ideas of answers that we can suggest for the next women's health strategy. What I would like to do is just ask you all for one thing that you would like to see included in the renewed women's health strategy, and for it to be a specific, measurable thing. I will come



to you first, Tori.

Dr Ford: I might take us back to where we started this session today. I would love to see more talk around the vulva. That is something that is really missing from the women's health strategy. It talks about vulval cancer, of course, but it does not talk about any vulval health conditions like vulvodynia, recurrent thrush, lichen sclerosus, vaginismus, and the whole host of issues that are really important when we are talking about menstrual health. If you have a vulva that is already in pain, trying to use menstrual products, whether they are pads or tampons, is going to be more difficult.

We know blood changes and hormone levels can affect these conditions. We definitely need to be thinking more about these intersections of different health conditions, using the word more, and then—as some of us have been mentioning today—more broadly thinking about the trans and gender-diverse people who also have vulvas or who also are menstruating. They are accessing the same services that are maybe branded under women's health, so we need to just be inclusive of that as we go forward.

Dr Sesay: Being in the social media space, I am very cognisant of the fact that there is loads of misinformation and disinformation. What I would love to see in the women's health strategy is something to provide some sort of guidelines or even repercussions for people who are selling fad information and perpetuating that negative narrative. I would like there to be something in place to ensure that the education that is being provided through social media is reputable, scientific, and evidence-based.

There is something called PIF TICK, which is the Patient Information Forum, which, again, is another accreditation to show that your content is credible. But it would be good if there was something in place to stop the misinformation and make that measurable. On YouTube—this is an actual stat—6.8 billion views in the UK alone in 2024 were on health conditions. People are using social media for their health information, so it needs to be accurate.

Chella Quint: The women's health strategy that came out in 2022 said that within 10 years, it wanted comprehensive menstruation education for boys and girls in all schools. That is too long. It has been three years, we are still waiting, we have to do it now. We want you to adopt a national cross-curricular menstrual literacy programme, which follows the three recommendations from the young people I worked with in 2013. Tell us everything. Do not leave anyone out. Show us who we can trust.

We want the whole span. Each of these events in our lives is not siloed. We are people who have menarche—a first period—and become postmenopausal one day. There are many ups and downs in reproductive health and menstrual knowledge along the way that get missed or not joined up. Include more positives and more powerful messaging, talk



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about ovulation, the positive feelings at different stages of the cycle, and talk about cyclical wellbeing.

Please fund a larger pilot for Period Positive. I trademarked the name so that nobody could steal it for a menstrual product company and use it as their slogan or hashtag. It is meant to be inclusive, educational, and by the people for the people, because I was tired of how I learned from some menstrual product company's free leaflets and a video. Then I wanted to buy that brand for the rest of my life, even when I could not afford it. Nobody needs to learn that way. It is weird. It is weird that schools use these resources or that they ever did. No other school subject is taught that way.

We want to adopt a way of evaluating this. How do you measure who gets free products, why and how, and who pays for them? How do we measure how well schools are doing and what they need to do better? Why can we not fund everybody to learn this all collectively, whether it is in teacher training programmes, in medical schools, or people who are already in the sector working, getting extra training? Take it off my hands. I want to do comedy shows about dinosaurs and maybe go back to my PhD, but please, please fund something. Take a risk and do something because the willingness is there, and I want to see it happen.

Dr Arif: The one thing I want from the women's health strategy is equity in healthcare for the whole life cycle. It was part of it, but it was almost wishy-washy. We took it upon ourselves, Professor Dame Lesley Regan and I, and came up with the Health Collective. These are grassroots organisations that are doing work for free. We can learn from them. We know what works. For too long, we admired the problem. We now have to make sure that we deliver on the asks from these grassroots organisations that work in different spans. They know exactly how to provide equity in healthcare. That is something that I would be more than happy to help deliver as part of the women's health strategy.

Kerry Wolstenholme: Similar to that, we need to really look at youth and community and how we can embed the women's health issues and the women's health responses in the community. Not just within health, not just within schools, but everywhere: girls' wear, women's groups, all that kind of stuff.

Rachel Taylor: Thank you. It has been an absolute pleasure. I never thought I would say that about talking about the vulva for the whole afternoon. Before you came in, we were discussing our medical misogyny report and how it might lead to "Medical Misogyny: The Musical." Perhaps it is "Vulva: The Musical" that we really want to see.

Dr Sesay: I can sing it: "Vagina, vulva, clitoris—rewind it!" There's a song.

Chair: That is a good way to end. That is the first time that we have ever ended a Committee session with a song. We did an inquiry on misogyny



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within the music industry, and we did not hear any songs. That is definitely the first time.

Chella Quint: I mean, there is a dance. It takes you two seconds: "Internal, external, disposable, reusable." And if it is little kids: "Inside your body, outside your body, throw it away, use it again." That is the quickest way if you do not know disc, if you cannot remember cup, if you do not want to name a particular brand. It comes from modern foreign languages education, linking vocabulary words to dance moves. It is a mambo and a conga line. I will not put pressure on you to conga line out of the room today. Maybe the next generation will.

Chair: Thank you so much. This brings possibly one of my favourite ever sessions to a close.