Written evidence from Brook [WRH0051]

Introduction

I. Brook is the national sexual health and wellbeing charity which has been providing clinical sexual and reproductive health services for 59 years through specialist young people's clinics and, more recently all age community sexual health clinics.
II. Brook is commissioned by local authorities to provide clinical sexual health services, counselling, Relationships and Sex Education and one to one support for young people.
III. Brook works closely with sector partners, professional bodies and providers to advocate for sufficient funding and for better commissioning policy to remove barriers to comprehensive sexual and reproductive health services.
IV. Brook is grateful for the opportunity to respond to this consultation: to contribute to ongoing improvements in provision of reproductive health services; and to improved outcomes for service-users.
V. Given the scope of clinical services Brook provides we are limiting this submission to the issue of Heavy Menstrual Bleeding and Dysmenorrhea.

What constitutes healthy periods and reproductive health?

VI. Redefining problematic bleeding HMB has been defined as menses that cannot be adequately managed with sanitary towels or tampons. However, it would be useful to broaden this definition within all policies and practices so that any menstruation-related pain or blood loss that results in other adverse outcomes is classified as problematic bleeding.
VII. Both can result in lack of participation in education, economic activity, or social activity which can have a significant impact on someone's quality of life, their mental health and wellbeing over many years. These impacts should be taken into account in commissioning of services, in assessing and treating problematic bleeding[i].

What are women's experiences of being diagnosed?

VIII. Historically the issue of heavy menstrual bleeding and pain has been neglected and even now it is sometimes treated as something normal that you just have to put up with, or treat with a 'hot water bottle and a painkiller' (something that only works for mild dysmenorrhoea). Younger women particularly have reported to Brook HMB and pain not being taken seriously, but this experience is in no way limited to specific age groups. For anyone who menstruates this attitude can result in i) lack of medical intervention to relieve symptoms and ii) years of suffering before investigations take place to exclude potential causes.
IX. Defining causes of problematic bleeding as 'benign' can also lead to deprioritisation for surgery that could significantly improve quality of life.
X. An additional impact of lack of care with HMB and pain may be a lack of trust in clinical services. Taking HMB and painful periods seriously is necessary for relieving current symptoms or identifying underlying causes. It is also vital to support people to become effective help seekers with the confidence to speak about gynaecological symptoms.
XI. Being told that HMB or pain is 'normal' when it is experienced as acute may result later on in people missing or dismissing their own significant symptoms that require medical investigation.

What disparities exist in treatment and diagnosis

XII. This inquiry is an opportunity to consider the potentially unequal impact of heavy menstrual bleeding and pain on different populations; and potential barriers to accessing appropriate care
XIII. Those with learning disabilities[ii] may need more support to self-manage periods and/or to seek help with problematic bleeding.
XIV. Those living in more deprived areas[iii] may experience more severe symptoms before seeking or gaining help, with consequent impact on quality of life over extended periods.
XV. Black women have reported having their reports pain dismissed or minimised[iv] and difficulty getting support - with consequent negative impacts on relationships, mental health and ability to work.
XVI. Trans men and non-binary people who menstruate may experience psychological as well as physical

distress as a result of menstruation and may experience additional barriers to accessing care.

XVII. When it comes to accessing LARC for both contraceptive and gynaecological purposes there are wide regional disparities in provision[v]

The role of stigma

XVIII. Some unequal experiences of care with problematic bleeding may be attributable to attitudes from different healthcare providers in relation to reports of pain.

XIX. Research on untreated pain points to lack of support from providers alongside lack of confidence to know when it is appropriate to ask for help[vi].

XX. Individuals' perception or expectation of what level of pain they should endure and of what care will be provided may impact reluctance or delays in seeking care.

XXI. This maybe be due to lack of information or 'menstrual literacy', knowledge of when, where and how to seek help – especially in communities or social groups in which it is a taboo to discuss menstruation.

XXII. Stigma around menstruation may result in embarrassment and shame, and increase reluctance to seek care.

XXIII. Where menstrual education focuses solely on accessing and using menstrual products, and managing and concealing bleeding, it may serve to reinforce stigma rather than tackling it.

XXIV. Young women participating in Brook's DHSC-funded period project reported a desire to ensure their male peers were educated about menstruation alongside them. Educating girls alone about periods can promote the idea that periods are something shameful to be talked about secret or to be hidden.

What Barriers exist?

XXV. At Brook anyone reporting HMB who is/has been sexually active is provided with Chlamydia and Gonorrhoea tests to exclude the possibility that the bleeding is related to an STI. This may not always be the case for those who report HMB outside of community sexual health – e.g. within general practice.

XXVI. Brook can provide hormonal contraceptive methods that can stop or reduce bleeding including the hormone coil (LNG-IUS). However, local authority funding is limited to contraception provision therefore Brook (and other Community Sexual health) clinicians are not commissioned to prescribe/fit these methods for someone who is not sexually active or intending to be.

XXVII. Commissioning arrangements mean GPs are responsible for addressing gynaecological indications. However, it is well documented that there is inadequate provision of IUDs including the hormonal coil (LNG-IUS) within GP practice as a result of funding issues related to fitting fees[vii].

XXVIII. The negative impact of this fragmented commissioning – preventing holistic reproductive health care for people in the setting of their choice, necessitating multiple visits to different clinicians, and resulting in additional preventable costs, has been widely reported.

Recommendations

1. ICSs adopt Goal 10 of the Hatfield Vision (FSRH)[viii]. Women and girls have access to a practitioner who is able to provide support, diagnosis and treatment for their menstrual health including pain, heavy bleeding and premenstrual mood disturbance at their general practice, specialist SRH services and community gynaecology services.
2. Address as a priority the inadequate funding for fitting that reduces access to LARC methods including the hormonal coil (LNG-IUS) in primary care; and counter-productive commissioning policies that reduce access to contraception for reasons other than pregnancy prevention in community sexual health.
3. Women's Health Champions - to be appointed by ICSs - must have a remit to:
4. map the availability of LARC for both gynaecological and contraceptive purposes in their region;
5. support collaborative commissioning with Local Authorities to maximise accessibility of LARC for both contraceptive and gynaecological purposes in a range of settings including both GP and community sexual health.
6. DHSC to develop a funding and training strategy to address the lack of LARC provision in General Practice
7. Ensure guidance and clear referral pathways are in place to help expedite diagnosis and care for those for whom hormonal contraception is inappropriate or ineffective in managing pain or HMB.
8. Improve menstrual literacy and tackle stigma associated with menstruation
    - within schools through the Relationships, Sex and Health Education Curriculum

- for the adult population through menstrual dignity programmes and all outlets where free menstrual products are available
- via public health campaigns
- through grassroots campaigns and faith and community groups

[i] Nice 2018 (updated 2021) Heavy menstrual bleeding: assessment and management https://www.nice.org.uk/guidance/ng88/chapter/Recommendations

[ii] Public Health England Health Inequalities: Menstrual Issues, https://fingertips.phe.org.uk/documents/Health)_inequalities_Menstrual_issues.pdf

[iii] Amit Kiran et al Women living in more deprived areas reported more severe HMB symptoms and poorer quality of life at the start of treatment in secondary care. https://bmjopen.bmj.com/content/8/2/e018444

[iv] Tap project 2022 Black Women's Reproductive Health https://tapproject.co.uk/wp-content/uploads/2022/08/a40c0490-2880-4ffc-b231-386415f0bd3f.pdf

[v] Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles: Total prescribed LARC excluding injections rate / 1,000, last accessed August 2023

[vi] Olsen M et al. 2022 The Persistent Power of Stigma: A critical review of policy initiatives to break the menstrual silence and advance menstrual literacy

[vii] Primary Care Women's Health Forum, 2023 On the brink The reality of Long-Acting Reversible Contraception (LARC) provision in primary care https://pcwhf.co.uk/wp-content/uploads/2023/07/PCWHF-LARC-Report-2023-3.pdf

[viii] FSRH, 2022. Hatfield Vision https://www.fsrh.org/documents/fsrh-hatfield-vision-july-2022/

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