Not misogynistic but myopic: the new UK women's health strategy (preferred)

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July 20 marked the eagerly awaited full publication of the women's health strategy for England. A welcome focus on women's health after crises like the Ockenden Review(1), which exposed the failures in care of women and babies at Shrewsbury and Telford hospital, or the Paterson Inquiry Report which documented the many ways in which women were harmed by a rogue consultant breast surgeon(2). When the NHS fails, women's lives and health are frequently broken. Indeed, this was the starting point of the women's health strategy. That and the recognition that although women might live longer than men, they spend more of their lives in ill health (3). There has also been an increasing acceptance that women's general health conditions like cardiovascular disease are poorly understood and based on a male prototype(4). The exclusion of women and non-white populations from medical research has been highlighted as a "glaring moral mistake" for decades (5). In the UK these themes have only recently trickled into mainstream medical thinking. It's therefore a shame that the women's health strategy is not a strategy for promoting women's health and wellbeing but a strategy for women's health services.

A call for evidence which received more than 100,000 responses and 400 responses from organisations and experts is to be celebrated. Respondent demographics were reasonable (99% were cis-gender women. The south of England and those already with a disability/previous condition were overrepresented. 80% of women were 25-59 years old and 91% identified as white). There are some important actions to come from it. A women's health ambassador will be useful. Equally, separate maternity disparities and menopause taskforces may focus political attention. The expansion of women's health hubs and specific assessments on women's health for medical students will all help. But these are still small steps in comparison to more than 20 countries, like India and New Zealand, which have had a dedicated Ministry to address women's specific needs including in health, and freedom from violence for decades. Other commitments like banning the availability of botox to under-18s for cosmesis, worthy as it might be, feels much like diverting a small river far downstream(6). And that is where the strategy falls down, in its singularity on downstream health services and treatment interventions. A holistic vision to address systemic and structural inequities is notably absent.

The word 'misogyny' or 'sexism' is not mentioned once. It would be unthinkable to publish a report on race and health without mentioning racism. Equity is only mentioned twice. Intersectionality, describing the compounding biases and discriminations against people from different marginalised groups is not considered. The contribution of women's economic inequalities to their poor health status remains unexplored. Women are more likely to live in poverty compared to men(7) and are more likely to hold precarious jobs(8).

Ironically, taboo is mentioned 20 times, but it is too taboo to discuss why topics like menstruation, miscarriage or infertility might carry stigma. 84% of women who responded said there were times when they were not listened to by healthcare professionals. We acknowledge that this phenomena is not unique to women and many other minority groups are silenced. But why this might be is not investigated. Only 2% of responses were from healthcare professionals (2%). Future research is

promised. Some may argue that as there are more female general practitioners than male ones in the UK that gender bias cannot be part of the problem(9). This does not recognise that there are still fewer women in leadership roles in medicine. It also ignores the history of medical misogyny that echoes through every part of medical practice. In Unwell Women, Elinor Cleghorn lays out the many ways that the role of healthcare professionals has supported society's desire to control women's bodies(10). Medicine and misogyny have been and remain entwined. Women healthcare professionals may have to imbue certain qualities and characteristics, to thrive in a profession established by men. And this may mean that gender biases are perpetuated. Of the four actions to address the two 10 year aims of "boosting health outcomes.." and improving the way the health system engages and listens to women, only one focuses on improving listening. "Boosting the representation of women's voices and experiences in policy-making…" is the answer. But lessons from other sectors have demonstrated that an add more women, shake and stir approach is not enough(11)(12). Root causes and culture, however painful, must be dug out. Only then can meaningful structural change occur.

Mental health is viewed through a life-course approach, but as a result gets lost and fudged into reproductive conditions. Research will be encouraged to look at the links between "menstruation, gynaecological conditions and mental health symptoms and outcomes". This type of thinking is a major step backward, reaffirming the medicalisation of women's mental health and ignoring upstream determinants such as trauma, oppression or life events like abuse, loss or grief that may cause normal variations in mental wellbeing (13). Other aspects of women's health like diabetes are nearly always discussed in respect to reproductive health conditions like PCOS with little focus on the social determinants of health. Of course, hormonal and physiological differences play a huge part. But this strategy firmly situates any aspect of women's health as a condition that orbits their reproductive and childbearing place in society. Such a view is regressive and will not help women be listened to.

No women's health strategy can be perfect. But other national strategies do at least mention gender equity and equality. Canada has had a women's health strategy since 1999(14), one that has a focus on gender-based analysis(15). The WHO European Region (16), India (17), and Australia (18) have women's health charters that go beyond the English strategy in considering the social, political and commercial determinants of health.

The current strategy is a step in the right direction, but it cannot be the finished product. Improving health services is not enough to improve health at a population level. For a stronger women's health strategy that is fit for 2022, an interdisciplinary effort, concentrating on understanding gender, sexism and misogyny will deliver progressive and health enhancing reform.

Competing interests
JB declares no competing interests. SH is co-chair of *The Lancet* Commission on Gender and Global Health and received a grant from The Wellcome Trust to fund the Commission. RS has been working on women's health issues in India and developed a perspective on women's health and well-being as a result of her engagement in the field. And the support that she has received for 3 decades work in women's health, is from foundations like Ford Foundation, MacArthur Foundation, Tata Trusts in India. RS has consulted for WHO, UNU IIGH assignments on Gender and Health. RS teaches and trains in gender and health issues – so has received honoraria from Azim Premji University, India, CARE India for the training /teaching assignments. RS is Commissioner on *The Lancet* Commission on Gender and Global Health and sits on several Non-Government Organisations in India. All unpaid

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