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MAR / APR 2022

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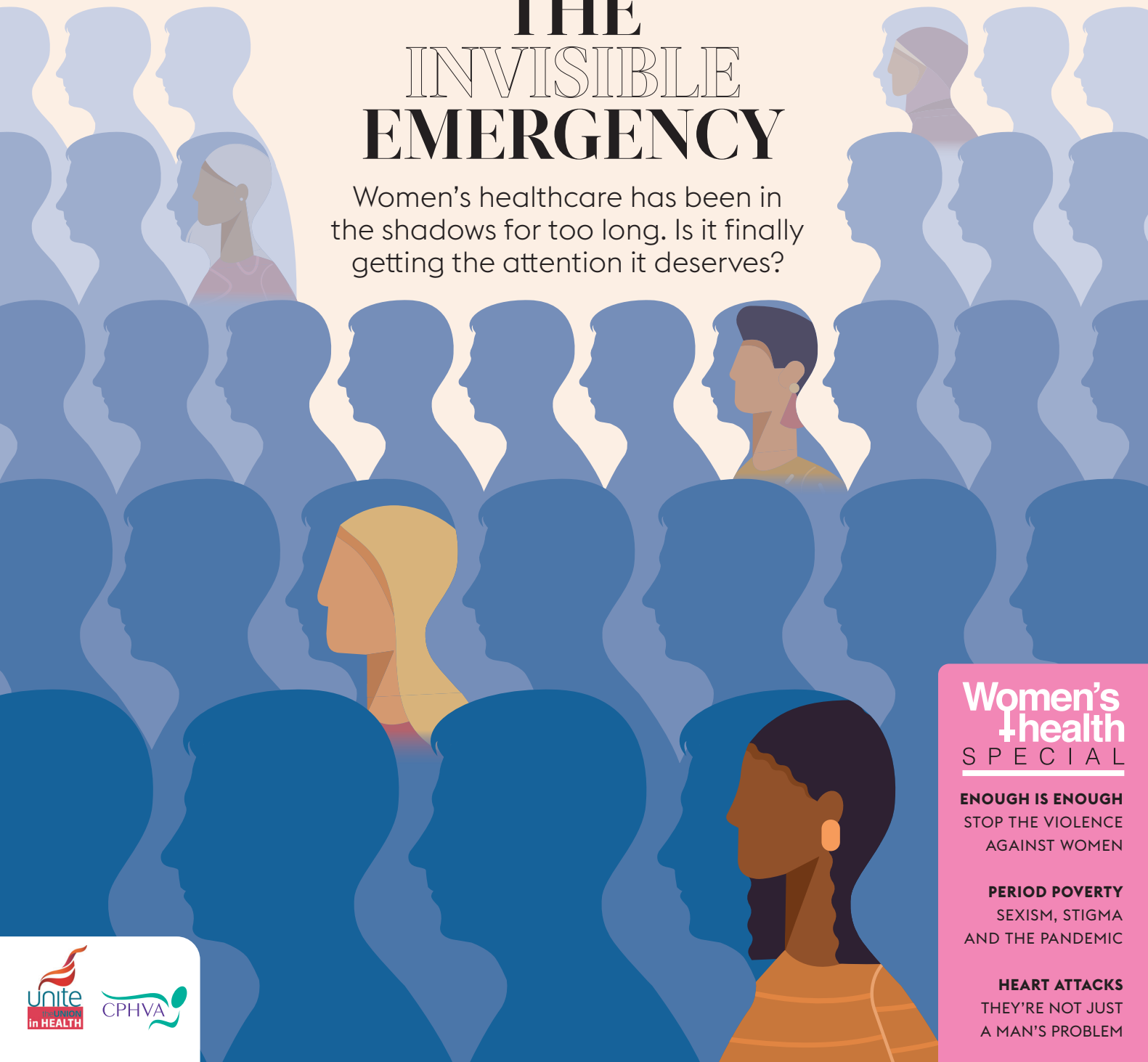
THE INVISIBLE EMERGENCY

Women's healthcare has been in the shadows for too long. Is it finally getting the attention it deserves?



Women's health SPECIAL

ENOUGH IS ENOUGH
STOP THE VIOLENCE AGAINST WOMEN

PERIOD POVERTY
SEXISM, STIGMA AND THE PANDEMIC

HEART ATTACKS
THEY'RE NOT JUST A MAN'S PROBLEM

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PRACTICE

PROFESSIONAL PAUSE

WELCOME

from your editor, Aviva

Introducing our women's health special... The pages this issue are packed with the usual insightful and evidence-backed content, but with a deserved focus on women's wellbeing. While every edition of the journal features women's concerns, in the words of our contributors – women's health has long been underserved, with clear gender inequalities in women's healthcare. We wanted to shine a light on the issues.

While recognition is the first step, and improvements are on the cards, what is being planned exactly to advance women's healthcare, and is any of it enough? Our cover feature (page 24) takes a closer look, and makes the important point that supporting women and girls to lead their best lives will in turn benefit everyone.

One area that has stalled somewhat, in part due to Covid, is period poverty. Furthermore, periods are still taboo, particularly among young people. The feature on page 31 asks how close we are to achieving period equality. The Big story (page 14) explores the sobering reality of violence against women and girls, highlighting the political will and cultural shifts needed to create change.

As always, the CP role is examined in all the issues covered.

With thanks to the CNO of Wales (page 20), and all contributors.

Tell us what you think of this special edition...

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Birth Prep & Recovery

by Lansinoh

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75% of women said they were unprepared for the physical pain & recovery after having a baby.[1]

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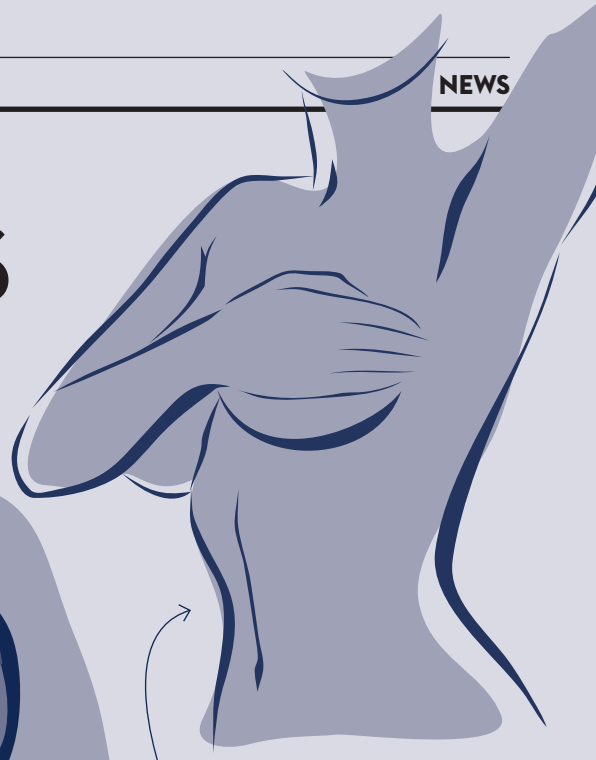
1 Lansinoh (2021) Postpartum Survey. Internal Lansinoh report. Unpublished.

2 Bourdillon, K., McCausland, T., Jones, S. (2020) The impact of birth-related injury and pain on breastfeeding outcomes. British Journal of Midwifery. Vol 28:1.

NEWS IN NUMBERS



84%

of the **110,123** respondents to a **'Women's health – let's talk about it' public survey** said they had experienced instances of **not being listened to** by health professionals

100+

clinicians have **signed a** joint **letter** calling on NICE to **reconsider and approve romosozumab** – the first new drug in decades to treat **osteoporosis** – **for** use in **England and Wales.** Romosozumab is already **approved** for use in **Scotland, Northern Ireland** and much of Europe

No. 1

The **biggest killer** of **women** globally is **cardiovascular disease.** The biggest global **cancer** killer of **women** aged **20 to 59** is **breast cancer**

99%

of all of the **c. 287,000** maternal **deaths** annually occur in **developing countries**

6%

of **IVF births** in the **UK in 2019** were **multiples** – the **lowest rate** ever, and **down** from a high of **28% in the 1990s**

390,000+

babies have been **born in the UK** thanks to **IVF treatment** since figures started to be recorded in **1991**

100%

of the **adverts** from 60 women's health companies were **rejected on Facebook and Instagram** over the last **three years,** because they were classified as **'adult products'.** They covered subjects such as **menopause, pelvic pain, menstrual health** and **fertility**

SHUTTERSTOCK

Find links to relevant reports and surveys highlighted in the news stories at **bit.ly/CP_news_in_numbers**

PUBLIC HEALTH LATEST

MMR VACCINATION AWARENESS DRIVE AS UPTAKE DROPS TO LOWEST LEVEL IN A DECADE

Government figures reveal that more than one in 10 children under the age of five aren't fully protected from measles and are at risk of catching it.

The UK Health Security Agency (UKHSA) and the NHS are now calling on parents and guardians to ensure their children are up to date with the measles, mumps and rubella (MMR) vaccine. Their campaign highlights the serious risks posed by measles, with a reminder that two doses of the MMR vaccine are needed for protection.

Since the start of the pandemic there has been a significant drop in the numbers getting their children vaccinated against MMR and other childhood vaccines at the right time, says the UKHSA.

Coverage of the first dose of the MMR vaccine in two-year-olds has dropped below 90%. Meanwhile, coverage for the two doses of MMR vaccine in five-year-olds in England is currently 85.5%, well below the 95% WHO target. Even a small decline in MMR uptake can lead to a rise in cases.

Moreover, research by the Department of Health and Social Care and UKHSA found that almost half of parents didn't know that measles can lead to complications such as pneumonia and brain inflammation, and only 38% knew measles can be fatal.

Vaccines minister Maggie Throup said: 'Parents and guardians – if you are unsure whether your child has had their full course of the MMR vaccine, check their "red book" or talk to your GP. The vaccine is safe, it will protect your child and their school friends and is very easy to access.'

bit.ly/ENG_MMR_drive

HALF OF WOMEN NOW CHILDLESS AT 30, CHOOSING TO DELAY MOTHERHOOD

Half of English and Welsh women born in 1990 – the most recent cohort to reach age 30 – remained childless by their 30th birthday, new figures from the Office for National Statistics (ONS) show.

This is the first cohort where half remain childless by 30, an ONS report states. The lowest level of childlessness by age 30 was for those born in 1941, at 17.9%, a figure that has been steadily rising since.

However, the percentage of women who remained childless in 2020 by 45 years old has remained fairly consistent since the late 50s, with 18.1% of the cohort born in 1975 having no children.

The report states this suggests women are delaying childbearing rather than not having children.

The most common age for the 1975 cohort to give birth at was 31, an increase compared with their mothers' generation (born in 1949), when it was 22.

'While two-child families are still the most common, women who have recently completed childbearing are more likely to have only one child or none at all [17% and 18% respectively] than their mothers' generation [13%],' said Amanda Sharfman of the ONS.

bit.ly/ENG_WAL_pregnancy_age

KEY

- Video
- Report
- Campaign
- Poll
- Website
- Health programme

A QUARTER OF OVER-50s ARE LESS ACTIVE THAN BEFORE THE PANDEMIC

44%

said lack of motivation was the reason they now did less activity

A report into the health of older adults during Covid-19 has found that 26% of over-50s are doing less exercise than before the pandemic. This was particularly acute in those over 75.

Women's physical activity levels were even more affected than men's. The top reasons given for doing less activity were lack of motivation (44%), and being out of the habit of exercising or socialising in person (42%).

The report, by the Physiological Society and Centre for Ageing Better, is calling for public health agencies across the UK to launch a national post-pandemic resilience programme.

The vision is to create a joined-up system of support for over-50s with tailored advice and guidance on improving health post-pandemic, both to restore pre-Covid activity levels and encourage more in the long term.

Different age groups preferred different ways to help them increase their activity, with 50- to 59-year-olds preferring activity monitors, 60- to 74-year-olds preferring social activity groups and those aged 75+ preferring tailored advice from a healthcare professional.

Report co-chair Professor Paul Greenhaff said: 'Given the role of physical activity in maintaining health, this [survey result] is a cause for real concern and it is likely that the health of older adults will have diminished as a direct consequence of the restrictions necessary to protect people from Covid-19.'

bit.ly/UK_help_50-plus_move

CHILD PAYMENT PLAN TURNS ONE AND IS DOUBLED AS ELIGIBLE PARENTS URGED TO APPLY

A year since its roll-out, eligible parents are being urged to apply for the Scottish Child Payment.

The £10 weekly payment started in February 2021 as a direct measure to tackle poverty. It provides regular and additional financial support to parents and carers to help with the costs of caring for a child.

The government is also asking people to encourage friends or family members who might qualify to find out more, as it's thought many only learn about it through word of mouth.

Since launching, the families of around 106,000 children have received £520 a year, say the government, with the payment set to double to £20 per week from April – four times the amount anti-poverty campaigners originally asked for.

By year-end – subject to data on qualifying benefits being made available by the Department of Work and Pensions – the payment is due to extend to include all eligible children under 16.

In the year 2023-24, the government estimates the Scottish Child Payment 'could lift 40,000 children out of poverty'.

Shona Robison, cabinet secretary for social justice, housing and local government, said: 'This is part of the national mission we have set ourselves and society to tackle child poverty, and our focus must be relentless and constant.'

bit.ly/SCT_family_payment

INCOME FOR CARE LEAVERS INTRODUCED IN PILOT SCHEME

All young people leaving care who turn 18 during a 12-month period will be offered the chance to take part in a basic income pilot, the Welsh Government has announced.

The pilot will begin during the next financial year, and will run for a minimum of three years. Each participant will receive a basic income of £1600 per month for a period of two years, starting from the month after their 18th birthday.

It's anticipated that more than 500 young people will be eligible to join the scheme. Support will also include financial wellbeing training.

The Welsh Government has also established a Technical Advisory Group, chaired by Professor Sir Michael Marmot, to inform the development and evaluation of the pilot.

Minister for social justice Jane Hutt said: 'Our basic income pilot is an exciting project to deliver financial stability for a generation of young people that need it most.'

bit.ly/WAL_care_leavers_income

ISTOCK / SHUTTERSTOCK

PROFESSIONAL UPDATE

‘We have made a clear and overwhelming case for radical action on race inequity in our healthcare system’

NEW CNO READY AND PROUD TO BEGIN HER ROLE

The appointment of a new chief nursing officer for Northern Ireland – Maria McIlgorm – was announced earlier this year, with her role set to commence in March.

Maria most recently worked as a professional adviser within the Scottish Government, and she has extensive leadership experience across acute and community settings in England and Scotland.

She trained and worked as a general nurse in Drogheda, County Louth, before moving to London to train as a midwife, where she spent several years working in various roles prior to moving to NHS Scotland.

She said she was ‘delighted and privileged’ to be appointed.

Health minister Robin Swann said Maria’s wealth of experience and knowledge ‘will complement the dedication and professionalism of the nurses, midwives and allied health professionals across the health and care sector’.

bit.ly/NI_new_CNO_starts

A NEW £1M FUND FOR SOCIAL CARE WORKFORCE

The £1m Workforce Wellbeing Fund for Adult Social Work and Social Care has been established by the Scottish Government to support projects that look after staff wellbeing.

It will be managed by Inspiring Scotland and provide grants of up to £10,000 until December 2022 (with applications closing 29 July 2022). The money must be spent by March 2023.

Projects could include activities or equipment to aid workforce wellbeing. Applications ‘can be as creative as possible’, and those in charge are being encouraged to ask their staff what they most want or need.

Minister for mental wellbeing and social care Kevin Stewart said: ‘This fund is about giving staff anything which makes them feel better and supports their resilience.’

He added: ‘Workforce wellbeing must remain a priority as we continue to move through this pandemic and recovery.’

bit.ly/SCT_social_staff_wellbeing

STARK ETHNIC INEQUALITIES IN NHS, REPORT REVEALS

A major review into ethnic inequalities in healthcare has found vast inequalities across a range of health services.

The report by the NHS Race and Health Observatory (NHSRHO) discovered that some of the biggest inequalities were in mental health and maternity care. In the latter, for instance, there was evidence of stereotyping, disrespect, discrimination and cultural insensitivity.

The review within the NHS workforce found evidence of an ethnic pay gap affecting black, Asian, mixed and other groups.

NHSRHO director Dr Habib Naqvi said: ‘By drawing together the evidence, and plugging the gaps where we find them, we have made a clear and overwhelming case for radical action on race inequity in our healthcare system.’

bit.ly/ENG_inequality_NHS

SHUTTERSTOCK

IMPROVING MENTAL HEALTH SERVICES FOR YOUNG PEOPLE

Health minister Robin Swann has published an updated 'Still Waiting' action plan, alongside its third annual progress report.

The action plan, which aims to improve child and adolescent mental health services (CAMHS), has been updated to reflect developments such as the impact of the pandemic.

The progress report said 'significant progress' had been made in implementing new CAMHS emotional wellbeing teams in schools, the Text-a-Nurse service, and the launch and ongoing implementation of the Children and Young People's Emotional Health and Wellbeing in Education Framework.

Robin Swann said: 'My department will continue to review the action plan to ensure actions are appropriately prioritised to make the maximum impact on the most important areas of our children and young people's mental health services.'

bit.ly/NI_still-waiting_action_plan

WHITE PAPER SETS OUT PLANS TO JOIN UP CARE FOR PEOPLE OF ALL AGES

The UK Government published a white paper setting out its vision for an integrated NHS and adult social care sector.

The paper aims to 'bring the NHS and local government closer together to improve care for all'.

The paper stated patients often had to 'navigate complex and disjointed systems'.

It wants health and care systems to 'better meet the needs of communities, reduce waiting lists and help level up healthcare across the country'.

President of the Royal College of Paediatrics and Child Health Dr Camilla Kingdon said: 'Substantively joined-up, cross-sector care can help drive improvements in child health outcomes and ensure children and young people can access the care they need, when they need it, and from the most appropriate person and team.'

bit.ly/ENG_joining_up_care

FIRST STEP TOWARDS CREATING A NATIONAL CARE SERVICE

The establishment of an expert group to support the creation of a National Care Service for Wales has been announced.

The Welsh Government's cooperation agreement with Plaid Cymru, published last year, sets out a shared ambition to create a National Care Service. It also committed to setting up an expert group.

The expert group intends to provide recommendations by April, and to develop an implementation plan by the end of 2023.

Members come from a range of backgrounds including academics, and those with experience of running social care services and local government.

Designated member Cefin Campbell MS said: 'Creating a new National Care Service, which is free at the point of need, will be a historic step forward in caring for some of the most vulnerable in our society.'

bit.ly/WAL_care_service

GLOBAL RESEARCH

▶ For more information on these studies, visit the **bit.ly** links

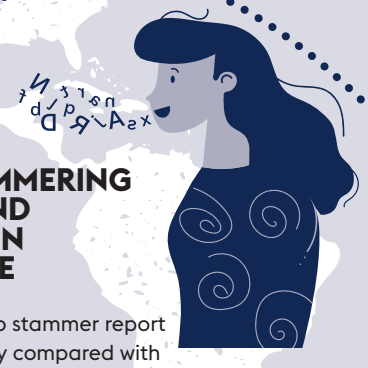
USA

URBAN DESIGN COULD AFFECT WEIGHT GAIN DURING PREGNANCY

A US study has found an association with the 'walkability' of a neighbourhood and expectant mothers' excessive weight gain during pregnancy. The study, published in *Obesity*, found that greater neighbourhood walkability is associated with lower odds of excessive gestational weight gain (GWG), potentially caused by expectant mothers' ability to walk more around their neighbourhoods during pregnancy. Among the 106,285 New York City births included in the study, 41.8% had excessive GWG, while 26.3% had inadequate GWG.

Researchers concluded that their findings 'provide further evidence for using urban design to support healthy weight status during pregnancy'.

▶ **bit.ly/O_pregnancy_weight**



UK

LINK BETWEEN STAMMERING AND ANXIETY FOUND FOR SOME CHILDREN AND YOUNG PEOPLE

Children and adolescents who stammer report elevated symptoms of anxiety compared with non-stammering peers, according to a study published in the *Journal of Speech, Language and Hearing Research*.

The study combined and reanalysed findings from 11 previous studies that compared children and adolescents (two to 18 years) who do and do not stammer on symptoms of anxiety and depression. There was substantial variation in reported anxiety symptoms, but overall children and adolescents who stammer report higher anxiety than their peers. There were too few studies on depression to reliably comment on risk for youths who stammer. Lead author Ria Bernard (UCL Psychology and Language Sciences), said: 'An important finding is that children and adolescents who stammer are not a homogeneous group.'

The study highlights the need for further research, and to carefully monitor the mental health and wellbeing of children and adolescents who stammer.

▶ **bit.ly/JSLHR_stammer_anxiety**

UK

LONELY TEENAGERS MORE LIKELY TO HAVE POOR EDUCATIONAL OUTCOMES

A study examining loneliness in adolescence found those affected were more likely to achieve poor educational outcomes. The study examined 2232 individuals born in 1994 and 1995, and loneliness was assessed when participants were aged 12 and 18. Stability in loneliness was explained largely by genetic influences (66%), while change was explained by environmental effects (58%).

Published in *Development and Psychopathology*, the study found those who reported loneliness at 12 and 18 had a higher risk of mental health problems, physical health risk behaviours, and education and employment difficulties. Those who only experienced loneliness at age 12 'generally fared better' but were still more likely to finish school with lower qualifications, according to the study.

▶ **bit.ly/DP_teenage_loneliness**

NORWAY AND FRANCE

WOMEN SMOKERS MORE AT RISK THAN MEN OF HOSPITALISATION WITH HEART FAILURE

Women appear to be at more risk of hospitalisation when smoking following high-risk heart attacks, a study in the *Journal of Women's Health* has found.

The research investigated the association of smoking with hospitalisations and death in women and elderly patients experiencing myocardial infarction (MI, more commonly known as a heart attack), complicated with left ventricular dysfunction or overt heart failure. According to researchers, the influence of smoking on morbidity differed according to sex following high-risk MI, with smoking significantly more associated with all-cause hospitalisations in women than in men.

The authors concluded that a person's smoking status provides important information for risk prediction of patients experiencing a high-risk MI complicated with left ventricular dysfunction or overt heart failure. They added that their findings further reinforce the need for preventative strategies for women.

▶ **bit.ly/JWH_MI_women**

USA

PSYCHOLOGICAL DISTRESS HIGHER IN ADOLESCENT AND YOUNG ADULT CANCER SURVIVORS

Adolescent and young adult (AYA) cancer survivors are more likely to experience psychological distress than adults with no history of cancer, a study has found.

The study, published in *Cancer*, an American Cancer Society journal, found that AYA cancer survivors were more likely to have psychological distress (11.5% of 1757) than adults with no history of cancer (5.8% of 5227). This distress was still found to be high many years after diagnosis, with 11.2% reporting distress for at least 20 years after their diagnosis compared with adults with no history of cancer. They were also more likely to smoke and have chronic conditions, and were less likely to exercise regularly.

The authors concluded that, in the US, where healthcare costs are paid by the individual, there is a substantial economic burden associated with psychological distress in AYA cancer survivors.

▶ **bit.ly/C_young_survivors**

GLOBAL

FGM HEALTHCARE COSTS SET TO ALMOST DOUBLE BY 2047

The economic burden of female genital mutilation (FGM) to healthcare is projected to increase to $2.1bn/year by 2047 if no action is taken to prevent it.

A study published in *BMJ Global Health* found that, assuming no change in practices occurs, prevalent cases in 27 countries will rise from 119.4 million in 2018 to 205.8 million in 2047 because of population growth. The current economic burden is placed at $1.4bn/year. However, fully eliminating FGM worldwide would reduce future costs to $0.8bn/year by 2047, according to researchers.

FGM involves the partial or total removal of external female genitalia, or other injury, for non-medical purposes. It is usually practised on young girls without their consent and is estimated to affect 200 million women and girls. Immediate health risks include haemorrhage, shock, extreme pain, genital swelling, infections, urinary complications and problems with wound healing. Longer-term consequences can include obstetric and gynaecological complications, sexual dysfunction and psychological harm.

The researchers concluded that increased political commitment and investment in the elimination of FGM is needed.

▶ **bit.ly/BMJGH_FGM_economic_burden**

SHUTTERSTOCK

ENOUGH IS ENOUGH

Almost a year on from the murder of Sarah Everard, asks journalist ***Juliette Astrup***, how can CPs respond to violence against women and girls?

The horrifying kidnap, rape and murder in London of 33-year-old Sarah Everard in March 2021 at the hands of a serving police officer sent shockwaves through the country, prompting protests and widespread calls for change.

And in January 2022, the murder of another young woman, 23-year-old teacher Ashling Murphy – attacked while out for an afternoon run in County Offaly, Ireland – again saw a shared sense of grief and outrage sweep the two nations.

These terrible crimes reflect a deep problem of violence against women and girls (VAWG), but amid a rising tide of public anger, and with the political spotlight now turned towards it, is this a watershed moment?

THE SCALE OF THE PROBLEM

The End Violence Against Women coalition (EVAW) presents a shocking picture of the prevalence of VAWG: a woman is killed by a man every three days on average in the UK; almost a third of women aged 16 to 59 will experience domestic abuse in their lifetime in England and Wales; and 97% of women in the UK aged 18 to 24 have experienced some form of harassment in public (EVAW, 2022).

Intimate partner violence is the most prevalent form (see *Domestic violence: the shadow pandemic*, page 16). As well as abuse and harassment, violence against women encompasses female genital mutilation, forced marriage, trafficking and, more recently, abuse in online spaces.

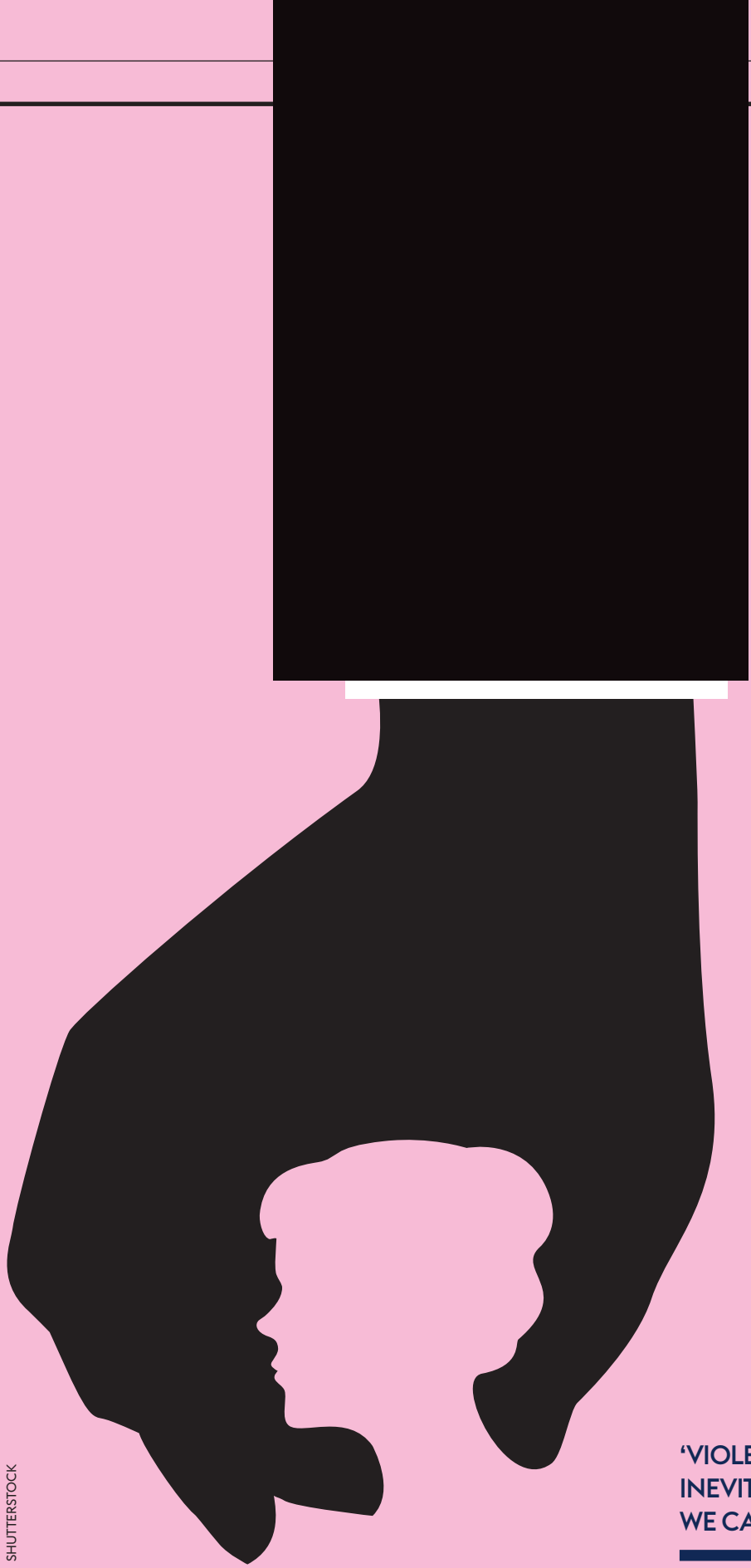
The legacy of VAWG is long-lasting, with recent analysis finding that 63% of rape victims reported mental or emotional problems and 10% had tried to kill themselves, while 89% of women in Great Britain who had experienced harassment said they felt 'very or fairly unsafe' walking on their own after dark in a park or other open space (Office for National Statistics [ONS], 2021a).

SAFETY ADVICE OR VICTIM BLAMING?

After the death of Sarah Everard, a debate followed on how women can stay safe, with common advice such as 'don't go out alone' or 'don't go out after dark' criticised as victim blaming – putting the onus on women to modify their behaviour, rather than focusing on men's actions.

North Yorkshire police commissioner Philip Allott, for example, sparked outrage and was forced to resign when he said women need to be 'streetwise' and should understand the process of being arrested – remarks made after the sentencing of Wayne Couzens (the police officer who falsely arrested and murdered Sarah Everard).

Meanwhile, 888 – BT's idea for a GPS tracking service for lone



SHUTTERSTOCK

women walking home, which would trigger an alert if they did not reach their destination on time – was well received by some, but also criticised as another example of putting the responsibility for avoiding violence onto women.

'Too often, we see concerns about male violence translate into women and girls being burdened with additional safety work to protect themselves: carrying our keys in our hands, sharing our location with friends,' says Andrea Simon, director of EVAW.

'We need to see action that focuses specifically on perpetrators' actions, frontline responses that don't dismiss and minimise women's experiences, investment in prevention work to tackle male violence at its root, and sustainable funding for specialist support services so survivors can access the help they need.'

However, taking sensible precautions is still as important as ever, particularly for community practitioners (CPs) who are visiting homes and travelling around their communities alone.

'When you start telling a woman not to walk down a street by herself, or talking about what sort of clothing she should wear, that's where you start blaming women for men's behaviour,' says Colenzo Jarrett-Thorpe, national officer for health at Unite. 'But there is good common-sense safety advice, like always telling someone where you are, opting for well-lit places, and going in groups if you can – it's about general safety and offering good advice, which applies to men as well as women.'

'VIOLENCE AGAINST WOMEN IS NOT INEVITABLE. WITH POLITICAL WILL, WE CAN CREATE POSITIVE CHANGE'

DOMESTIC VIOLENCE: THE SHADOW PANDEMIC

Intimate partner violence is by far the most prevalent form of violence against women and girls (WHO, 2021), and it has surged during the pandemic and its resulting lockdowns, during which many women have been isolated with an abusive partner.

In England and Wales there was a **6%** year-on-year increase in recorded domestic abuse crimes in the year ending March 2021 (ONS, 2021b). However, that's likely to be the tip of the iceberg, with domestic abuse charities reporting a surge in activity. Refuge has said that calls and contacts to its helpline were up by average of **61%** between April 2020 and February 2021 (Refuge, 2021).

CPs can find themselves on the frontline. 'Domestic violence is part of our caseload as health visitors and school nurses,' says Janet Taylor. 'Health visitors ask specific questions at antenatal visits, as well as postnatal visits, regarding domestic violence. These are asked when the mum is alone with the health professional.

'In schools, children may make a disclosure or teenage girls may already be in abusive or unhealthy relationships. That education needs to start early on, teaching boys and girls about healthy relationships and what is and isn't acceptable.'

HVs visit all families, regardless of other services that may be involved, and school nurses are often a first point of contact for the school-age population. 'We will have issues and concerns reported to us as key health professionals, or pick up on comments people say that raise concerns and can uncover those issues – whether that's domestic violence or something like grooming or online abuse – and we have a duty of care to flag and follow up,' says Janet. 'We also have safeguarding nurse specialists and all staff have access to their expertise with an open-door policy. They also provide regular supervision to staff.'

Trusts will also have a vulnerable adult policy and guidance for staff on how to help prevent vulnerable adults becoming victims of violence and abuse.

Together, says Janet, HVs, school nurses and public health practitioners, safeguarding nurse specialists and named nurses for safeguarding form 'a formidable support for those at risk'.

6%

Year-on-year increase in recorded domestic abuse crimes in the year ending March 2021 ONS, 2021b

61%

The average increase in calls and contacts to the Refuge helpline between April 2020 and February 2021 Refuge, 2021

SHUTTERSTOCK

Janet Taylor, CPHVA Executive chair, adds: 'Most of our staff are women and we always have to be mindful of the safety of lone workers – staff travelling alone, going into homes alone – which is why we need to follow our lone worker policies.

'Consider a joint visit with a colleague when possible, or when you're going alone, let someone know when you arrive and say you will ring when the visit is complete, or arrange for a colleague to ring you at a pre-arranged time.'

TAKING ACTION

It appears that calls for action have been heeded at the top, with both police and policymakers taking steps to implement change.

In Scotland, the Domestic Abuse (Protection) (Scotland) Bill 2021 gave the nation's police and courts more powers to protect people who are at risk of domestic abuse, enabling them to ban suspected abusers from re-entering the person at risk's home and from approaching or contacting them. Police Scotland is also developing a new strategy to tackle VAWG, set out by its deputy chief constable Malcolm Graham to the Scottish Police Authority in January.

In Northern Ireland, the only part of the UK without a specific strategy on VAWG, ministers have called for views on two strategies that aim to tackle it.

In July last year, the home secretary set out Westminster's new strategy to keep women and girls safe at home, online and on the streets. December saw the launch of a new policing framework in England and Wales that sets out actions to make women and girls safer and is based on three core principles: relentlessly pursuing perpetrators, creating safer spaces and rebuilding trust in the police.

Is this enough? 'Last year put VAWG on the agenda like never before,' says Andrea. 'While we've seen big commitments from politicians, the police and our

justice agencies, we are yet to see the funding, accountability and meaningful internal change that is needed to radically transform the approach, rather than simply papering over the cracks in a broken system. Violence against women is not inevitable. With political will, we can create positive change.'

A SHIFT IN THINKING

Threaded through both public reaction and national action is the understanding that preventing VAWG must involve tackling its root causes, and that means challenging societal and cultural norms that can lead to violence.

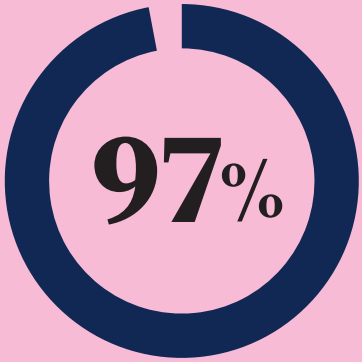
This shift in thinking is much in evidence, from the 'call-out culture' set out by England and Wales's new policing framework, to the House of Lords voting to make misogyny a hate crime, to Northern Ireland's Equally Safe Strategy, which is specifically designed to address societal attitudes, beliefs and behaviours.

> 'IT'S ABOUT A MINDSET SHIFT IN POLICING, IN EDUCATION – CREATING A CULTURE WHERE VIOLENCE IS NEVER ACCEPTED'

As Northern Ireland deputy first minister Michelle O'Neill puts it, we need to understand 'the progression from damaging attitudes towards abusive behaviours' – whether that's entrenched gender inequality and everyday sexism, or the likes of catcalling, objectification of women, locker room 'banter' and rape 'jokes'.

This shift needs to be embedded from childhood, says Andrea, who is calling for investment in prevention and quality, as well as specialist-led work to identify and address abuse in schools. 'We can change this so that young people and future generations are free from gendered violence,' she says.

'School is where children and young people's attitudes are shaped, and the government must commit to putting adequate resourcing behind relationships and sex education and prevention work.'



of women in the UK aged 18 to 24 have experienced some form of harassment in public
EVAW, 2022

Maggie Blyth is the recently appointed national police lead for VAWG, whose role is to coordinate police action across England and Wales on this issue. She has called for a 'whole-system approach' and the need to 'work as a society' to create change.

'It can't stop with policing,' she says. 'Policing cannot arrest its way out of solving VAWG. We can play our part – and we need to do that better, we need to shine the light on what isn't working – but we also need to work in partnership with other sectors, other parts of society. We need that whole-system approach to really making a difference.

'At this moment in history, so many organisations, individuals and women and girls themselves are calling for change – that is really important to me.'

BE THE CHANGE

Every individual has a role to play in calling out the attitudes and behaviours that underlie a culture in which VAWG persists. 'This is a problem for all of us, not just a problem for women,' says Colenzo. 'We all have to call it out where we can.

'Women should definitely lead the conversation as to what's acceptable, but it's also about the discourse happening between men. If someone is speaking about or behaving in a way that would not be an acceptable way to talk about or treat your daughter, your sister, your mother, your wife, it isn't an acceptable way to speak about any woman or girl.'

Janet adds: 'I hope this is a turning point. I think the message has to be that, in all we see and do, we all must call out inappropriate behaviour – even if that's a "joke" or what somebody might think of as "banter".

'If we don't tolerate the little things, they don't escalate, and they're easier to tackle than the big things. It's about a mindset shift, which needs to be underpinned by laws and policies in government, in policing, in education – creating a culture where violence is never accepted.'

For references, visit **bit.ly/CP_news_big_story**

RESOURCES

- Refuge, domestic violence charity with 24-hour national helpline **refuge.org.uk**
- End Violence Against Women (EVAW) **endviolenceagainstwomen.org.uk**
- EVAW and their member organisation the Women's Liberation Collective, which works with and for practitioners around VAWG **ownmylifecourse.org/training**
- Against Violence and Abuse charity **avaproject.org.uk**

RIGHTS AT WORK

MENOPAUSE AT WORK MATTERS

Unite-CPHVA is serious about women's rights at work during menopause, says Unite national officer **Colenzo Jarrett-Thorpe**.

Unite-CPHVA has been proactive and positive about women and the menopause by calling for a united workplace agenda for equality backed up by new legal rights to support unions in advancing a positive equality agenda. This means recognising the importance of the health and wellbeing of older women and campaigning for fairer treatment at work, including new rights for women at this time in their lives.

The TUC published a report back in 2003, *Working through the change*, which found that women's menopause symptoms are made worse by work. This means that employers up and down the country should ensure that workplaces recognise and help women going through the menopause.

Hostile workplace attitudes to the menopause add to stress at work when a woman may be dealing with a whole range of difficult issues at home too, including lifestyle changes, concerns about health, and caring responsibilities. Negative attitudes experienced by women have included the following:

- Criticism from managers about sick leave related to the menopause
- Embarrassment or difficulties in discussing the menopause with employers
- Criticism, ridicule and harassment from managers when they raise the subject
- Pressure and lack of understanding from colleagues
- Humiliation – such as direct comments to women accusing them of poor hygiene.

WHAT CAN BE DONE?

Menopause is not just a women's issue but an issue for men too. They have a responsibility to know what happens to a women during menopause and support them accordingly.

Women often find the menopause difficult to talk about even though it is a natural occurrence. Unite-CPHVA wants to help members take a positive and informed attitude to the menopause in the workplace. You can:

- Encourage your Unite-CPHVA local accredited representatives (LARs) and managers have training about the menopause
- Become a Unite-CPHVA LAR or safety representative to use your experience as a community practitioner dealing with health issues for women and families.
- Check out our Unite women's health guide, *Working women: stronger together*, at **bit.ly/Unite_working_women**
- Put leaflets and posters in prominent places in your workplace regarding the menopause and work
- Talk to men (and women!) about the impact of menopause and how the workplace can be more sympathetic to women going through it.

We can all do our bit to end the hostile environment that menopause can have in the workplace and raise workplace standards for all.

UNITE-CPHVA ON MANDATORY COVID-19 VACCINATION IN ENGLAND

Our Unite in Health guidance and frequently asked questions on mandatory Covid-19 vaccination has been published. Read it at **bit.ly/mandatory_vaccination_guidance**

It remains useful despite the government's intention to revoke the regulations that were due to make double vaccinations a condition of deployment for patient-facing health and NHS staff working in CQC registered facilities from 1 April 2022 in England.

We have a clear position of encouraging voluntary vaccination of all our members and not supporting mandatory vaccination as condition of employment.

FEEDBACK

NEW WAYS OF WORKING

A health visitor reveals how she coped and thrived while in post (and shielding) during the pandemic, plus member recognition.

I am a 63-year-old health visitor living in West Sussex and I have remained in my post throughout the pandemic. I worked from home for much of 2020 and into the autumn of 2021 as part of the shielding population. The positives from this were that I had time to reflect and plan my work far more, without the daily stresses that we all face driving to see different families and trying not to run late with visits.

My contact with families underwent a huge change, from being face to face with people to – for the first time in 34 years – sitting in front of a computer screen. Although this has removed me from families' homes, it also came with the advantage of using my time to discuss emotional issues in more depth with families.

One of my successes has been the ability to give far more time to breastfeeding mothers and to help with feeding issues. A great deal more video or phone contact has been possible and just to offer a call can be very reassuring – a mother or father can feel that someone has remembered them.

Before the pandemic, our team was a busy, vibrant hive of up to 15 workers, all in quite a small office. Much laughter, tears, upsets and happy times were shared. Suddenly, though, I was at home, along with my partner and grown-up son, with no colleagues to share worries or uncertainties with.

However, I am nearing retirement, so my energy levels are not quite as high as they were and being at home a lot more has been comfortable, especially on cold, rainy days.

It did take time to adapt, and I still had an urge to offer home visits, but I learned ways of digesting information online and via email. I reduced my stress levels, felt calmer and greatly enjoyed keeping in contact with colleagues. Now restrictions are easing, coffee slots are go!

The pandemic offered the chance to remember that we are all human. It has given me time to work hard and give my best to families, and to think through all the doubts we share as practitioners.

It has also reminded me why I love my job – if I was starting all over again, I think I would still bring all the enthusiasm I came with when I first started training in 1986.

FRAN GRIFFIN,
health visitor, West Sussex
[February 2022]

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YOU SAID IT!


RESEARCH

TRANSITION TO ADOPTIVE PARENTHOOD: A CONCEPT ANALYSIS

Tracey Long, Catriona Jones, Julie Jomeen and Colin R Martin define transition to adoptive parenthood and identify associated experiences and challenges, when becoming parents by adoption.

LIZZIE ETTE
@busygirlizzie

Always great to see colleagues/ex-colleagues in print! **Tracey @JulieJomeen @Colin_R_Martin @CatrionaJones6 @CommPrac**

AMANDA HOLLAND
@AmandaHollanda4

Great to see Bonnie **@BonnieHarley8** one of our Cardiff Uni Alumni & past SCPHN HV students awarded a MacQueen bursary through the CPHVA development trust, for CPD activities. Pictured in the **@CommPrac** journal today. Well done 👏


MACQUEEN BURSARY 2022

YOUR CHANCE TO BE REWARDED

Winning a bursary can progress your professional development and further the work you do. Find out how to enter, plus hear from some of last year's recipients.

We would love to hear from you
As always, you can give feedback on the journal, talk about work projects, or share how practice is going for you. Simply tweet **@CommPrac** or email **aviva@communitypractitioner.co.uk**

LISTENING, LEARNING, LEADING

ONE-TO-ONE INTERVIEW

Almost six months into her role as Wales' top nurse, **Sue Tranka** talks about her journey so far and her key priorities for the future, including for the CP workforce.

Sue Tranka was appointed chief nursing officer (CNO) for Wales in August. It is a role she describes as 'an honour' following her near 30-year career in nursing – a journey she has 'absolutely relished'.

Born into a long line of nurses and nursing professors, her interest in the profession was piqued at a young age, but she adds: 'I had no idea then I would embark on a long, enriching and fulfilling career.'

For Sue nursing has remained 'the most rewarding profession'. She adds: 'There is no greater privilege than being able to provide the physical care and emotional and spiritual support to others when they most need it.'

TIRELESS EFFORTS

Arriving in the role in the middle of a pandemic, the impact of Covid-19 has been at the forefront of Sue's mind. 'I have spent the past few months speaking to staff on the frontline – the workforce that has been working so hard, so tirelessly, during the pandemic – to check in with them to get a sense of whether what I'm hearing is exactly what they're experiencing,' says Sue.

'What I have learned is that the key priorities for the community practitioner [CP] workforce are recruitment, retention and health and wellbeing, particularly for a workforce that has been through such a difficult period. I also want support a systematic approach to leadership development, building capacity and capability in the system, and improving patient outcomes, including tackling inequalities – something the pandemic laid bare.'

With staff under such pressure, stepping up recruitment is among Sue's first priorities for 2022. 'In the short term we have to close the vacancy gap,' says Sue, citing a new NHS international recruitment scheme to support 400 nurses joining the Welsh workforce. She adds: 'In the longer term, our workforce planning needs to be robust: we're working with Health Education and Improvement Wales on strengthening the planning.'

She adds: 'We have already made huge increases – since 2016, nurse training places have increased by 69% and midwifery training places by 97% – but I would really like do some granular work in terms of the number of CPs we need, and discuss with the professions the potential for accelerated pathways into those roles.'

Given the workforce challenges facing health visiting and school nursing services specifically, Sue says: 'We need to build the capacity of those teams and have the right workforce in place. By that I mean not only having adequate numbers, but the right workforce, including the registered component.'

She says current work on developing an acuity tool for health visiting and formulating a universal programme of delivery contacts for school-age children 'is predicated on identifying the workforce numbers required, including associated skills mix' with the aim of proving a 'team around the family' approach and highly skilled teams. It is also important to 'think about how health visitors and CPs can be supported in the long term', adds Sue. 'Their career framework and the need for parity across community practice and acute workforce in terms of banding and the level at which they work.'

SUE'S CV

- Sue came to the UK from South Africa in 1999. She trained as a midwife, registered general nurse, and mental health and community nurse, with leadership experience across operational and clinical roles.
- Before her current role she was deputy CNO in England, taking on the key role of director of infection prevention and control just months before Covid-19 hit.
- Prior to that she was deputy CNO for patient safety and innovation at NHS England and Improvement.
- She has had a career-long passion for patient safety and quality improvement, and has held a role of honorary visiting professor at the University of Surrey.
- In October 2020, she was voted one of *Health Service Journal*'s 50 most influential BME people in health.

'THERE IS NO GREATER PRIVILEGE THAN BEING ABLE TO PROVIDE PHYSICAL CARE AND EMOTIONAL AND SPIRITUAL SUPPORT TO OTHERS'

SKILLS CONCERNS

Having met with health visiting teams during her fact-finding first few months, Sue is aware of concerns raised about the skills mix. She says: 'I want to hear their concerns about the skills mix and understand what's driving it,' she says. 'It's not about diluting or devaluing professional roles – that's something that is really important to me as a nurse, and nor has the government set out to do that – quite the opposite.

'We want to enable the workforce to work at the top of their licences, using the skills and knowledge they have worked so hard to gain doing the most appropriate tasks, while being able to delegate appropriate tasks to members of the team. We have started work on preceptorship and clinical supervision which is important for the workforce health and wellbeing,' says Sue.

One of her ambitions is to see good practices like debriefing and clinical supervision being enshrined in policy. She adds: 'I have an NHS secondee coming to work in my office to support the development of a policy around clinical supervision, because it is so important to allow the workforce time to reflect and discuss difficult and challenging experiences and to create a safe space in which

to do that.' And while the pandemic has meant the importance and value of nurses has never been better understood, and that has already 'translated into investment and training numbers', says Sue, the question remains: 'Have we done enough?'

While there is plenty going on behind the scenes, Sue's first major public-facing step in her new post was the launch in late January of the Maternity and Neonatal Safety Support Programme in Wales, 'a significant piece of work in maternal and neonatal services, supporting the Welsh Government's ambition to improve outcome and quality of care'.

This £1.15m plan, which includes the appointment of maternity and neonatal champions to every health board in Wales, reporting back to Sue, aims to ensure a consistent approach and improve the safety, experience and outcomes for mothers and babies in Wales.

A MILESTONE FOR ALL

Taking on the role of CNO for Wales is not only a major milestone in her own career, but also an important step forward in a wider context, says Sue: 'I am the first CNO in the UK to come from an ethnic minority background, which shows how far we've come in breaking down barriers, and is fantastic for Wales – I think it's clear that promoting equality is a priority in Wales, evident from the Race Equality Action Plan.

'But I also want to say I am so much more than my ethnicity; I am in this role because I have worked incredibly hard, I am good at what I do. I have come up through the ranks and put in the time and effort – and I am also from an ethnic minority background.

'I don't go around thinking of myself as a role model, but at the same time I am acutely aware that my appointment to a very senior role signifies change, and sends out a signal to other women and girls from ethnic minority backgrounds that it is possible to break through those barriers, and what is achievable if you work hard, and are invested in and supported to grow.

'It is so important to me that we do all we can to support the development of other women from black and minority ethnic backgrounds seeking senior roles in our NHS. Mentoring is something I have always done in my career, and outside of it through my work with the charity Bridge Builders; I want to help all young women and girls see that they can achieve what they set their hearts to.'

FRONTLINE HEROES

With children and families at the heart of the Welsh Government agenda, Sue is quick to recognise the role of those staff on the frontline. She says: 'As we enter the third year of this pandemic, I would like to say a heartfelt thank-you to CPs for the care and support you have given and continue to give to the families and children in our communities, and for your professionalism, compassion and your dedication.'

Sue adds: 'We need to build on that best practice we already have and look forward to an exciting future delivering our plans and strategies for the wellbeing of our future generations, allowing children in Wales to fulfil their potential.'

ON WOMEN'S HEALTHCARE

Sue says: *'I believe strongly that advice and support must be provided to girls and women across their life course to enable them to remain healthy throughout their lives, thus moving away from providing an intervention purely when problems are experienced.'*

For more, visit **bit.ly/CP_O_features**

LIFE LESSONS

What drives you?
Witnessing injustice and inequality. Growing up among profound inequalities in South Africa has spurred me on to ensure I do better for others. My career in patient safety over many years has made the pursuit for excellence stronger.

How do you unwind?
Spending time with my family. Many of our activities are centred around food, so naturally I love eating it – not so much cooking it!

Any pearls of wisdom in aiming for senior roles?
Remember to be kind: first to yourself, then to others. Don't ever let this compassion leave you – it is what makes you a nurse first and a great leader second. Also remember, there is no single road map to success.

Final word...
Nursing was my professional beginning; it has been my ticket to the world. The profession has shaped me into the person I am today.

WORDS: JULIETTE ASTRUP

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UK HEALTHCARE PROFESSIONALS AWARDED WATERWIPES® BURSARY FUND FOR THEIR 'BEYOND INCREDIBLE' CARE FOR FAMILIES, PARENTS, AND BABIES

Veronica Steele, Claire Slater and Tori Payne have been awarded this year's Pure Foundation Fund from WaterWipes®, the world's purest baby wipes. The Pure Foundation Fund celebrates the achievements of healthcare professionals working with families and their babies in midwifery, neonatal and community settings.

SHE IS A COMPLETE SUPER WOMAN

Health visitor, Veronica Steele from Kettering was nominated by Laura Moore for her support after a traumatic and life-threating birth which left her with PTSD and anxiety.

Laura said: *"Veronica is one of the most incredibly caring and hard-working people I've ever met. After I had a life-threatening birth and was struggling a lot with postnatal anxiety, depression and PTSD Veronica made herself available to us 7 days a week. She is a complete super woman. I don't believe there is any hurdle in life she hasn't conquered, and she is a huge part of the reason I am still alive and battling through every day."*

▲ Health visitor Veronica Steele with her award

▶ Lindsey and partner with daughter Maeve

SUPPORTING LGBTQ+ PARENTS

Midwife, Claire Slater, who works at Worcestershire Royal Hospital and is a community midwife at Princess of Wales Community Hospital, Bromsgrove, was nominated by first-time LGBTQ+ parent Holly Foss for her compassionate and inclusive practice.

Claire said: *"It was a real joy and genuine privilege to be able to care for and to support Holly and her lovely partner through their pregnancy and also since the birth of beautiful baby Dylan."*

▼ Midwife Claire Slater with her award

TORI ALWAYS MADE TIME FOR OUR FAMILY

Neonatal nurse, Tori Payne was nominated by parent Lindsey Troy for her involvement with the vCreate Platform at the Royal Hampshire County Hospital, which enables her neonatal unit to send parents photos of their babies on the ward.

Lindsay, who nominated Tori, said: *"Our daughter Maeve was born unexpectedly at 28 weeks, and we spent around 10 weeks on the unit. Tori always made time for our family, even when the unit was very busy."*

CELEBRATING OUR HEALTHCARE HEROES

Ailbhe O'Briain, WaterWipes® HCP Marketing Manager for UK & Ireland, said: *"We were delighted to launch the second Pure Foundation Fund in 2021, to celebrate the dedication of our healthcare heroes who have provided beyond incredible care for expectant or new parents and their babies – and we were thrilled to see such fantastic and remarkable entries. Stories of those nominated included devoted health visitors, nurses and midwives, who supported parents throughout the pandemic, helping with difficult births, home births, and upping the ante to take care of unwell babies and struggling parents during a particularly difficult year for the world." #PureFoundationFund*

If you are a healthcare professional and would like to find out more about WaterWipes®, please visit **waterwipes.com/uk/en/health-care**

WaterWipes | Pure Foundation Fund

There finally seems to be a focus on longstanding inequalities in women's health. But what needs to be done to truly improve the quality of life for women and in turn, everyone? Journalist ***Anna Scott*** investigates.

THE INVISIBLE EMERGENCY

In August last year, Scotland became the first country in the UK to publish a Women's Health Plan, saying it wanted to be a 'world leader' in women's health. It set out 66 actions to 'ensure all women enjoy the best possible healthcare throughout their lives' (Scottish Government, 2021a). The question then became, when will the rest of the UK catch up? And, of course, does the Scotland plan go far enough?

In December, England followed suit with proposals for a Women's Health Strategy that aims to enable a 'healthcare system that prioritises care on the basis of clinical need, not gender' (Department of Health and Social Care, 2021a) and to address 'decades of gender health inequality'. The government's vision document set out the findings of its public consultation that received nearly 100,000 responses. The particulars of England's Women's Health Strategy are due to be set out in spring this year.

The Department of Health in Northern Ireland says it has no plans to deliver a gender-specific health strategy because it would largely duplicate actions it already takes to target women or men when there is a difference in health behaviours or outcomes.

Meanwhile, the Welsh Government hopes to publish details about future plans for supporting women's health by spring 2022. It set up its Women's Health Implementation Group (WHIG) in 2018. (See page 26 for more details on all plans.)

But is any of this enough? Charity Wellbeing of Women called the England plan 'long overdue' but a 'unique opportunity'. However, Hilary Maxwell, a gynaecological specialist nurse at The Eve Appeal, a cancer charity, notes that any initiatives need to be 'living documents, not ones that are two-dimensional paying lip service to the notion of women's health'.

Both the documents for Scotland and England emphasise what has been clear for some time now: that gender inequality in healthcare has long been neglected and health and social care services need to meet the needs of all women, everywhere (Scottish Government, 2021a). 'Women's health is not just a women's issue,' said Scotland's women's health minister, Maree Todd, when the strategy was published. 'When women and girls are supported to lead healthy lives and fulfil their potential, the whole of society benefits.'

VITAL FOR EVERYONE

Dr Bella Smith, a GP and co-founder of The Well HQ – a training organisation and movement attempting to erase institutional biases when working with women in sport – says women tend to make the majority of health decisions in families. 'We are in control of our family's health,' she says. 'We are looking after everyone else and if we don't thrive, they don't thrive. We need to focus on women's health because it affects us, but it also affects our entire family.'

Diana Holland, assistant general secretary, equalities, Unite, agrees that the prime caring responsibilities for children, young people and older people, not always, but often, fall to women. 'Women are more likely to encourage people to think about their health and to follow up on conditions, and they have the direct experience,' she says. 'There are overarching issues about investment in the NHS, and public preventative health. It's important for everybody but I think it's particularly important for women because of the way women traditionally have so many responsibilities and demands.' But many women feel they do not get the support they need from healthcare professionals. More than four in five (84%) of survey respondents in England say there have been instances when they (or the women they had in mind) felt they were not listened to by healthcare professionals (Department of Health and Social Care, 2021b).

▷ CONTINUED ON PAGE 28

SHUTTERSTOCK

WHAT EXACTLY IS UK POLICY ON WOMEN'S HEALTH, PLANNED OR OTHERWISE?

ENGLAND

The vision document explains the aims of the strategy, which seeks to improve both the way the health and care system listens to women and their health outcomes, and puts women's voices at the centre of this discussion (Department of Health and Social Care, 2021b). It highlights a number of priority areas including fertility, pregnancy, pregnancy loss and postnatal support, the menopause and mental health (Department of Health and Social Care, 2021b).

On publication of the vision document, minister for women's health Maria Caulfield said: 'Many of the issues raised require long-term system-wide changes, but we must start somewhere', calling the document 'the first step' (Department of Health and Social Care, 2021a).

In the documents for England and Scotland, the government announced plans for a new leadership role or roles that should highlight women's health concerns. In the case of Scotland, a national 'women's health champion' and a 'women's health lead' in every NHS board, and in England's case, a women's health ambassador to 'drive women's health to the top of the agenda' (Scottish Government, 2021a; Department of Health and Social Care, 2021a).

NORTHERN IRELAND

A spokesperson for the Department of Health explains their stance on a non-gender-specific plan: 'Where gender inequalities or specific health needs exist in Northern Ireland, they are already addressed within specific strategies or through service delivery.'

The country's six Health and Social Care trusts provide health services for a number of gender-specific conditions, including breastfeeding support, sexual health services, promotion of uptake of cancer screening and support services, and work with lesbian and bisexual women.

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WALES

The Women's Health Implementation Group (WHIG) was announced in 2018 by then minister for health and social services, Vaughan Gething, tasked with 'overseeing specific areas of women's health requiring urgent attention and improvement' over a five-year period, with £5m government funding.

'Women's health is a priority for us and this is why we set up and fund the WHIG,' a government spokesperson says. 'The group has helped to achieve a number of key initiatives, including establishing a network of pelvic health and wellbeing coordinators in each health board.

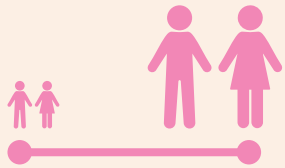
'More recently it has supported the recruitment of a network of specialist endometriosis nurses in each health board to develop national pathways to help to reduce diagnostic times across Wales.'

SCOTLAND

Among the Scottish plans for women's health actions are to establish a women's health research fund to close gaps in scientific and medical knowledge, develop a menopause and menstrual health workplace policy and promote it across the public, private and third sectors, and set up a Women's Health Community Pharmacy Service (Scottish Government, 2021b).

Actions within Scotland's Women's Health Plan have been split into short, medium and long term, to begin being delivered within the year. Among those already established are a central platform for information on women's health on NHS inform.

And in October 2021, the Scottish Government launched the NHS inform menopause information platform. 'We are bursting menopause myths, highlighting menopause symptoms, options for care, treatment and support, mental health and much more,' says a government spokesperson. 'Our ambition is to ensure that all women and girls enjoy the best possible health throughout their lives.'



UK LIFE AND HEALTH EXPECTANCY FOR WOMEN AND MEN

Life expectancy at birth in the UK 2018-20 is **females: 82.9** years; **males: 79.0** years (ONS, 2021b).

Even though women's life expectancy is greater than men's, **women spend over a quarter of their lives in ill health and disability**, compared with about one-fifth of men's lives (ONS, 2021c).

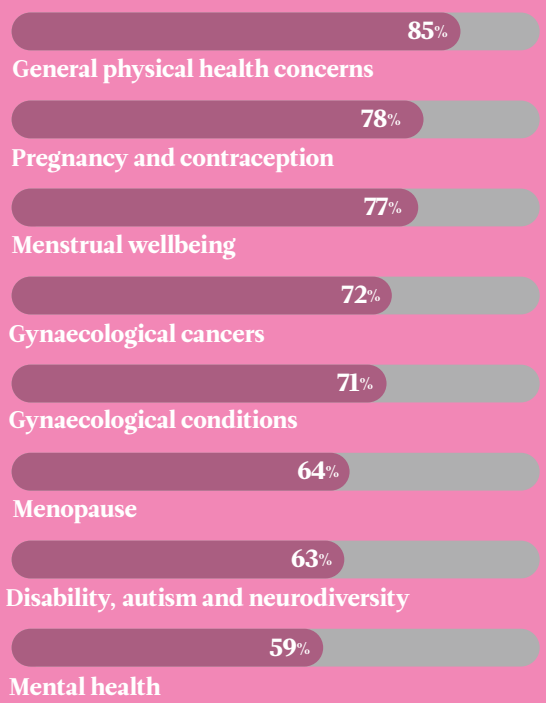
Women's healthy life expectancy – the number of years people are expected to spend in different health states – has **fallen** from 63.7 years in 2014 to 2016, to **63.3 years** in 2017 to 2019. Men's healthy life expectancy has remained stable, at about 62.9 years (ONS, 2021c).

In 2017 to 2019, **men** could expect to spend **62.3 years** of their lives **free of disability**, whereas **women's disability-free** life expectancy was **61.0 years,** a decrease of just over a year on the previous two-year period (ONS, 2021c).

These figures do not take into account the impact of Covid-19 on health.

IT'S GOOD – BUT HARD – TO TALK

According to the consultation reported in the vision document, women generally feel comfortable talking about healthcare issues with healthcare professionals but they also say that, ideally, they'd rather talk to friends about such matters. The overall proportion of women who feel (or are perceived to feel) comfortable talking to healthcare professionals varies by topic:



Department of Health and Social Care, 2021c

Many women said they felt symptoms were dismissed upon first contact with GPs and other professionals, they had to persistently advocate for themselves to secure a diagnosis over multiple visits, months and years, and they found that post-diagnosis discussions about treatment options were often limited or preferences ignored (Department of Health and Social Care, 2021b).

Bella highlights the gender data gap in healthcare, citing a study that suggests women are 50% more likely than men to be given an incorrect diagnosis after a heart attack (University of Leeds, 2016). 'We are trained as doctors to recognise the symptoms men experience – chest pain – and actually women [can] have more flu-like or indigestion symptoms,' she says. (Though key symptoms may not differ – see page 48).

'We think we're the same, but we're not. There's this whole gap of knowledge that needs to be looked into.'

Author and journalist (former editor of *Elle* and *Cosmopolitan*) Lorraine Candy, who co-hosts the podcast *Postcards from midlife*, says women need to be listened to properly. 'If the NHS were to join up the dots of women's health, from puberty to menopause, we could prevent many issues occurring and save the NHS time and money. A consistent record for women's health in their lifetime would save the health service so much time,' she says.

EDUCATION IS KEY

'We need to hear what is important to women and how poor health is impacting on their lives at all levels,' says Hilary, who also runs Ask Eve, a specialist gynaecological health information service for women and their families and friends who may have questions about cancers.

She says there is a common perception that women are 'moaning'. 'Women's health is complex with many layers to it,' says Hilary. 'This can make disease difficult to diagnose – you are asking people to describe symptoms which can often sound vague and non-specific, but most often are not. This leads to frustrations for both patients and clinicians.'

It doesn't help that awareness of sex-specific conditions is an issue among both healthcare professionals and women. All these factors contribute to healthcare treatment for women lacking in many areas.

Bella says many women's health conditions have been previously misunderstood: premenstrual dysphoric disorder, endometriosis, the menopause, vaginal atrophy and urinary incontinence. Only now are they beginning to be fully recognised, correctly diagnosed and appropriately treated. '[As many as] 69% of women will experience urinary incontinence, but only half will seek help. We [as health professionals] need to do better.' Complications of the menopause such as osteoporosis, heart disease and dementia are also underserved, she says.

Lorraine says educating both the medical profession and women is key. 'The myths and misconceptions around perimenopause and menopause and the prescribing of hormone replacement therapy [HRT] need to be addressed,' she says. '[There is evidence that] HRT is a preventative medicine for osteoporosis and heart disease and should be prescribed as the first line of treatment based on patients presenting with symptoms of perimenopause.'

The Well HQ does a lot of work with sportswomen, and one of the issues that arises is the number of women who leak urine but haven't had children. 'For some reason leaking urine is only acceptable after you've had a baby, and that's the only time anyone really talks about it,' says Bella. But the problem could be caused by a range of factors, from weak pelvic floor muscles to medication (as well as obesity and neurological conditions). 'These young women don't talk to each other about it because it's like it's the biggest taboo of all. It's almost as if women are only given permission to seek help for certain conditions at certain phases of their lives.'

'Women's health is surrounded in shame and stigma and embarrassment, women are literally suffering or dying of embarrassment.' Bella is clear in her view on what should be happening: removing stigma and talking in clear language is crucial, and should start at school with teachers, boys and girls, and continue in the workplace.

'WOMEN'S HEALTH IS SURROUNDED IN SHAME AND STIGMA AND EMBARRASSMENT – WOMEN ARE LITERALLY SUFFERING OR DYING OF EMBARRASSMENT'

THE RESEARCH GAP

Another issue is that many areas of academic research (not just medical) assume men are the standard of measurement. 'If I think about health and safety and the way a number of occupational standards were set at one point, the average standard was the male US marine,' says Diana Holland. 'Obviously that doesn't fit a lot of men either, but it's absolutely unsafe for women.' In this context she believes that women's healthcare, including research and treatment, should be considered in the context of their whole lives rather than individual conditions or issues.

This is also crucial for a truly intersectional view of women's healthcare. Black women are more than four times more likely than white women to die in pregnancy or childbirth (MBRRACE-UK, 2021). And there are differences in women's life expectancy across socioeconomic groups, with those in the most deprived areas dying 7.6 years earlier than those in the least deprived areas of England (Office for National Statistics (ONS), 2021a).

'It's really important that [research and treatment] looks specifically at women then looks at the circumstances for black women, for disabled women, for lesbian, gay, bisexual and trans women, for example,' Diana says. Both documents from the Scottish Government and the Department of Health and Social Care include references to healthcare needs of transgender men, non-binary people and intersex people, or people with variations in sex characteristics, who may also experience menstrual cycles, pregnancy, endometriosis and the menopause.

Women's health research itself has also been lacking, says Bella. She says that research into the impact of hormones on women's health is critical, yet the little that is done is carried out at the wrong time of the menstrual cycle, when hormone levels are more similar to men's.

'No one is taking into account the fact that for most of our lives we have a beautiful roller-coaster of hormones that affects the way we digest food, metabolise medicine, the way we think, the way we sleep, our body temperature. No one understands how that affects us, mentally, physically, emotionally,' she says.

Bella says the bias and 'systematically ignoring half the population' in healthcare and medical research is not intentional but a lack of insight into the fact that women are different. But the good news is that there is a growing appetite from employers for support and guidance on women's healthcare.

'The number of hours lost through work because of the menopause or other women's health issues is very high, and I think corporations are now realising this and understanding that they need to support women and have the ability to adapt,' says Bella.

That subjects such as the menopause and guidance on pelvic floor exercises are on the school curriculum in England and increasingly in the public arena also shows things are getting better. 'Women's voices are being heard,' says Lorraine. 'There are so many more books being published by experts and Channel 4's documentary *Sex, Myths and the Menopause* with Davina McCall addressed [the menopause] very publicly.'

A BRIGHTER FUTURE?

Hilary says: 'Over the next five to 10 years we need to see real change and action at the grassroots level. We have to invest more. We simply cannot keep marginalising women's health at the back of the cupboard in the hope it either gets forgotten and goes out of date or the next generation forget what went before and they have to start all over again from scratch.'

Improved understanding, treatment and knowledge of women's healthcare issues would impact community practitioners, both personally, as many are women, but also professionally, as they may be implementing new policies, Diana says. 'Hopefully, some of the multiple and more complex [health] issues may be reduced. And there may be more solutions for them to refer to. It [an effective women's health policy] should both improve health outcomes for women and make the job of a community practitioner more rewarding.'

RESOURCES

- BMA's reply to the Women's Health Strategy **bit.ly/BMA_WHS_reply**
- RCOG's *Better for women* report **bit.ly/RCOG_BFW_report**
- Vision for Women's Health Strategy for England **bit.ly/GovUKEng_vision_WHS**
- Wellbeing of Women's reply to the Vision for Women's Health Strategy **bit.ly/WOW_reply_vision**
- Women's Health Plan for Scotland **bit.ly/GovScot_WHP**

For references, visit bit.ly/CP_features

Problem

Passive safety pen needles protect you from needlestick injuries, but come with challenges of their own:

Lack of needle visibility[1]

Premature activation of the safety mechanism[1]

Limited control during the injection process[1]

71% agreed that the safety pen needle activates before they have finished administering the injection[1]

69% agreed that premature activation of the safety pen needle makes them unsure that the full medication dose had been delivered to the patient*[1]

* Of the 71% of healthcare professionals who had experienced safety pen needles activating before they had finished administering the injection.

1. Project Saturn A (2017) Online study commissioned with an independent market research agency. Data on file.

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A BLOODY SHAME

How close are we to achieving period equality? Free products are now in UK schools, but periods are still taboo, especially among young people, and poverty still exists. Journalist ***Sarah Campbell*** takes a closer look.

SHUTTERSTOCK

'I do think pads should be free because it's a natural thing – every girl will end up having her period at some point in their life and not everyone can afford 'em.' That's the view of Sophie, 14, from Hull (Plan International UK, 2018).

She is not alone in this perception. More than a third of UK girls and young women aged 14 to 21 have struggled to afford period products since the pandemic began (Plan International UK, 2021), up from one in 10 pre-pandemic (Plan International UK, 2018). Among those who can afford products, almost a quarter struggled to get hold of them, mostly because of shortages in the shops (Plan International UK, 2020).

'At a time when the financial fallout from Covid-19 has pushed families already at the sharp end of poverty into further financial turbulence, period poverty will continue to have a devastating impact on the trajectory of a young person's life,' wrote anti-poverty activist Amika George in March last year (George, 2021).

Thanks in part to Amika's work with the Free Periods charity, which she set up while still at school, the UK now has schemes to provide free period products in schools. Scotland started in 2018, Wales in 2019, England in January 2020, and Northern Ireland launched a pilot in September last year. However, with schools closed for much of 2020, many young people were unable to rely on their usual source. It threw period poverty into even greater relief – and campaigners and charities found themselves busier than ever.

TOXIC TRIO

'Periods don't stop in a pandemic,' says Rachel Grocott, director of communications and public fundraising at Bloody Good Period (BGP). 'We've just celebrated our fifth birthday –the intention was that we would be winding up. But thanks to the pandemic we are actually escalating what we're doing because the need is so great. We don't want to be around in another five years because we don't believe we should have to do this.'

BGP focuses mostly on asylum seekers and refugees, but at one point during the pandemic it was supplying period products to NHS hospitals because staff were struggling to find supplies in the shops after working long shifts. The problem pervades all of society, and goes far beyond simply being able to pay for period products.

'At Plan International UK, we consider period poverty to be made up of a toxic trio of issues – affordability, a lack of menstrual health education, and finally the

shame, stigma and taboo that surrounds periods,' says the charity's health and wellbeing specialist Emma Thompson-O'Dowd.

This 'toxic trio' can be seen at work through the example of the introduction of free period products in England. Ninety-four per cent of secondary schools and 90% of post-16 organisations had made at least one order since the scheme began in January 2020. The equivalent figure for primary schools is lower, at 61% (Department for Education, 2021). But lockdown took children away from schools, and half of girls and young women aged 14 to 21 in the UK who had struggled to access period products during the pandemic couldn't afford anything at all (Plan International UK, 2021).

'We also know that girls are bullied and teased because of their periods,' says Emma, citing a survey that found one in five girls and young women aged 14 to 21 had encountered this behaviour (Plan International UK, 2019). 'If the shame and stigma isn't addressed, then period product schemes are not necessarily accessed by those who need it.'

Finally, there's the 'period talk'. Emma says: 'Girls tell us they're taken out to a separate room, which adds to the sense of taboo. Girls say one solution they want is a single-sex approach where they can have that space, but also co-education that helps address the stigma and shame. We know from our research that boys and young men say they want to be educated on it as well.'

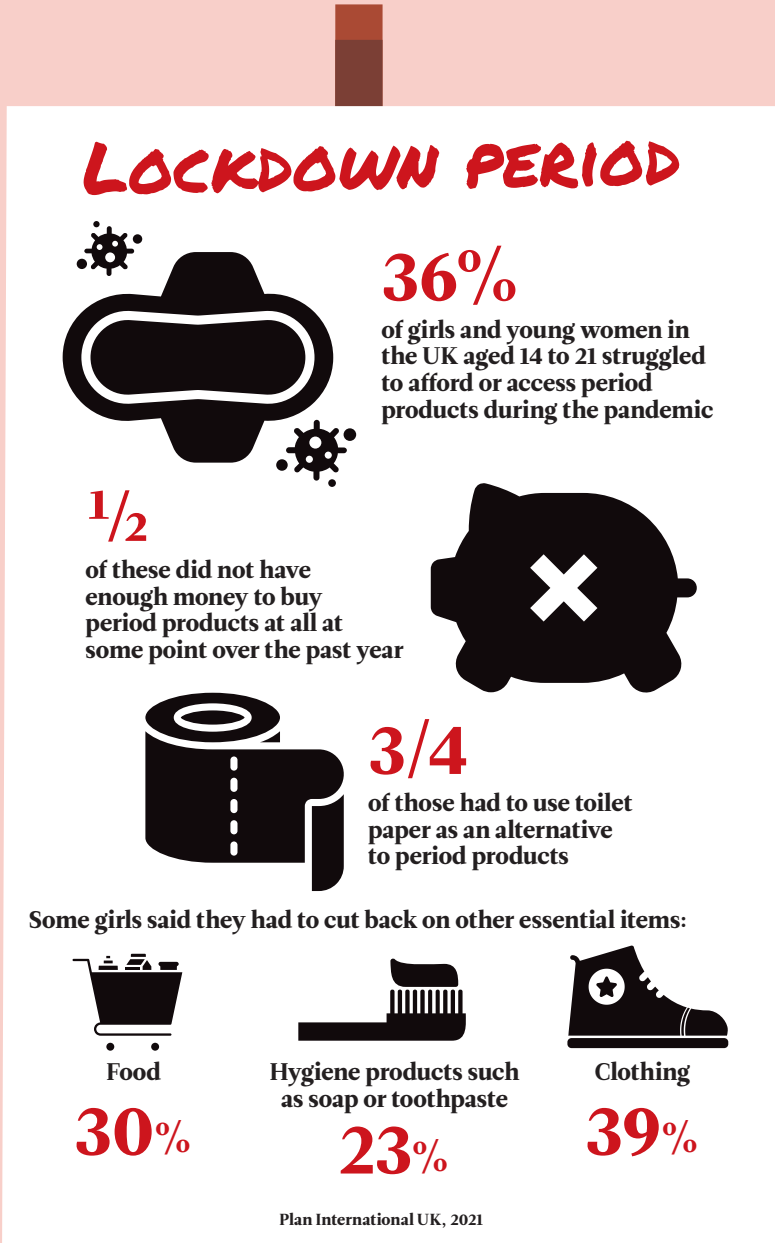
THE EVEN WIDER PICTURE

While period poverty is a complex issue in itself, it is also a symptom of a greater malaise in terms of women's rights and general poverty.

Nikki Pound, women's equality policy officer at the TUC, speaks about it in no uncertain terms. 'Period poverty reflects the poverty that exists in society. There's a root problem here of poverty and living in a fundamentally sexist society that thinks women have to just get on with these things. It cannot be right that in the UK there are women and young girls who cannot afford period products. That is just unacceptable,' she says.

Rachel agrees, pointing to the increase in demand during and after the pandemic. She says: 'Covid-19 took inequalities and made them so much worse. But towards

'THERE'S A ROOT PROBLEM HERE OF POVERTY AND LIVING IN A FUNDAMENTALLY SEXIST SOCIETY THAT THINKS WOMEN HAVE TO JUST GET ON WITH THESE THINGS'



SHUTTERSTOCK

the end of last year we started seeing demand go up again. So we're supporting more refugees, including those from Afghanistan. Also, the cost of living went up, furlough was cut, Universal Credit was cut. We started to get reports from partners across England and Wales. And more than 100 of them now say that things like in-work poverty [when a working household's income is insufficient to meet their needs] is starting to go up again.'

A PERIOD-EQUAL FUTURE?

As a cost of living crisis starts to bite and fuel prices soar, the poverty landscape in general looks bleak. But there is cause for optimism when it comes to tackling period poverty and working towards period equality, which Emma defines as 'the ability to thrive in life, regardless of whether you're having your period or not'. In 2020, Scotland was the first country in the world to pass an act obliging local authorities to provide free products for anyone who needs them – not just in schools – and many councils have made substantial headway with this (see *How to normalise periods*, right). A similar bill is making its way through the Northern Ireland Assembly (NIA, 2021).

Emma points out that menstrual health is now on the English schools curriculum (schools in Scotland, Wales, and Northern Ireland have guidance on teaching it, but it's not yet statutory). 'That's [in England] good progress, as long as that education is delivered in a way that meets girls' needs,' she says.

'A lot of fantastic work has been done by grassroots organisations. It's more present in the media as well. But we still have a long way to go to address the stigma and taboo. Girls are still missing school for fear of leaking: that's all tied up in the shame that surrounds it.'

HOW TO NORMALISE PERIODS

Before the Period Products (Free Provision) (Scotland) Act 2020 was passed, Aberdeen City Council was asked to carry out a pilot project in 2017.

The project was led by local poverty reduction charity Community Food Initiatives North East (CFINE). It used its extensive network to help place period products into toilets in schools, community centres and libraries. In the past financial year it has distributed 26,000 packets of disposable period products and 1400 packets of reusable products in Aberdeen.

'During the pandemic, CFINE has popped some period products into emergency food deliveries where appropriate. It means folk don't have to go and ask. In lockdown, it was really difficult for some women to find that provision,' says councillor Lesley Dunbar, spokesperson for young people.

Because CFINE's delivery network consists of numerous groups, simply adding period products has helped reduce stigma, Lesley adds.

'Accessibility is such a key part of this; it's fundamental to the project being a success and also the wider campaign around stigma. There's nothing wrong with in-your-face campaigning, though – we need as many ways as possible [of normalising periods].'

CP CALL TO ACTION

Make a big difference

- Encourage schools to sign up to free period product schemes
- Avoid using the words 'sanitary' and 'hygiene' when talking about periods – it reinforces the negative stigma. Use 'periods' and 'menstrual' instead
- Help schools and workplaces ensure that period products are easily accessible (for example, freely available in toilets)
- Where possible, include men and boys in conversations about menstrual health
- Talk to your health and safety workplace rep about how menstruation is taken into account.

RESOURCES

- Read *Break the Barriers*, a report into girls' experiences of menstruation in the UK **bit.ly/Break_The_Barriers**. And see its follow-up project, *Let's Talk. Period* at **plan-uk.org/act-for-girls/lets-talk-period**
- How schools in England can sign up for free period products **bit.ly/Schools_Free_Products**
- Period Dignity Action Plan consultation (Wales) **bit.ly/Wales_Action_Plan**
- Northern Ireland Period Dignity Pilot Scheme **bit.ly/NI_Dignity_Scheme**
- Guidance on the Scottish Period Products Act **bit.ly/Scot_Period_Act**

For references, visit **bit.ly/CP_features**

WHY CULTURE COUNTS

Alis Rasul looks into a recent evaluation of how the mental health of BAME Muslim families can be supported when health visitors deliver a culturally sensitive early intervention parenting programme.

ISTOCK

Perinatal mental health is a significant public health concern (NICE, 2014). It is a major risk factor during the perinatal period as it is associated with maternal complications, as well as poor cognitive and emotional outcomes for the baby (Napier et al, 2014; Stein et al, 2014; Pawlby et al, 2009). If left untreated, perinatal mental health problems can escalate into more severe mental illness. Maternal suicide remains the leading direct (pregnancy-related) cause of death in the first year after pregnancy (MBRRACE-UK, 2021).

Research has found a strong association between the socioeconomic backgrounds of some communities and cultures and a greater risk of perinatal mental health issues. Black, Asian and minority ethnic women (BAME) are most at risk (Cooper et al, 2013). Psychological and physical wellbeing varies across cultural societies (Henshaw et al, 2017; Sewell, 2009). A recent Lancet Commission on culture and health evidenced a fundamental argument that 'the systematic neglect of culture in healthcare is the single biggest barrier to the advancement of the highest standard of health worldwide' (Napier et al, 2014).

Significant gaps in mortality rates between women from different ethnic groups, levels of deprivation and of different ages exist. For example, women from Asian ethnic groups are almost twice as likely to die in pregnancy as white women (MBRRACE-UK, 2021).

A lead service that supports the early assessment and identification of perinatal wellbeing issues is that of the health visitor (Public Health England, 2016; Lewis et al, 2011). HVs play a key role in ensuring that the impact of perinatal mental illness (which can vary from universal to complex) and other complications do not adversely affect the child's health and wellbeing (NICE, 2014; Public Health England, 2021).

THE PROJECT

In 2017, Birmingham Community Health Care NHS Foundation Trust, in partnership with St Paul's Children's Centre, agreed to fund two health visitors, who would be trained in the Approachable Parenting programme. For more than 10 years, the programme has been providing support and information to local black, Asian and minority ethnic (BAME) families – in particular Muslim families. Birmingham has one of the highest Muslim populations in the country at around 27% (Miller and Rodger, 2019), up from 21% in 2011 (Birmingham City Council, 2022) and this opportunity allowed for the evaluation of the co-delivery of the Approachable Parenting programme, and in particular the delivery of a culturally sensitive service by health visitors to enable equity in healthcare.

PROJECT AIM

To evaluate the role of the HV in delivering a culturally sensitive early intervention parenting programme to support the mental health of Muslim families.

PROJECT OBJECTIVES

- To map the Approachable Parenting programme's objectives to the HV role in improving public health outcomes for the mental health of Muslim families.
- To identify Muslim parents' views on the sociocultural factors that would enable them to engage with the HVs in delivering the aims of the programme.
- To establish Muslim parents' sociocultural perceptions of mental health needs, both for themselves and their children.
- To compare and map Approachable Parenting objectives to Care Quality Commission equality indicators for service improvement in the wider context of health visiting for Muslim families.
- To determine the impact of relational HV support in promoting Muslim families' mental health and resilience through delivery of the programme.

METHODOLOGY

The 'logic model' (Public Health England, 2017) was used to inform a realist evaluation of the HV role in enabling and delivering the culturally sensitive elements of the Approachable Parenting programme for Muslim parents. Realist evaluations offer a focus on real-world practice. It allows for a greater depth of data to be collected in relation to everyday process outcomes, which in turn are likely to reflect more complex interventions (Doi et al, 2017). Focus groups were conducted with parents who attended the Approachable Parenting programme, and self-evaluation forms were completed by the parents in order to produce a robust report of the topic.

FINDINGS

Three themes emerged from the findings of this study: relationships, trust, and 'me time'. The findings indicate the need for health organisations, policymakers, Health Education England and academia to work together to support the perinatal mental health of BAME communities as early as possible. Future health services need to evidence equity in healthcare with service user involvement so that the services provided are fit for purpose and receive full engagement from the communities that they serve. These services should also be identified by the service users as high quality and culturally safe for them.

A range of services is required to assist in preventing these effects where possible, as well as to identify and seek treatment to reduce the impact on the family (PHE, 2021). This is strongly endorsed by the NHS *Long-term plan* (2019), with a major shift towards and focus on prevention in tackling health inequalities. This is done by meeting the health needs of communities through integrated care schemes working across organisational boundaries.

Other support for parents, in particular in relationship building, can be provided by parenting programmes (Symonds, 2018). In particular, there has been growing evidence to support culturally-competent parenting programmes (Vesely et al, 2014; Calzada, 2010). The Approachable Parenting programme is one such programme, and has been in practice in Birmingham, Manchester and London for the past 10 years. The Approachable Parenting programme was developed with BAME parents – and particularly Muslim parents – in mind. This is because access, engagement, and retention by traditional parenting programmes of BAME communities has previously been low (Wells et al, 2015; Ullfsdotter et al, 2014; Barker et al, 2010; Griner and Smith, 2006).

There is evidence to suggest the benefits of the Approachable Parenting programme on both maternal and child mental health of Muslim families in Birmingham (Thomson et al, 2018). This has also been evidenced in other BAME communities (Griner and Smith, 2006). The overall aim of parenting programmes is to promote positive parenting by employing attachment and social learning theories. These theories support parents in strengthening their relationship with their child and improve their mental health.

The Muslim population of the city is estimated to be 27% (Miller and Rodger, 2019), with the English average being 5% (Birmingham City Council, 2022). A large proportion of Muslims are from a south Asian background, and 38% have a Pakistani heritage (Muslim Council of Britain, 2015). There are currently limited statistics on religion and perinatal mental health, particularly for Muslim women. However, research shows that depression is higher in Pakistani women in the UK who confirmed their religion as Islam (31%) compared with their white counterparts (12.9%) (Husain et al, 2012).

CONTEXT – MECHANISM – OUTCOME

Context	Settings or conditions in which programmes are implemented	Health visitor co-delivery of parenting programme
Mechanism	**Causal forces, powers, process interactions that generate change within the programme**	**Culturally sensitive parenting programme for Muslim parents**
Outcome	Intended and unintended outcomes	Early intervention and health promotion information fitting into belief system

DEPRESSION IS HIGHER IN PAKISTANI MUSLIM WOMEN IN THE UK COMPARED WITH THEIR WHITE COUNTERPARTS

CULTURE AND PERINATAL MENTAL HEALTH

There is a strong evidence base on cultural perceptions and stigma of perinatal mental health in BAME communities (Watson et al, 2019; Anderson et al, 2017; Prady et al, 2016; Husain et al, 2012). Some of the studies reviewed note that Muslim women felt they had to keep their mental health issues to themselves and not share them with family and friends. There was also some indication that some Muslim women disassociate themselves from mental illness altogether, since it is culturally considered a form of physical deformity; the mental health of some of the mothers was thus not considered a priority (Hanley and Brown, 2014; Parvin et al, 2004; Fazil and Cochrane, 2003). This could be related to Muslim populations increasingly using spiritual and/or cultural coping mechanisms compared to women from other beliefs in the UK (Meer and Mir, 2014).

THE LAW

The NHS is under a legal and moral duty to deliver services to local people and communities who share protected characteristics, as defined in the Equality Act (2010). This duty is further laid out in the NHS constitution (2015).

However, there still appear to be major gaps in both service provision and major statistical data. For instance, infant mortality is nearly double in Asian babies (highest in the Pakistani ethnic group) and higher still for babies in the black ethnic group compared to that in white infants (ONS, 2021). Service delivery, access to service, and culturally sensitive services are still major problems in mental health services for BAME families (Prady et al, 2016).

EVALUATION DESIGN

To ensure that evaluations succeed in achieving the desired outcomes, the chosen method for this study is that of realist evaluation. Realist evaluation has been distinctive in asking the questions of what works, for whom, how, in what circumstances, and why, as opposed

to merely 'does it work' (Pawson and Tilley, 2013). Realist evaluation offers an understanding of social systems described as programmes, and describes a continuously evolving interplay between human agency and social structures. The realist theory has three main components: building, testing, and refining programmes theories. This is undertaken by exhibiting the core interaction of context, mechanism and outcomes (CMOs): see table on opposite page.

Seventeen parents registered for the programme, of whom 11 completed the Approachable Parenting requirements. The reasons parents gave for not completing was because of family circumstances or childcare issues. This report is, therefore, based on the 11 parents who completed the course and both the pre- and post-programme questionnaires.

The following three main themes of interest emerged from the thematic analysis: relationships, trust and 'me time'. The relationships theme covered the context of the initial programme theory; the trust theory was in relation to the mechanism; and the 'me time' covered the outcome. These themes will be discussed further below, when presenting the results and discussing the findings.

Most participants openly shared the importance of personal and professional relationships. The HV relationship was explored in this theme. Participants reported that they received significant support from the HV in all areas of health promotion and early intervention during the course of the programme.

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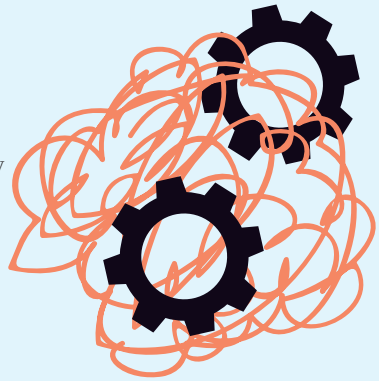

All of the participants discussed their motivation for attending and all identified their child's health and welfare as the primary motivator. There was also a discussion on why the Approachable Parenting programme served to motivate their attendance.

Apart from focusing on how valuable the delivery of the culturally sensitive Approachable Parenting programme was, a few participants consistently cited 'me time' as an outcome with positive results. 'Me time' is described as giving oneself compassionate self-care to ensure wellbeing by looking after oneself (Baker, 2019).

The findings of the present study support the wider literature conclusions: BAME patients and service users frequently experience challenges in seeking and accessing support for perinatal mental health services (Watson et al, 2019; Masood et al, 2015; Husain et al, 2012; Templeton et al, 2003). Furthermore, the present findings reveal that BAME patients and service users are generally willing to engage actively with services. Significant evidence also states that it is not only challenges in seeking, accessing support for mental health service but also attitudes of professionals referring into services as well as those delivering services, which causes 'othering' and mistrust of BAME service users (Watson et al, 2019; Anderson, 2017; Prady, 2016; Husain et al, 2012).

The present findings reveal that BAME patients and service users are generally willing to engage actively with health services. There is a reduction in service uptake only when there is a conflict in understanding information about services. Further to this, participants confirmed a mismatch of perception of ill health that service users cannot relate to when services are not adapted.

These findings indicate that services will only be fully endorsed by BAME communities when they are perceived safe. There also needs to be some recognition that health services for BAME communities should be delivered and developed by BAME professionals – this may not have come out directly during the focus groups but will need further exploring. The study also demonstrates hope: the participants reaffirmed that where there is co-production through 'true' engagement, compassion and trust, our health services can be considered culturally diverse.

Culture matters, as it is in the hearts and minds of individuals. There are core beliefs that individuals and communities hold when accessing, receiving and evaluating their healthcare. If there are current or developing trends in these core beliefs, these need to be explored further, as the duty of care lies with the healthcare organisations and practitioners whose role it is to facilitate the engagement. This is especially important in health visiting, since the HV acts in a core community capacity role.

It matters that all children receive a fair start in life and fair access to services that meet their cultural needs. These should be services that they can relate to, understand and implement in daily life. It matters because every child matters, and no parent should lose a child, regardless of their belief, ethnicity or culture.

Alis Rasul is Interim Divisional Lead HV for Birmingham Community Healthcare.
Her study was funded through a Mary Seacole scholarship.

For references, visit bit.ly/ CP_P_features

ISTOCK

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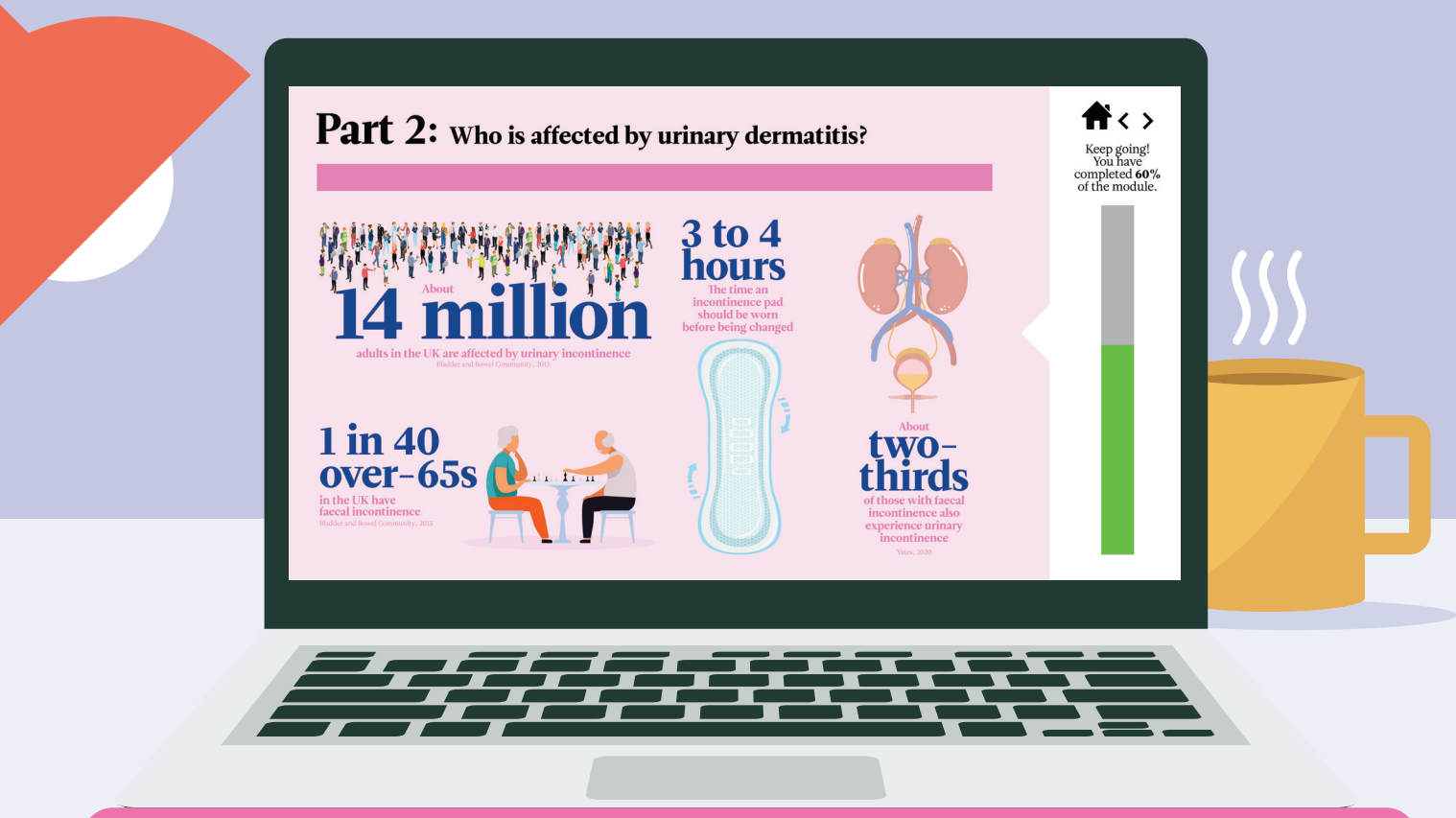

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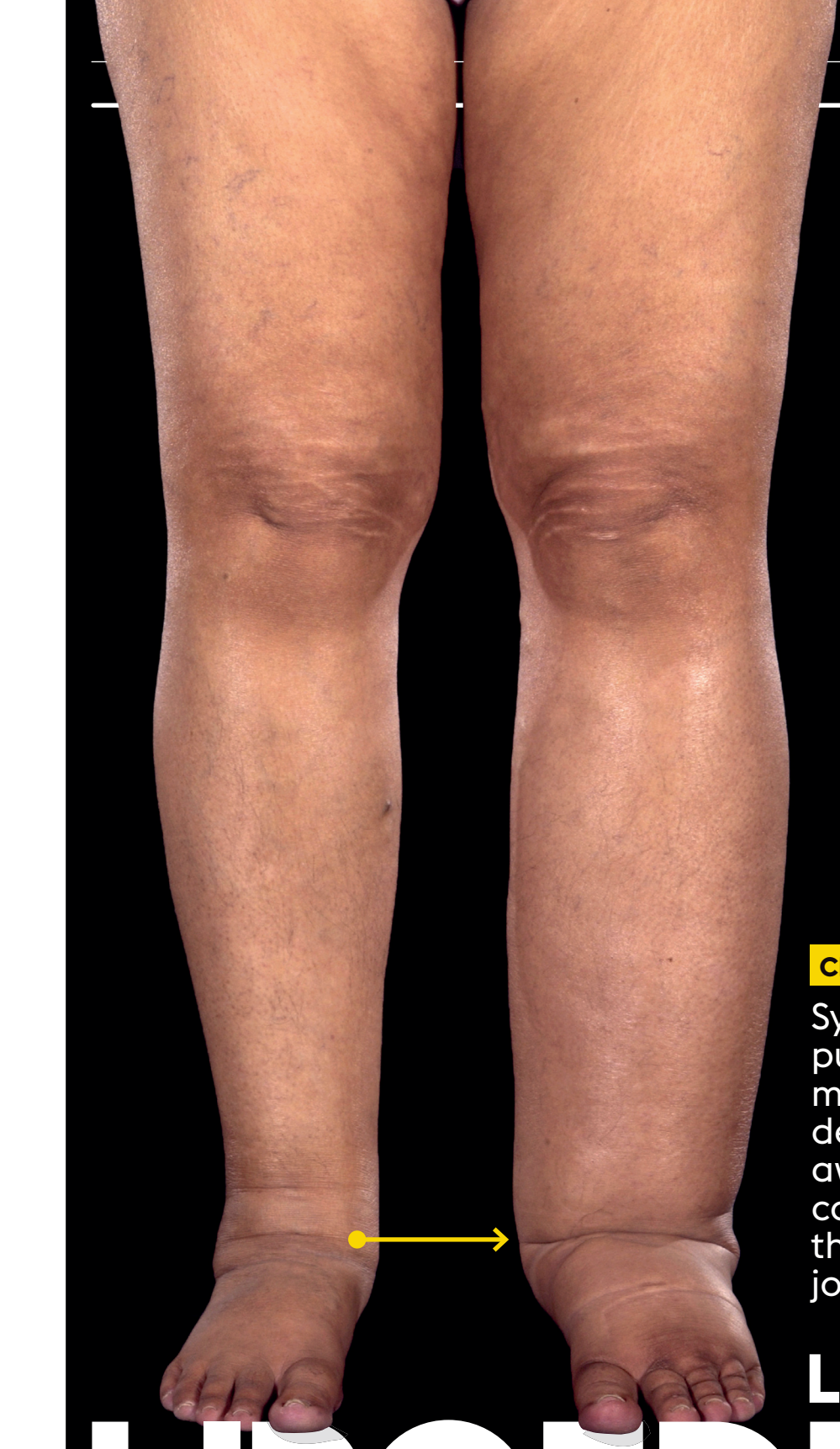

LIVING WITH LIPOEDEMA

CLINICAL

Symptoms often start in puberty, yet diagnosis may not happen until decades later. Increasing awareness of lipoedema can help to address this imbalance, writes journalist ***Julie Penfold***.

Lipoedema is a body fat disorder that causes a disproportionate enlargement of a woman's lower extremities. It is a relatively common condition, and while its prevalence is not fully known, it's estimated to affect around one in nine women (Buck and Herbst, 2016). However, it can be confused with and mistaken for obesity or lymphoedema. The issue of late diagnosis in primary care can have a devastating impact on women's lives.

'Lipoedema is a fat and connective tissue condition where there is an increase in the size of fat cells, together with inflammation that develops around that,' explains lymphoedema and lipoedema nurse consultant Dr Anne Williams. 'There may also be other connective tissue problems happening that are not just due to changes in the fat cells,' says Anne, who is also a trustee at the charity Talk Lipoedema. 'Lipoedema skin is soft and ▶

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very, very pliable. It doesn't have the same stiffness that you find in other skin conditions, and even in lymphoedema.

'This change in fat and connective tissue is a distinct and usually symmetrical pattern that can lead to disproportionate shape between the upper and lower body,' adds Anne. 'Women will often be slimmer on top and they may have a smaller waist too. The first sign is usually a change in the lower leg or the shape of the ankle is lost. As time goes on, there is an increase at the ankles, around the knees and at the hips.'

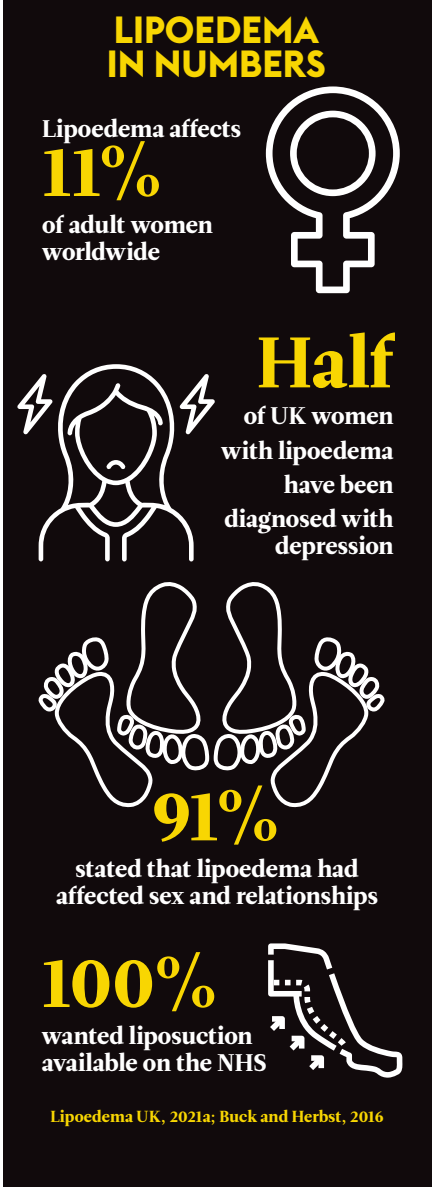
A key way to determine whether a patient potentially has lipoedema and not typical cellulite is they are much more likely to have painful legs, advises Anne. 'Cellulite is a difficult word as it is really just a type of fat. The upper body being disproportinately smaller than the lower body is a key characteristic of lipoedema. Whereas obesity is more evenly distributed in the body.'

STAGES OF LIPOEDEMA

There are four stages of lipoedema, although there are various ways that these are classified. Generally, stage one is where someone would first notice a change in their lower leg or ankle shape. 'At stage two, you have the beginnings of the skin dimpling and there may also be some changes at the knee,' explains Anne. 'At stage three, there is a more obvious enlargement at the knee and further loss of leg shape. By stage four, lipoedema is reclassified as lipo-lymphoedema [lymphoedema that is secondary to lipoedema]. People may also have chronic oedema, redness on the legs and a history of cellulitis. In addition, some women will also have lipomas [harmless fatty lumps that grow under the skin] that you will be able to feel.'

Movement between the stages varies and some people do not progress from one stage to the next, so it is possible to have a mild form of the condition. 'Often, the change can be triggered by life events, such as puberty, pregnancy, menopause and trauma,' explains Anne.

Diagnosis is based on clinical presentation. Anne has noticed that more GPs are now recognising lipoedema. This could partly be due to increased public awareness as a result of the experience of Shaughna Phillips, a *Love Island* contestant in 2020. Shaughna received cruel taunts on social media while on the show because of how her legs looked. After learning, following the show, that she had lipoedema, she had 2.5 litres of fat removed via liposuction surgery in September 2020.



Awareness could also be growing as a result of an online course for GPs and primary care practitioners to improve diagnosis, treatment and management of patients presenting with lipoedema symptoms. The e-learning course was developed by the Royal College of General Practitioners (RCGP, 2018) in partnership with Lipoedema UK.

CHRONIC LIPOEDEMA

Lipoedema UK was invited last year to contribute to the development of NICE guidance on non-cosmetic liposuction in the treatment of chronic lipoedema. The final guidance will be published later this year (NICE, 2022).To provide insight, Lipoedema UK surveyed its members on non-cosmetic liposuction and other treatments (Lipoedema UK, 2021a). When asked about quality of life, 91% said they had mobility issues, and 79% said lipoedema had a moderate to severe impact on their general health. Almost all respondents experienced pain, swelling, discomfort and heaviness in areas affected by lipoedema.

When asked about how lipoedema affected their psychological health, 86% reported having mental health issues including anxiety and depression. And 97% said lipoedema had a moderate to severe impact on their confidence and self-esteem. Living with lipoedema also affected their ability to work and to enjoy social activities and family life. All respondents said day-to-day living is affected.

'Our survey found the majority of women first noticed symptoms at the age of 11 to 18 but most didn't get a diagnosis until 20-plus years later,' says Kate Forster, a trustee of Lipoedema UK. Kate has personal experience of living with lipoedema as it has affected both her and her mother. While Kate has been able to treat her condition successfully through private liposuction surgery, her mother has had a far worse experience. 'My mum got married at 19, had me when she was 20 and my brother at 23,' Kate explains. 'By the age of 30, she was unable to walk properly.' But Kate's mother wasn't diagnosed until decades later, when her condition was at an advanced stage.

Kate's symptoms began when she started puberty but she wasn't diagnosed until her mother learned that she had it. 'I was underweight until I hit puberty and suddenly became the right weight for my height. I had stretchmarks down the front and back of my thighs. They

were very visible and I felt very self-conscious.'

There appears to be a strong genetic and hormonal link. Hormonal changes – during puberty, during and after pregnancy, around the menopause and while taking the contraceptive pill – can lead to the onset or worsening of lipoedema (Lipoedema UK, 2021b; NHS, 2020). Earlier diagnosis could help women have an informed discussion about finding the right contraceptive and lifestyle options that won't worsen their symptoms, says Kate.

'Although there is limited evidence around contraceptive management with lipoedema, our members' anecdotal feedback is that chopping and changing contraceptive options can be unhelpful.'

In Scotland, charity Talk Lipoedema received confirmation at the end of 2021 that the Scottish Government will provide additional funding to further increase their support provision. Talk Lipoedema have also been tasked with developing a pathway for lipoedema care in Scotland.

MANAGING SYMPTOMS

Lipoedema has no cure, but there are ways to effectively treat and manage it to improve quality of life. Those with the condition should be encouraged to learn more about it, eat well, drink plenty of water and minimise their intake of foods that promote inflammation. Regular exercise can help to improve lymphatic drainage, strengthen muscles, maintain joint mobility and prevent weight gain. But when the legs are heavy and painful, keeping fit isn't easy. Compression garments can be particularly helpful, says Kate. 'Sports or medical compression clothing can help women to feel more supported and comfortable whenever they exercise.'

Low-impact activities such as swimming, aqua classes, cycling, yoga and pilates are popular fitness options. Learning how to carry out self-treatments based on manual lymphatic drainage, a gentle type of massage, can also help to provide symptom relief. Keeping the skin moisturised is important and some women enjoy dry skin brushing, although care must be taken not to damage the skin.

When symptoms are more severe, liposuction may be needed. However, this might not be available on the NHS, and that's why women such as Kate choose to go private. In 2016, 1.9 litres of fat was removed from her legs. 'Surgery has hugely improved my quality of life,' she says. 'My balance has improved and my legs are no longer tender and painful. The only discomfort I get now is during long car journeys.'

Some women also develop chronic pain and end up on medications such as gabapentin and various opioids long-term. Anne says it tends to be women who haven't received much medical support and haven't understood their condition, meaning it has worsened over the years. 'People on strong pain medication need access to specialist services such as chronic pain clinics. But there can be a lack of understanding about lipoedema in external services and that can be difficult for patients,' she says.

'Community practitioners such as school nurses and health visitors can help by keeping lipoedema on their radar. They can also play an important role in signposting women who may have potential signs of lipoedema to get more information.'

ISTOCK

CHARACTERISTICS OF LIPOEDEMA

- Almost exclusively affects females
- Age of onset is usually 10 to 30
- Family history link is common
- Usually bilateral and symmetrical, without involvement of the hands and feet
- Weight loss will be disproportionately less from lipoedema areas
- Skin bruises easily, often with no known cause
- Skin may have the texture of orange peel and have larger dimples
- Skin is often painful and tender
- Hypersensitivity to touch in the affected areas
- Consistency of affected skin is soft, cooler and may also be looser.

Wounds UK, 2017

RESOURCES

- Lipoedema UK **lipoedema.co.uk/about-lipoedema**
- Lipoedema UK's LEGacy – younger members have started a project for young people with lipoedema **instagram.com/lipuk_legacy**
- LEGacy information for young people **bit.ly/LEGacy_lipoedema**
- Talk Lipoedema in Scotland **talklipoedema.org**
- NHS advice on lipoedema **nhs.uk/conditions/lipoedema**

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Your work in print

RESEARCH

ABRIDGED VERSION

TRANSITION TO ADOPTIVE PARENTHOOD: A CONCEPT ANALYSIS

Tracey Long, Catriona Jones, Julie Jomeen and ***Colin R Martin***

define transition to adoptive parenthood and identify associated experiences and challenges, when becoming parents by adoption.

RESEARCH SUMMARY

- This paper aims to conceptualise transition to adoptive parenthood.
- The transition is acknowledged in universal health services and recognised in the role played by community practitioners, in particular health visitors, within 'high-impact area 1.
- The specific needs of transition to adoptive parenthood can be overlooked or conflated with transition to biological parenthood.
- A literature review was undertaken and, in line with Rodgers (2000), antecedents, attributes and consequences were identified.
- Understanding transition to adoptive parenthood through concept analysis has been useful in highlighting to community practitioners the importance of context when considering adoption and also the circumstances preceding adoption (antecedents) as a route to parenthood.
- Transition to adoptive parenthood is contextual and should therefore be understood in the context of the situation and circumstance of those becoming parents.

BECOMING A PARENT is a key life transition. Transition to parenthood refers to the period following the birth of the first baby and the early weeks. In the case of adoption, when parents don't experience 'preconception', or the 'birth of the first baby', transition to parenthood is less clear.

Transition to adoptive parenthood is lacking in definition, and risks being grouped with transition to biological parenthood. This could result in specific needs being overlooked or not understood in the context of preconceived ideas or assumptions.

This paper shares findings from a concept analysis undertaken to advance knowledge of transition to adoptive parenthood, offer a working definition of transition to adoptive parenthood and inform services for children, young people and families. It is deemed relevant for health visitors, school nurses, looked after children's nurses, community nursery nurses, and other practitioners working with adoptive parents.

METHOD

This concept analysis uses the evolutionary approach of Rodgers (2000), thought relevant when considering a concept which can change over time and influenced by the context to which they are used. This was important when understanding 'transition to adoptive parenthood', related to policy, law, and understanding within different disciplines, including health and social care.

It was important to understand significant literature and therefore a review of books was undertaken, identifying seminal work and key authors, considered important for the concept analysis. Kirk (1984), whose findings included role handicaps of adoptive parents when adopting children, Goldberg (2010), who explored the differing parenthood trajectory for adoptive parents, and Goldberg (2012), highlighted the experiences and challenges for adoptive dads identifying as gay.

A review of the literature was also undertaken, shown in **Figure 1**. This concept analysis utilised thematic analysis, chosen because it was considered a flexible yet structured approach to conceptualise transition to adoptive parenthood (**Figure 2** on **page 46**) by identifying antecedents, attributes and consequences.

ANTECEDENTS

Understanding antecedents of transition to adoptive parents is important for informing discussions with adoptive parents during the needs assessment process, supportive of the community practitioner considering parental experience, prior to the placement of a child.

Identity transformation

A priority of becoming parents was present (Moyer and Goldberg, 2017), with parenthood being desired from the start of marriage (Bejenaru and Roth, 2012) and for some expected as a sequel to marriage (Daly, 1988). Daly (1988) suggests that

FIGURE 1: LITERATURE REVIEW FLOW CHART

before adoptive parents can identify with adoptive parenthood they need to relinquish biological parenthood, requiring a transformation of identity.

Decision to become a parent by adoption

This decision was highlighted in numerous papers. Weir (2003) highlighted infertility as the main reason for the decision to adopt.

Application, assessment and training

Dance and Farmer (2014) highlighted the application process and the adoption process. The latter was also referred to in several other papers.

Exclusive decisions

Adoptive parents are required to make decisions, exclusive to adoption, including child characteristics (Tasker and Wood, 2016; Gianino, 2008), level of disability, behaviour, number of children, (Dance and Farmer, 2014), regarding the adoption agency (Gianino, 2008) and pertaining to parental history of drug or mental health.

ATTRIBUTES

Understanding the attributes of transition to adoptive parents differentiates it from transition to parenthood, by birth. Several attributes were identified.

Becoming parent by order of court

This forms a 'legal relationship' Ryan and Whitlock, 2007), requiring assessment of parental fitness (Senecky et al, 2009).

Becoming parent without pregnancy

Adoptive parents are denied thepregnancy experience. Issues with this were identified including a lack of due date (Sandelowski et al, 1991), no cues afforded by pregnancy (Brodzinsky and Huffman, 1988) and lack of scans and other sources of information (Sandelowski et al, 1993).

Becoming parents to an infant or child (notbaby)

Several age groups for children adopted were identified, including under or mostly under one-year-olds (Daniluk and Hurtig-Mitchell, 2003), an average age at placement being two years and seven months (Meakings et al, 2016). Ages were wide-ranging, from newborn to 15 years old (Moyer and Goldberg, 2017), two months of age to 11 years old (Messini and D'Amore, 2018) and between five months and five years of age (Bejenaru and Roth, 2012).

Becoming parents to a child not biologically their own

This attribute could raise issues about meeting the child (Lewis, 2018; Bejenaru and Roth, 2012), parental legitimacy (Daniluk and Hurtig Mitchell, 2003) and child responsibility (Bejenaru and Roth, 2012; McKay and Ross, 2010). Furthermore, 'issues' or 'needs' may present with the children, from historical trauma (Foli et al, 2017), past abuse or neglect (Meakings et al, 2016, Tasker and Wood, 2016; Brodzinsky and Huffman, 1988) or in utero exposure to drugs, alcohol and domestic violence, or from having different homes prior to placement (Meakings et al, 2016).

Unpredictable timeline

An unpredictable timeline was highlighted in several papers, from sudden and unpredictable (McKay and Ross, 2010)to being experienced over years (Ryan and Whitlock, 2007).

Exclusive support requirements

Exclusive support needs were evident, relating to the child's history and therapy (Goldberg et al, 2014; Identity (Daniluk and Hurtig-Mitchell, 2003), foster carers (Lewis, 2018; Bejenaru and Roth, 2012), and communication with the child, (Bejenaru and Roth, 2012).

TRANSITION TO ADOPTIVE PARENTHOOD, IN CONTEXT

Adoptive parents were found to be typically older than biological parents (Canzi et al, 2019a). Adoptive parents were found to have positive educational achievement and employment. They had above average education and occupational status levels (Daly, 1988) and were highly educated (Gianino, 2008; Ryan and Whitock, 2007). There was a predominance, when considering ethnicity, of Caucasian, white or white British adoptive parents (Tasker and Wood, 2016; Goldberg et al, 2014; Daniluk and Hurtig-Mitchell, 2003).

The sexual orientation that adoptive parents identified with included gay or lesbian (Goldberg and Smith, 2011), lesbian (Ryan and Whitlock 2007), gay (Gianino, 2008) or lesbian, gay and heterosexual couples (Goldberg and Smith, 2009; Goldberg et a. 2010; Goldberg et al, 2014).

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Louise Wolstenholme*, *Jo Cooke*, *Lisa Manlove* and *Tracey Long

discuss sharing good practice when developing a 0 to 19 research network.

A NEW VISION FOR RESEARCH

In November 2021, the chief nursing officer (CNO) for England launched the first strategic plan for nursing research with a vision 'to create a people-centred research environment that empowers nurses to lead, participate in and deliver research, where research is fully embedded in practice and professional decision-making' (NHS England and NHS Improvement, 2021). This vision builds on that of the National Institute for Health Research (NIHR) which has a 'mission to improve the health and wealth of the nation through research' (NIHR, 2021).

There is a growing body of evidence that demonstrates research conducted alongside practice improves the quality of care provided. For example, a study reviewing embedded research practitioner positions describes the benefits of increased research activity and collaborations, service improvements and workforce skills development and an enhanced research culture (Wenke et al, 2017). Boaz et al (2015) suggest that having research as part of organisational structures contributes to improved healthcare performance and describes this as a 'by-product' of the research itself.

This paper describes a research network developed over eight years that resonates and reflects such a vision in practice for 0 to 19 practitioners. In most instances, specialist community public health nurses (SCPHNs) have undertaken a postgraduate qualification and are well placed to participate in research, but we often lack confidence to do this. Developing a research network can be a good first step. It supports a collective approach that brings interested people together and enables research capacity.

Our ambition was to support research 'close to practice' in four ways:

- First, by **using** research in practice.
- Second, by **delivering** research in practice through recruiting children and families into ongoing research. It can also include delivering intervention projects, where practitioners learn new skills and evaluate impact on families.

- Third, by **developing and leading** research. This is ideally done within practice, academic posts and partnerships.
- And finally, through **co-production and priority setting** where practitioners help identify research priorities and participate in the design of the research from inception onwards.

BACKGROUND TO THE NETWORK

The 0-19 Research Network Yorkshire and the Humber (Y&H) is a pioneering initiative aimed at public health professionals working within 0 to 19 services. Health visitors and school nurses are our key audience.

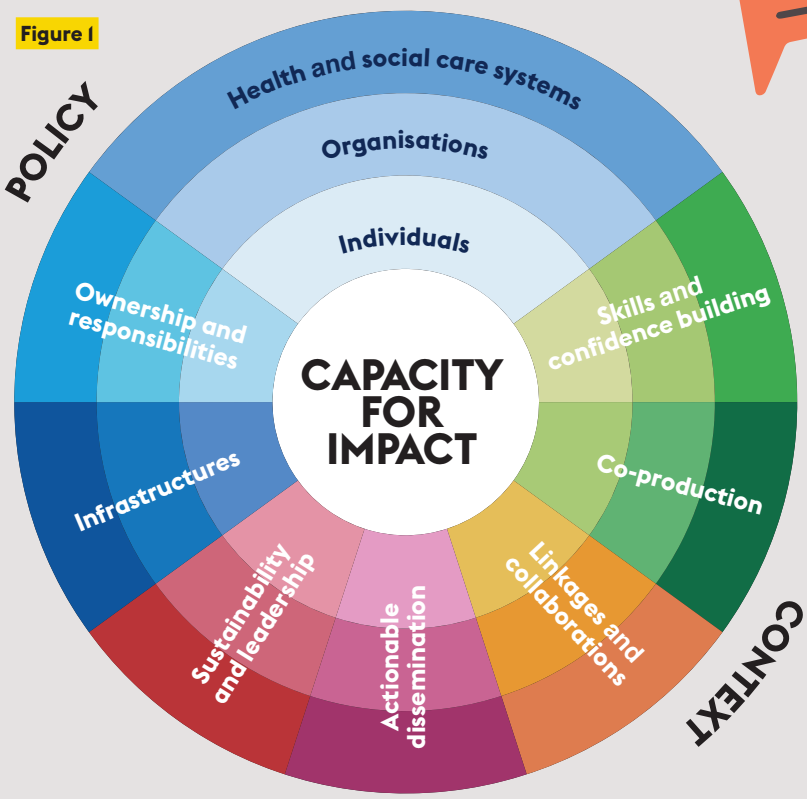
Formerly known as the North of England Health Visitor Research Network, it was created in 2013 by academics from Sheffield Hallam University and the University of Central Lancashire. At its outset it postulated that a facilitative approach could support research capacity-building, provide learning opportunities and start to inspire knowledge generation.

In 2016, a collaboration with the Y&H NIHR Clinical Research Network (CRN) was established, which supported further meetings, networking and increased reach whereby membership included others with an interest in 0 to 19 public health research, such as school nurses, public health practitioners, commissioners and managers. The objectives then included research delivery as an additional function.

In December 2020, the 0-19 Research Network was relaunched and became hosted by 0 to 19 services at Sheffield Children's NHS Foundation Trust. It is run by a practitioner project group following the retirement of its founding member. The network includes members from most NHS trusts/local authorities. Our aims are:

- To increase research engagement and capacity of public health professionals working with the 0 to 19 age group (building research capacity and engagement).
- To support and increase the participation and recruitment of children and families in health services and public health research (research delivery).

Figure 1



OUR EXPERIENCE IS THAT DEVELOPING A RESEARCH NETWORK SUPPORTS A COLLECTIVE APPROACH THAT BRINGS INTERESTED PEOPLE TOGETHER AND ENABLES RESEARCH CAPACITY

CAPACITY FOR IMPACT

The network has been guided by the research 'Capacity for Impact' framework (Cooke, 2021; 2005) shown in **Figure 1**, which includes seven principles that aim to guide and evaluate research capacity interventions like a research network. Many of the examples of achievements, challenges and interventions are influenced by several of the seven principles, demonstrating the interconnectedness and complexity of research capacity development. It also serves to identify gaps and future planning while recognising achievement.

Skills and confidence building

Our network has helped to build research skills and confidence in practitioners. We host an email-sharing platform and run virtual events for members where practitioners, researchers, academics, managers and commissioners have an opportunity to get together and share ideas and research. We disseminate research training opportunities and promote our online learning events. Members have gained personal research internships and PhD opportunities (see **Table 1**), and we believe the network itself is a learning environment that 'brings research within reach' to practice. **Table 2** highlights topics presented at meetings.

Linkages and collaborations

Our network helps to share knowledge between professionals and researchers,

SHUTTERSTOCK

TABLE 1: PERSONAL AWARDS AS A DIRECT RESULT OF THE 0-19 NETWORK

- Six members have achieved Health Education England-NIHR integrated clinical academic internships, and one member has achieved a Collaboration for Leadership in Applied Health Research and Care research internship (impact examples: establishing a dental health intervention, evaluating Pregnancy, Birth and Beyond© programme, undertaking a systematic review of dietary interventions, and developing a local community of research practice).
- One member on the NIHR 70@70 Senior Nurse Research programme (three-year funded secondment with a focus on building research capacity within 0 to 19 services).
- One member secured funding for a part-time PhD, alongside a change of role focus to that of building research capacity.
- One member on the NIHR/CRN First Steps into Research programme.

and between research-interested practitioners. We also explore experience and options for current and future postgraduate study. Importantly, we share ideas and vision for future service development, evaluation and research, and help practitioners get involved with small studies.

During the pandemic we have moved to virtual meetings, which has enhanced opportunities to engage with researchers regionally and nationally. The Institute of Health Visiting (iHV) and the School and Public Health Nurses Association (SAPHNA) have both endorsed the network, and their respective chief executives have presented on research priorities (**Table 3**).

We have worked collaboratively with researchers and other key stakeholders (for example, the iHV) on research projects that improved service delivery. These 'close to practice' intervention projects have a short route to impact and research benefit is felt quickly by services. This promotes and maintains enthusiasm and interest in the workforce, which can positively impact on staff retention.

Actionable dissemination

Projects that improve services and promote action stimulate motivation and capacity to do more. Intervention studies provide opportunities to promote impact and action. But unfortunately, such studies for HV practice are minimal. We also recognise that if practitioners are involved from the outset including identifying research needs, and influencing design, there is an increased likelihood for developing relevant findings and actionable recommendations and research outputs (Greenhalgh et al, 2016). We therefore promote further collaboration between practitioners and academics to work together co-productively. We are also undertaking research priority setting to shape work, for example engaging with other research/researchers.

WE SHARE IDEAS AND VISION FOR FUTURE SERVICE DEVELOPMENT, EVALUATION AND RESEARCH, AND HELP PRACTITIONERS GET INVOLVED WITH SMALL STUDIES

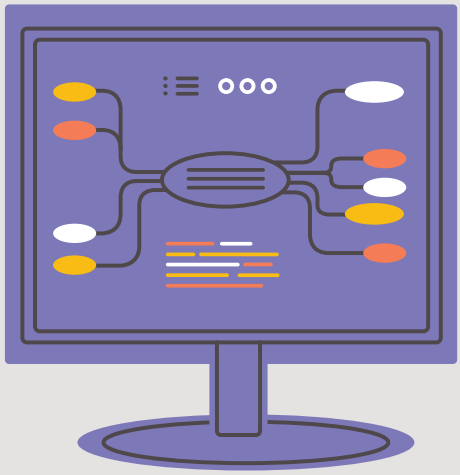
Ownership and responsibilities

Three smaller geographically dispersed communities of research practice (CoRPs) have developed with the support of our network promoting ownership and responsibility to research at an organisational level. These groups have a recognised lead and meet regularly in their host organisation and we have shared how to set these up and adapt terms of reference. They have an overarching aim to increase research capacity at an organisational level through supporting delivery of externally funded research projects; developing and conducting research, service evaluation and audit; participating in and delivering training; implementing research findings into practice; discussing innovative practices; networking and supporting staff development; and offering postgraduate peer support.

Sustainability and leadership

Building research capacity is challenging when research is not seen as core business within services. We have experienced that staff that have completed the NIHR/Health Education England ICA internships then leave practice for academia because this offers research career progression. Such roles and research career pathways in 0 to 19 services hardly exist and need managerial support.

Embedding research as a core business within services requires a shift in culture and a drive from leadership to transform services. Our network advocates for this to happen, as we recognise this as a block in getting research close to practice. While we welcome the financial support from the CRN, applying for this annually is also a challenge for sustainability of our network.



Co-production

We see this is where the greatest progress could be made. Our experiences have shown that 0 to 19 services are approached as potential sites once the research project has been written and funded. This is too late. Moving forward, we hope to strengthen collaborations with academics and be considered earlier in the research process and be funded as clinical collaborators to make this happen.

Infrastructure

Infrastructure spans a variety of organisational systems. The CRN supports and funds our network, providing administrative support, leadership time, room bookings, travel, materials and media costs. In return, our network helps to deliver research. We have also developed an infrastructure at an organisational level through the CoRPs. These enhance access to organisational infrastructure, including R&D departments, library services and service improvement departments. Infrastructure is vital as it provides the space to meet, collaborate and innovate.

AMBITION

Families are now being invited to take part in research in Y&H that has the potential to impact on their health outcomes, and practitioners are gaining new knowledge and skills through research which positively affects the care they give.

This achievement is all the greater for having been delivered at a regional level, enabling practitioners who often work in local silos to share best practice and learn from one another in a way that has never previously happened. However, we have described some difficulties and issues, particularly in relation to embedded research practitioner roles and funding to support sustainability.

There is a momentum behind SCPHN research, and there are policy drivers to make it happen through the CNO for England's strategic plan (NHS England and NHS Improvement, 2021), the Care Quality Commission Strategy encouraging research and innovation (CQC, 2021) and the draft *Standards of proficiency for specialist community public health nurses* (NMC, 2021).

The CNO's vision of an empowering research environment for nurses could include running journal clubs, undertaking research projects, completing a service evaluation and evidence-based improvements, contributing to a paper, supporting individuals as clinical academics and creating research roles in practice.

We have described how a network can enable this. Ours was initially created by academics but is now led by practitioners demonstrating how close to practice research can happen. It has been pivotal in providing research successes within our region. We believe this approach can be mirrored elsewhere and would contribute to the CNO research vision.

TABLE 2: TOPICS PRESENTED AT MEETINGS

- Building a research network – Louise Wolstenholme
- How and where the O-19 Research Network might work – Professor Jo Cooke
- Research readiness and clinical academic careers: a personal account – Tracey Long

TABLE 3: COLLABORATORS' RESEARCH PRIORITIES

- Reporting the findings from the iHV State of Health Visiting survey and future research priorities – Alison Morton, iHV director
- A call to arms for research by SAPHNA – Sharon White OBE, CEO, SAPHNA

Louise Wolstenholme is O to 19 services research lead and health visitor, Sheffield Children's NHS Foundation Trust, and NIHR 70@70 senior nurse research leader; Jo Cooke is professor of research capacity building at the Health Sciences School, University of Sheffield; Lisa Manlove is O to 19 services team leader and health visitor, Sheffield Children's NHS Foundation Trust; Tracey Long is community practice educator and PhD researcher, Children's Care Group, Rotherham Doncaster and South Humber NHS Foundation Trust.

ACKNOWLEDGEMENTS

We would like to thank the CRN for funding the O-19 Research Network, and the project group from the research department at Sheffield Children's NHS Foundation Trust, alongside the speakers who have presented at our events, for their support.

For references, visit **bit.ly/CP_P_features**

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HEART ATTACK GENDER GAP

It's a common misperception that heart disease is a 'man's disease' and doesn't affect women. In fact, coronary heart disease (CHD) kills more than twice as many women as breast cancer in the UK every year (British Heart Foundation (BHF), 2019a). It is also the single biggest killer of women worldwide (World Economic Forum, 2021). In the UK, 830,000 women are currently living with CHD and 35,000 women are admitted to hospital following a heart attack each year – an average of 96 women a day, or four every hour (BHF, 2019a).

At Heart Research UK, we want to challenge the misperception of heart disease as a 'man's disease' and encourage women of all ages to take action to look after their heart health, and to understand the risks and recognise the symptoms of a heart attack. As community practitioners (CPs), you can play a major role in this.

NEEDLESS DEATHS

A survey by Heart Research UK, produced in conjunction with Damart, questioned over 4000 women about their understanding of their heart health and found that:

Heart disease is the single biggest killer of women, so why is it still labelled a 'man's disease'? ***Helen Wilson*** from Heart Research UK on raising awareness and encouraging women to look after their heart health.

- A third (33%) of women have never had their blood cholesterol level checked
- Nearly half (48%) have never had their blood pressure checked or not had it checked in the last six months
- More than half of the women questioned (58%) were unaware that their risk of CHD increases after the menopause (Heart Research UK, 2017).

These startling statistics underline women's limited awareness of their own risk of developing CHD, and lack of knowledge of the importance of medical and lifestyle risk factors.

CHD is usually the cause of heart attack. Contrary to popular belief, research conducted at the University of Edinburgh (Ferry et al, 2019) has found no difference in key heart attack symptoms between men and women. Chest pain was found to be the most common symptom in type 1 myocardial infarction, with 93% of both sexes reporting this. Similarly, both men and women reported pain that radiated to their left arm (48.4% and 48.9% respectively).

The conclusion of the research was that incorrectly assuming that women having a heart attack suffer different symptoms from

men could lead to misdiagnosis, delayed treatment and less intensive medical interventions.

But women having a heart attack tend to delay getting medical help longer than men because they are less likely to recognise the symptoms, which in turn reduces their chances of survival (BHF, 2019b).

Notably, women are not taking part in clinical trials to the same extent as men and have therefore been under-represented in clinical research (BHF, 2019b). Consequently, the development of diagnostic techniques and treatments for cardiovascular disease have been based on research conducted primarily on men.

Wu et al (2018) has shown that women have a 50% higher chance of receiving the wrong initial diagnosis after a heart attack, and so are less likely than men to promptly receive the life-saving treatments they need. In addition, research has found that women were about half as likely as men to receive recommended heart attack treatments (Lee et al, 2019). This means that women with CHD are dying unnecessarily from heart attacks and have worse outcomes than men because they do not receive the same care and treatment.

The resulting differences in care for women have been estimated to have contributed to over 8243 avoidable deaths in England and Wales over a decade (BHF, 2018).

Our CEO, Kate Bratt-Farrar, says, 'In light of these numbers, we are really urging women to take action to understand the risk factors for CHD, such as high blood pressure, high cholesterol levels, a family history of CHD, smoking, obesity and diabetes.

'After menopause, these factors may be more likely to lead to CHD in women. We need your help to remove the gender inequalities in heart attack diagnosis and treatment, and work to prevent these avoidable deaths.'

'WE NEED YOUR HELP TO REMOVE THE GENDER INEQUALITIES IN HEART ATTACK DIAGNOSIS AND TREATMENT'

It has been found that pre-menopause, women in general have a lower risk of developing CHD than men. It is thought that oestrogen, a naturally produced hormone, helps to control cholesterol levels and reduces the risk of fatty plaques building up inside artery walls. Therefore, oestrogen may provide some protection against CHD, resulting in pre-menopausal women being less likely to develop the condition than men (Mehta et al, 2016).

However, the onset of menopause can have a significant effect on a woman's susceptibility to CHD due to declining levels of oestrogen (Mehta et al, 2016).

WHAT CAN YOU DO?

We've now established that women need to become aware of their risk of developing CHD and have a better knowledge of the importance of both medical and lifestyle risk factors. These are all areas where CPs can have a significant impact on their communities, to support, raise awareness and advise women.

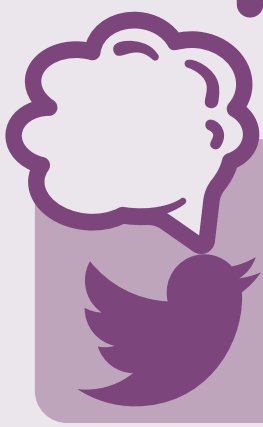
Encouraging women to take advantage of the NHS Health Check is a great way to start. According to the NHS, during its first five years, this programme is estimated to have prevented 2500 heart attacks or strokes (NHS, 2019).

Lifestyle factors that impact negatively on heart health include poor diet, being overweight, low physical activity levels, smoking and excessive alcohol intake. As a CP, talking to women about their current lifestyle habits and helping them to identify where changes can be made to improve their heart health is a good start. Discussing the barriers to behaviour change, such as a lack of time or money, and helping women to find solutions that suit them, without being judgemental about their lifestyle choices, can be empowering and motivating. CPs should be aware of up-to-date resources available to support women in making and maintaining healthy lifestyle changes. For example, the NHS Better Health website supports people to lose weight, get active, stop smoking and reduce their alcohol intake.

Helen Wilson is head of research at Heart Research UK and has worked for the charity since 2008. She is responsible for the strategic planning of the charity's research activities and management of the research portfolio, ensuring that Heart Research UK supports high-quality projects.

RESOURCES

- Heart Research UK **heartresearch.org.uk**
- HRUK information on heart attacks **bit.ly/HRUK_heart_attacks**
- NHS Health Check **nhs.uk/conditions/nhs-health-check**
- NHS Better Health **nhs.uk/better-health**



TIME TO REFLECT

How can you encourage women to improve their heart health? Are your clients aware of the risk factors for CHD? Join the conversation on Twitter using #WomensHeartHealth via **@heartresearchUK @CommPrac**

For references, visit bit.ly/CP_features

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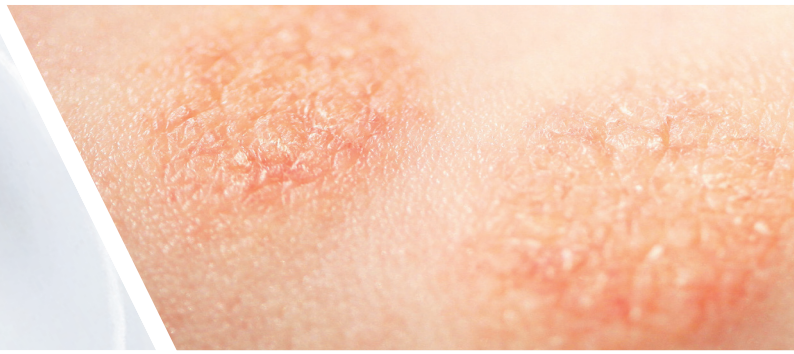

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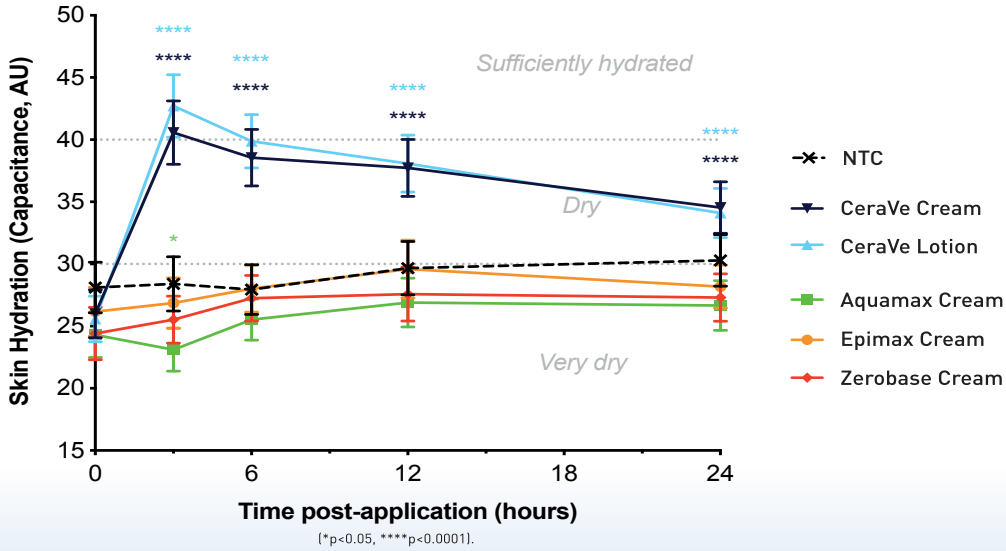

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[1]"An investigation of the skin barrier restoring effects of a cream and lotion containing ceramides in a multi-vesicular emulsion in people with dry, eczema-prone, skin: THE RESTORE STUDY PHASE 1" Danby SG, Andrew P, Kay L, Pinnock A, Chittock J, and Cork MJ