Recent Women’s Health Strategies, published in Scotland1 and announced for England,2 are a welcome recognition that for too long women have lived within health and care systems designed mostly for men, by men.2 Their explicit focus on women’s health needs throughout the life course is sorely needed.

Women face significant health inequalities across their lives. Although women typically live longer than men, fewer of those years are in good health.2 Those living in social and economically deprived settings experience even poorer outcomes.3 These inequalities have been exacerbated by the COVID-19 pandemic, including increased period poverty,4 increased domestic violence,5 and women carrying a greater burden of home schooling and unpaid care work.6

WHAT COULD (OR SHOULD) THIS MEAN FOR PRIMARY CARE?

Primary care needs to be at the heart of any strategy to support and enhance women’s health. Primary care can (and does) play a central role in supporting women from before menarche to the menopause and beyond. GPs support women who might never need (or want) specialist input from secondary care. However, even where women are supported in secondary care, the GP’s role encompasses care before, during, and beyond periods of specialist or focused resources, education, and services that will enable GPs to support patients throughout the life course, and across their physical, psychological, and social wellbeing needs.

Women’s health and primary care: time to get it right for the life course

“Evidence and resources that understand the role of primary care in women’s health and recognise the complexity of what primary care can and does do, are needed in order to optimise this capability and potential.”

... this is an opportunity to call for primary care focused resources, education, and services that will enable GPs to support patients throughout the life course, and across their physical, psychological, and social wellbeing needs.”

Women’s health is often narrowly focused on reproductive health but, in primary care, GPs care for all of women’s health needs throughout the whole life course. Evidence and resources that can inform and support holistic and longitudinal care are needed yet currently lacking in many areas of women’s health.

In our work on endometriosis12 and female genital mutilation (FGM),13–14 we found that the majority of evidence deployed in primary care is derived from specialist settings and then extrapolated back to the primary care setting, where the populations and needs may significantly differ.

Most women across the spectrum of women’s health (before adolescence to menopause and beyond) are cared for exclusively in primary care, with a relatively small number of women referred for specialist care. Those who are referred are more likely to have symptoms that are difficult to understand or manage, or more complex health needs. Using evidence and guidance predominantly derived from specialist settings presents a denominator problem for primary care clinicians trying to determine risk, share decisions, or advise on management options, where the knowledge and evidence relates to a different population from the one they are working with. For example, the National Institute for Health and Care Excellence guidance on endometriosis suggests that referral for specialist care is considered if symptoms are not controlled with first-line therapies such as hormonal treatment or non-steroidal anti-inflammatory drugs.15 This leaves GPs facing uncertainty about how to support women with impactful period pain, whose symptoms are well controlled with first-line therapies, against the backdrop of widespread reporting of delayed referrals to specialist endometriosis clinics.12

Another example is the predominance of FGM research in obstetric and midwifery
settings resulting in a lack of evidence or resources for how GPs might support women with FGM beyond their reproductive years and through the menopause.11 Where potential gaps in care are identified, all too often the conclusion is that GPs lack knowledge and awareness, and that increasing these would improve care.12 However, our work on endometriosis demonstrates GPs are rarely working with a lack of knowledge, but rather engage with complex and nuanced considerations. They are already balancing multiple possibilities and involved in complex shared decision making with women based on knowledge about known uncertainties and the challenges at the primary to secondary care interfaces.

CONCLUSION

These new Women’s Health Strategies offer opportunities to put primary care at the heart of enhancing women’s health throughout the life course. But to achieve this we need evidence and knowledge developed with, from, and for primary care.

We need to ensure that the services and resources developed in response to these strategies do not become too symptom or condition specific, risking compartmentalising women’s lives and bodies into organs, conditions, and phases of life. Instead, this is an opportunity to call for primary care focused resources, education, and services that will enable GPs to support patients throughout the life course, and across their physical, psychological, and social wellbeing needs.

Within primary care, there are opportunities to identify and mitigate against health inequalities in women’s health, which would benefit all of society.

Primary care’s huge strength is being there for the journey. It would be a missed opportunity if the conclusion and outcome of these consultations defaulted to an explanation of ignorance and to pilloying GPs to simply know more.

Instead, we urge policymakers to positively utilise the wisdom and experience of GPs and patients, in research and consultation, to support an effective and meaningful women’s health strategy inclusive of primary care.

Sharon Dixon,
GP and Researcher, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford.

Abigail McNiven,
Senior Qualitative Researcher, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford.

Anne Connelly,
GP, Bevan House Healthcare, Bradford; Chair, Primary Care Women’s Health Forum; Clinical Champion, Royal College of General Practitioners Women’s Health.

Lisa Hinton,
Senior Research Associate, The Healthcare Improvement Studies Institute, University of Cambridge, Cambridge.

Open access
This article is Open Access: CC BY 4.0 licence (http://creativecommons.org/licenses/by/4.0/).

REFERENCES
10. It’s time to expand the definition of ‘women’s health’. Nature 2021; 596(7870):7.

ADDRESS FOR CORRESPONDENCE
Sharon Dixon
Nuffield Department of Primary Care Health Sciences, University of Oxford, Radcliffe Primary Care Building, Radcliffe Observatory Quarter, Woodstock Rd, Oxford OX2 6GG, UK.
Email: sharon.dixon@ph.ox.ac.uk

Funding
Lisa Hinton, Sharon Dixon, and Abigail McNiven’s work on endometriosis in primary care, including this editorial, were funded by the National Institute for Health Research (NIHR) School for Primary Care Research (project number: 403). The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care. Lisa Hinton is based in The Healthcare Improvement Studies Institute (THS Institute), University of Cambridge. THS Institute is supported by the Health Foundation, an independent charity committed to bringing about better health and healthcare for people in the UK.

Provenance
Commissioned; externally peer reviewed.

Competing interests
Anne Connelly has received funding for lecturing, which is documented in full on www.whopaysthesdoc.org. All other authors have declared no competing interests.

DOI: https://doi.org/10.3399/bjgp21X717713