Call for Evidence on Women's Health Strategy 2021.

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Written by

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This submission is written on behalf of the United Kingdom (UK) Preconception Partnership and the Venice Forum[†]. We are pleased to see the HM Department of Health and Social Care's (DHSC) initiative conduct this consultation to help inform the Women's Health Strategy. Policies arising from this consultation have the potential to benefit both women and the national economy. Such policies need to adopt coordinated multi-sectoral actions in reproductive, maternal, newborn, and child health (MNCH) that include a life-course approach built on scientific knowledge and strengthened healthcare systems, addressing long-standing inequities in health and independence suffered by women, and recognising that investment in women's health will benefit population health and wealth.

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Recommendations for key themes in the strategy

Based on some gaps in populations targeted in the consultation, we present recommendations for the strategy:

Theme 2: Improving the quality and accessibility of information and education on women's health

Training and resources for healthcare practitioners:

- **There is a need to provide training and support for healthcare practitioners to discuss pregnancy intentions and provide nutritional and health information at every contact with women in the reproductive age group and their partners, and to discuss preconception and pregnancy factors that affect maternal and offspring health.**
- Over one in five pregnant women in the UK have obesity (body mass index [BMI] ≥30 kg/m^2) and one in two have overweight.[1] However, despite the increasing evidence on the importance to mother and baby of obesity during pregnancy, and the related condition of gestational diabetes (GDM), translation of this knowledge into clinical and public health practice remains inadequate.
- Low prioritisation of preconception care, coupled with reduced support for prevention in health, for nutrition, weight management and other health advice, are inadequately communicated to women. In addition, women have reported feeling stigmatized by consultations related to the management of obesity.[2,3,4] Conversations with trained healthcare professionals that address women's most pressing needs effectively are required to address the issue.
- The International Federation of Gynecology and Obstetrics has developed a **simple nutritional risk assessment tool** that can be used to identify women with nutritional issues, as well as initiate a conversation on nutrition and healthy weight gain during pregnancy.[5] Pilot studies have shown that this tool not only helped healthcare practitioners to identify women with poor nutrition and diets likely to affect their pregnancy, but was also acceptable to women during early pregnancy. Similarly, training using techniques such as Healthy Conversation Skills helps conduct two-way active conversations about behaviour change and has shown promise for improving discussions in clinical settings.[6,7]

Information and education in schools:

- **Early intervention is key to preventing the development of overweight and obesity and associated non-communicable diseases such as cardiovascular disease and diabetes. Studies have effectively shown that young people and adolescents in schools can receive health messages related to preconception health and improve their health literacy. Mandatory Relationships education, relationships and sex education (RSE) in schools can use simple messages that health is something to be considered before any future pregnancy**.

- **Educational interventions need to be directed at all people of reproductive age, including young women and male partners,** to improve intergenerational health. A whole population approach for education on preparation for parenthood, life skills, scientific and digital literacy is recommended, along with increased engagement of teenagers and young people in conversations about healthy diets and prevention of non-communicable diseases. Young

people are largely unaware of the concept and importance of preconception health and the notion of necessary preparation for pregnancy. Our public engagement work with diverse groups of reproductive-aged people identified a desire to learn about pregnancy preparation, and suggests school-based education and social media campaigns supported by a trusted source such as the NHS are priority strategies to raise public understanding and awareness. These educational interventions will require **language and messaging that are meaningful and appropriate to young people which include language that is positive, encouraging, inclusive and gender-neutral where possible. Messages need to simple, specific and realistic**.

- Interventions based on health education can prevent obesity in adolescent boys and girls.[8] Novel interventions such as the LifeLab programme improve health literacy by giving young people the opportunity to carry out "hands-on" scientific experiments in a hospital setting, to understand how their diet and lifestyle (sleep, activity) can influence their health across their life-course. LifeLab is a collaboration between the University of Southampton, University Hospital Southampton and the City Council. It aims to improve knowledge, attitudes, and behaviour in young people about the risk of non-communicable diseases and how these can be transmitted from one generation to another. Its banner is "Me, my health and my children's health". A recent randomised controlled trial-based evaluation of the programme showed that the intervention led to a more critical judgement of adolescent's health behaviours and improved health literacy even a year after the intervention. [9]

Theme 3: Ensuring the health and care system is responsive to women's health and care needs across the life course

We welcome a life-course approach to reduce transmission of risk factors to the next generation and opportunities to engage with women and men in the reproductive age group.

- Maternal nutrition and lifestyle have important effects on offspring during childhood and later life (e.g. maternal folic acid and offspring neural tube defects; vitamin D intake and offspring bone health; maternal iodine status and offspring neurobehavioural development; maternal obesity and offspring non-communicable disease risk). Other modifiable influences include excessive gestational weight gain, maternal smoking, GDM and short duration of breastfeeding.[10, 11, 12]
- **Pregnancy preparation** is low in the UK with around 45% of pregnancies unplanned. [13, 14] Unplanned pregnancies have a higher risk of obstetric complications and antenatal and post-natal depression. In addition, inequalities exist in preconception health - more than 45% of adolescents who became pregnant under the age of 19 were in the lowest quintile of deprivation and had the highest rates of complex social problems in the population, including alcohol or drug misuse, being recent migrants or asylum seekers, difficulty with reading or speaking English and domestic abuse. Less than 10% of them took the recommended folic acid supplement in preparation for pregnancy. Major inequalities are also seen in the prevalence of obesity, with higher rates among more deprived areas. **We call for a strong focus on the preconception period and adolescent health to improve sexual and reproductive health and for obesity prevention strategies.**
- Another barrier in preconception care is the lack of clarity regarding which stakeholders have the responsibility to support pregnancy preparation and, for women who do not intend to

have a pregnancy, providing appropriate contraceptive support. While the responsibility for preconception health is not solely for the healthcare systems and should be part of economic planning and wider policies, we highlight opportunities in primary care for providing preconception care and recommendations for making preparing for pregnancy the norm. We encourage clinicians to routinely ask patients of reproductive age about their intention of having a baby/ pregnancy in the next year.[15] This will help in identifying their need for further support for pregnancy or effective contraception.

- Major international studies show that children of mothers who had overweight or obesity before pregnancy are at a higher risk of obesity,[16] but trials of maternal dietary lifestyle interventions *starting* in pregnancy have shown no impact on maternal or early childhood obesity.[17] Although pregnancy remains an important time for effective conversations between women and health care professionals about healthy lifestyles, **the preconception period is seen as an increasingly important life stage** to improve dietary behaviour and reduce obesity across two generations. [19, 20]
- Alongside preconception weight management to reduce the risk of childhood obesity and its consequences for the next generation, **correcting micronutrient deficiencies in women of reproductive age before pregnancy is essential.[12, 13]** We strongly endorse the mandatory fortification of flour with folic acid which will undoubtedly have a major public health impact to reduce the risk of neural tube defects.
- The **inter-pregnancy or inter-conception period also provides an opportunity** for targeted interventions at the clinical and community level, including home visits for women with a history of GDM or obesity. This is a time when couples can be engaged with the health issues affecting them and their children and the health care professionals involved are more easily defined. However, a multi-stakeholder approach that included both health and non-health professionals is needed to ensure care in the inter-conception period including GPs, health visitors, dieticians and nutritionists, health psychologists, community groups, local authorities and charities. Clinical stakeholders can contribute to this agenda through routine appointments, however, they will require empowering communication skills using behaviour change techniques, such as Healthy Conversation Skills. Risk assessments and intervention should be conducted based on previous pregnancies, for example through follow-up care after GDM.[20, 21,22,23] A recent meta-analysis of lifestyle interventions in women with GDM found that intervention implemented within 3 years of delivery (but not during pregnancy) led to a **43% reduction in the long term risk of type 2 diabetes.[24]** Thus evidence supporting targeted intervention at critical stages to reverse the increased risk of chronic disease in later life is now clear. Continuity of care is needed with a better bridge connecting the life stage across the reproductive period for each woman and consistent online and in-person support.
- **Inequalities in women's health:** There is a clear correlation between the effects of deprivation, socioeconomic status, education and poor diet quality and malnutrition. Low levels of income and education are associated with unhealthy diets and lack of physical activity and micronutrient deficiencies. Often, participation in interventions and uptake of information is higher among more educated and socioeconomically advantaged women, and public health programmes need to ensure that inequalities are not widened as a result. The recent ONS report[25] indicating higher rates of stillbirths among Black women further highlights the need to address inequalities. The urgency of attending to **MNCH as a prerequisite to improve population health and future economic prosperity** has not gained traction despite

evidence even before the pandemic of increasing rates of non-communicable diseases such as cardiovascular disease, diabetes, mental health issues and obesity having their origins in early life in the womb and early childhood.[26] We recommend targeted interventions for known high-risk groups for better support before and during pregnancy, as well as for prevention of non-communicable disease risk factors such as obesity. All antenatal and postnatal services (including contraception, abortion, and care during labour) should deliver full support, especially for women at a higher risk of complications. We also welcome the proposal to use evidence-based approaches to target inequalities in women's health.[27]

DHSC must recognise the connections between the long-term impact of improved MNCH on population health and the economy.

Theme 5: Ensuring research, evidence and data support improvements in women's health

- **Disaggregated data** by sex and gender are needed to understand the biological and sociocultural factors that influence women's health. Appropriate data collection is also needed for recognising the disadvantaged groups – particularly to understand the causes for a higher incidence of adverse maternal and newborn outcomes in BAME populations in the UK.
- **An annual report card[14]** was proposed in 2019 to describe and monitor preconception health in England using routine data sources. This is critical to determine the preconception health and care needs of people of reproductive age now and in the future. We have identified a comprehensive set of preconception indicators that can be assessed using national population-based datasets**. We are currently producing a first report card to describe the state of preconception health in England.** Recommendations will be developed for Public Health England and DHSC to ensure ongoing monitoring of improvements in preconception health and evaluation of the impact of policy changes.
- **Data collection and linkage should also extend beyond pregnancy, childbirth, and the immediate postpartum period. We recommend an initiative to establish a "Maternity and Newborn Data Hub" under the auspices of Health Data Research UK.** Further extending linkage of data beyond maternity and newborn services with routine data collected during preconception, interconception and childhood is needed to track individual reproductive health trajectories and model the impact of preconception interventions on maternal and child health and development. Such linkages are also being considered by the Ministry of Justice.[28] NHS Digital already collate, link and make available healthcare data from numerous NHS services, which should be extended to include national primary care data and data collections such as the Sexual and Reproductive Health Activity Dataset and the National Child Measurement Programme. Suggested indicators for preconception health have been collated in our recent review.[29]
- **Evidence from multiple sectors** needs to be considered while developing policies for women's health – including environment, housing, parental leave, and policies for supporting breastfeeding. **For example, parents can be empowered** to provide support for nurturing child care in the pre-school years, through paid parental leave (for either parent and incentivising men), home-visiting and community-based programmes which will have long-term benefit for the child's development and future productivity.

Theme 6: Understanding and responding to the impacts of COVID-19 on women's health

MNCH influences population health and socioeconomic resilience in both the short- and longer-term, from effects on educational and socioeconomic attainment to risk of non-communicable diseases across the life-course and across generations.

- **Lessons from previous socioeconomic shocks**, from natural calamities to the 2008 global financial crisis, show the adverse effects on pregnancy outcomes including growth restriction, preterm delivery, maternal and infant mortality and, longer-term, the passage of non-communicable disease risk across generations.[26, 30] Labour market prospects for women are likely to be more severely affected than men, widening existing gender inequalities. [31]
- There is much data showing that **investing in MNCH offers high rates of return in the medium- to longer-term**, in addition to reducing the burden of short-term outcomes such as maternal and child deaths and stillbirths,[32] particularly for children from low-income families. Interventions for early childhood health and development, including community health workers recommended by the recent WHO-UNICEF-Lancet Commission[33], have shown long-term benefit for adult health.[34]
- As mortality and hospitalisation due to COVID-19 have been lower among women and children compared to men, **MNCH has received insufficient attention in the context of the COVID-19 pandemic, though it has had a much wider adverse impact on women.** The unemployment, reduced household incomes, stress and domestic violence, reduced access to sexual and reproductive health services, confinement and food insecurity associated with the widespread response to COVID-19 have had a disproportionate impact on MNCH, especially in low-income communities, further widening inequalities.[26, 30] It is also worth noting that several risk factors for a severe COVID-19 – such as obesity, hypertension, and type 2 diabetes – are more common among disadvantaged groups and minority communities. We propose a novel way of thinking for the women's health strategy to **include the social justice case** for reducing inequalities in MNCH, which is sensitive to how social structures interact with risk factors for health. This will have far-reaching implications on the uptake of women's health services and mental health. [35]
- We argue that in addition to the need to mitigate its impact in the post-pandemic recovery phase, the Women's Health Strategy should consider **recognition of causal pathways** in early life which increase the risk of non-communicable diseases for the woman as well as her baby, and how this affects development and economic/educational attainment in future generations. There is a need to operationalise the **strong evidence supporting interventions at critical stages** such as interventions in the postnatal period for women diagnosed with GDM, which will additionally require better communication across maternity care and primary care.

The pandemic offers an unparalleled opportunity to promote population health and resilience by focusing on women's health. The Venice Forum's and the Preconception Partnership's evidence is built on three pillars: science, economics and social justice. As it considers the development of an evidence-based strategy, which includes women's voices, we urge DHSC to recognise the positive economic and health impact of investing in MNCH, in particular preconception health and preparation for a healthy pregnancy.

The Preconception Partnership *is a coalition of groups representing different aspects of preconception health in women and their partners. The Partnership includes the Royal College of General Practitioners, the Royal College of Obstetricians and Gynaecologists, the Faculty of Sexual and Reproductive Healthcare, Public Health England, Tommy's Charity, the Medical Women's Federation and academics in reproductive and sexual health, neonatal medicine, obstetrics and gynaecology, population health and epidemiology, nutritional sciences, behavioural sciences, and school education. The group pioneered the concept of a Preconception "report card" for the UK and has led several publications and actions to advocate for the normalisation of pregnancy preparation.*

The Venice Forum *is a network of health and social science experts, economists, public health leaders from academia and other international organisations who recently called for a radical rethink of current investment for a sustainable future through prioritisation of the health of women and young children. The group collectively works towards an ambitious goal of greater equity and social justice for vulnerable women and children and is leading the development of a roadmap focusing on maternal, neonatal and child health in the post-COVID era, working with the Partnership for Maternal Newborn and Child Health (PMNCH) hosted by the World Health Organisation. The Venice Forum held a virtual multi-disciplinary global Forum (March 22-24, 2021) to make the case for rethinking existing economic frameworks and assigning value to unremunerated contributions to work and societal wellbeing, largely done by women. There was agreement that MNCH - including health before and between pregnancies -represents a period in the life-course that should be a primary target for policies to improve population health.*

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