Addressing the Gap in Manchester: Women's Health, Systemic Barriers & the Case for Change

Manchester Community Central
Policy & Influence Team

Key Findings and Takeaways

May 2026

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Introduction

This report captures the key findings and recommendations from the event titled, **"Addressing the Gap in Manchester: Women's Health, Systemic Barriers & the Case for Change"** that took place on the 7th of May at the St Thomas Centre, Ardwick Green. The event brought together 45 delegates from a range of professions; health professionals, policymakers, community leaders and lived experience voices for an honest, solutions-focused conversation about what needs to change to achieve better health outcomes for women in Manchester and beyond. Through short talks, facilitated conversations and networking, the delegates had the opportunity to discuss and explore the evidence on women's health inequalities, share frontline insights and identify opportunities for collaboration, as well as any steps to be taken forward.

Our speakers included:

- Tanisha Paulas: Wellbeing of Women and the Health Collective
- Dr Omolade Allen, University of Manchester
- Consultant Midwives, Manchester Foundation Trust, NHS
- Jackie Driver, Associate Director for Equality and Inclusion at NHS GM,
- Sharmila Kar, Joint Director for Equality, Inclusion and Engagement at NHS Manchester Integrated Care Partnership/Manchester City Council

Together, with partners from the VCSE sector, Manchester City Council, the NHS, the University of Manchester and national voices, we discussed local challenges, priorities and innovative solutions aligned with the refresh of the national women's health strategy and local initiatives taking place in Manchester and GM-wide.

The Women of the North study, published by Health Equity North, highlights that women in northern England tend to have a lower healthy life expectancy, possess fewer qualifications, experience poorer mental health and are at greater risk of domestic violence and involvement with the criminal justice system compared to women in other parts of England. In the most deprived areas of Manchester, women face an 8-10 year disparity in life expectancy when compared to those in less deprived areas. Discussions emphasized that this gap has largely remained unchanged in recent years, alongside other inequalities that have been worsened by the socio-economic impacts of the pandemic.

The conversations throughout the day focused not only on identifying and unpicking these challenges, but also on how to develop solutions alongside the problems.

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> Every woman affected, deserves to have a seat at the table

Introduction

This was achieved by harnessing local knowledge, expertise and the pockets of successful work already underway within different parts of the city.

This report captures those insights and is structured around six themes that emerged from the discussions:

- **Practical barriers to access**
- **Attitudinal and cultural barriers**
- **The structural burden carried by women**
- **What works in community-led approaches**
- **The system changes needed**
- **Priorities for the Manchester Women's Health Action Plan.**

What Questions Did We Ask?

Our table discussions covered the following questions and topics:

- What are the most significant barriers women in Manchester face that hinder their ability to live healthy lives?
- Are there specific issues affecting marginalised women that we should prioritise?
- What steps can we take to ensure that healthcare and support services are truly accessible to everyone who needs them?
- How can we better identify and reach women who are currently underserved or facing barriers to access?
- What role can community-led initiatives play in improving service accessibility?
- How can services be adapted to better meet the cultural, linguistic and social needs of diverse women?
- What barriers exist to early intervention, and how can we overcome them?
- What models of collaboration have shown promise in addressing complex health and social issues?

With regard to the new Manchester Women's Health and Social Justice Strategy and Action Plan, the following questions were asked of the cross-sector delegates:

- What are the key priorities and principles that should underpin the Manchester strategy?
- What actions are needed to address inequalities rooted in race, class, age, disability or other social factors?
- How can we measure progress and ensure accountability in advancing women's health and social justice?
- How can Manchester leverage the wider national women's health strategy to strengthen our local efforts; is there anything else we should consider to make Manchester stand out as a leader in women's health and social justice?
- How can community voices and lived experiences be better integrated into strategy development and decision-making?
- What long-term cultural shifts are necessary to sustain positive change?

Findings from Table Discussions: Practical Barriers to Access

Women and girls across Manchester face a wide range of practical obstacles that prevent them from accessing healthcare in the first place. Discussions highlighted that these barriers often compound each other: for example, a woman facing poverty, language challenges and caring responsibilities faces a very different set of difficulties compared to someone without these pressures. Intersectionality emerged as a central theme throughout all areas of discussion: **women's health inequalities are complex and interconnected, affecting multiple aspects of health, from research and GP support to A&E services and medical treatments.**

GP Access and First Point of Contact

GPs are the front door of the NHS, and for most women in Manchester it is the first, and sometimes only, route into healthcare. Yet attendees were consistent in describing GP access as one of the most significant barriers they face. The problems begin before a woman even speaks to a clinician.
GP receptionists were repeatedly described as gatekeepers who create barriers rather than facilitate access, especially around getting appointments and the triage process. Women reported feeling questioned, judged or turned away at the first point of contact, with little opportunity to explain the complexity of their situation. For women who lack confidence, whose first language is not English, or who are already navigating significant stress, this experience can be enough to prevent them from trying again. As one attendee put it, **getting a GP appointment can feel less like accessing a health service and more like going into battle**. This was further emphasised by the amount of third sector support on health advocacy and knowing your rights. Many delegates acknowledged that this experience is not applied to every single GP but a consistent experience across a woman's lifetime.

Appointment timings magnify these difficulties significantly. Standard GP hours are largely built around a working day that does not reflect the reality of many women's lives. Women with children, caring responsibilities or inflexible employment often cannot attend appointments during the hours they are offered. Attendees noted that even wanting to prioritise a health appointment can mean making a conscious sacrifice elsewhere i.e choosing between a screening and school pick-up is not a choice the system should be asking women to make. Having more flexibility or getting GP pop-ups was noted as a useful way of improving access to services.

When women do manage to access a GP, their experience is not always one that encourages them to return. Attendees described a recurring pattern of not being believed, having their concerns minimised and being sent away without adequate investigation or follow-up. Although this is explored further in the report, it has immediate practical consequences: women who feel dismissed by a GP are less likely to book future appointments, less likely to attend screenings and more likely to delay seeking help until their condition has significantly worsened. Appointment fatigue was identified as a major barrier to healthcare, with the exhaustion of attending multiple appointments, retelling symptoms and still not being heard recognised as a real and under-acknowledged phenomenon. **However, it is important to note that this experience also reflects access to primary healthcare for the general public. For women specifically, there are distinct life experiences and intersectional challenges that require recognition and demand a nuanced, multi-layered approach and response.**

Attendees also highlighted the impact of 'failed to attend' policies, which were described as disproportionately punishing women who are already experiencing the most significant disadvantage. These policies make no allowance for the circumstances that may have prevented attendance i.e a childcare crisis, a missed bus, an episode of poor mental health and in some cases result in women being removed from patient lists or deprioritised for future appointments. Attendees were clear that this is an area where local systems can support, developing neighbourhood-level operating models that treat non-attendance with the same contextual understanding they would want applied to any other aspect of a patient's situation. The notion of 'professional curiosity' is a key term in this discussion which encourages GPs to enquire why patients may be struggling to attend or at least be aware of the barriers to access support around women's health.

There was also discussion of the potential value of open contact between carers and GPs, with attendees suggesting that direct lines of communication, rather than relying solely on written notes, could help ensure that women with complex needs are properly understood rather than repeatedly having to re-explain their situations to new professionals. This is particularly relevant for women whose first language is not English, or who lack the confidence or support to advocate for themselves effectively. It is worth noting that this needs to be implemented sensitively in some cases i.e around honour-based abuse and symptoms or issues being communicated in a different language that may be mis-leading or not truly representing the symptoms truthfully.

Transport, Cost and Geography

For women in Manchester's most deprived areas, getting to a health appointment is not straightforward. The cost of public transport is a genuine barrier for women living in poverty, and knowing how to navigate routes into the city centre cannot be assumed for everyone. **When services are concentrated in particular areas rather than distributed at neighbourhood level, the practical burden of access falls on those least able to bear it.**

Positive examples were shared of screening and health check programmes, including lung health checks and eye tests, being brought into community settings, significantly increasing uptake among populations that would otherwise not engage. **When services go to communities rather than expecting communities to come to services, the results are measurable. Attendees called for this to become the norm rather than the exception.**

Language and Communication Barriers

For women whose first language is not English, challenges begin at the point of booking an appointment. App-based translation tools were flagged as a particular risk, accuracy in sensitive or complex medical contexts cannot be guaranteed, and receiving difficult health news via an app is not equivalent to receiving it through a skilled, empathetic interpreter who understands both the language and the cultural context.

In-person interpreters, connected with local language and cultural centres, were identified as the more appropriate model but one that requires proper investment. Attendees also stressed that health information produced from an English-speaking perspective does not land equally across all communities regardless of whether it has been translated, cultural framing and tone matter as much as language.

It is important to highlight that, alongside providing access to interpreters and integrating language-sensitive approaches in healthcare, there must also be a focus on investing in programmes that improve women's access to learning English. This is closely linked to social justice, women's independence and addressing systemic issues that often leave women reliant on others, unable to communicate effectively, or access services independently.

Digital Exclusion and Health Literacy

The shift towards digital health services has created a new layer of exclusion for women who lack the skills, devices or connectivity to use them. Attendees were clear that digital should be an option, not a default.

Attendees called for health communications and services to be co-designed with communities, including those with the lowest literacy levels, and for in-person and telephone options to be maintained and properly resourced. No woman should be excluded because of the medium through which services are delivered.

Screening and Early Intervention

When screening takes place only at centralised locations, the women most likely to benefit, those in the most deprived communities, are also the least likely to attend. Attendees pointed to positive models where services have been brought into community settings, demonstrating significantly higher uptake. Increasing screening uptake requires more than awareness campaigns; it requires rethinking where services are delivered and who delivers them. Going to communities rather than expecting communities to go elsewhere was clearly noted.

Attitudinal And Cultural Barrier

Alongside practical barriers, attendees described deeply embedded attitudinal and cultural obstacles, within healthcare settings and within communities, that prevent women from seeking and receiving appropriate care. Many of these barriers are harder to see and harder to change than structural ones, but their impact on women's health is no less significant.

Medical Misogyny and the Male Default

A consistent theme across discussions was that the healthcare system was built around male experience and continues to operate through that lens. Conditions including ADHD and chronic pain are routinely described and diagnosed through a male default, leading to women being missed, dismissed or incorrectly treated. Women are frequently not believed, and the normalisation of female pain means they are often only taken seriously if they present in extreme, visible distress - a dynamic that is compounded for women from global majority backgrounds.

Conditions such as endometriosis face unacceptably long diagnostic timescales (7-10 years), reflecting the systemic undervaluing of women's health. Attendees were clear that this is not simply a matter of individual clinicians, it is a structural problem, embedded in medical training, research priorities and clinical culture.

> “No one has ever asked me: what would work for you to feel healthier? What has worked for you before?”

Trauma and the Absence of Trauma-Informed Care

The absence of trauma-informed approaches within healthcare was identified as a significant and ongoing issue. Many women have had damaging prior experiences with health services, and rather than being met with understanding, they encounter systems that label and dismiss them. This overall issue throughout women’s health from menstrual health, menopause, maternal health and overall health support has led to a structural mistrust in the healthcare system. Women are routinely expected to recount traumatic experiences to multiple professionals, causing further harm rather than facilitating recovery. Many third sector groups now provide women’s health advocacy tools on how to fight for further investigation on women’s health and to be heard as a response of medical misogyny and absence of trauma informed care.

A paper trail following a woman through the system often reflects poor prior encounters rather than genuine understanding of her circumstances, resulting in labels that stick rather than care that adapts, these include “this is normal do not worry”, “it is just a period”. When discussing trauma informed approaches, **‘trauma passports’ were referenced as a positive step in some areas in GM. This would prevent individuals from relaying traumatic experiences or information multiple times. However, attendees recognised the challenges in implementing something like this and stressed that it must be done carefully in terms of information sharing and patient safety.**

Cultural Stigma and Shame

Stigma and shame around menopause, periods, and mental health (including postpartum depression), particularly within some global majority communities, prevent women from seeking help. For women from global majority backgrounds, these issues intersect with cultural norms and the role of faith leaders in complex ways that mainstream health services are often poorly equipped to navigate. Many misconceptions are spread amongst communities and online that makes it more difficult for women to seek help.

Women from global majority backgrounds described situations where they had no real choice about being examined by a male clinician. Natural remedies and culturally rooted health practices are not adequately recognised by healthcare professionals, leaving women feeling pressured into interventions they are not comfortable with. Attendees were clear that cultural competence must be embedded in service design and clinical training, not treated as an optional extra.

> **“Cultural competence is not optional - it cannot be a performance.”**

The Burden of Women- Social and Structural Context

Health inequalities in Manchester cannot be fully understood without considering the broader socio-economic pressures that influence many women's lives. Discussions made it clear that the health system operates within, and often reinforces, wider structural inequalities that disproportionately burden women. The conversations highlighted the intersectional factors affecting women's quality of life and, most importantly, their health – factors that both define their well-being and set limits on what they can achieve, depending on other circumstances in their lives. In addition, the system tends to address issues in isolation rather than recognising how these factors interact, which is essential for tackling the complexity of women's experiences and challenges. Below, we have summarised some key points from the discussions that our attendees felt were particularly relevant in the Manchester context.

Poverty and Its Impact on Health

Poverty shapes health in multiple, intersecting ways, affecting food quality, the ability to exercise, capacity to travel to appointments and access to the time and headspace needed to prioritise health. For women in Manchester's most deprived areas, the conditions required to maintain good health are often simply not available, regardless of how good the services on offer may be. Attendees challenged health services to understand poverty not as a backdrop to women's health, but as one of its primary drivers.

The Invisible Labour of Caring

Women disproportionately carry the mental and emotional weight of running households and caring for family members, often on top of paid employment. Their own health consistently becomes the lowest priority as a result. **Society's expectation that women keep showing up regardless of personal health challenges reinforces this pattern, creating feelings of guilt when women do attempt to put themselves first.**

Services operating within standard working hours exclude women with caring responsibilities. Even basic access to a GP appointment can require sacrificing another part of family life. Attendees described this not as a personal failing but as a structural problem that health services must actively work to address through flexible, accessible, and neighbourhood-level provision.

> "I have to ask myself: if I want to go on that walk or take that gym class, which part of my children's care do I drop?"

How Health is Measured and Who Gets Left Out

Attendees challenged the rigid metrics used to define a healthy lifestyle. Measures such as minutes of intentional exercise fail to account for the significant physical activity involved in domestic and household labour, leaving many women feeling shamed and misrepresented by health professionals rather than supported. The way health is framed and measured reflects the same male default that shapes clinical practice and has real consequences for how women understand and relate to their own health.

What works: Community-Led Approaches

Despite the significant challenges discussed, attendees identified a range of community-led approaches that are making a real difference. These were not described as supplementary to the health system but as models that demonstrate what good looks like and that should be properly funded, valued and learnt from.

Trusted Community Spaces and Peer Support

Community women's hubs, peer support groups and trusted local spaces were highlighted as effective models: offering services, information and connection in environments where women feel comfortable and understood. Low-cost classes and information hubs, funded through VCFSE organisations, are utilised at a neighbourhood level so that all women can access support regardless of financial means. Attendees described these spaces as interventions that the formal health system cannot do, precisely because they are embedded in communities rather than standing apart from them.

Reaching Communities Through Trusted Voices

Engagement that works does not begin with a leaflet or a website, it begins with a trusted person, in a trusted space, having a real conversation. Attendees highlighted the importance of community health champions and advocates embedded in GP practices and community settings, who can help women navigate the system and ask questions they might not feel able to raise with a clinician directly.

Men were also identified as important allies. Several attendees highlighted the value of engaging men, as partners, fathers, and community members, in encouraging the women in their lives to seek support and in challenging stigma within their own communities.

> People in power, share the power.

Communications That Reach People Where They Are

Health communications must be tailored to specific communities and the platforms they use. WhatsApp, longer-form video and community social media were all cited as effective channels depending on context. The key principle is that communications should start from where communities already are, rather than asking communities to find their way to official channels. Utilising community group-chats was noted as useful platforms to share support, activities and opportunities, that can be accessed by community members.

Health information must also be genuinely accessible, plain language, active links, up-to-date contacts and easy navigation were all described as basic requirements that are still frequently absent. Health education champions, trusted voices within specific communities, were suggested as a way of reaching people through channels they already trust

Genuine Reciprocity With Communities

A strong message from attendees was that women working within community groups are experts in their own experience, and that researchers and professionals seeking to learn from them must come to them, in their venues and communities, rather than expecting communities to come to formal consultation spaces. This must be a genuine two-way relationship, including sharing findings back with communities, acknowledging their contribution, and offering appropriate remuneration for their time and expertise.

System Change: Collaboration, Co-Production and Accountability

Improving women's health in Manchester requires more than individual service improvements. It requires fundamental changes to how the health and care system is organised, who it listens to, and how it shares power. Attendees were consistent in noting that the solutions already exist within communities, the system's task is to create the conditions for those solutions to be properly resourced and scaled.

Connected, Integrated Services

Services currently operate in silos, creating fragmented care and significant gaps in support for women with complex needs. **Integrated referral pathways between the NHS and VCFSE sector are essential, and the role of pharmacists and community-based services in providing accessible first-line support is significantly underutilised**. Better signposting and a broader understanding of the range of services available at community level were identified as relatively straightforward improvements that could make an immediate difference.

Attendees also highlighted the opportunity to embed health information and signposting within existing digital touchpoints, such as apps people already use to book appointments, as a way of reaching people without requiring them to seek out additional services or platforms. Additionally, GPs being aware of local support from the VCFSE sector may also help a patient with something specific. Overall better communication and access between the two services was flagged as imperative.

Diversity in Leadership

Meaningful diversity in leadership across the health system is essential if the changes discussed are to be embedded rather than surface-level. Doctors and professionals from global majority backgrounds are not currently being supported or encouraged into leadership roles, a gap that slows the pace of systemic change and perpetuates a system that was not designed with all women in mind. Attendees called for active investment in developing diverse leadership pipelines, not as an aspiration but as a structural priority.

Real Co-Production, Not Consultation

Co-production was strongly endorsed throughout the discussions, but attendees were equally clear about what makes it real versus performative. Genuine co-production means communities see the outcomes of their input, what changed, why, and how. Engagement fatigue is a real and growing problem: when multiple organisations approach the same communities with the same questions and provide no feedback, trust is damaged and future engagement becomes harder. There is an appetite for two-way relationships from the VCFSE sector at the public sector.

The VCFSE sector's contribution to decision-making has demonstrable value. Attendees cited the example of SARA's involvement in GMP's reintroduction of rape investigation teams as evidence that community insight, when properly engaged, can drive significant systemic change. This contribution should be actively sought and properly resourced rather than treated as optional.

Priorities for the Manchester Women's Health Action Plan

The final part of discussions focused on what the Manchester Women's Health Action Plan should include to deliver a real difference. There was a clear consensus that this must be more than a strategy document, it must drive measurable change, be accountable to communities and be honest about what has not worked before.

Community Voices at the Centre of Design

The voices of grassroots organisations and communities must be central to the co-design of the action plan and strategy, not consulted at the margins. Manchester City Council and the NHS were advised to go directly to the spaces where women already are, through the grassroots organisations that have built trusted relationships over years, rather than expecting communities to come to formal consultation events. This means investing in those intermediary organisations, not simply using them as a route to reach residents.

A Holistic, Cross-Sector Approach

Women's health cannot be addressed through NHS services alone. It is shaped by housing, employment, education, social care and every other part of the system. Women, as primary carers in their families and communities, are vulnerable to injustices and difficulties across our health-care system. A plan that focuses narrowly on healthcare will not close the gap. Attendees called for a cross-sector approach that names the structural drivers of women's health inequalities and commits to addressing them through joined-up action across council departments, the health system and partner organisations.

Accountability and Transparency

Regular forums must be established to report back on what has been actioned from commitments made, not just what has been discussed. Progress must be measurable and communities must be kept genuinely informed of what difference their input has made. **Manchester has the opportunity to set a different standard, to build a Women's Health Action Plan that is distinguished not just by its ambitions but by its transparency, its community ownership and its willingness to be held to account.**

To move forward, we should build on the national Women's Health Strategy while also seizing the opportunity to go beyond it - by emphasizing authentic community co-production focused on prevention and committing to systemic change that endures beyond individual programmes or political cycles. The discussions at this event demonstrated that the city already possesses the knowledge, experience and determination needed to drive that change.

It is crucial for Manchester's approach to emphasise not only how we collaborate to provide accessible services but also how we work together as a system to serve as a safety net for those in need. We must invest in women as fundamental agents of societal change to foster a lasting shift in our perspectives and behaviours.

Thank you to all the VCFSE groups, NHS professionals and Local Authority colleagues who attended and shared their insight and lived experience.

> "No one has ever asked me what would work for you to feel healthier."

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