Director of Public Health Report 2025

Women's Health

Working Together to Improve Women's Health in Grampian

Plan
for the
Future
Healthier Together
2022 - 2032

publichealth
helping health happen

NHS
Grampian

Aberdeen City
Health & Social Care
Partnership
A caring partnership

Aberdeenshire
Health & Social Care
Partnership

HEALTH &
SOCIAL CARE
MORAY

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Glossary

- **Allied Health Professional:** is a trained healthcare worker who provides essential services to support the diagnosis, treatment, rehabilitation, and prevention of illness and disease, other than those provided by doctors, dentists, and nurses.
- **Anchor Organisations:** Established organisations that are stable and unlikely to move, such as NHS Grampian. They can influence the wider local economy and subsequent health of the population.
- **Blue spaces:** are natural or built environments that prominently feature water and are associated with benefits for health, wellbeing, and quality of life.
- **Community Appointment Day:** Community based events that bring together health and social care services and community support to holistically address a health issue or inequality.
- **Community Planning Partnership(s):** Services that come together to take part in community planning, there is one partnership per local authority area and three in Grampian.
- **Community Wealth Building:** Creating local economic approaches, such as Anchor organisations, that enable communities to have greater ownership and retain more of the wealth generated from improvements to the local economy.
- **Deprivation:** Circumstances in which people lack access to the resources, services, and conditions needed to live and maintain a healthy life.
- **Equity:** The principle of being fair by recognising and addressing existing difference in health when designing and delivering interventions.
- **Gender-based violence:** Term used to describe crimes that are overwhelmingly, but not exclusively, carried out by men against women.
- **Healthpoint:** Resource delivered by NHS Grampian that provides free and confidential health information and support.
- **Health and Social Care Partnerships:** Integrated NHS and local council services.
- **Health Impact Assessments:** A systematic way of assessing the impacts of a policy, strategy or plan on the health of the population.
- **Health Needs Assessment:** A systematic way of assessing health needs of a population, this can involve different pieces of evidence including local data and/or lived experience.
- **Framework:** Document that outlines a long term vision and provides a shared structure for understanding an issue, aligning stakeholders, and guiding decision making over time.
- **Inclusion groups:** Inclusion-health groups are people who experience social exclusion and associated health inequities.

- **Inequalities:** Measurable difference in health or other areas, such as income or education.
- **Inequities:** Unfair inequalities, differences resulting from systemic barriers that unfairly affect an individual or subgroup of the population.
- **Life Expectancy:** The average length of life expected for a population.
- **Local Outcome Improvement Plan:** Document made by community planning partnerships outlining their plan for improving outcomes for local communities.
- **Menstruation:** (Period) Monthly shedding of the lining of the uterus.
- **Mortality:** Measure of number of deaths within a population.
- **Nature Prescription:** Health and care professionals refer people to nature based activities and settings to improve wellbeing.
- **Neurodevelopment:** Development of the brain and nervous system.
- **Obesity:** In adults, obesity is defined as a Body mass index (BMI) of 30-39.9. For some ethnic groups health risks occur at lower BMI levels and therefore for adults from Asian, Chinese, Middle Eastern Black African or African Caribbean backgrounds, obesity is defined as a BMI of 27.5 or above. A BMI of 40 or above is defined as severely obese.
- **Overweight:** In adults, overweight is defined as a BMI of 25-29.9. For adults from Asian, Chinese, Middle Eastern Black African or African Caribbean backgrounds, overweight is defined as a BMI of 23-27.4.
- **Population Health Organisation:** Population Health Organisations focus on improving the health outcomes of entire populations by addressing health inequalities and the broader determinants of health.
- **Postnatal:** The period immediately following childbirth and up to 8 weeks after birth.
- **Premature birth:** Defined as birth before 37 weeks' gestation.
- **Premature mortality:** Deaths under the age of 75 years.
- **Relative poverty:** Households earning less than 60% of the UK average income after accounting for housing costs.
- **Social Prescribing:** Health and care professionals connect people to non-medical support, such as community groups, sport and exercises classes or financial advice; to tackle wider factors that may be affecting their poorer health or wellbeing.
- **Stakeholder:** An individual, group, or organisation with an interest in or influence over an area of work or decision.
- **Whole-systems approach:** Understanding how the wider health and social care systems, and people's physical and social environments, interact and using this understanding to identify actions that address these interconnecting factors.

Abbreviations

ACHSCP	Aberdeen City Health and Social Care Partnership
ADHD	Attention Deficit Hyperactivity Disorder
ALISS	A Local Information System for Scotland
CAD(s)	Community Appointment Day(s)
CAMHS	Child and Adolescent Mental Health Services
CPPs	Community Planning Partnerships (CPPs)
CVD	Cardiovascular Disease
GBV	Gender Based Violence
GIRFE	Getting It Right for Everyone
GMVP	Grampian Maternity Voices Partnership
HMP Grampian	His Majesty's Prison and Young Offenders Institution (HMP) Grampian
HSCP	Health and Social Care Partnerships
HPV	Human Papilloma Virus
LARC	Long-Acting Reversible Contraception
LGBTQI+	Lesbian, Gay. Bisexual, Transgender, Queer, Intersex, Plus
MECOPP	Minority Ethnic Carers of People Project
MMR	Measles, Mumps and Rubella
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PMOS	Polyendocrine Metabolic Ovarian Syndrome (PMOS)
SIMD	Scottish Index of Multiple Deprivation
RSV	Respiratory Syncytial Virus
TSI	Third Sector Interface(s)
tsiMoray	Third Sector Interface Moray
WHO	World Health Organisation

Foreword

This year's Director of Public Health Annual Report is about women's health. With the second phase of the **National Women's Health Plan**[1] now in place, it feels timely both to recognise the excellent work already underway to improve women's health, and to be clear about where greater collective effort is still needed. Women's health is not only a women's issue. It is a population health issue that affects families, communities and society as a whole.

Through the **NHS Grampian Health Equity Plan**[2] we committed to using local data to better understand inequities in access to healthcare and health outcomes for women, in support of delivering the **National Women's Health Plan.**[1] This report represents an important step in that journey. It is intended as a catalyst for engagement, supporting meaningful conversation with individuals, groups and communities. During 2026/27, I am committed to working with NHS Grampian's Women's Board and our partners in Health and Social Care Partnerships (HSCP), Community Planning Partnerships (CPPs) and the third sector to engage further with a wide range of stakeholders — including individuals, groups and communities to co-develop a Grampian Women's Health Action Plan that responds to the themes in this report.

Women's roles in society have changed significantly over the last 50 years. Today, 71.7% of women in Scotland are employed, approaching the proportion of men (77.1%).[3] However, women remain far more likely to work part-time, earn less, and carry a disproportionate share of caring responsibilities — all factors that have a direct and cumulative impact on health and wellbeing. Some women face more barriers to good health than others—particularly women from inclusion groups, those living in deprived communities, and women with disabilities. These challenges often overlap and reinforce each other.

Gender-based violence also continues to disproportionately affect women and girls, with profound consequences for health across the life course.

This report sets out the current health status of women in Grampian, alongside the programmes and interventions already in place to support improvement. Using the **Population Health Framework for Scotland,**[4] it also highlights where we need to focus our efforts to make the greatest difference.

Central to this work must be the voices of women themselves. I would like to sincerely thank all the women who have already shared their experiences and stories.

Their voices are reflected throughout this report. Listening to women is fundamental to improving women's health and what we have heard so far is not the end, but the beginning of wider public engagement that will help us to identify gaps, understand priorities and drive meaningful change.

No single team or organisation delivers the work described in this report. I would like to thank colleagues and partners across Grampian for their ongoing commitment and contribution to improving women's health. I hope this report inspires continued collaboration — using our shared strengths to improve data, plan collectively and deliver prevention-focused action — recognising that when women's health improves, everyone benefits.

Professor Shantini Paranjothy,

Director of Public Health, NHS Grampian

Update from Director of Public Health Report 2025/2026

Last year, I wrote about **Children and Young People in my Director of Public Health Report.**[5] Since then there has been measurable progress with developments seen in child poverty mitigation and early intervention pathways. Progress has been strongest where data, lived experience and the influence of Anchor Institutions have been brought together deliberately. However, inequities linked to deprivation and geography remain deeply rooted and will continue to require coordinated action. This will be progressed through the work of NHS Grampian's Children's Board and with partners across the system.

Key areas of progress

- **Putting children and young people at the centre of planning**

Children and young people's voices are increasingly shaping service design, including co-designed employability pathways for care experienced young people, youth informed obesity work and strengthened mental health services planning. Local surveys[6] show a rise in the proportion of young people who feel listened to, indicating progress from consultation towards meaningful engagement.

- **Mitigating child poverty and financial insecurity**

Local Child Poverty Action Reports[7-9] have been delivered across all local partnerships. Enhanced use of linked data, notably through the Aberdeen City Low Income Family Tracker, has improved targeting of income maximisation support, identified previously unclaimed entitlements and prevented homelessness for families at risk. **The Health Equity and Learning Project (HELP)**, a short-term funded project delivered in partnership with Aberdeenshire Council, provided cash first support for 22 families who required financial assistance to attend a hospital appointment for their child. Within the same project, **The Archie Foundation** supported over 400 low-income families with food and essentials while they were in hospital with a child. Despite this progress, overall poverty rates have remained relatively static, reinforcing the need to scale up interventions.

- **Strengthening early years and pregnancy support**

Evidence-based early intervention remains a strong focus. Financial inclusion pathways are now routinely embedded within maternity, health visiting and family nursing services. This will be rolled out to allied health professionals working with families in the next year. Targeted programmes, including infant feeding and the **Family Nurse Partnership**, show positive impacts in deprived communities, supporting healthier starts in life and narrowing inequalities.

- **Improving mental health and neurodevelopmental support**

There has been a real shift towards prevention and early intervention, including expanded digital mental health provision, parent-led mental wellbeing support in Moray and whole-system redesign to reduce avoidable **Children and Adolescent Mental Health Service (CAMHS)** referrals. New investment will deliver a single, family-centred neurodevelopmental pathway, supporting earlier identification and tailored support for children and families across Grampian.

- **Improving transitions and continuity of care**

Transitions between key life stages (early years, school and adulthood) have been prioritised within mental health, neurodevelopment and employability pathways. Work is underway to reduce fragmentation by improving continuity, navigation and relationship-based support - system-wide consistency remains a priority for delivery.

- **Embedding health equity and anchor roles**

NHS Grampian and Local Authorities continue to strengthen their role as Anchor Organisations, using employment, procurement, planning and service access decisions to reduce inequalities.

- **Responding to climate change and climate anxiety**

Growing recognition of climate anxiety as a mental health issue has informed partnership discussions, with CPPs identified as critical vehicles for supporting constructive, youth-led climate engagement without shifting responsibility to young people alone.

Introduction

Listening to Women: Understanding what matters.

National policy, including both phases of the National Women's Health Plan,[1,10] has been shaped by women's lived and living experiences. In Grampian, we are committed to building on this foundation by taking a **Putting People First** approach - listening closely to local women and understanding what matters to them. This helps us understand not only which services people use, but also the wider factors in daily life that shape health and wellbeing.

To deliver the best possible care, everyone — staff, partners and the public - should have a meaningful voice in shaping how we work. This represents a shift from traditional models of decision making towards designing care *with* people, not *for* them. It places value on lived experience, strengthens partnership working and deepens collaboration with the third sector.

By doing this, we can move away from medicalised models of care and towards approaches that are preventative, inclusive and person centred.

Community Appointment Days (CADs) bring together health services, social care and community partners to offer holistic support in a community setting. They are co-designed and centred on "**What Matters to Me?**" conversations, enabling people to express their priorities, make informed choices and connect with local support.

At a recent CAD, focused on **Women's Health**, women identified mental health, reproductive health, screening and neurodivergence as important areas. They also emphasised the value of being listened to, having reliable information and being able to access services when needed.

Some of their experiences have been developed into a digital story, which sits alongside a summary version of this report. We have also produced a set of '**Getting it Right for Everyone**' (GIRFE) **questions** to support further conversations in workplaces and communities.

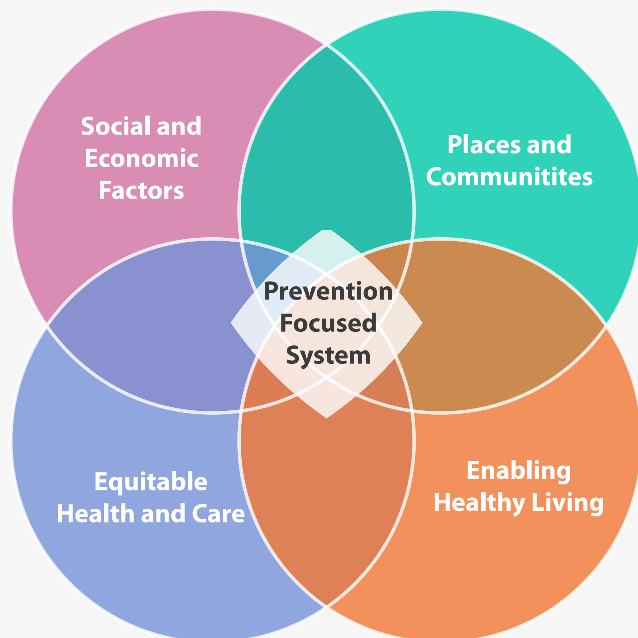
We can continue to build strong foundations by:

- Making listening and involvement a clear and visible priority.
- Building staff skills and confidence to involve the public meaningfully.
- Testing community led health approaches, such as CADs, where the NHS works as an equal partner alongside the voluntary and charitable sector and people with lived and living experience.

Throughout this report, we highlight the lived and living experience that has informed our work. While the stories shared so far reflect only an initial contribution, our aim is to embed the routine sharing of women's lived experience as a normal and expected part of how we listen, learn, and improve.

What this report covers

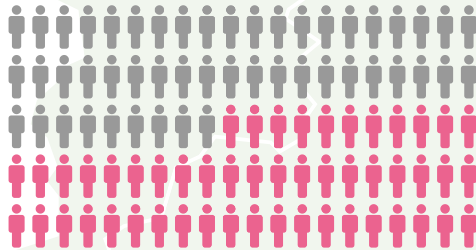
Previous **Director of Public Health Reports**[11] have set out the four major threats to population health. While these remain important, this report is structured around the drivers of population health set out in the **Population Health Framework,**[4] explored through the experiences of women. For the purposes of this report, the term woman/women aligns with the definition in the **Equality Act 2010.**[12]

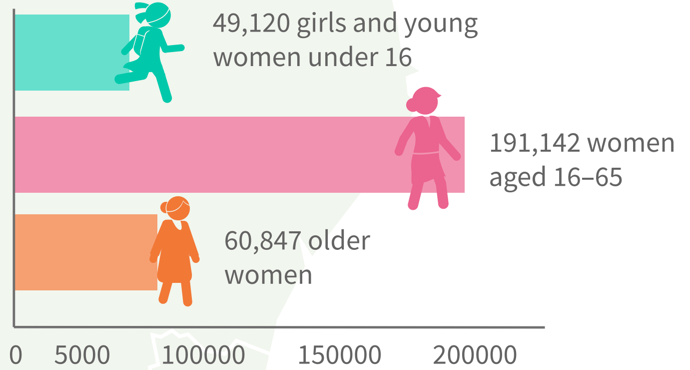


Influenced by the King's Fund Population Health Pillars and the Institute of Health Equity's eight Marmot principles.

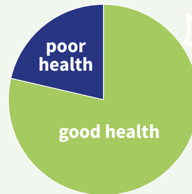
What do we know about the health of women in Grampian?

In Grampian: Women make up 51% of the population:





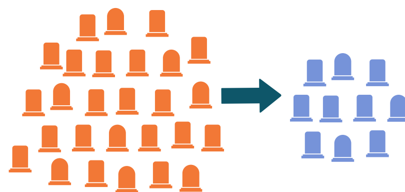
Women spend an average of **64.5 years in good health and 17.3 years in poor health.**



Women in the least deprived areas **live 6–8 years longer** than those in the most deprived areas.

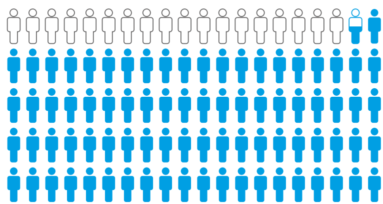
Life expectancy for women in Grampian is 80–82 years, similar to Scotland as a whole.

Premature mortality is **2.4–2.7 times higher** in the most deprived quintile.

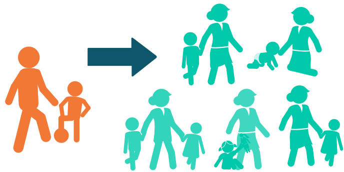


Cancer is the leading cause of premature mortality for women.

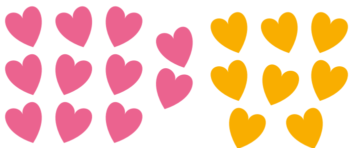
Social and economic factors



Women make up 81.5% of the NHS Grampian workforce and 81% of the social care workforce.

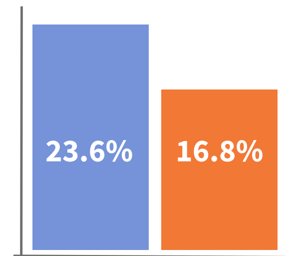


Female lone-parent families outnumber male lone-parent families by more than five to one.

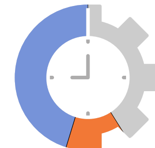


11% of women provide unpaid care, compared with 7.9% of men.

23.6% of women aged 16–64 are economically inactive (compared with 16.8% of men).

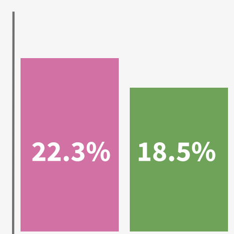


45.5% of employed women work part-time (compared with 13.5% of men).



Healthy living

Women spend, on average, three more years in poorer health than men.



22.3% of women report a limiting disability (compared with 18.5% of men).

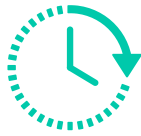
Referrals to Child and Adolescent Mental Health Services (CAMHS) for girls increased by 25% between 2015 and 2021.

Women experiencing deprivation are more likely to have higher rates of overweight and obesity (including in pregnancy), smoking, alcohol use and substance use.

One in five women were prescribed an antidepressant in 2025, and women are twice as likely as men to be taking medication for anxiety.

Equitable health and care

Women experience longer waits for inpatient and day case admissions and spend longer in Emergency Departments.



Women in the most deprived areas are less likely to take up screening or vaccination programmes.

Women who have disclosed domestic violence or who are care experienced **are more likely to have a baby with a low birthweight.**

Women from ethnic minority groups are more likely to book late for maternity care.

Women's health is complex, and a one size fits all approach will not meet population need. Women experience distinct patterns of health, illness and inequities across their lives. Biological differences, social and economic roles, caring responsibilities and the impacts of gender based inequities all shape outcomes in ways not always seen in wider population analyses. The remainder of this report explores these issues in depth, drawing on local data and women's experiences in Grampian to build a clearer picture of the challenges and opportunities ahead.

Social and economic factors

Early years and child development

Health inequalities begin in infancy and are significantly worse for children living in the most deprived areas. These include higher rates of developmental concerns, higher levels of obesity, increased tooth decay and lower uptake of vaccination programmes. While poverty affects all children, evidence from Scottish studies[13] on early childhood development and mental wellbeing suggests that gender influences how socio economic disadvantage is experienced and expressed. In early childhood, girls are more likely to internalise distress and less likely to present with overt behavioural difficulties. This means that emerging needs may be less visible to services at the point they first arise.[14] In the context of deprivation, this increases the risk that early signs of difficulty among girls are recognised later, potentially delaying access to support. Although published national data[15] do not consistently allow outcomes to be analysed by sex and deprivation together, this interaction is an important consideration for women's and girls' health.

Education

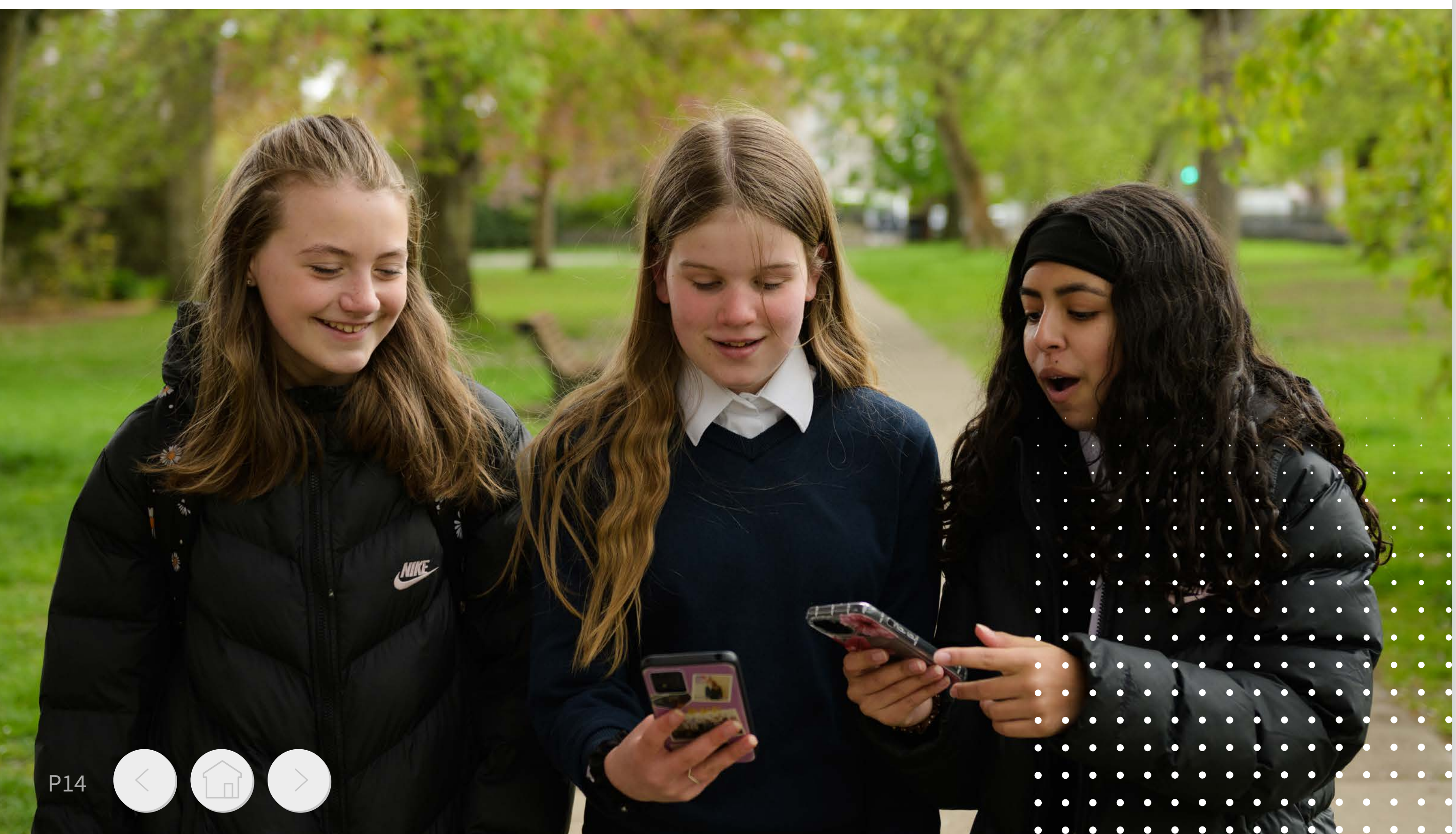
Neurodevelopmental needs are placing increasing pressure on education and health systems.[16] Referrals for specialist assessment continue to rise, highlighting the importance of early identification and support within home, early learning and school environments. These needs intersect with persistent socio economic inequalities – children in the most deprived areas experience higher rates of developmental concerns, which can affect language development, social interaction, emotional regulation and school readiness.

Recent Scottish research[17] highlights gender disparities in the recognition and diagnosis of neurodevelopmental conditions. Girls are consistently under identified in childhood, with some reports suggesting girls are diagnosed on average five years later than boys. Historically, more boys than girls have been diagnosed with autism or Attention Deficit Hyperactive Disorder (ADHD), but this is now understood to reflect systemic under diagnosis rather than genuine prevalence differences.

Three factors are thought to contribute:

- **Gender bias in diagnostic criteria:** Assessment tools were developed using samples that included very few girls, making them less sensitive to female presentations.
- **Different symptom profiles:** Girls often show fewer outward social or communication difficulties and are more likely to present with inattentive subtypes of ADHD.
- **Masking:** Many girls consciously or unconsciously mask their symptoms, especially in social settings.

NHS Grampian is taking forward a programme of work to strengthen the neurodevelopmental pathway. This includes earlier identification, coordinated multi agency support and the integration of gender aware approaches — such as improved practitioner understanding of female autism and ADHD presentations — to reduce variation in access and outcomes for both girls and boys.



Economic activity and income maximisation

Good quality work is a key determinant of health. Evidence[18] consistently shows that safe, secure employment with fair conditions, supportive management and opportunities for development improves physical and mental wellbeing. Good work supports gender equality, reduces child poverty and strengthens social connections. By contrast, poor quality work or worklessness is linked with poorer health across the life course.

However, women still face systemic barriers that limit access to secure, well paid and progressive roles. Women remain overrepresented in part time, low paid and insecure work, particularly in care, hospitality, retail and cleaning. Pregnancy, childcare and caring responsibilities continue to interrupt many women's careers, affecting progression, income and long term financial security – which is directly linked to poorer health outcomes.[19]

Women living with long term conditions — including mental health issues, musculoskeletal problems and gender specific health needs — face additional obstacles to gaining and sustaining employment. These challenges reinforce workplace inequalities and contribute to poorer health outcomes.

The economic case for workplace health improvement is strong. Sickness absence costs the UK around £100 billion per year.[18] Women are also more likely than men to be economically inactive because of long term sickness: 1.5 million women are out of the workforce for this reason, over 200,000 more than men.[20] Supporting women to stay, return and progress in work strengthens health outcomes, workforce sustainability and the wider economy.

Employers can play a critical role by regularly reviewing workplace policies to ensure women can remain and thrive in work.

Community Wealth Building

Community Wealth Building is an approach that aims to reshape local and regional economies so that people and communities share more directly in the wealth they help create.

Anchor organisations - large institutions rooted in their communities play a key role in this transformation.

As an Anchor Institution, NHS Grampian is preparing for the forthcoming **Community Wealth Building Bill**[21] by working closely with partners across the North East. We are committed to using our role as a major employer, purchaser and asset holder to help reduce child poverty and support women to enter, remain and progress in good work.

NHS Grampian employs a large female workforce and is an accredited **Living Wage** employer. Across the organisation, a wide range of policies and development opportunities support women to thrive.

During 2025/26, virtual engagement workshops with Domestic Services staff provided important insights into positive experiences and areas for improvement.

What works well

- Flexible working that supports caring responsibilities
- Regular and protected pay, including annual leave, carers' leave and maternity leave
- Strong team connections and sense of belonging
- Feeling part of patient care

What needs to improve

- Lengthy and complex recruitment processes
- Accessibility of interview arrangements
- Feeling valued across the organisation

NHS Grampian Domestic Services are also working with **Project Flourish** to create supported employment opportunities for young people experiencing or at risk of homelessness with 18 placements completed to date. This includes flexible recruitment, supportive induction and access to training through Hays Learning. Plans are underway to pilot placements within Domestic Services in Aberdeenshire, widening access to secure and meaningful work. Alongside this, staff facing education and wellbeing support has expanded. Initiatives such as Managing Together workshops, menopause awareness sessions, wellbeing talks and monthly clinics at Dr Gray's help staff identify symptoms, understand support options and access appropriate referrals.

As an Anchor Institution, NHS Grampian can further strengthen support for women entering, staying in and progressing through work. By aligning this with our child poverty commitments, we can help reduce financial pressure on families.

Over the coming period, we will make use of Scottish Government funding to:

- strengthen parental employability pathways
- create paid placement opportunities
- build supportive employability infrastructure
- encourage parents experiencing or at risk of poverty to enter or return to work

These actions will help improve family income, reduce child poverty and support women's long term health and economic security.

Places and Communities

Social Prescribing

Sometimes people become unwell because of things going on in their lives — like feeling isolated, struggling financially, or not getting out much. Social prescribing helps people find practical, non medical support, such as local groups, advice services, exercise classes or volunteering. It's about supporting the whole person, not just treating symptoms.[22]

Social prescribing has grown in recent years.

It enables healthcare and community practitioners to refer people to non medical, community based support that can improve health and wellbeing. The evidence base is strengthening, showing that social prescribing can be effective as a stand alone health intervention,[24] while also addressing the wider social and economic conditions that drive health inequalities.

Evidence from NHS England[23] shows the important role social prescribing can play in improving women's health. In 2023, women made up 60% of the 1.3 million people referred to social prescribing services, and 42% of referrals came from minority ethnic communities. This reinforces its value as an approach for addressing the needs of migrant communities and those disproportionately impacted by unmet social and economic needs.

In Grampian, work is underway to develop a social prescribing toolkit to support partners establishing new initiatives, including guidance on information governance and practical implementation. Nationally, a Social Prescribing Framework is being developed as part of the **Population Health Framework.**[4]

The role of green and blue spaces in social prescribing has also received increasing attention. In Aberdeen City, a partnership with the **Royal Society for the Protection of Birds (RSPB)** has led to the development of a Nature Prescriptions[25] pilot as part of the Local Outcome Improvement Plan. The project supports mental wellbeing by encouraging people to connect with local nature through simple, accessible outdoor activities such as walking, gardening or spending time in green spaces tailored to individual needs, ability and circumstances.

Case Study

RSPB Nature Prescriptions Pilot (Aberdeen City)

The pilot has provided GP practices, Link Practitioners and Health Improvement teams with training and practical resources, including nature based calendar booklets co designed with local communities to reflect the seasons, local places and accessible outdoor activities. Early learning shows positive engagement from both practitioners and participants, helping shape plans for broader roll out.

Link Practitioners have reported that Nature Prescriptions offer a simple but highly effective tool for helping people reconnect with nature, supporting a renewed sense of purpose and daily routine.

Several local Health Improvement funds have supported place based projects that connect people with nature. One *example* is **Walk and Talk Therapy at St Fittick's Park in Torry**, delivered by Friends of St Fittick's Park, offering outdoor counselling and group activities. These community led approaches play an important role in supporting preventative mental wellbeing, particularly for women.

To support sustainability, a train the trainer model is being explored to develop local champions who can embed Nature Prescriptions within their own teams and services.

Accessing nature is especially relevant for women experiencing stress, anxiety or social isolation, offering a low cost, non clinical way to support mental wellbeing while strengthening connection to place, community and everyday sources of resilience.

As part of the Aberdeen City Local Outcome Improvement Plan work, NHS Grampian has led a collaboration with partners and **ALISS** (A Local Information System for Scotland) to develop an interactive **Green Health Map** on the **Aberdeen City Health and Social Care Partnership** (ACHSCP) website. Between May and September 2025, 410 services were viewed across selected areas, reflecting diverse community interests and needs, including support groups, wellbeing programmes, social activities and local initiatives.

Place Planning

Aberdeenshire Community Planning Partnership have shifted decisively towards place based planning. This approach recognises that health and wellbeing are shaped by the interplay of social, cultural, economic and environmental factors that vary significantly between communities. Solutions are therefore most effective when they are locally led and reflect the experiences of residents.

From a women's health perspective, this shift creates valuable opportunities. Place based planning allows women's lived experiences—such as their caring responsibilities, perceptions of safety, access to services, transport needs, housing quality and employment circumstance to be heard and considered in local decision making.

As highlighted elsewhere in this report, issues such as gender based violence, poverty, access to services and mental wellbeing affect women disproportionately, and often in place specific ways. Work by the **Scottish Women's Budget Group** across Aberdeen City demonstrated how applying a gender lens to poverty and inequality, starting from local women's experiences, can highlight immediate issues and generate practical recommendations for action.

Embedding women's health within place plans could support earlier, upstream action. By aligning public health intelligence, community engagement and local planning, place based approaches can address structural determinants of women's health rather than relying solely on service responses. However, without explicit gender sensitive analysis and active support for women's participation, place planning carries a risk of reinforcing existing inequalities. Ensuring women's voices are heard, valued and acted on will be essential to achieving equitable outcomes.

Climate Change

Climate change is widely recognised for its environmental impact e.g. storms, heatwaves and coastal flooding, but its role as a major determinant of health is less well understood. As highlighted in previous **NHS Grampian Director of Public Health Reports**,[11] climate change is already affecting health, places and communities, and will shape the lives of today's children well into the future.

Evidence shows that women and girls are disproportionately impacted. According to **UN Women**[26] climate change interacts with existing gender inequalities by limiting access to essential natural resources, intensifying economic and social pressures, and increasing exposure to gender based violence. Climate change can make life harder for women because of inequalities that already exist. For example, during floods, droughts or rising living costs, women may take on extra caring responsibilities, lose income, or be forced into unsafe situations — all of which can increase their risk of harm.[27]

The **Intergovernmental Panel on Climate Change Sixth Assessment Report**[28] further illustrates how climate related risks compound wider determinants of health, including nutrition, livelihoods and wellbeing. It highlights how public health actions—such as promoting good nutrition, improving access to clean energy and supporting active travel—can generate health, economic and environmental benefits, particularly for women and children. At **COP30**, the **Belém Gender Action Plan 2026–2034**[29] was adopted, recognising the specific impacts of climate change on women and girls. To support this, the four principles of the Belém Plan should be shared widely and translated into action:

- Strengthen insight and understanding of the links between climate and gender.
- Engage with women on climate issues through partners such as **NESCAN** and existing CPP engagement approaches.
- Incorporate gender responsive approaches into policy and practice to build community resilience.
- Take action across the public health system to build gender resilience to climate impacts.

Strengthening Links

Collaboration with the third sector underpins much of our work. However, recent engagement with our **Third Sector Interfaces (TSIs)** shows that NHS Grampian does not yet have a clear, strategic approach to planning and collaborating with the sector as a whole.

Over the next year, we plan to work closely with the three TSI leads to develop a more proactive and strategic partnership. This will help us identify shared priorities, coordinate funding opportunities, and develop collaborative approaches to improving health and wellbeing for women and families across Grampian.

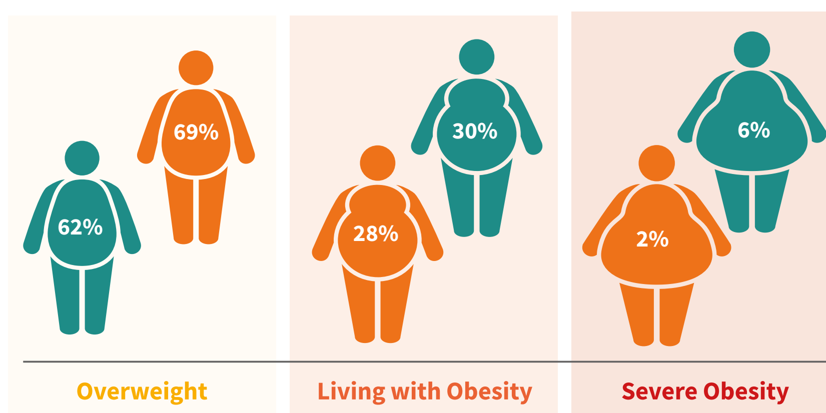
Enabling healthy living

Food Environment and Nutrition

Across Grampian, excess weight remains a major public health challenge. Data shows that 65% of adults are overweight and 29% are living with obesity.[30] This equates to:

- 124,521 overweight adults and 36,111 living with obesity in Aberdeen City.
- 137,301 overweight adults and 39,817 living with obesity in Aberdeenshire.
- 52,305 overweight adults and 15,168 living with obesity in Moray.

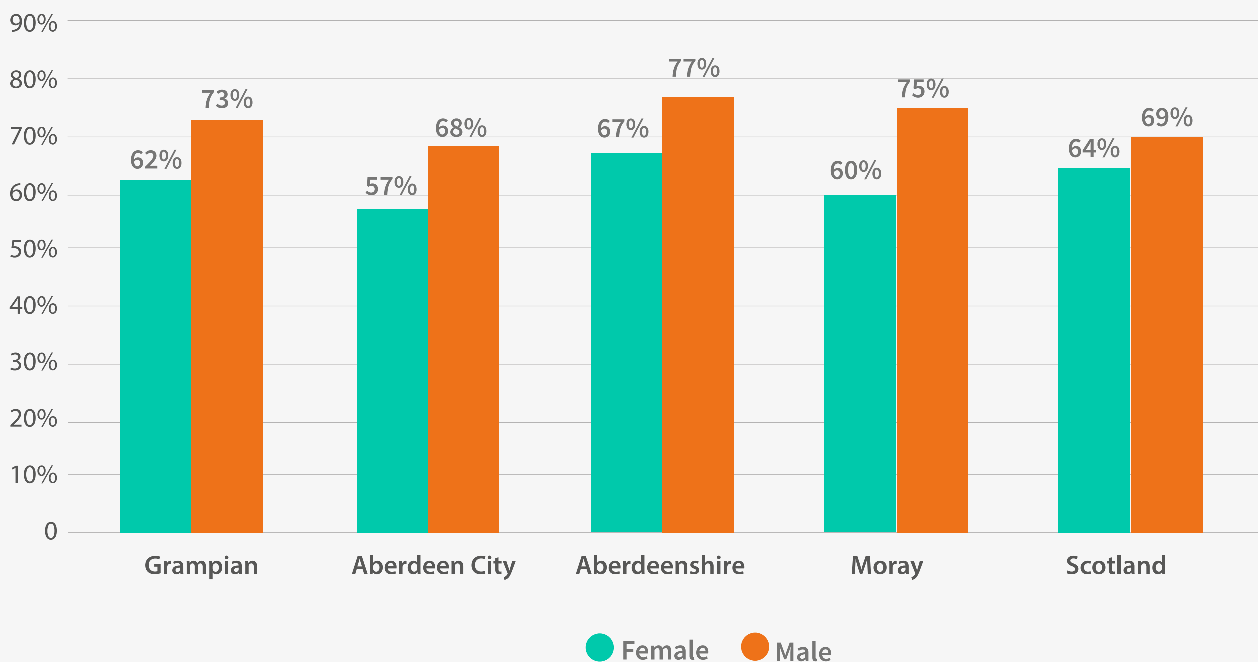
Looking at trends by gender:



62% of women are overweight (including those living with obesity); 30% are living with obesity - 6% have severe obesity.

69% of men living in Grampian are overweight (including those living with obesity); 28% are living with obesity – 2% have severe obesity.

Figure 1: Proportion of adults in Grampian who are overweight or living with obesity, 2021-2024.



Source: Scottish Health Survey

Concerningly, childhood trends mirror this pattern: in Primary 1, between 12–14% of children are overweight and 10–11.5% are living with obesity.[31]

Women from more deprived backgrounds are much more likely than their less deprived counterparts to be living with overweight and obesity during pregnancy. About 60% of pregnant women in the most deprived SIMD quintile were recorded as overweight or obese, compared to about 50% in the least deprived SIMD quintile.[32]

In response, all three HSCPs in Grampian are taking forward a **Whole Systems Approach**[33] to healthy weight.

The approach recognises that healthy weight is influenced not only by individual behaviours but by the wider social, environmental, economic, cultural and policy contexts. It brings partners together to understand local drivers and co produce coordinated, sustainable, system wide actions.

Complementing the Whole System Approach, the **Local Levers to Diet and Healthy Weight framework**[34] identifies seven key areas where local authorities and the NHS can work together:

- Restricting advertising of products high in fat, sugar or salt.
- Using planning policy to shape healthier local food environments.
- Strengthening public sector food procurement standards (e.g. at least 75% healthier choices).
- Working with the out of home sector to reduce calories on menus.
- Increasing uptake of school meals.
- Promoting and supporting physical activity.
- Protecting, promoting and supporting breastfeeding and healthy early diets.

Each local authority area has undertaken engagement and is developing action plans incorporating these levers. The whole population focus is complemented by specific actions targeted at settings such as nurseries, schools and breastfeeding support.

To strengthen regional leadership on the obesogenic environment, the North East Population Health Alliance has endorsed actions to restrict advertising of foods high in fat, sugar and salt across partner organisations and to support the Eating Out, Eating Well Framework.[36]

Aberdeen City: Healthy Weight Aberdeen Action Plan	**Key actions include:** • Exploring restrictions on advertising high fat, sugar and salt products around bus stops, train stations, leisure centres and school zones. • Using health impact assessments to inform planning decisions about food outlets. • Encouraging healthier retail choices in the vicinity of schools. • Supporting implementation of the **Good Food Nation Plan.**[35] • Increasing the availability and promotion of healthier food and drink in NHS, local authority and leisure facilities. • Adapting the **Eating Out, Eating Well Framework**[36] for local use. • Working with the out of home sector on calorie reduction, including options for portion size changes or calorie caps.
Moray: Healthy Weight Moray Action Plan	**Key actions include:** • Ensuring Healthy Eating and Physical Activity are addressed in planning and licensing Health Impact Assessments. • Creating a 'Business Healthy Eating Charter' to support healthier commercial food provision. • Normalising and supporting breastfeeding through **Breastfeeding Friendly Scotland** spaces and strengthened early years nutrition education. • Delivering practical, low cost cooking and nutrition skills through parent workshops, mobile chef outreach, community kitchens and CADs.
Aberdeenshire: Healthy Eating, Active Living (HEAL)	Aberdeenshire's long standing HEAL programme is now in its second cycle of action planning, taking a place based approach centred on Banff and Peterhead Academies. In Banff, a Food & Active Living Summit in March 2026 identified priorities including: • Improving school meal uptake • Using planning powers to influence the food environment • Working with out of home providers on calorie reduction • Supporting breastfeeding and healthy child nutrition • Enhancing opportunities for physical activity Banff Academy is also working with the council catering team and Bite Back Scotland, where pupils are redesigning the dining environment and menu to increase school meal uptake.

Physical Activity

In Grampian, 69% of people meet the recommended physical activity guidelines, above the national average.[31] However, a gender gap remains: 74% of men meet the guidelines compared with 66% of women.[31]

Women and girls are also affected by menstruation (periods) and their willingness or ability to participate in sport or physical activity. Research suggests that an interest in sport and fitness diminishes in 84% of teenage girls with around 33% being uncomfortable in participation during menstruation.[37] Despite the introduction of Free Period Products following a change in legislation[38] in 2021 to address period poverty, a recent evaluation has shown that the availability and variety of products remains inconsistent and sub-standard. Aberdeenshire schools were a part of this evaluation – only 33% of respondents believed that their school provided enough products for their pupils, suggesting that there is an opportunity to meaningfully engage and work with young people to overcome barriers to accessing free products e.g. lack of products, lack of variety of products and stigma and shame.[39]

Increasing opportunities for women to be active benefits not only weight related outcomes, but also wider health and wellbeing. Across the life course, regular physical activity reduces the risk of conditions such as obesity, type 2 diabetes and cardiovascular disease. **The Burden of Disease Study**[40] estimates a 21% increase in Scotland's annual burden of disease over the next 20 years, underlining the importance of prevention.

The Chief Medical Officer's physical activity guidelines[41] emphasises the importance of maintaining activity from childhood into older age. Activity is also promoted during pregnancy and after birth.

Frailty, falls and musculoskeletal health are major issues for older women and closely linked to loss of confidence, and reduced independence. Women have higher rates of osteoporosis and fracture, particularly hip fractures, which can result in long hospital stays, long term care needs and increased mortality.

Musculoskeletal decline is a key contributor to poorer quality of life in later years. Bone health is particularly important for women due to biological changes during the life course. Weight bearing and muscle strengthening activity can improve bone density, maintain musculoskeletal health and reduce the risk of osteoporosis and fractures — especially after menopause when oestrogen levels decline. Regular activity also supports cardiovascular health, cognitive function, sleep quality and mental wellbeing.

NHS Grampian provides grant support to the Grampian 50+ Network, which runs regular walking groups for over 1,000 older people across Grampian. Evidence from several systematic reviews[42] shows that regular walking for more than six months helps to preserve bone and may reduce hip fractures in post-menopausal women. When complemented by other forms of exercise it may also achieve broader skeletal benefit.

Dental and Oral Health

Good oral health is an essential part of women's overall health and wellbeing, yet it remains an area that is often overlooked within wider health policy. Across the life course, women experience distinct oral health needs shaped by hormonal changes, pregnancy, socioeconomic circumstances and access to NHS dental services.[43]

In Grampian, oral health inequalities persist and mirror wider patterns seen across women's health. Women living in the most deprived communities experience higher levels of dental disease, greater unmet treatment need and lower access to preventative care. Cost continues to be a barrier, particularly for women with caring responsibilities or those working in part time or lower paid roles.[44]

While access to NHS dental services has improved over the past year, it remains inconsistent across the region. Women living in rural communities often face longer travel times, higher transport costs and fewer available appointments. Women from inclusion groups including ethnic minority communities, Gypsy/Travellers and women affected by gender based violence report additional barriers linked to stigma, trauma, cultural expectations or previous negative experiences.

Women experiencing poverty are more likely to delay dental treatment, prioritise their children's care over their own, or seek help only when in pain or crisis. These patterns reinforce the connection between oral health and the wider social and economic inequalities affecting women.

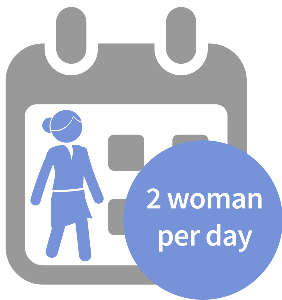
NHS Grampian supports women's and families' oral health through a range of prevention focused programmes. This includes Childsmile, Healthpoint and Maternity and Infant Nutrition work, which help promote good oral health habits early in life. Smoking cessation pathways for pregnant women already include oral health guidance, and trauma informed approaches are increasingly being incorporated into primary care dentistry.

The NHS Grampian Chidren's Oral Health Improvement Action Plan (2024–2029)[45] strengthens these efforts by prioritising prevention, improving equitable access and addressing longstanding inequalities. The plan sets out a coordinated approach to ensure that children, and the women who care for them, receive consistent, prevention focused support across services. Key actions include:

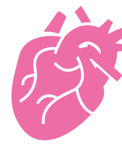
- Improving access to NHS dental care for women facing socioeconomic disadvantage, rural isolation or unstable housing.
- Strengthening oral health messaging across pregnancy pathways, menopause support, gender based violence services and inclusion health initiatives.

Taken together, these actions recognise oral health as an important component of women's health and a meaningful opportunity to reduce inequalities across the life course.

Cardiovascular Disease (CVD)



CVD is a major and often underestimated health issue for women. Heart attacks are the second leading cause of death among women and on average around 2 women died every day in Grampian in 2025 from CVD.



For every 100,000 people living in Grampian, around 268 have CVD. This increases to 426 per 100,000, among the those living in the most deprived areas.[46]

Overall prevalence of CVD remains higher in men, but women often have heart attacks at older ages than men; and many describe or experience symptoms differently to men. These differences can contribute to delays in recognising a cardiac emergency, and women are more likely to receive an incorrect diagnosis. Even after diagnosis, women receive around half as many cardiovascular treatments as men - the consequences for women are significant and often severe.[47]

Genetic heart disease

Women experience delayed or missed diagnosis.

Present differently.

Heart failure

Women present older with multiple other health conditions.

Less likely to get pacemakers to protect from sudden cardiac death.

Fewer referral for advanced therapies.

Pregnancy complication can increase risk.

Heart valve disease

Smaller heart which means there's less reserve. Small drops in function can affect symptoms sooner.

Blood vessel disease

Less likely to be referred for diagnosis.

Worse outcomes following heart attack.

Programme of recovery after a heart attack or treatment

Lack of awareness on the impact of lifestyle on cardiovascular risk.

Reluctance to revisit hospital setting after heart problem.

Barriers to programmes – lack of time, work/family commitments.

Heart rhythm disorders

More likely to wait longer for diagnosis.

Multiple additional reasons for increase in blood clots e.g. hormonal.

Investigations

Smaller chest cavities and breast tissue affect diagnostic accuracy.

More likely to have a diagnosis of unexplained chest pain when related to CVD.

Cancer

Cancer treatments can damage the heart.

Delayed diagnosis.

Hormonal differences.

Heart diseases people are born with

Greater incidence of genetic heart disease in women.

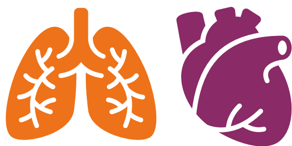
Lack of understanding of genetic heart diseases in different genders.

Women also experience several risk life-course factors for CVD, including:

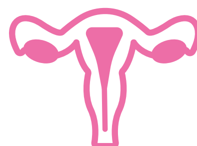
- Reproductive health conditions such as Polyendocrine Metabolic Ovarian Syndrome (PMOS) and endometriosis, which are associated with increased cardiovascular risk.
- Pregnancy related complications, including pre-eclampsia, gestational diabetes and pregnancy induced hypertension, which substantially increase long term risk.
- Menopause, where the loss of oestrogen's protective effect contributes to higher blood pressure and increased vulnerability to heart damage.

There are also protective factors. For example, women who breastfeed have a reduced risk of CVD, coronary heart disease, stroke and fatal cardiovascular events.[48]

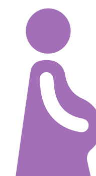
A Health Needs Assessment is currently underway in Grampian to better understand local patterns of cardiovascular risk and identify priority groups for prevention and early intervention. Understanding female specific risks and their implications across the life course will be a key component. Once complete, the intention is to take a whole systems approach, coordinating action across NHS services, local government and community partners to strengthen prevention, detection and treatment, with a focus on reducing inequalities.



In Grampian, CVD is the second leading cause of death in women after lung cancer.



Women who start their period early have a greater CVD risk than women who start later.

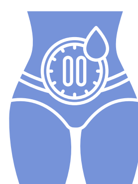


Conditions in pregnancy such as pre-eclampsia can increase CVD risk.

Women are more likely to develop conditions such as lupus, rheumatoid arthritis, and depression which are risk factors for CVD.

Women are less likely to recognise they are having a heart attack.

Women are more likely to have traditional CVD risk factors such as reduced physical activity and obesity.



During menopause levels of oestrogen drop which can increase the risk of CVD.

Although not specific to women, the **Scottish Government's Cardiovascular Disease Risk Factors Programme**[49] aims to reduce avoidable deaths from cardiovascular disease by 20% over 20 years. The programme focuses on improving the identification and management of major risk factors: high blood pressure, high cholesterol, raised blood sugars, obesity and smoking.

In Grampian, we are supporting GP practices to deliver this work and have produced an **animation** to help patients understand the importance of cardiovascular risk management. We are also piloting a referral scheme enabling GPs to refer patients to Healthpoint, offering holistic lifestyle consultations to support risk reduction.

A range of NHS Grampian services already play an important role, including smoking cessation support, weight management programmes, physical activity interventions, maternal and infant nutrition services and alcohol reduction initiatives. The challenge is to optimise access and uptake of these services to support equitable health outcomes for all.

Partnership with the third sector is also strengthening local prevention and awareness efforts. Collaboration with **Chest Heart & Stroke Scotland** has helped establish a new Grampian Hub in Aberdeen, alongside support for a CAD, Women's Health events and Fraserburgh Wellbeing activities. Grampian Hubs are located at the **Aberdeen City Vaccination & Wellbeing Hub** at the Bon Accord Centre and at **Get Active Northfield (Sport Aberdeen)** and offer free health checks such as blood pressure and cholesterol checks as well as advice and information on the prevention of CVD conditions. A tailored Women's Health pilot is also planned, supporting women's heart health through the delivery of women's specific groups and establishing networks with new and existing partners in the area.

Mental Health and Wellbeing

Women's mental health is influenced by many everyday pressures. Women are more likely than men to experience low income, insecure work, caring responsibilities, domestic abuse, and pressures linked to body image and identity. Together, these increase long term stress and make mental health problems more likely.[50–53]

Across Scotland,[54] women consistently report poorer mental wellbeing than men. While men are more likely to die by suicide (around three times higher rates than women), women experience higher levels of ongoing emotional distress such as anxiety and depression.[55] This highlights different patterns of need: women carry a heavier burden of day to day distress, while men face higher suicide risk.

In Grampian, there are clear inequalities.[56] Women living in the most deprived communities are around twice as likely to be referred to mental health services as those in the least deprived areas. Suicide rates also show sharp differences, with deprived areas of Moray reaching 14.3 per 100,000, compared with 4.2 per 100,000 in more affluent areas.[57]

Over the last 10 years, mental health pressures have increased in Grampian:

- The increase in emergency department attendances since 2020 - 2022 is almost entirely attributable to an increased rate for girls.
- Between 2015 and 2022 Emergency department attendances for mental health reasons increased by 42%.
- Between 2015 and 2022 Child and Adolescent Mental Health Service (CHAMS) referrals increased by 9%.

Teenage girls account for much of this rise. Girls are now the most likely group to be prescribed antidepressants, attend emergency departments for mental health reasons, and be referred to CAMHS.[58] School wellbeing surveys[59]

show that girls report worse mental health than boys at every stage of secondary school.

Autism and ADHD have historically been diagnosed far less often in women and girls, not because they are less common, but because they are harder to recognise using current diagnostic approaches. Many women and girls show different signs, are more likely to hide their difficulties, and are often misdiagnosed with anxiety or depression instead. As a result, many receive a diagnosis late in life or not at all, limiting access to the right support. Autistic women experience particularly poor mental health outcomes and face a higher risk of suicide. Third sector organisations such as the Scottish Women's Autistic Network provide vital pre and post diagnostic support, but there is a widely recognised lack of clear policy, pathways and system wide provision for neurodivergent women and girls in Scotland. Improving awareness, diagnostic practice and tailored support is therefore a critical unmet need.

Mental health during pregnancy and after birth remains a key priority. Pregnancy and the postnatal period can be times of increased vulnerability, and work continues to improve prevention, access to support and use of women's lived experience to shape services.

The Building Blocks of Mental Health and Wellbeing framework[60] developed in Grampian, helps explain these inequalities. It shows how mental health depends on secure relationships, safe environments, financial stability and emotional support across the life course. While there has not yet been a dedicated focus on women's mental health, strong foundations are in place for future action.

Positive and Secure Relationships

Strong, trusting relationships with family, peers and communitites provide the emotional foundation for mental wellbeing throughout life.

Protection from Adversity

Reducing exposure to poverty, trauma, discrimination and unsafe environments is essential to preventing mental health problems and reducing inequalities.

Mentally Healthy Environments

Supportive environments in which people live, learn, work and connect help reduce stress and strengthen the conditions for good mental wellbeing.

Development of Cognitive and Emotional Skills

The ability to understand, manage and express emotions supports coping, relationships and wellbeing throughout life.

Early, Compassionate Safety Net

Timely, accesible and non-stigmatising support as the earliest signs of distress helps prevent problems from escalating and causing long-term harm.

Positive Identity and Agency

Feeling valued, included and able to influence decisions that affect ourselves strengthens confidence, purpose and mental wellbeing.

Community based prevention is already making a difference. A Mental Health and Wellbeing Community Appointment Day brought several services together in one place in Fraserburgh, where mental health and access to services had been previously highlighted as key priorities. Most attendees were women, and early evaluation has been very positive. Women valued being able to speak to different services in a single visit and found the support welcoming, compassionate and practical. 85% of attendees who completed evaluation forms reported increased knowledge of tools they can use to support their wellbeing, while 95% reported increased knowledge of services and supports available to support them. Here is some feedback from CAD participants:

> *"Very impressed by the wide range of services available. Everyone I spoke to was extremely friendly and helpful."*

> *"This need to be a regular event to keep the community informed of what support is available."*

> *"...You have been friendly and kind - it's good to know there are people who care and want to help"*

Despite progress, there is still a clear lack of mental health prevention approaches designed specifically for women. Anxiety, depression and loneliness remain common, especially in more deprived communities. Older women are at particular risk of loneliness and anxiety following life changes such as bereavement, retirement or declining health. Loneliness is linked to poorer health outcomes and higher use of services.[61]

The Building Blocks framework[60] highlights key opportunities to improve women's mental health:

- strengthening relationships and social support, especially around pregnancy and parenting.
- reducing adversity through access to financial, housing and domestic abuse support.
- creating safer, fairer environments, including childcare and fair work.
- supporting girls' emotional wellbeing early through schools.
- ensuring a 'No Wrong Door' approach so women receive compassionate support wherever they seek help.

Case Study

Chilling Women - Keith, Moray

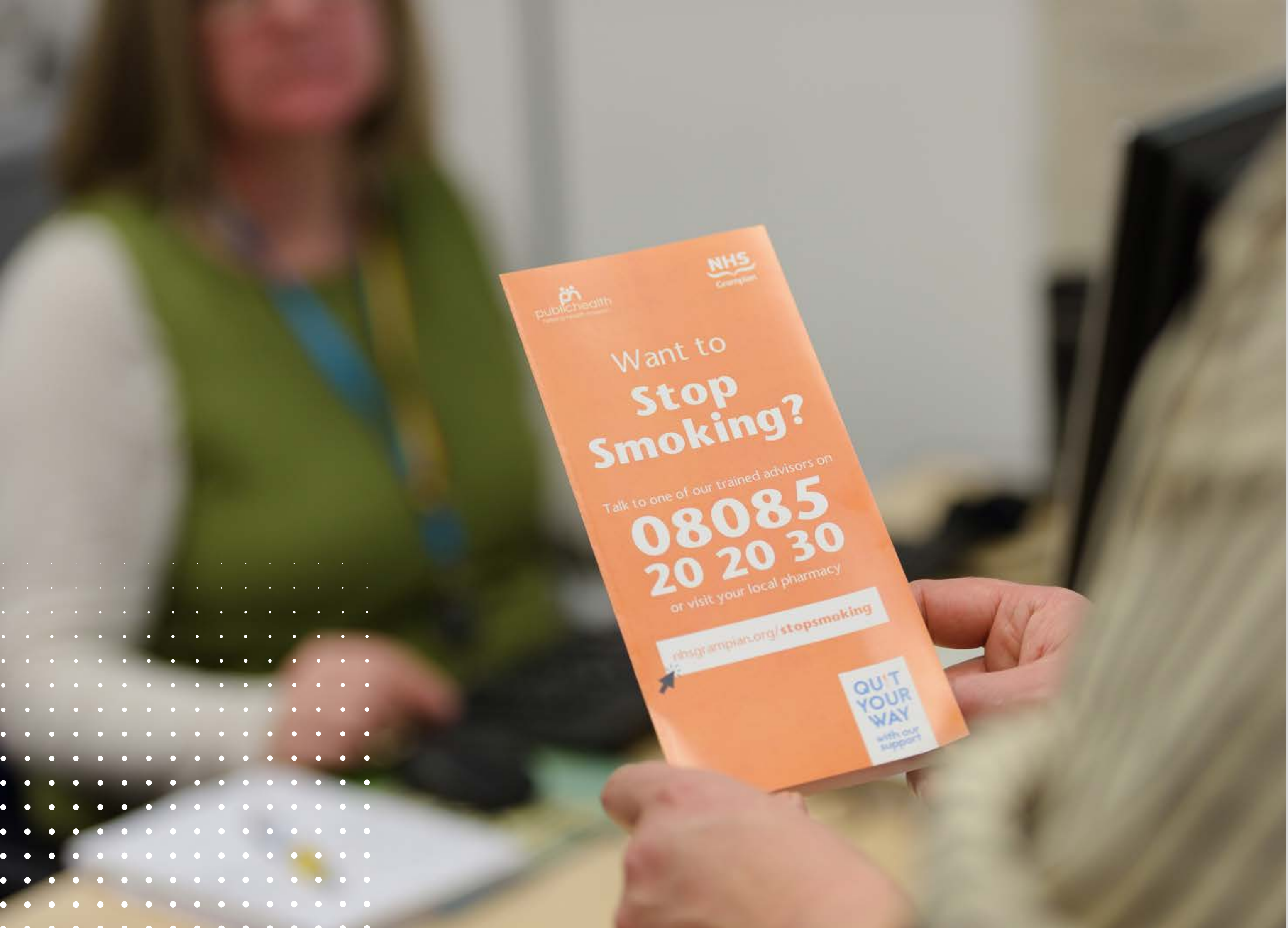
Chilling Women is a peer-led wellbeing group for women aged 18 and over in Keith and the surrounding rural communities. Launched in 2023, the group was created in response to a gap in local support for women experiencing low mood, anxiety, loneliness and low confidence. Community members recognised the need for a confidential, non-judgmental space where women could connect and feel understood. The group was established and was initially supported by Networks of Wellbeing.

The group meets weekly during term time and offers a wide range of accessible wellbeing activities, such as arts and crafts, relaxation sessions, yoga, movement and guided discussions. These activities are rooted in the CHIME principles (Connection, Hope, Identity, Meaning and Empowerment), helping women rebuild confidence and strengthen supportive relationships.

A key feature of the group is its flexibility. Women can join simply to take part in an activity, helping to reduce self-stigma and the fear of being seen attending a "mental health group" in a small town. Over time, many choose to share experiences around parenting, neurodiversity, grief and past trauma, finding empathy and validation from others facing similar challenges.

Attendance has grown significantly, from early sessions with only one or two women to regular groups of 10–20 participants. A virtual group helps maintain connection for women unable to attend in person, ensuring group members have other ways of connecting with the group. Some women have regained the confidence to return to work, while others describe finally feeling part of a community after moving to the area.

Sustaining the group is an ongoing focus. Support from **TSI Moray**, local fundraising and contributions from a local supermarket have helped the group grow. The group also provide opportunities for participants to become peer facilitators. Above all, Chilling Women offers a warm, inclusive space where women can connect, build confidence and support each other through shared experience.



Tobacco and Smoking

In Grampian, 13% of women aged 16 and over smoke (approx. 34,000), and many are working hard to quit. Between April and December 2025, 1,229 women began a quit attempt, with 316 women (25.7%) remaining smoke free after 12 weeks.[62]

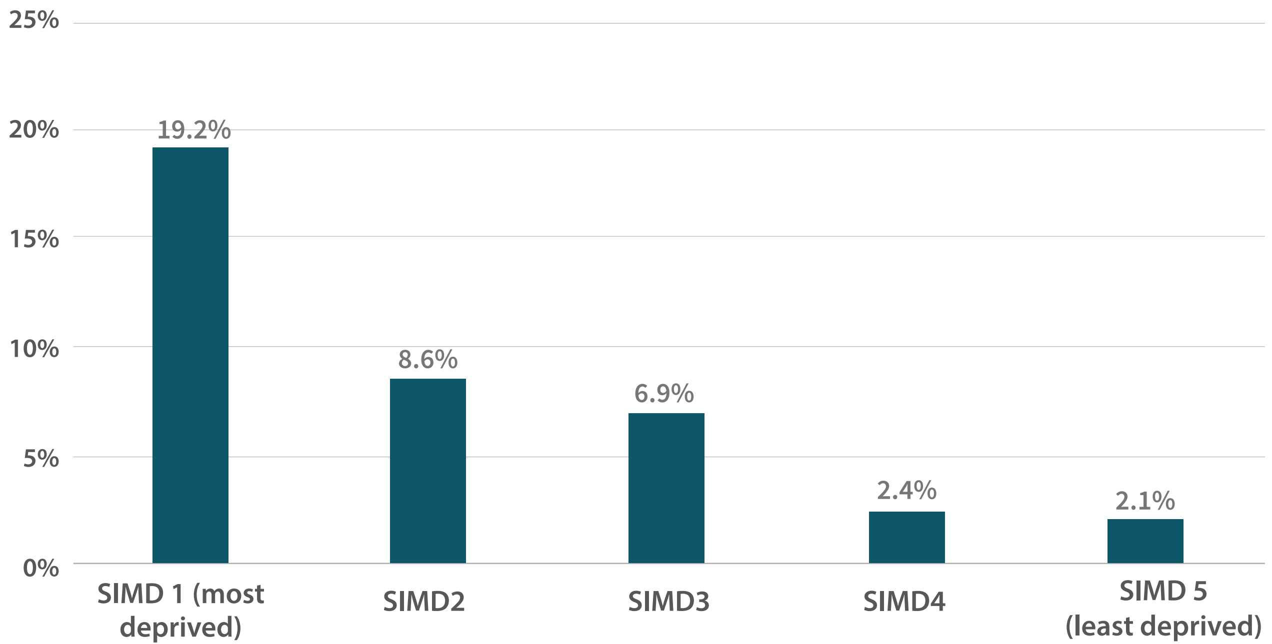
Around 7% of pregnant women in Grampian smoke, although this varies significantly by Scottish Index of Multiple Deprivation (SIMD) quintile (Figure 2).[63]

NICE guidance[64] recommends that 5% of the population are supported to set a quit date and then 35% of those who set a quit date to achieve a 4-week quit.

Smoking affects everyone differently, but for women there are specific health risks linked to biological and reproductive stages of life. These include increased risks of cervical cancer, heart disease, stroke, blood clots and osteoporosis, as well as complications during pregnancy (low birthweight, premature birth and miscarriage).[65]

Stopping smoking is one of the most important actions women can take to protect their health at any age or stage of life. Every quit attempt matters, and support is available across Grampian to help women take the first step.

Figure 2: Smoking Rates at Maternal Booking by SIMD Quintile, 2024/25



Source: Badgernet, NHS Grampian

NHS Grampian has introduced a new approach to better support pregnant women who smoke, helping more families start their pregnancy in the healthiest way possible. Previously, pregnant women were asked whether they wished to be referred for stop smoking support. Many declined, meaning only a small number received help. A new opt out referral pathway now ensures that all pregnant women who smoke, have recently quit, or record a raised carbon monoxide level at booking are automatically contacted. This approach is warm, supportive and non judgemental, ensuring that every woman is offered information and help that may benefit her and her baby.

The new pathway is already showing positive impact. Carbon monoxide testing at booking appointments has increased from 62.4% to 80.1%, and more women have been connected with Healthpoint for personalised support. In the last year, advisors have helped 45 women set a quit date — around 14% of those contacted.

Stopping smoking is only one part of the conversation. Healthpoint Advisors also provide advice on oral health, infant feeding, gestational diabetes, vaccination, screening and overall wellbeing, helping women access wider support during pregnancy.

We are currently reviewing data on maternal smoking at the time of birth. This will inform whether the existing 12 week programme should be extended so women can receive support throughout pregnancy and beyond. Our aim is to provide the right support, for as long as it is needed.

Journey 1

When this woman joined the Smoking Cessation Service, she had already tried several approaches to quitting — including gum, e-cigarettes and patches — but none had worked for her. With support, she was able to find an approach that suited her needs and helped her stay on track.

Alongside stop smoking support, the woman was offered wider wellbeing information and resources, including:

- Infant feeding support
- Healthy eating and nutrition materials
- Information on gestational diabetes
- A Confidence to Cook recipe book
- Advice on free dental care during pregnancy
- Guidance on registering their baby
- A link to Turn2us to check financial support
- A Home Energy referral for the colder months

As the woman worked as a delivery driver, she also discussed her general health and wellbeing. Due to recent weather conditions and the physical demands of the job, she chose to reduce heavy parcel deliveries and increase food delivery work.

After a successful 12 week quit, the woman reports feeling healthier, no longer experiencing cravings and is looking forward to welcomingher baby.

Journey 2

This woman joined the Smoking Cessation Service after struggling to quit while managing her mental health and caring for a toddler. She had recently stopped using cannabis and was seeking support to stay smokefree.

As part of her wellbeing support, she was offered:

- An Infant Feeding referral
- A 'Confidence to Cook' recipe book
- Toothbrushes and toothpaste for the family
- Links to trusted information about ADHD, which they found reassuring
- Advice on recognising smoking triggers, particularly stress and emotional challenges
- Suggestions for alternative coping strategies

Together, she explored the difficulties of balancing pregnancy, parenting and day-to-day pressures, and developed approaches to manage cravings without returning to smoking.

During the 12-week programme, the woman also received information on:

- Mental health support and selfcare techniques
- Useful NHS Inform resources following a brief hospital stay with vertigo
- Additional coping tools during recent bad weather, when childcare and routine were disrupted.
- She was offered a Home Energy referral but chose not to take it up.

The woman has now achieved a full 12-week quit and is delighted with her progress. She looks forward to receiving her congratulations letter and plans to stay in touch until her baby arrives.

Substance Use

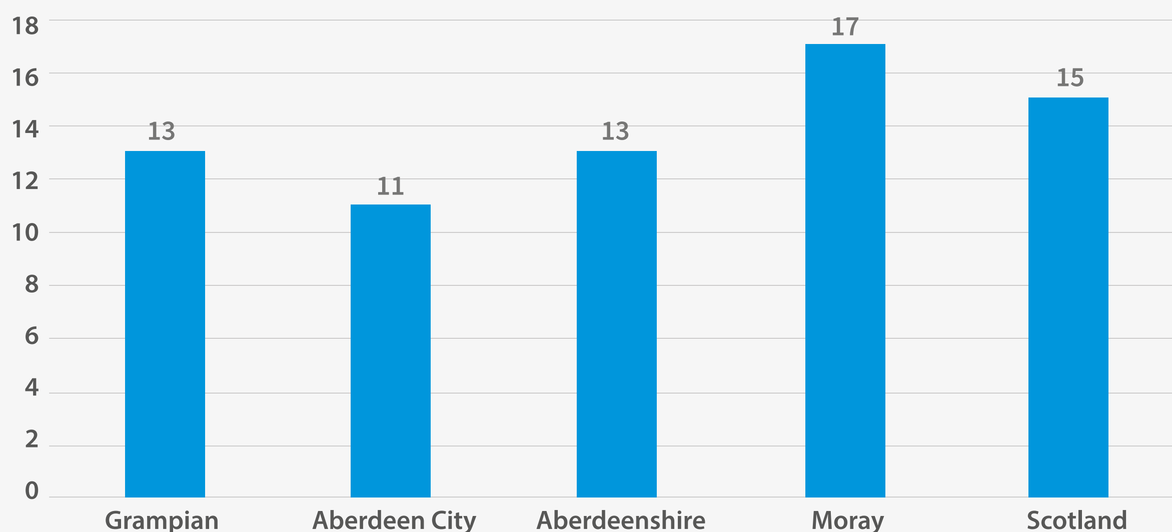
Across Scotland it is increasingly recognised that women can experience alcohol related harm differently, shaped by stigma and whether support feels safe and designed with women in mind. Grampian is no different. Women's alcohol consumption in Grampian is comparable with Scotland as a whole, and lower than men locally (Figure 3).[66]

Figure 3: Mean weekly units of alcohol consumption, 2012-2024, Grampian (Males/Females)

Source: Alcohol Dashboard, Public Health Scotland.

Overall, the proportion of women drinking above the 14 unit weekly guideline is broadly in line with Scotland (Figure 3) - Scottish Health Survey data[67] indicates that the proportion of women exceeding 14 units per week was highest in Moray (17%), lowest in Aberdeen City (11%), with Aberdeenshire (13%) in the middle, compared with 14% for Scotland; the difference for Moray versus Scotland was not significant.

Figure 4: Proportion of women in Grampian experiencing hazardous/harmful drinking (above 14 units per week), 2021/2024.



Source: Alcohol Dashboard, Public Health Scotland.

In 2023/2024 there were 938 referrals in NHS Grampian to support women whose alcohol use had become harmful enough to require specialist support.[68] Of these, 332 (35%) related to Aberdeen City, 401 (43%) to Aberdeenshire, and 205 (22%) to Moray.

In 2024, the alcohol specific mortality rate for women in Grampian which was wholly attributable to alcohol related causes was 9.9 per 100,000 women. This was lower than the comparable rate for Scotland which was 13.1 per 100,000 women (Figure 4).[66]

This prompts us to learn directly from women about what helps or hinders early help seeking, and whether women feel listened to, treated with dignity, and supported without judgement when they do seek help. A future curious approach asks: what opportunities to reduce preventable harms sit upstream of alcohol related deaths for women — hospital admissions, mental health crises, domestic violence and safeguarding concerns, unintentional injuries, loss of housing, family strain, and cumulative stigma — and are women able to access support early enough?

National Records of Scotland[69] reports that healthy life expectancy in Scotland is below England and Wales, with females in the most deprived areas experiencing almost 10.5 fewer healthy years than those in the least deprived areas. Against this backdrop, women's alcohol harm is not confined to "alcohol specific" conditions; much of the burden comes through partially attributable physical health harms such as cancers, cardiovascular disease, digestive disease and injuries.

Public Health Scotland's Alcohol Consumption and Harms Dashboard publication[66] shows that, over 2012–2020, hospital admissions from conditions either wholly or partially attributable to alcohol peaked for females in 2019 (774 per 100,000), while deaths from conditions either wholly or partially attributable to alcohol peaked for females in 2016 (45 per 100,000). These wider harms include women specific outcomes such as breast cancer: **Scottish guidance**[70] reports that

in 2022, there were 5,139 new cases of female breast cancer in Scotland and estimates that 14% of female breast cancer cases were attributable to alcohol.

In line with **Scottish Government strategy**[71] to prevent harm, promote recovery and embed a human rights based public health approach to alcohol and drugs, we will work towards assessing success not only through activity or throughput, but through whether people experience support that fulfils the right to the highest attainable standard of physical and mental health. Public Health Scotland sets out the **AAAQ framework**[72] Availability, Accessibility, Acceptability and Quality—as a core component of human rights based public health practice and a recognised standard for understanding need, shaping services and addressing inequality. Practically, this means testing whether options exist at the right times (availability), can be used in real life (accessibility), feel safe and culturally appropriate (acceptability), and are consistent and person-centred (quality). This will increasingly underpin future work in population needs assessment, service design and quality standards led by Alcohol and Drug Partnerships.

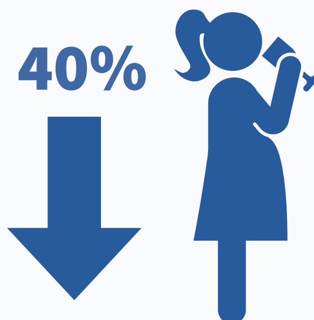
What does it feel like for a woman to disclose alcohol use in pregnancy — and what makes disclosure safer?

An alcohol in pregnancy project illustrates how this can be learned. In Aberdeen City, the Health Improvement Team has led a project to reduce alcohol use in pregnancy in the 40% most deprived communities, emphasising prevention, early intervention and equity.

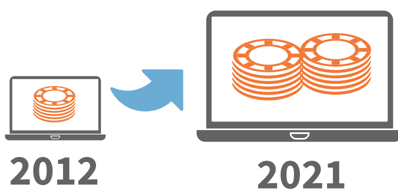
The project adapted and tested the evidence based 'Drymester' campaign through community listening events and Healthy Beginnings sessions, which highlighted gaps in awareness—including the message that no alcohol is safe in pregnancy—and the need for clear, non judgemental communication.

Community feedback has shaped local resources, including visual materials and an Aberdeen specific Foetal Alcohol Spectrum Disorder awareness video, with ongoing work to resource messaging across maternity and community services. This will include gathering women's feedback on access, acceptability and outcomes and acting on what it shows.

In Aberdeen City, the Health Improvement Team has led a project to reduce alcohol use in pregnancy in the 40% most deprived communities



Gambling harms

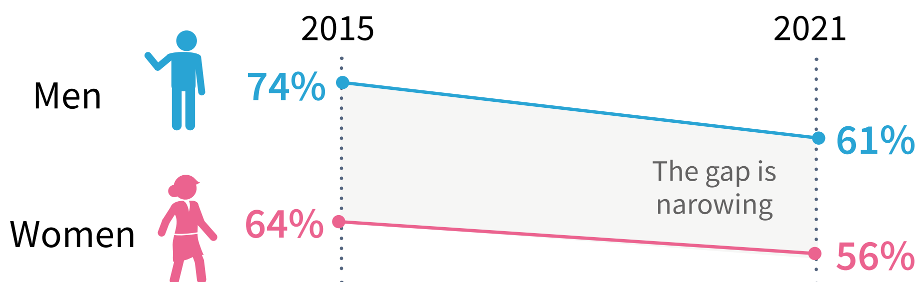


Gambling is common across Scotland.

In 2021, 58% of adults reported gambling in the previous year, and rates of online gambling had doubled since 2012.

While men still gamble slightly more than women (61% compared with 56%), the gap is narrowing — in 2015, 74% of men gambled compared with 64% of women.[73]

Although many people view gambling as a recreational activity, it can lead to significant harm.



Gambling related harm can affect many aspects of life, including:

- Money — debt, unpaid bills and loss of savings.
- Relationships — conflict, breakdown of trust and pressure on family life.
- Health — stress, anxiety, depression and physical illness.

These harms extend beyond the individual. For every one person experiencing gambling harm, an estimated six to ten others may be affected.[73]

Women often experience gambling harm differently. Studies[74] show that women who gamble report lower mental wellbeing than men, with many describing high levels of stress, anxiety or depression when seeking support. Women may also experience a faster progression from recreational gambling to harm — a pattern known as telescoping. This may help explain why 67% of women experiencing gambling harm report being in debt, compared with 48% of men.

Local data specific to women is limited, and the true extent of women's gambling related harm in Grampian is not yet fully understood. However, it is estimated that 2,000–3,000 adults in Aberdeen City experience moderate to severe gambling harm, with an associated cost to the city of £4.4 million.[75] Despite this, fewer people in Aberdeen seek support compared with the national average.

Two key barriers contribute to this:

- Stigma and shame, which prevent people from asking for help
- Low awareness among both the public and professionals about available support

Most support is currently provided by third sector organisations, and links with NHS and social care services are still developing.

NHS Grampian and partners have secured funding from the Gambling Levy to develop a Local Gambling Harms Recovery Network in Aberdeen City, informed by **Public Health Scotland's Healthcare Needs Assessment.**[76] This recommends accessible, person centred, stigma free support — particularly in areas experiencing higher levels of deprivation. The network will be delivered jointly by Aberdeen City Health & Social Care Partnership and the Scottish Recovery Consortium, with a strong emphasis on lived experience, peer support and community involvement. Tailored support for women will be considered as a priority.

The aims of the project are to:

- Identify gambling harms earlier.
- Increase access to support.
- Improve coordination between services.
- Co produce recovery options with people who have lived experience.
- Reduce stigma.
- Ultimately reduce gambling related harms and the inequalities that shape them.

This work offers an important opportunity to strengthen prevention and early help, ensuring that women in Grampian can access safe, non judgemental support when they need it.

Menstruation

Menstrual health is a core component of physical, mental and social wellbeing. It affects daily life, participation in education and work, and long term health outcomes. When menstrual conditions such as endometriosis or Polyendocrine Metabolic Ovarian Syndrome (PMOS) are not identified or treated early, they can significantly affect quality of life.

Endometriosis affects around 1 in 10 women,[77] often causing chronic pelvic pain, heavy or painful periods. If untreated this can lead to fertility challenges. PMOS is the most common hormonal condition and is frequently associated with irregular or heavy periods, excess hair growth, difficulty conceiving and longer term risks such as diabetes, cardiovascular disease, and endometrial thickening.

Delays in diagnosis, variation in menstrual health expertise, and long waiting times can prolong symptoms, increase psychological distress and affect education, employment and social participation. Prioritising menstrual health enables earlier intervention, reduces complications, and supports women to manage their wellbeing effectively.

Awareness of menstrual health has been strengthened through national E-learning modules, and trauma informed, person centred approaches are increasingly embedded across services.

In Grampian, we have expanded community based support to improve access and understanding. The Women's Health CAD provided multidisciplinary advice, wellbeing resources, expert talks and '**What Matters to You**' conversations. This model offered both booked appointments and drop in access, helping women understand their symptoms and navigate available services. Health passports supported personalised guidance and encouraged self management.

We have made good progress in improving menstrual health pathways. A new national opt out system for heavy periods is now in place, meaning women automatically

receive relevant information and can choose to book an appointment if needed. General Practitioner checks are becoming more consistent across practices, helping reduce unnecessary referrals. Clear written guidance supports clinicians to manage more care locally, and straightforward cases are now seen in Community Gynaecology.

Similar improvements have been made for pelvic pain and endometriosis, and work has begun to strengthen support for PMOS. Endometriosis information evenings — developed with **Endometriosis UK** — are helping raise awareness and improve access to support.

Teams across gynaecology, sexual and reproductive health, physiotherapy, mental health and the third sector are working together to create a more joined up regional service.

Challenges remain, particularly around high demand and long waiting times. In Grampian, people are currently waiting more than 30 weeks for an outpatient appointment.

A coordinated approach across the region has helped reduce delays by sharing hospital capacity and balancing outpatient and inpatient work to bring waiting lists down. Our next priority is to strengthen support in primary care through improved education, clear clinical guidance and easy to use advice pathways. This will help reduce variation in assessment and ensure earlier intervention.

We will continue to review and redesign the workforce as preparations continue for the move to **The Baird Family Hospital**. Public involvement will remain central, supported by ongoing Endometriosis Information Evenings and CADs. Continued use of health passports and feedback through Women's Voices will ensure lived experience continues to shape and guide service improvement.

Preconception and Pregnancy

Findings from the **Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Maternal (MBRRACE-UK)** Report[78] highlight the need for a whole system approach to maternity care that addresses both clinical safety and the wider determinants of women's health. Although overall maternal mortality in the UK has stabilised, stark and avoidable inequalities persist: women in the most deprived areas experience around twice the mortality rate of those in the least deprived areas, and women from Black and Asian ethnic backgrounds face a significantly higher risk of death during pregnancy or the postnatal period. These national patterns closely mirror the inequalities seen locally across Grampian.

Nearly half of maternal deaths in 2021–2023 were considered potentially preventable with different care. Contributory factors included delayed recognition and escalation, fragmented care pathways, poor continuity, and failures to listen to women's concerns. This reflects local learning, where women report barriers to timely access, later booking for maternity care in some communities, and difficulties navigating complex systems—particularly among those affected by poverty, discrimination, trauma, or insecure housing.

Mental health is a major and growing concern. Psychiatric causes, including suicide, are among the leading contributors to maternal deaths, especially between six weeks and one year after birth. This aligns with local

rising mental health need among women and girls and reinforces the importance of embedding perinatal mental health support, trauma informed practice and early intervention as core elements of maternity care rather than stand alone services.

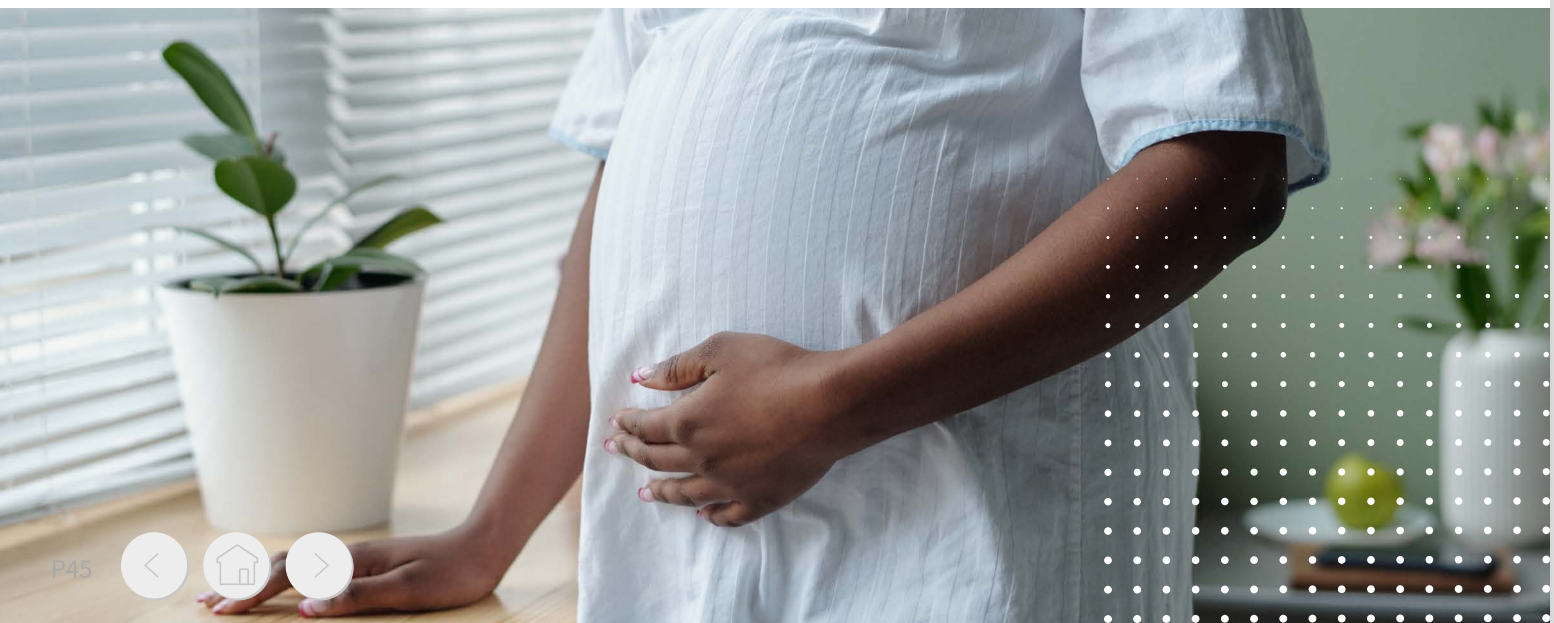
Maternity outcomes are shaped by factors beyond pregnancy alone, including pre conception health, poverty, insecure work, caring responsibilities, gender based violence, substance use and systemic racism. MBRRACE UK[78] emphasises that maternity services cannot address these risks in isolation; coordinated action across public health, primary care, mental health, social care and the third sector is essential.

A consistent message throughout the report is the critical importance of listening to women and acting on what they tell us. Many maternal deaths involved missed opportunities where concerns were not heard or acted upon. This principle underpins NHS Grampian's approach and is reflected in community engagement activity, co produced health needs assessments, priorities identified by the local **Maternity Voices Partnership**, and partnership working with ethnic minority and inclusion health groups.

Overall, the evidence is clear: improving maternal outcomes requires sustained action to reduce inequalities across women's lives. Tackling deprivation, strengthening continuity and compassion in care, addressing discrimination, and designing services around women's lived experience are essential to reducing avoidable harm. Maternity care is therefore a shared system responsibility, embedded within a wider commitment to women's health, equity and prevention across Grampian.

Grampian continues to make progress on the priorities set out in the Scottish Maternal and Infant Nutrition Framework[79] and the **Scottish Infant Feeding and Breastfeeding Strategic Framework 2025–2030**.[80] A core element of this work is improving nutrition before pregnancy. This includes promoting folic acid uptake, supporting women to achieve a healthy weight, and reinforcing positive nutrition throughout pregnancy.

Maintaining and increasing breastfeeding remains a central priority. This work is supported through ongoing implementation of the **UNICEF Baby Friendly Initiative (BFI) standards**[81] across NHS Grampian services. Delivering high quality, evidence based infant feeding support relies on staff having the right knowledge, tools and capacity. Specialist teams provide enhanced support for mothers and babies experiencing feeding difficulties, ensuring a consistent and well coordinated approach.



Universal infant feeding support continues to be well established. Antenatal Infant Feeding sessions are delivered across Grampian, with a direct referral pathway from midwifery services that is improving accessibility for families. A new suite of infant feeding videos also provides clear, consistent guidance, reinforcing key messages and helping families feel more confident as they begin their feeding journey.

Infant Feeding and Beyond, a targeted project codesigned with local women, provides enhanced support in communities with historically low breastfeeding rates. Early findings indicate higher exclusive breastfeeding rates among participants. Changing cultural norms around breastfeeding is a long-term ambition; further work is planned to strengthen community-based support and expand targeted programmes to additional areas. Early feedback is summarised in the box below.

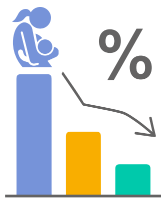
"This is an amazing project, and I don't know how I would have gotten on without it. The assurance and encouragement from the team was incredible. As a new mum it was exactly what I needed."

"…We consider ourselves so lucky to have the support of the team and feel that it has made the beginning of our parenting journey so much easier. The team are so knowledgeable and provide information in easy-to-understand ways which is very helpful when you are surviving on such little sleep. The antenatal class was also very informative and empowering as it gave us confidence in our feeding choices and knowledge of how to get off to the best start from even the first few minutes after birth. Thank you so much for all your support."

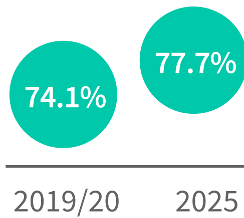
"I think all pregnant women should be given a chance to be part of that project and get contacted while being pregnant. I'm sure a lot of women and babies would benefit from having that support. This should be available to every woman who wants/needs some help with breastfeeding experience."

"This project has been invaluable to myself my husband and my baby. We honestly don't know what people do without the support of the team. Everyone we have worked with has been kind, knowledgeable, supportive and so dedicated to putting us as a family first- something we really appreciated at a time. Thank you so so much."

Breastfeeding

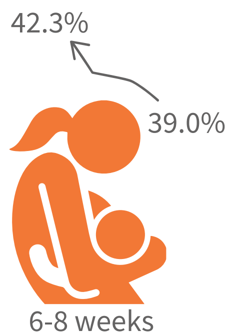


Breastfeeding drop-off between birth and the 6–8-week review has reduced steadily, from 31% in 2019/20 to 23% in 2025.[82]



Over the same period, the proportion of babies ever **breastfed increased from 74.1% to 77.7%.**

Exclusive breastfeeding at 6–8 weeks has risen from 39.0% to 42.3%, alongside a marked increase in overall breastfeeding at this stage from 51.6% to 58.4%.



Continuation rates at 13–15 months, however, have remained static, with exclusive breastfeeding at 12.8% and overall breastfeeding at 26.2%, indicating an ongoing need for sustained support beyond infancy.[82]

The multi agency **Grampian Maternal and Infant Nutrition Group** continues to provide universal support, alongside targeted work in areas of higher deprivation where breastfeeding rates remain lowest. Specialist Infant Feeding staff deliver evidence based training to a range of professionals and offer direct support to families facing feeding challenges. Grampian also provides one of Scotland's most responsive tongue tie services, with babies routinely assessed within one week of diagnosis. Rollout of the **Breastfeeding Friendly Scotland Scheme** (BFSS) continues to expand. More than 400 businesses across Grampian are now registered. Early Learning and Childcare settings are progressing through their scheme pathway, and implementation of the Local Authority Scheme is planned for this year.

Breastfeeding peer support has also strengthened significantly. The Breastfeeding Peer Support Service now includes 53 trained volunteers who provide support in Aberdeen Maternity Hospital's postnatal wards, across 15 community groups, and through online platforms.

Breastfeed Grampian now has more than 5,500 followers on Facebook and 1,600 members in its private support group. Over the past year, volunteers delivered 712 hours of support, reaching 1,657 individual contacts.

Taken together, this coordinated work reflects a strong commitment to improving maternal and infant nutrition, strengthening early years health, and ensuring all women receive consistent, evidence based support throughout pregnancy and early parenthood.

> *"...Having only been peer supporting for 6 months, I have found it to be so incredibly rewarding to support mums in their feeding journeys, whether that be to reassure them an experience is normal (or support when it's not!), and also to be there to share in their highs and lows of new parenthood." NHSG Peer Support Volunteer.*

> *"I know women need their place to go and talk*
>
> *to each other and to see breastfeeding as the normal thing to do. I feel blessed that I can provide a listening ear! I'm like the granny for them all and that's fine by me! More retired midwives should consider this! It's giving something back and that helps me feel useful!" NHSG Peer Support Volunteer*

The Grampian Maternity Voices Partnership (GMVP) is an independently led working group made up of women and pregnant or birthing people who are passionate about improving maternity care. The group works collaboratively with NHS staff to share experiences, gather feedback and identify ways to develop and enhance maternity services across Grampian.

Membership also includes third sector organisations with a strong interest in maternity and family wellbeing. This helps ensure that the voices of women, birthing people and families are heard, represented and meaningfully included in service improvement.

The Maternity Voices Partnership aims to ensure that all families receive compassionate care, evidence based information and support throughout their transition to parenthood, and that they are welcomed with individualised care and enabled to make informed choices.

The latest report can be accessed here: **Annual Reflections 2025.**[83]

Supporting Women and Partners with Infertility

The Aberdeen Fertility Centre provides fertility treatment for people across the North of Scotland. It supports patients from Grampian, Highland, Orkney and Shetland, and aims to provide fair access, high-quality care and follow national guidance. The centre also manages the fertility preservation pathway for people who are about to start cancer treatment or need urgent medical care that could affect their fertility. Over the past year, the service has improved consent processes, sped up fertility preservation referrals, strengthened donor governance, and worked more closely with partner Health Boards to better understand demand and access. Links with Third Sector organisations have also increased awareness of support needs, including pregnancy loss, BMI related barriers to treatment and LGBTQI+ inclusion. However, there are still challenges. These include keeping a specialist workforce, securing enough anaesthetic time for egg retrieval, updating older information systems and meeting new national standards for genetic testing. Donation rates for eggs and sperm have fallen both nationally and locally, while demand has increased. A donor recruitment campaign is being developed to help address this and reduce reliance on external donor banks.

Patients continue to highlight how emotionally difficult infertility can be. They stress the importance of timely communication, clear information and compassionate support. Streamlined pathways and simple, clear explanations of consent and treatment options especially for women undergoing invasive tests or fertility preservation before cancer treatment, make a significant difference to their experience of care.

Menopause

Grampian continues to make strong progress in improving menopause care (when referring to menopause we mean peri and post menopause), in line with the national **Women's Health Plan.**[1] Work is advancing across clinical pathways, workforce development, policy alignment and community engagement.

NHS Grampian remains closely involved in developing the Scottish Government's *Once for Scotland* menopause policy. Local policy work runs in parallel, guided by a local Menopause Working Group.

Key priorities include improving equitable access to specialist clinics, building capability in primary care, providing clearer pathway guidance and strengthening case based advice for clinicians. Specialist menopause nurse training is also expanding, supporting nurse led reviews for stable patients and helping develop a more sustainable model of care.

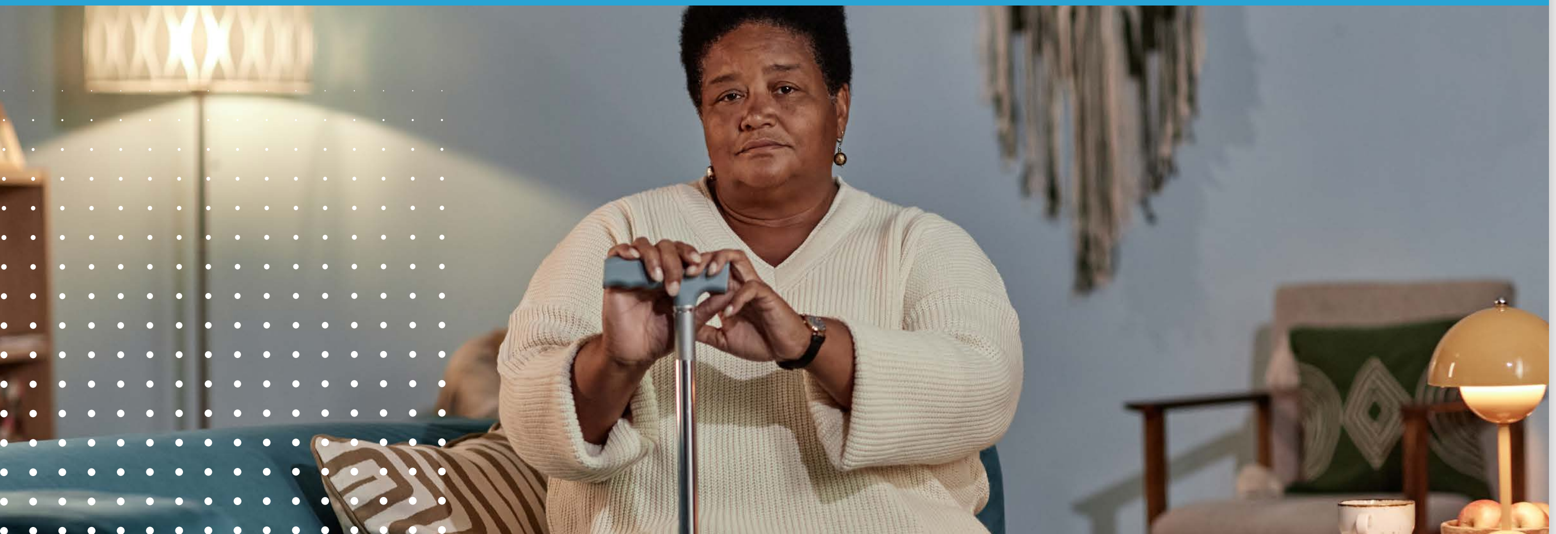
Clinical pathway development has continued to progress. Work is underway to standardise testosterone prescribing guidance and refine the post menopausal bleeding pathway for women using Hormone Replacement Therapy, ensuring alignment with recommendations from the **British Menopause Society**. These updates require coordinated work across disciplines to ensure clear eligibility criteria, safe prescribing practice and consistent use across services. Challenges remain, including high demand for specialist care, workforce pressures and delays in implementing national testosterone guidance due to resource constraints and the absence of shared care agreements.

The Aberdeen Health Improvement Fund, delivered through the Aberdeen City Health and Social Care Partnership, has also contributed to menopause work by supporting community led projects., through small scale preventative funding. The fund has enabled activity aligned with national women's health priorities, including menstrual and menopause health, pregnancy and postnatal wellbeing, culturally appropriate engagement and women's mental health.

Examples of projects in 2025 include:

- Community based menstrual and menopause education delivered by The Period Place.
- Culturally specific women's health engagement through the African Women Health Talk Series.
- Menopause focused wellbeing and nutrition programmes, such as Confidence to Cook for Women's Health.
- Pregnancy and postnatal support, including Grampian Birth Buddies, Community Birth Prep Classes and Bumps & Babies.
- Holistic wellbeing and befriending support for women from minority ethnic communities through the Unity in Wellness Project.

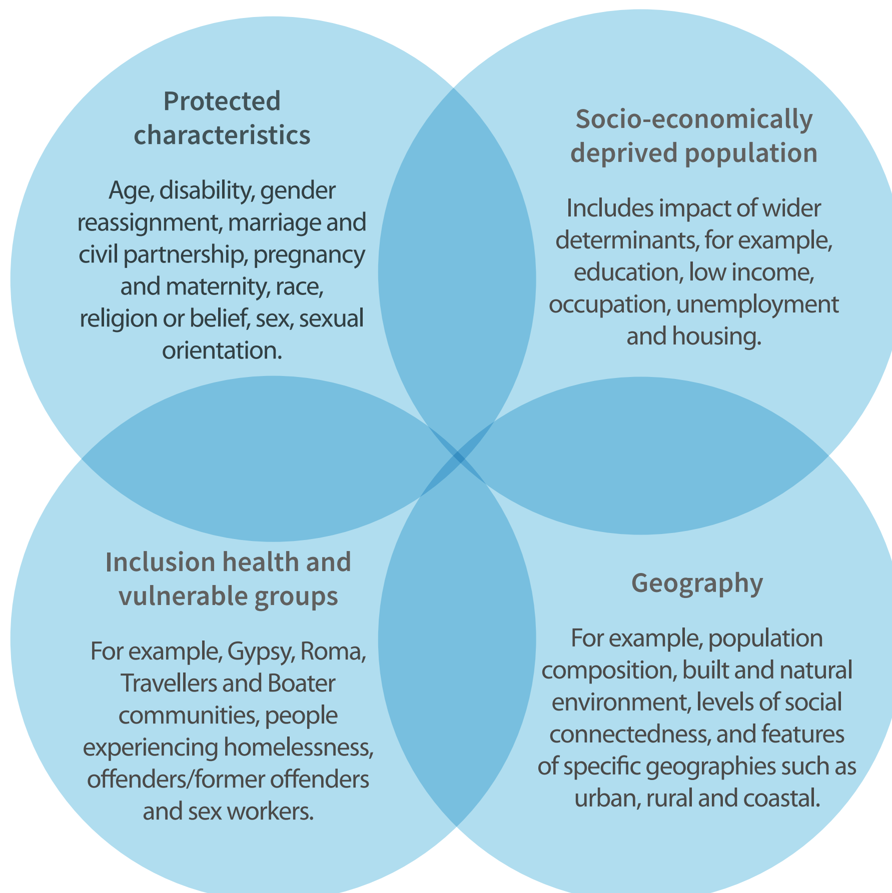
Equitable health and care



Healthcare Inequities

Health inequity is the observable differences in health outcomes across the population and between different population groups (Figure 5)

Figure 5: Groups who experience direct health inequities and demonstration of overlap.



Source: Public Health England

Inclusion health refers to people who are socially excluded and who often experience multiple, overlapping risks such as poverty, violence, discrimination and stigma.[84] These factors contribute to poorer health and can make it harder to access healthcare. Many people in inclusion health groups face barriers because services are not always designed in ways that meet their needs. This can lead to reluctance to seek help in the future, even when health needs are high.

While not usually described as an 'inclusion group', NHS Grampian know that many older women face cumulative disadvantage stemming from lower lifetime earnings, interrupted employment due to caring, and reduced pension income. Women are more likely than men to provide unpaid care in later life, often while managing their own health conditions. These social and economic pressures contribute to persistent health inequalities by deprivation and place.[85]

During 2025, a health needs assessment with the Gypsy/Traveller community was completed, including a specific focus on women's health. Research from the **King's Fund**[86] shows that women from White Gypsy or Irish Traveller ethnicities have the highest all cause mortality rates of any ethnic group in the UK, and are among the least likely to hold formal qualifications.

Local census data[86] also highlights the inequalities experienced by Gypsy/Traveller women in Grampian:

52.7% of women aged 16–64 are economically inactive, which may reflect a high burden of disability (41.1% live with a long-term condition that limits daily activities) and substantial caring responsibilities (20% provide unpaid care).

52.7% of women aged 16–64 are economically inactive

20% provide unpaid care

41.1% live with a long-term condition that limits daily activities

As part of the **Health Needs Assessment**, we worked with the charity **MECOPP** to understand the lived experiences of Gypsy/Travellers, including women and children. We visited local authority travelling sites on three occasions and were supported by Gypsy/Traveller liaison officers to engage with families living in houses or on the roadside. Access to primary care and maternity services was frequently described as challenging, due to the travelling lifestyle, limited continuity of care and barriers linked to literacy and communication.

> *'There should be more assistance at receptions to help people register as a lot of the older ones can't read or write.... It is humiliating if people are rushing you [and] you can't complete the forms'*

> 'Before it was awful, no one would see you, either a doctor or a dentist if you had no fixed address.'

Improving women's health within this community is therefore vital — both for women themselves and for those they care for. Research from NHS Lothian and MECOPP shows that many Gypsy/Travellers obtain health information, including information about vaccination, from within their family or community. Older women, in particular, are key sources of trusted advice. Locally, women we spoke to identify the need to tackle stigma around mental health:

> *'Mental health is not talked about in the Traveller community due to stigma and should be more talked about.'*

> *'[Men] find it too embarrassing to talk about these things.'*

Building on these insights, the NHS Grampian Gypsy/Traveller Working Group has begun developing actions to improve health outcomes. This includes creating accessible resources to help people navigate health services and delivering cultural awareness sessions for health professionals to strengthen understanding and reduce barriers.

Nationally, **Anti Racism guidance**[88] has been issued to all NHS Boards, with a requirement to develop local Anti Racism Plans. A workshop was held last year with key partners to begin shaping NHS Grampian's plan, building on work already underway. As part of this wider focus on equity, a health needs assessment was also carried out to better understand the experiences of ethnic minority women using maternity services in Grampian.

Persistent ethnic inequalities in maternity outcomes remain a major public health concern across the UK. Despite many years of policy attention, women from minority ethnic backgrounds continue to experience poorer maternal and perinatal outcomes than White women.

To better understand local experiences, we worked with third sector partners to run focus groups with women across Grampian. To reduce barriers to participation, sessions were offered in person and online, during the day, evenings and weekends, with childcare, travel reimbursement and payment for time provided. A survey was also made available in English, Arabic, Polish and Russian and shared widely across minority ethnic communities. A parallel survey was undertaken with maternity staff.

Women shared both positive and negative experiences:

> *"They said they don't usually do certain exams at that stage of pregnancy, but they did them to reassure me. They were respectful and flexible. Later on, when concerns were raised about the baby's weight, I had frequent scans and felt well monitored. When induction was suggested, I explained my worries because of a previous C section, and they respected my choice. In the end, I opted for a C section at the last minute, and the team was so friendly — they felt like family."*

> *"Sometimes you know its bias… because if it wasn't me, somebody else would have been helped."*

Local data[89] has also been analysed to compare maternity outcomes for women from minority ethnic backgrounds and for women experiencing or at risk of vulnerability, including women seeking asylum or facing challenges with substance use.

This analysis, alongside the lived experience, has been shared with maternity services to inform a health needs assessment. Thirteen evidence-based recommendations have been co-produced, identifying groups of women who experience poorer outcomes. These recommendations will be used to more effectively target services towards women who are most likely to benefit. They also highlight barriers within maternity care, including low staff confidence in understanding cultural and religious practices, and variability in the quality of interpreter services.

The Moray Health Improvement Team was approached by a Project Assistant from Moray Council's Refugee Resettlement Team regarding a group of women resettled from Afghanistan. Through sustained engagement, the Project Assistant has developed a trusting relationship with the community and identified a significant gap in the women's awareness of available support and information relating to women's health.

In response, the Health Improvement Team undertook focused planning and research to identify appropriate translated resources. These covered key areas including self-care, national screening programmes, routine immunisations, and how to access healthcare services in Scotland. Materials were selected to ensure they were culturally relevant, linguistically accessible, and appropriate for the age range of participants (15 years and over).

Consideration was given to creating a safe and culturally appropriate environment for the session. A community member's home was chosen as the venue, offering a familiar and comfortable setting that supported open discussion and engagement. Cultural practices, norms, and sensitivities were integrated into the planning and delivery approach.

This work was delivered through effective multiagency collaboration, involving **Moray Council**, NHS management, translation and interpretation services, and consultation with **GREC**. This partnership approach helped ensure that the session was inclusive, respectful, and **responsive to the needs of the women involved**.

Women in the Justice System

Women who come into contact with the justice system often have significantly higher health and wellbeing needs than the general population. These needs are shaped by long term experiences of trauma, abuse, violence and complex social circumstances.[90] Such experiences can make it harder to engage with mainstream services and can limit access to timely care and support.

In response, the Moray Health Improvement Team, working in partnership with the Moray Justice Social Work Team, delivers a voluntary health and wellbeing programme for women supported by the Community Justice Team.

The programme is called RISE — a name chosen by the women when the group was first established. It is not linked to statutory requirements and is designed to offer a safe, trauma informed space where women can focus on their health at a pace that feels right for them.

RISE provides accessible information on a wide range of women's health and wellbeing topics and connects participants to holistic support services across Moray. These links help strengthen physical health, improve mental wellbeing and support financial stability, enabling women to build more resilient and independent lives.

Sessions are held in a welcoming, non clinical setting and include dedicated one to one time, allowing staff to develop meaningful relationships and tailor support to individual needs. Peer support plays a central role, helping reduce isolation and fostering a sense of acceptance and belonging.

Now in its third year, the programme has strengthened collaboration between local services and justice teams. It also plays an important role in reducing stigma by enabling practitioners to hear directly from women about their experiences and to better understand the challenges they face.

"Carla" joined the RISE women's justice group whilst also very early in her recovery from alcohol and was initially very wary of services. With encouragement from her Community Justice worker, who accompanied her at first, she began attending the group and found the weekly structure helpful to her.

She described the group as a safe, pressure-free space where women supported one another without needing to share personal experiences. Over time, Carla's confidence grew, and she became more involved. Carla found sessions from external services were particularly valuable, helping her better understand family member's health needs and prompting her to address her own through a 1:1 lifestyle check. A gym session further boosted her confidence and sparked a fitness routine which she is now sustaining.

Carla emphasised feeling respected and never judged or experienced any stigma by the partners delivering activities, including visiting artists who treated participants as equals.

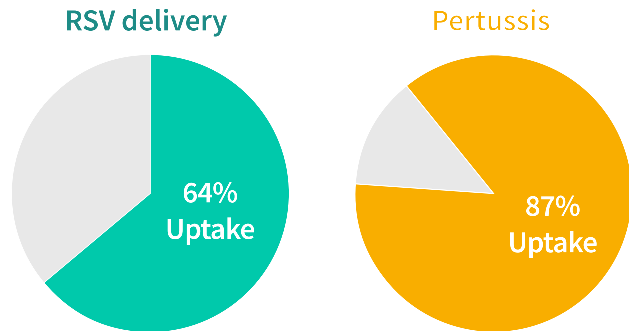
When asked how more women might be encouraged to attend, she noted that many feel vulnerable and may not be ready to engage. She believed she would not have attended without strong practical and emotional support from her social work team. She suggested inviting women to commit to a short block of sessions (3–4), as this was how long it took her to feel comfortable.

Overall, Carla felt that RISE group and the support around it played a significant role in her recovery.

Vaccination and Immunisation

Three vaccines are offered during pregnancy — pertussis, respiratory syncytial virus (RSV) and flu. All help protect pregnant women and their babies during pregnancy and in the first months of life. Pertussis and RSV vaccines are given by midwives as part of routine antenatal care.

Uptake in Grampian is strong: 87% for pertussis, and 64% in the first year of routine RSV delivery. Maternal pertussis vaccination provides around 90% protection against disease in infants under three months old, and the Scottish RSV programme has reduced hospital admissions for bronchiolitis in babies under one year by 80%.[91]



The flu vaccine is offered during the autumn–winter season, but because of limited clinic time it is not delivered within antenatal appointments. Instead, midwives advise pregnant women about the vaccine and provide a fast track form for use in vaccination clinics. Uptake remains lower than for other vaccines offered in pregnancy.

Protection from the Measles, Mumps and Rubella (MMR) vaccine is especially important during pregnancy. Measles can lead to severe disease, miscarriage or pre-term birth, and rubella infection can cause congenital rubella syndrome, which may result in deafness, blindness, cataracts, heart problems or, in some cases, the death of the baby.

Vaccination against human papillomavirus (HPV) is a key part of the World Health Organisation (WHO) global work to eliminate cervical cancer.[92] Infection with high risk HPV types is the main cause of cervical cancer, and vaccinating young people and older individuals at higher risk can break this pathway. Evidence shows cervical cancer is significantly reduced in people vaccinated before the age 18. A major achievement of the Scottish HPV programme is that no cervical cancers have been diagnosed in fully vaccinated women who received the vaccine at age 12–13 since the programme began in 2008.[93] Similar results have been seen internationally.[94]

Aberdeen City Health and Social Care Partnership (ACHSCP) recently carried out a quality improvement pilot to streamline the school immunisation programme and improve uptake. The pilot took place in three schools - Hazlehead Academy, Lochside Academy and St Margaret's School for Girls - and combined what were usually three separate immunisation visits into a single session. This reduced disruption for schools, improved efficiency and created more opportunities to engage with pupils.

A key strength of the model was the extended time in schools, which allowed vaccinators to revisit pupils who were absent or hesitant, support informed decision making and address concerns. Vaccinators and healthcare support workers were available to offer reassurance and answer questions.

The results were highly positive. HPV uptake increased by an average of 10.7%, with improvements ranging from +6.8% to +15.9% across the participating schools. Staff feedback was also strong: 82% of vaccination staff and 100% of school staff recommended wider rollout. Based on these results, the model will initially be expanded to seven further schools, with further rollout thereafter.

Screening

Screening plays an important role in supporting women's health. Women take part in a wide range of national screening programmes including breast, bowel and cervical screening, and pregnancy and newborn screening within maternity care. Together, these programmes support early identification of conditions, promote informed choice and help reduce inequalities in health outcomes

Breast screening uptake in Grampian remains strong and above the national average,[95] supported by mobile screening units that improve access for rural communities, although clear inequalities persist between more and less deprived areas. Cervical screening uptake is slightly higher than the Scottish average[96] but remains well below the national target, with a steep socioeconomic gap that continues to disadvantage women living in the most deprived communities. Pregnancy and newborn screening in Grampian remains strong,[97] with consistently high coverage supported by close maternity and paediatric working, and newborn bloodspot screening has now expanded to include Spinal Muscular Atrophy. While bowel screening uptake among women is above the national target,[98] continued partnership working, targeted outreach, better use of data and trauma informed approaches are key to improving equity across all screening programmes, particularly for women facing disadvantage. Full details on screening programmes performance is available in annual reports.

People's experiences of screening are shaped by access, lived experience and the realities of daily life. Across Scotland and within Grampian, inequalities in screening uptake persist with certain population groups less likely to particpate including those who experience socio-economic disadvantage, ethnic minority groups, people with learning disabilities and LGTBQ population. Often, the people who could benefit most are those least likely to take part. Our focus has been on ensuring every woman can engage with screening in a way that feels safe, equitable and person centred. Work has taken place with communties across Grampian to develop culturally appropriate communication materials addressing barriers to participation. Training has also been developed to support health care professionals and community members to have informed conversations about screening.

Work to reduce screening inequities has been enabled by **Friends of ANCHOR**, and has included taking screening into workplaces, using trauma informed approaches, and offering 'Meet the Nurse' clinics to help women feel more comfortable attending. Efforts also include integrating screening into women's health sessions in primary care, working with community partners such as Friends of ANCHOR and contributing to national work to improve access for women in His Majesty's Prison and Young Offenders Institution Grampian (HMP Grampian). A key priority is strengthening trauma informed practice across all screening programmes. By ensuring communication, environments and interactions feel safe and supportive, screening can become more accessible, helping reduce missed appointments and improving engagement.

Cześć, dostałam zaproszenie na badanie szyjki macicy...
NHS Grampian
MAJA
W Polsce działa to inaczej. Dlaczego tutaj jestem zapraszana tylko raz na pięć lat?
ANNA
Jest tak, ponieważ badanie wykrywa teraz obecność wirusa brodawczaka ludzkiego (HPV), który może powodować zmiany w komórkach, więc nie musimy już powtarzać go tak często.
No dobrze, ale co, jeżeli coś mnie martwi?
Jeśli zauważysz COKOLWIEK dziwnego, na przykład nieregularne krwawienie lub ból podczas stosunku, nie musisz czekać. Wystarczy porozmawiać ze swoim lekarzem rodzinnym.
Dobrze wiedzieć Zarezerwuję wizytę już teraz!
Bądź na bieżąco. Zrób badania przesiewowe w Szkocji.
Aby dowiedzieć się więcej o badaniach przesiewowych szyjki macicy, zeskanuj kod QR lub odwiedź stronę: nhsinform.scot/cervicalscreening

Case Study

To support the refresh of NHS Grampian's cancer screening resources, local community groups were identified and engaged to provide insight into the development of revised materials. In Moray, consultation focused on groups from lower SIMD areas. While individual postcodes were not collected, two groups agreed to participate, supported by Children 1st teams. Most participants were women experiencing multiple vulnerabilities, including parenting support needs or involvement with care services.

Two small groups met initially to share their experiences of accessing health information, with a particular focus on cervical screening. Participants provided valuable feedback on preferred ways to receive information and highlighted the importance of accessible language, use of clear imagery, and thoughtful poster layout—especially for individuals with low literacy or dyslexia.

The groups were revisited twice more: first to review and comment on draft materials, and later to view the final printed resources and accompanying video booklets. This iterative approach ensured that community insights directly shaped the final products.

Participants reported feeling valued and listened to and pleased to have influenced the changes made in the materials. One individual noted that they appreciated being asked for their views, as they did not typically feel their opinions were sought. A Children 1st staff member further reflected on the positive impact of the consultation:

"The individual who had been vocal about the posters felt that the changes were a big improvement and had told her friends about it, and one had definitely gone for screening.

The group felt that it was nice to be involved, that the changes they identified were made, and all felt that the revised cervical screening resources were easy to read and they liked the format."

This engagement demonstrates the importance of co-design with communities, ensuring that cancer screening information is accessible, relevant, and responsive to the needs of those who may face barriers to participation.

Ongoing work will remain focused on ensuring screening services meet women's needs at every stage of life.

Sexual Health and Blood Borne Viruses

Sexual health is an essential part of women's overall health and wellbeing. Our aim is to ensure women can experience positive sexual health by having equitable, consistent access to services. This includes timely access to abortion care, contraception, and testing, diagnosis and treatment for sexually transmitted infections and blood borne viruses.

We also support women with the wider issues that influence sexual health, such as healthy relationships, freedom from coercion, sexual difficulties and the impact of stigma.

The Sexual Health and Blood Borne Virus Network works across Grampian to develop and coordinate local actions, informed by national policy, including the **Sexual Health and Blood Borne Virus Action Plan**[99] **for Scotland** and the **Women's Health Plan.**[1]

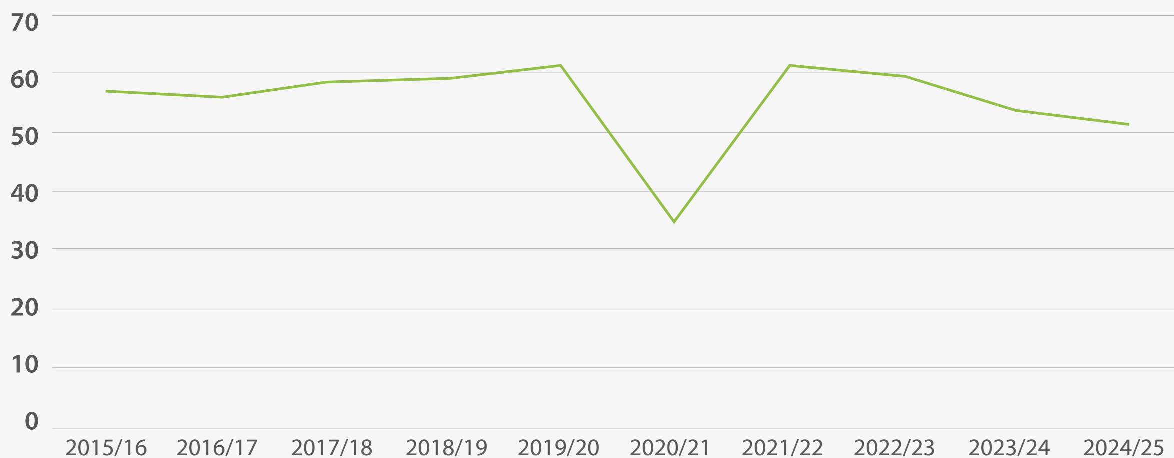
Over the past year, work has focused on raising the profile of sexual health within the broader context of women's health and improving our understanding of where the greatest gaps lie. This has included:

- A postnatal contraception staff survey.
- Focus groups with inclusion groups, **including women in prison** and Black African women.
- Research to increase HPV vaccination uptake in prison settings.
- Work with primary care to explore how HIV Pre Exposure Prophylaxis can be made more accessible to women who may benefit but are not currently using it.

Emergency department opt out testing for blood borne viruses is now offered to all adults having blood tests, helping reduce stigma associated with testing for both women and men. We have also redesigned our sexual health website to make trusted information easier to access and introduced self booking for appointments.

Challenges remain. Demand for abortion care continues to rise, while use of contraception, particularly hormonal methods and long acting reversible contraception (LARC), has fallen locally and nationally. Although LARC uptake recovered after the pandemic, it has since declined. This has prompted exploration of the factors affecting uptake, including access, service design, perceptions of contraception and the growing influence of hormone hesitancy and misinformation.

Figure 6: Long-Acting Reversible Contraception (implant, intrauterine device & intrauterine system) from primary care and sexual health settings, prescribing rate in Grampian per 1000 women aged 15-49



Source: Long Acting Reversible Methods of Contraception (LARC) in Scotland - Year ending 31 March 2025 - Long Acting Reversible Contraception (LARC) Key Clinical Indicator (KCI) - Publications - Public Health Scotland

Declining contraception use is likely contributing to increasing demand for abortion care across Grampian. Both LARC uptake and abortion rates show a strong link with deprivation: LARC use is lowest among women living in the most deprived areas, and abortion rates in these areas are double those in the least deprived. These patterns highlight wider inequalities in women's health.

There is significant opportunity to build on the work already underway. Listening to and acting on women's lived experience will be central to improvement. A self audit against **Healthcare Improvement Scotland Standards**[100] has identified priority actions, including strengthening access to contraception and improving links with partners who deliver aspects of sexual health support outside specialist services.

Improvement work is progressing, such as piloting evening drop-in clinics for LARC and upskilling a wider workforce, including maternity staff, to have opportunistic or planned contraceptive conversations.

Gynaecology

Gynaecology services have continued to make good progress this year, with improvements to how care is organised and delivered. More appointments and treatments are now provided in community and outpatient settings, helping make services easier to access. Teams have also been preparing for relocation to **The Baird Family Hospital** by reviewing care pathways, planning equipment needs and improving patient flow through clinics, ensuring services are ready for transition.

Several redesigns have improved the efficiency and responsiveness of gynaecology pathways. These include improvements to the menopause care pathway process and changes to surgical pathways, such as a same day discharge pilot for hysterectomy patients and a criteria led discharge pilot for pelvic floor repair surgery.

Pelvic floor services have expanded; preventative care has also remained a priority, with smear clinic activity across Grampian helping to improve screening uptake and reduce backlog pressures. Continuity of care has been strengthened through enhanced cancer navigator roles in both breast and gynaecology services. Nursing education has been refreshed in partnership with **SANDs** to ensure trauma-informed practice remains embedded in day-to-day care.

Prevention Focussed System

A key part of the Population Health Framework[4] is working together to take responsibility for improving health outcomes and reducing health inequalities. This means focusing more on preventing ill health, rather than only treating people once they are unwell. As part of the renewal process, NHS Scotland needs to change how it sees its role shifting from being mainly about treatment to being about improving the health of the whole population. This involves working closely with partners to prevent ill health, reduce inequalities, and make sure health and care services offer good value and can be sustained in the long term. Becoming a Population Health Organisation means working together to improve health and wellbeing for everyone, tackle unfair differences in health, and deliver high-quality, sustainable care.

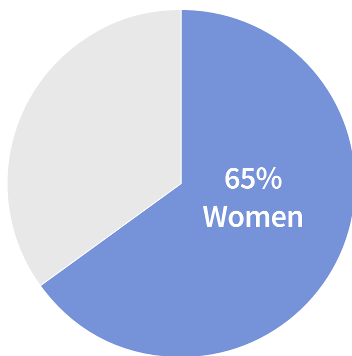
The examples earlier in this report show some of the ways this is already happening in Grampian, as well as areas where we need to do more. This section highlights some further examples specific to women's health.

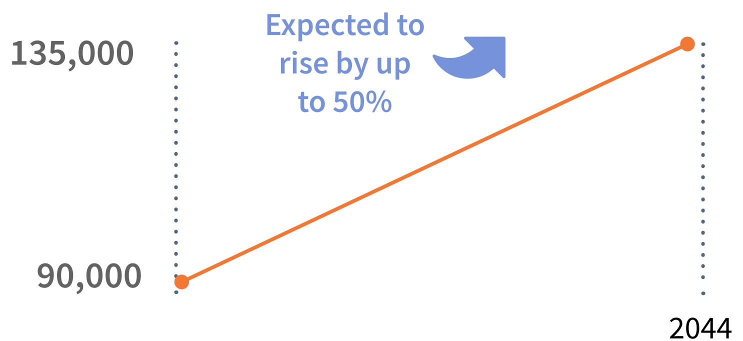
Brain Health

Dementia is a significant and growing public health challenge for women in Scotland. Around 90,000 people are currently living with dementia; approximately 65% are women.[101]

With the number of people affected expected to rise by up to 50% by 2044, strengthening dementia prevention and support is becoming increasingly urgent. Women are also disproportionately affected in caring roles, making up 60–70% of unpaid carers, which further highlights the gendered impact of dementia.

Around 90,000 people are currently living with dementia

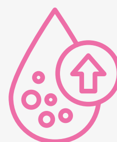




The 2017[102] and 2020 Lancet Commissions[103] reported that up to 40% of dementia cases may be preventable by addressing fourteen modifiable risk factors:

Lower quality or lack of education in early life

Hearing Loss



High low-density lipoprotein (LDL) Cholesterol

Hypertension

Obesity

Diabetes

Traumatic Brain Injury

Vision Loss

Smoking

Physical Inactivity

Excessive Alcohol Consumption

Social Isolation

Depression

Air Pollution

* The 14 risk factors occur across different life stages, more information can be found in the Lancet Publications.

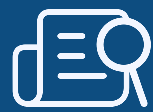
In response to this growing need, a two year Brain Health Service demonstrator funded by the Scottish Government was launched in December 2023 at the **Alzheimer Scotland Brain Health** and Dementia Resource Centre in Aberdeen. Delivered in partnership with NHS Grampian Public Health and **Brain Health Scotland**, the service aimed to provide early intervention and personalised lifestyle action plans through a structured pathway, from awareness and initial engagement (Stage 1) to specialist clinical assessment (Stages 2 and 3).

An independent evaluation[104] found that between December 2023 and January 2025, 159 people accessed Stage 1 of the pathway. Most were aged 60–79, and 55% were women. Users described the service as positive, person centred and reassuring. Personalised action plans supported meaningful lifestyle changes, and stakeholders emphasised the importance of early intervention — particularly for women, who experience a higher prevalence of dementia.

Key recommendations from the evaluation included:

- Strengthening evidence on the economic benefits of proactive dementia prevention.
- Embedding brain health services within wider public health strategies.
- Integrating proactive brain health into national dementia and healthcare policies to support consistent adoption.

While the demonstrator highlighted clear benefits, partners agreed to focus available resource on upstream brain health work. This is now delivered through NHS Grampian Healthpoint, offering person-centred conversations on dementia risk factors, along with personalised lifestyle support and action plans. The Alzheimer Scotland Brain Health and Dementia Resource Centre continues to operate, and national work is underway to take forward the evaluation's recommendations.

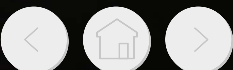


Case Study

Susan, 47, first sought help from the Brain Health Service after several years of increasing memory problems, including word-finding difficulties and misplacing items. Concerned that her symptoms were worsening, and prompted by an advert about dementia, she attended the service with her husband.

Susan met the Centre Manager, completed the Brain Health Questionnaire, and was referred to the Brain Health Clinic for a clinical assessment with the Nurse. Her memory test scores were lower than expected for her age, which the Nurse felt could be linked to English being an additional language and perimenopause. Together, they created a personalised action plan that included a GP appointment, dietary changes, increased exercise, and psychological therapy.

Susan found the action plan reassuring and motivating. After starting HRT following her GP visit, many of her symptoms improved quickly. She reports better mental health and is now training for a career change. She exercises four days a week (two weight training, two other activities), and her new routines have positively influenced her husband and son, particularly through shared dietary changes.



Functional Conditions

Some health conditions appear to be more common in women, including a group often described as functional conditions. This term refers to persistent physical symptoms and impairments that cannot currently be fully explained by any known disease or physical cause. These include conditions such as functional neurological disorder, irritable bowel syndrome[105] and fibromyalgia.[106]

Evidence from work between the Glasgow School of Art, NHS Grampian and Robert Gordon University[107] shows that people living with functional conditions often experience poorer outcomes, greater health inequalities and higher use of health and care services. A major factor is the absence of a defined and coordinated pathway of care.

Patients frequently describe being "bounced" between multiple specialties, with diagnosis often slow and complex: "...you feel that... you are being passed around the departments and nobody is going to do anything about it" Many report frustration at repeated or unnecessary investigations such as MRI, CT or X ray scans and treatments or medications that do not address their needs. These experiences can worsen symptoms and increase psychological distress. Clinicians reflect similar concerns and highlight the difficulty of providing effective care without a clear pathway.

More than £1.5 million has been awarded by **NHS Grampian Charity** to develop and deliver a new approach to the pathway of care for people living with functional symptoms. This will support between 1,300 and 1,500 patients each year by trialling a holistic approach, tailoring support to individual needs and cocreating self-management resources with people who have lived experience. The main aim is to improve health and wellbeing and prevent people from feeling lost within the health and social care system.

The project will begin later this year and run for two years. Although the term functional is being used for now, one of the early priorities will be to work with people with lived experience to ensure the language we use feels appropriate, meaningful and well understood. The service will take a networked approach, addressing physical and biological needs (such as mobility), psychological needs (such as mood and wellbeing) and social needs (such as employment and community participation).

A core part of the pathway will focus on supporting self-management through a mix of individual and group interventions. Unlike other pathways, this work will place strong emphasis on the emotional journey — mapping experiences of care before, during and after diagnosis across home, community, primary and secondary care settings.

The project will involve close partnership working across health and social care and with third sector organisations. Education will also be central, helping staff feel more confident supporting people with functional conditions. A women's health lens will be applied throughout development to identify ways to better support women, particularly around the impact of hormones and menopause on symptoms and self management.

Evaluation will be essential to understanding what a sustainable service should look like. Throughout the project, there will be a strong focus on patient experience, accessibility, health outcomes and key performance measures linked to service quality.

Gender Based Violence

Gender-based violence (GBV) is one of the clearest indicators of gender inequality. The overwhelming majority of this violence is perpetrated by men against women and girls. Women who experience violence face increased risks of chronic pain, poor mental health, substance use, sexual and reproductive health problems and long-term conditions. Children and young people are also affected — both through direct experience of abuse and through living in households where violence occurs.

The impacts of gender inequity and GBV are not felt equally across all parts of society. Inequalities related to immigration status, disability, ethnicity and LGBTQI+ identities mean some groups of women and girls face a higher risk of violence and/or have more limited access to support, safety and justice. Women with low incomes, who are unemployed, or classified as living in poverty are more likely to experience violence at the hands of a partner. Women from Black and minoritised ethnic communities are more likely to be subjected to domestic abuse and to endure abuse for longer before receiving help.

Across Grampian, multiagency Violence Against Women and Girls Partnerships are responsible for delivering Equally Safe.[108] Scotland's national strategy to prevent and eradicate violence against women and girls. This work spans prevention, early intervention, protection and recovery. GBV is a major public-health, equality and human-rights issue, with wide-ranging impacts on physical and mental health, wellbeing and life chances. It includes, but is not limited to:

- Domestic abuse, including coercive and controlling behaviour.
- Stalking.
- Rape and sexual assault.
- Sexual harassment.
- Commercial sexual exploitation, including selling or exchanging sex, stripping and pornography.
- Honour-based abuse.
- Forced marriage.
- Female genital mutilation.

During the 16 Days of Activism against Gender-Based Violence, the Aberdeen City Violence Against Women and Girls Partnership launched a position paper on Commercial Sexual Exploitation. The paper set out a shared understanding of commercial sexual exploitation within the context of constrained choices, consent, trauma, poverty and vulnerability. Alongside this, intensive training was delivered by the Women's Support Project for practitioners across the NHS, Police Scotland, local authorities and the third sector to strengthen knowledge and improve support for people involved in selling or exchanging sex.

In 2008, a Scottish Government Chief Executive Letter[109] directed health boards to introduce Routine Enquiry of Abuse (REA) in five priority areas where people experiencing abuse are most likely to present. REA involves asking all people attending a service direct questions about their experience of abuse. Work is underway in NHS Grampian to develop a consistent organisation-wide domestic abuse policy, including approaches to disclosure and routine enquiries of abuse.

In NHS Grampian maternity services, the percentage of women who were asked about or proactively disclosed abuse during pregnancy increased from 79% in 2020 to 90% in 2025.[110] We aim to build on this progress and explore how similar improvements can be made in other priority areas such as health visiting.

Despite progress, significant challenges remain. Demand for specialist services continues to exceed capacity, and workforce pressures across statutory and third sector organisations limit the pace at which new approaches can be embedded. Data on gender-based violence also remains fragmented, although work is underway to strengthen a coordinated, cross-Grampian approach to data and intelligence. Persistent gender inequality and poverty continue to drive risk, particularly for women experiencing multiple disadvantages.

Research and Innovation

We recognise that there are still substantial gaps in women's health data and research, which limits our ability to design services that fully meet the needs of women and girls. National evidence[1] shows that while some information exists, it is often fragmented, collected inconsistently between areas or not comparable at a national level. This makes it difficult to use for robust planning, monitoring or understanding trends over time.

Significant gaps remain including menstrual and reproductive health, contraception, menopause, maternity, mental health and long term conditions with several areas lacking routine or standardised data collection. **The Women's Health Plan 2021–2024: Data Landscape Review**[111] highlighted the lack of detailed data that reflects the diverse experiences of different groups of women, including differences linked to ethnicity, disability, deprivation and rurality. Without this level of detail, it is harder to understand how outcomes vary across communities or where inequalities are most pronounced.

In response, NHS Grampian is committed, through its **Health Equity Plan**[2] to strengthening our own data and insights, contributing to national developments, and improving how local intelligence is gathered and used. This includes working with partners, where appropriate, to link data and create a more complete picture of women's health. We also recognise the importance of contributing to emerging national research collaborations to address evidence gaps and ensure the experiences of women in Grampian help shape Scotland wide research priorities.

At the same time, we remain committed to supporting women and girls to access clear, consistent and trusted information. We will work with local communities to ensure national resources reflect their needs and are available in accessible formats. We know that women are disproportionately affected by digital exclusion, and therefore many women do not have access to information, appointment systems and support when offered via exclusively digital channels. Through this work, we aim to strengthen local understanding, reduce inequalities and contribute meaningfully to the national ambition that all women and girls enjoy the best possible health throughout their lives.

Summary and Actions

Improving women's health in Grampian requires coordinated action across the whole system. Over the coming year, NHS Grampian will continue to work with partners to develop a local Women's Health Plan that is responsive to national ambitions and rooted in the needs and priorities of women across Grampian. Based on the evidence, lived experience and learning set out throughout this report, the following areas for action are highlighted for partners to consider within their own roles and responsibilities.

Shared actions for all partners

- Work collaboratively to create the conditions for better women's health.
- Embed listening to women, ensuring lived and living experience is prominent in planning, service design, delivery and evaluation.
- Build skills and confidence across the workforce to involve women meaningfully, including trauma-informed, culturally competent and inclusive approaches.
- Use local data and insights alongside lived experience to make variation visible, particularly by deprivation, geography and life stage, and to guide prioritisation.
- Ensure we meaningful represent the needs of inclusion groups and reduce inequities.
- Focus on prevention and early intervention, recognising that women's health outcomes are shaped long before needs arise.

NHS Grampian

- Strengthen prevention, reduce unwarranted variation, and continue to embed trauma informed practice across clinical and non-clinical services and women's health pathways.
- Improve completeness, quality and use of data, to create opportunities for earlier support (e.g. later pathway contacts, financial inclusion).
- Recognising NHS Grampian as an Anchor organisation, support women's health and wellbeing at work, including flexible working, menopause support, caring responsibilities and access to fair work.
- Test and scale community led approaches, such as CADs, where statutory services work as equal partners alongside the third sector and people with lived experience.

Primary Care

- Strengthen early identification and management in primary care through clear clinical guidance, education and easy-to-use advice pathways for women's health conditions.
- Support consistent, person-centred conversations about prevention, contraception, mental wellbeing, menopause and cardiovascular risk.
- Work with partners to reduce variation between practices, particularly in areas of deprivation and rurality.
- Contribute to the development of a women's health data dashboard to inform and improve population health needs.

Health and Social Care Partnerships (HSCPs)

- Embed women's health priorities and whole system approaches within local strategic plans, including alcohol and drug strategies, mental health plans and other associated population health programmes.
- Strengthen community based, preventative support, including social prescribing, peer support and community mental wellbeing initiatives, especially for women experiencing inequalities.
- Support joined up 'No Wrong Door' rights based approach, particularly for mental health, substance use and women affected by GBV.

Local Authorities

- Take a gender lens to place based planning, ensuring women's voices actively shape priorities and solutions.
- Use planning, transport, housing and economic levers to create healthier, safer environments for women and families.

- Align actions in relation to child poverty, employability, housing and violence prevention, recognising their cumulative impact on women's health.
- Build on the principles of the Belém Gender Action Plan to support climate resilience.

Employers (Public, Private and Third Sector)

- Review and strengthen workplace policies to support women to remain and thrive in work, including flexible working, menopause, pregnancy, caring responsibilities and mental wellbeing.
- Promote good quality work as a health intervention, recognising links between fair work, income, mental health and long term outcomes.
- Work collectively as anchor employers, aligning with Community Wealth Building ambitions to reduce poverty and inequality.

Community Planning Partnerships (CPPs)

- Treat women's health as a shared population outcome, not solely as a health issue.
- Use CPP governance to align action across partners, linking women's health to local priorities, place plans and prevention agendas.
- Ensure women's voices are heard and acted on, particularly those experiencing multiple disadvantage.
- Support shared learning and accountability, using local data and lived experience to track progress.

These areas for action are not exhaustive, nor the responsibility of any single organisation. They reflect opportunities emerging across Grampian to work differently — using evidence, lived experience and partnership approaches — to improve women's health outcomes. Progress will depend on sustained collaboration, shared leadership and a continued commitment to prevention and equity.

We would like to invite anyone with an interest in this to get in touch: **gram.directorofpublichealth@nhs.scot**; progress will also be shared on our webpages: **Director of Public Health's Annual Report.**

Acknowledgements

With heartfelt thanks to the individuals and groups of women who were kind enough to share their stories.

I would also like to extend my gratitude to all colleagues who contributed to this report, including those in:

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- Planning, Innovation and Performance
- Public Involvement
- Women's Services and Women's Board

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- Luan Grugeon, Strategic Development Manager
- Melanie Dolan, Advanced Public Health Practitioner
- Emma Blue, MVC Designer
- Belle Robb, Business Support Officer

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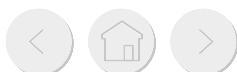

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