

# WOMEN'S HEALTH ROUNDTABLE

## Glasgow North East

# Introduction

In Glasgow, the North East has a disproportionately high number of the most deprived data zones compared with other areas. Women's health is a national priority under Scotland's Women's Health Plan, yet social and economic pressures, including austerity and the cost-of-living crisis have worsened physical and mental health outcomes. The 2024 Adult Health and Wellbeing Survey shows widening gender inequalities, with women, particularly in the most deprived areas, experiencing poorer health than men. Deprivation has a greater impact on women's health, especially for those with long term conditions, highlighting the need for targeted services. Access barriers persist, particularly in diverse communities. Women in the North of Glasgow report higher levels of loneliness, isolation, depression, and safety concerns, with only 61% feeling safe walking alone (compared to 81% of men) and men also reporting feeling safer on public transport.

The idea for a roundtable session came after discussions between Dr. Narjes Mehdizadeh, Health Improvement Senior in the Health Improvement Team of North East Glasgow City Health and Social Care Partnership (HSCP) and the Scottish Women's Convention team.

During these discussions Dr. Mehdizadeh indicated that NHS Greater Glasgow and Clyde conduct an Adult Health and Wellbeing Survey every three to five years. The survey captures perceptions of health and wellbeing across the population, including the impact on women of issues such as safety, mental health, isolation, childcare, access to services, and employment. It is important to create opportunities to discuss the survey findings and explore whether they resonate with women's lived experiences.

The Scottish Women's Convention agreed that this would be an area of work that they would be interested in working with Dr. Mehdizadeh on and subsequently the event was promoted and organised for Friday November 28th 2025.

The roundtable session aimed to foster open discussion, shared understanding, and collective learning, while developing a unified response to the challenges faced by women. As part of a broader conversation on women's health, focusing on North East Glasgow, it brought together stakeholders from health services, community organisations and local women who shared their lived experiences.

The conversations focused on identifying gaps in services and community engagement, as well as exploring practical actions that could help improve health and wellbeing for women in the North East of Glasgow. The discussions also aimed to understand women's experiences and assess whether the feelings expressed in the North East Adult Health and Wellbeing Survey were similar to those of the women attending the session.

This report presents the findings of this roundtable session and summarises the key themes, insights, and recommendations that emerged.

We are grateful to the women we spoke to for their participation and for sharing their many stories with us. We hope that by creating this report, we are able to play even a small part in helping to improve services in their area which will benefit their overall health and wellbeing.

## Access to Healthcare and Service Delivery

Women taking part in the session acknowledged that improvements had been made in physical access to healthcare in the North East of Glasgow through the development of health hubs, which they found more convenient. The women also indicated that they felt the new surroundings were less intimidating than their previous GP practices. However, the women stressed that having these new buildings did not automatically mean that they were receiving proper care; obtaining adequate treatment remained problematic.

Accessing GP services was identified as one of the most significant barriers to women's health across the area. The women described trying to access appointments systems as exhausting and incompatible with women's lifestyles, particularly those with disabilities, who were juggling caring roles, poor mental health and with limited access to transport.

· **"...they tell you to phone again tomorrow morning at half past 8 and then they don't answer the phone because the lines are full."**

Many of the women emphasised that they often lacked the time, energy, or confidence to continuously challenge healthcare professionals which often resulted in delayed diagnosis and worsening health outcomes.

· **"Once you're rushed or shut down, you don't want to open up again."**

## Women's Health, Menopause, and Reproductive Care

Women involved in the session often felt routinely dismissed, especially when presenting with complex symptoms or having researched their own health concerns. Hormonal health, menopause, chronic pain, thyroid conditions, and gynaecological issues were frequently minimised or normalised as just being part of being a woman.

· **"GP's laugh at you when you say you've researched your own symptoms."**

· **"I know my own body, but I still have to fight to be believed."**

· **"It's like when you're going in with something and you have to wait six to eight weeks, sometimes months, on a waiting list just to get in your mind that there's nothing wrong or whatever."**

· **"I've been to a menopause clinic at the hospital, and they've still not given me a blood test because of my age."**

The women described long-term physical and emotional symptoms and strongly challenged the idea that hormonal health followed specific timeframes. Being consistently told this was the case often led to confusion, anxiety, and self-doubt.

· **"We're not taken seriously, not with our health, in business, not anywhere."**

· **"We're grateful for the scraps because we've learned not to expect more."**

Some of the younger women told us they often felt dismissed when presenting with serious reproductive symptoms, including prolonged bleeding or extreme fatigue, and that this was often attributed to age or 'just your hormones' without any further investigation. One woman spoke about the absence of aftercare after her daughter had an early miscarriage as well as the use of distressing language and a lack of sensitivity towards her which had left her deeply damaged.

**·“My daughter had a miscarriage and was made to sit in a waiting room with pregnant women.”**

**·“Calling a miscarriage an ‘incomplete abortion’ can be incredibly triggering.”**

## **Support, Education and Awareness**

Overall, participants in the session touched on the significant lack of accessible, place-based health education for women and girls in the North East of Glasgow. Information about hormonal health, menopause, pelvic floor health, medication interactions, and chronic illness were described as absent or fragmented at best. Information or education in most areas of women's health was seen as arriving too late, often only after severe illness, and was heavily reliant on women seeking information independently: digital exclusion, language barriers, and the lack of centralised local information further reinforced inequalities.

The women challenged the fact that there was insufficient training in women's health when prospective doctors and other health professionals were undergoing medical training and education and that this must be addressed as a priority going forward.

**·“I don't just want them to give me medicine; I want a proper diagnosis.”**

**·“Women lose muscle tone much faster than men, but no one explains that to us.”**

## **Trauma and Psychological Wellbeing**

Feedback from women indicated a key concern about the distinct lack of choice when trying to speak to a female doctor. Women with histories of sexual abuse, domestic violence, or childhood trauma reported feeling unheard and having their requests ignored. They described being asked to disclose sensitive information during telephone conversations and then being allocated an appointment based on availability rather than what they had requested.

The women felt that they were being placed in situations that triggered past trauma, including being examined by male doctors, after explicitly stating that this would be distressing or unsafe for them.

This often resulted in consultations that felt unsafe, embarrassing, or ineffective, particularly when discussing intimate or trauma-related health issues.

·**“I told them I couldn’t see a male doctor because of my past experience of being molested and they still sent me to one...that made me feel even worse.”**

·**“A huge thing affecting women is not feeling comfortable talking about what they’re experiencing but they don’t seem to care.”**

The women also spoke about how their trauma overlapped with substance abuse, eating disorders, and self-harm. However, they reported being denied access to mental health support unless they first stopped their addictive behaviour, effectively excluding the most vulnerable women from receiving the relevant care.

·**“Drinking, eating disorders, self-harm...these are all coping mechanisms, not the problem.”**

## **Opening Up about Mental Health**

Those who contributed to the session agreed that recently the women in the North East of Glasgow were more willing to talk about their mental health than in the past. However, this increased awareness was seen as being at odds with a serious lack of capacity in adequate mental health services. Women described a pattern in which their distress was verbally acknowledged but in practice was largely unsupported. Early intervention was repeatedly seen as being lacking, with support typically only being offered when women had reached crisis point, with many of them having had years of having to cope alone.

• **“Women here are definitely talking more, but there’s nowhere for us to go.”**

The women also spoke on their grave concerns in relation to crisis responses, particularly following suicide attempts, or acute mental health episodes. One woman described having been discharged from hospital with no continuity of care and limited community support.

This lack of aftercare was seen as contributing to her feelings of abandonment and worthlessness. For women already facing poverty, trauma, or isolation, this absence of ongoing support was devastating. Mixed-sex mental health wards and emergency accommodation were described as unsafe and retraumatising for women. Rather than promoting recovery, these environments were seen as exposing women to further harm, exploitation, and fear. Statutory processes, such as historical abuse investigations or rigid safeguarding procedures, were also described as impacting on women’s mental health.

·**“You survive the crisis, then you’re sent back to the same life with nothing changed.”**

From participants’ contributions, it was clear that trauma was a defining feature of women’s health in the North East of Glasgow. They described widespread experiences of domestic abuse, sexual violence, bereavement, addiction, in both themselves and within their families, migration-related trauma, and intergenerational factors.

## Gendered Health Inequalities and Caring Responsibilities

Much like the findings from our The Realities of Scottish Social Care for Women conference and report, the women in the North East of Glasgow described how caring responsibilities fall disproportionately on them, including care for children with additional support needs, disabled family members, and elderly relatives. They described this unpaid labour as being invisible to healthcare professionals despite its profound impact on women's physical and mental health.

According to the women consulted, services are largely designed around the assumption that women will cope, absorb the pressure, and sacrifice their own health in the process.

## Women's Health and the Impact of Work Patterns

Those who contributed to the session identified anxiety and depression as being closely linked to modern working conditions, particularly sedentary jobs and working from home. The women described long hours of prolonged sitting, limited movement, and exhaustion that prevented engagement in exercise or self-care.

Several women discussed being left with musculoskeletal pain, stiffness, and fatigue without being offered a clear explanation or holistic treatment. These physical symptoms fed anxiety and led to a growing fear that something was "wrong," even when they were reassured otherwise.

The lack of medical support and proper health advice helped reinforce a cycle of poor physical health, declining mental wellbeing, and a reduced capacity to seek help.

**·“We're sitting for eight to ten hours a day, then we're too exhausted to look after our health.”**

Women involved in the discussions described widespread musculoskeletal issues that were often treated in a haphazard way. They talked about needing multiple referrals and facing long waiting periods, despite many of their symptoms being interconnected.

**·“The physio only looks at one body part at a time, but the pain just moves somewhere else.”**

Many of the women expressed frustration at being prescribed medication without proper diagnosis for example being given anti-depressants for menopause symptoms.

Several of them described having to carry out independent research, experiment with exercise which often made symptoms worse, or pay privately for medical help so they would not lose out on pay. They felt that these situations proved that these kinds of services were becoming increasingly privatised, creating inequity for those unable to afford private treatment.

Despite this, some women involved in the discussions felt empowered that they were learning about their bodies and standing up for themselves in clinical settings. However, it was acknowledged that many women lacked the confidence, energy, or even the support to challenge medical practitioners.

**·“What about the women who don’t have the energy or confidence to keep pushing... who sticks up for them?”**

## **Social Media and Health Empowerment**

Participants noted that increased information about women’s health on social media, such as PMDD, endometriosis and hormonal disorders, had helped many women feel validated rather than “crazy.” However, social media was described as a double-edged sword, providing both awareness and harmful comparisons.

Body image pressures were described as affecting women of all ages, undermining confidence, and reinforcing feelings of inadequacy. Feedback from women emphasised the importance of spaces that promote realistic, diverse representations of women’s bodies and experiences.

## **Intersectionality, Migration, and the Postcode Lottery**

Women from migrant communities, non-English speakers, disabled women, and those living in areas of high deprivation described facing increased barriers to health and other services. They described numerous incidents where there were failures around interpreting services, access to transport, digital access, and local availability of support.

Postcode stigma was identified as a powerful influence on a woman’s confidence, expectations, and the treatment they received. Those who contributed to the session felt that being from the North East of Glasgow, or other housing schemes, often meant being underestimated, dismissed, or expected to be grateful for what they get.

**·“...they look at your postcode, and they just assume that you’re not worthy.”**

**·“I think it’s the poverty that’s the underlying cause for nearly every single issue we face.”**

## **Safety, Community, and Environmental Factors**

Women involved in the discussions overwhelmingly reported feeling unsafe in their communities. Poor street lighting, lack of visible safety measures, and fear of violence, especially knife crime, were cited as major concerns. Many women described having to change their behaviour, their clothing, and their routines in order to reduce risk.

**·“I used to walk home or get the midnight bus from town and never felt afraid but now I go to the city centre and I’m like; this feels really unsafe.”**

Disabled women reported heightened vulnerability, while women from minority ethnic backgrounds were identified as facing persistent harassment, racialised sexualisation, and daily verbal abuse. Many participants highlighted how racism, anti-immigrant narratives, unhelpful media content, misogyny, and body shaming intersect to undermine women's confidence, safety, and mental health.

- **"Women are constantly sexualised, and if you complain, you're told you're overreacting."**
- **"Black women are harassed every single day just for existing."**

Safety measures were often framed as being a woman's individual responsibility, requiring women to bear the financial and emotional cost of having to protect themselves.

- **"Why are women expected to pay for their own safety when they live in areas like this?"**

## **Community Strengths and Preventative Approaches**

Despite significant challenges, women involved in the discussions highlighted the strength, solidarity, and pride of women and communities in the North East of Glasgow. The small number of community-led models, such as women's hubs, trusted local organisations, and informal networks, were described as offering dignity, continuity, and genuine care.

Although these women only spaces were seen as critical to women's health in terms of prevention and early intervention, many of them were drastically underfunded and were relying on short-term funding and individual workers rather than robust, sustainable investment.

## **Conclusion**

The roundtable session made clear that women in the North East of Glasgow face deep and persistent health inequalities rooted in poverty, trauma, and inequality. While awareness of women's mental health has increased, local services remain overstretched, fragmented, and largely underfunded.

Women are navigating systems that frequently dismiss their experiences, retraumatise them in moments of crisis, and which often place the burden of their health, education, and safety onto themselves and their families.

Without significant structural change, sustained investment, and more community based health initiatives, focusing on knowledge and trust, these patterns will continue to reproduce poor health outcomes and deepen inequality for women in the North East of Glasgow.

# Key Recommendations

## 1. Strengthen Training and Education on Women's Health

Develop mandatory training programmes for all healthcare professionals on women's health, including hormonal health, reproductive health, menopause, chronic pain, and gender-specific conditions. Integrate women's health modules into undergraduate and postgraduate medical, nursing, and specialised health curricula.

## 2. Include Trauma-Informed and Gender-Sensitive Care Across All Services

Require all healthcare settings to adopt trauma-informed approaches, ensuring women can request female practitioners and feel safe disclosing sensitive issues. Reintroduce Well Woman clinics.

## 3. Access to Publicly Funded Physiotherapy and Other Self-Referral Services

Increase funding for NHS physiotherapy, podiatry, and similar services to reduce reliance on costly private options which are often unable for women.

## 4. Improve Professional Accountability for Dismissing Women's Symptoms

Introduce systems for monitoring diagnostic delays, missed diagnoses, and repeated dismissal of symptoms reported by women.

## 5. Improve Community Safety

Invest in improved street lighting and safer transport options by working with local women to design safer public spaces and community safety strategies.

## 6. Reduce Inequalities Faced by Marginalised Women

Ensure equal access to interpreting services, transport options, digital resources, and culturally sensitive health information. Adopt intersectional approaches into service planning, recognising how racism, disability, trauma, and poverty compound health inequalities for women.

# **Thank You!**

The Scottish Women's Convention and HSPC North East thank all women who contributed to this important discussion.

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