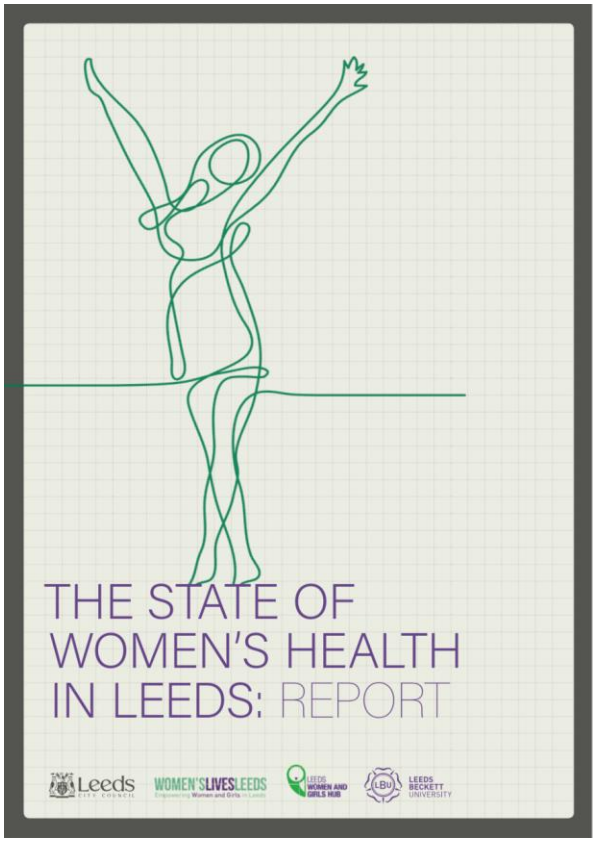

White A., Erskine S., and Seims A (2019) The State of Women's Health in Leeds, Leeds City Council, Leeds

12. Use of health services

12.1 Introduction

Leeds is well supported by health care services, with one of the largest teaching hospitals in Europe, dedicated teams of primary health care professionals and a thriving 3rd sector. The Health and Wellbeing Board is continually striving to improve the health of the city, through its Leeds Health and Care Plan and its Health and Wellbeing Strategy (Leeds City Council 2016; Dannhauser 2018).

Despite this high level of commitment to providing a people-centred health and social care provision the Women's Voices in Leeds study (Thomas and Warwick-Booth 2018), identified many barriers to accessing services within the City that included financial, language, childcare, timing, location, confidence, cultural and physical (such as building design for disabled women). A common theme from people's experiences was that services were not designed with them in mind, coupled with a lack of awareness of what is available. This also came out of the evaluation of the Women's Lives' Leeds (WLL) initiative (Warwick-Booth et al. 2019), where even really helpful services were just not getting the right sort of uptake, either due to people not knowing they were there, or a lack of confidence or ability in being able to access them effectively.

A further important finding from the Women's Voices study and the WLL evaluation (that has been supported elsewhere), is the need for an option on female-only services. In part this may be a cultural requirement but is also a real need for women who have experienced abuse at the hands of a man or simply do not feel confident or comfortable with men.

> *'… pretty much unanimously it is, 'Yes. I feel safer. I feel more confident communicating. I feel that I can share things with her that I wouldn't share with a male worker.' … I think that's a really big thing, particularly with these women that we're working with, the really vulnerable women, a lot of whom will have negative experiences of men as well.'* [CT1] quote from Women's Lives Leeds Evaluation *(Thomas and Warwick-Booth 2018)* p 26

Women are generally greater users of health services, mostly as a result of their reproductive health needs such as contraception, and screening tests, however

contrary to popular believe, this does not mean they are always better users of services.

In the Cancer Awareness Campaign lead by the Department of Health and evaluated by Cancer Research UK (Moffat et al. 2016) found that on average, women reported more barriers to reporting symptoms than men. Women were more likely than men to report that finding it difficult to get an appointment with a particular doctor; disliking having to talk to the GP receptionist about their symptoms; and having a bad experience at the doctor's in the past, would put them off going to the doctor. Women were also more likely to report being worried about what they might find wrong, worried about what tests they might want to do, and were more worried the doctor wouldn't take their symptoms seriously.

The difficulties in using GP services was evident in the Women's Voices study (Thomas and Warwick-Booth 2018), with difficulty getting an appointment, the short time to explain complex problems and the lack of home visits, which are structural issues. There were also concerns over doctors lacking a 'human approach' and more focused onto computer notes or held stereotypical views about older women.

> *"I found that when I was going through the menopause that's probably when I had the least relationship with my Doctor's…I didn't feel like they connected very well with me about that. I didn't wanna take drugs or HRT I didn't want any of that. And that's* ***all*** *they could offer. And then other symptoms that I felt were happening because of the menopause they just didn't recognise they were- they weren't, interested in…" (p20)*

There are a greater proportion of women as compared to men that are given a diagnosis of 'medically unexplained symptoms' (MUS) (NHS 2018), which is where a person can experience physical symptoms but it is difficult for the GP to identify a specific cause. It can be the case that these symptoms are a result of conditions that have previously been difficult to diagnose, such as fibromyalgia or are a result of emotional difficulties creating physical symptoms (psycho-somatic or somatoform diseases) (RCP 2015; Razali 2017; Rosendal et al. 2017; NHS 2018). Whatever theunderlying problem, it can cause distress for both the patient and the doctor and unless managed well, can exacerbate the problem and make the relationship with the GP more difficult (Stone 2014; Sowińska and Czachowski 2018). It has been

proposed that GPs should adopt a more empathetic approach and that better communication can lead to better outcomes for both the patient and the GP (Chew-Graham et al. 2017; Houwen et al. 2017; Rosendal et al. 2017).

There were also concerns over hospital-based services, especially around the issue of communication, in terms of patient's frustrations of having to repeat their history to many different practitioners (which can also be traumatic when dealing with sensitive issues) and also when communication was poor between departments and staff.

This section explores the issues facing women with regard to health screening, the NHS health check, the use of mental health services, dental registration, smoking cessation and weight loss.

12.2 Health Screening

Screening offers an invaluable opportunity to identify early cancers, to pick up on cardio-vascular health problems (such as hypertension and high cholesterol levels) and diabetes; all conditions which benefit greatly from early detection and management. Currently across the country , women are offered breast cancer, cervical cancer, and bowel cancer screening (Leeds City Council 2017) and the opportunity to have the NHS Health Check (Leeds City Council 2018).

The Million Women study (Floud et al. 2017) found women with disabilities were 36% less likely to attend breast screening and 25% less likely to participate in bowel screening than women who were disability free. Those with self-care difficulties, mobility disabilities and vison disabilities had the lowest compliance

For some groups within society, the take up of screening is more problematic than for others (PHE 2013), with specific attention required to help address their needs. These include:

- Individuals who have hearing problems or are deaf.
- Individuals with a visual impairment.
- Individuals who have a physical disability.

- People from ethnic minority backgrounds who have no or poor understanding of the English language.
- Travelling communities.
- Lesbian and bisexual individuals.
- Transgender individuals.

In addition women with learning disabilities have been found to be under-represented in screening up-take (Osborn et al. 2012; Connolly 2013; Willis 2016), with less than half of the eligible national population taking up the NHS Health Screen, 1 in 3 engaging in cervical cancer screening, 52% completing breast screening and 3 in 4 completing bowel cancer screening (NHS Digital 2017). A Canadian study (Willis 2014, 2016) found a key factor in improving access is the role of the paid carer and better information to the whole family. There are some excellent initiatives that are supporting women with learning disabilities. Tenfold[1] is a forum that runs within Leeds to support third sector organisations working with or for people with learning disabilities. 'Through the Maze'[2] is an information and support service for people with learning disabilities in Leeds. "Bee together" [3] is a Leeds Time to Shine community development project aimed at supporting older women and men with learning disabilities at risk of social isolation.

People who are born profoundly deaf have specific health needs (Emond et al. 2015), with higher than the general population's levels of obesity, hypertension, diabetes, mental health difficulties, and with low health literacy. The main causes of hearing loss in the elderly are noise-induced hearing loss (working environment, loud music etc), hypertension, diabetes, genetic factors and hormonal changes post menopause (Oghan and Coksuer 2012). Hearing loss tends to be greater in men than in women, but there are still a substantial number of women who are missing out on hearing aids (Scholes and Mindell 2014), with hearing loss most pronounced in those from lower socio-economic areas and those most in need of social support. Those who are blind or partially sighted can also experience difficulty with regard to being aware of screening opportunities or the mechanics of screening, such as

[1] http://www.tenfold.org.uk/
[2] http://www.through-the-maze.org.uk/
[33] https://timetoshineleeds.org/projects/learning-disability-community-development

needed for the bowel cancer faecal occult blood test (FOBT) stool sample (RNIB 2015).

Women with sight impairment accessing to health services can experience difficulties in a number of different ways. Reminders for general health screening such as breast screening are often sent by letter which is difficult if not impossible for some to read/access. People generally with a visual impairment can lack confidence going to new places without assistance and can in fact avoid going for fear of not finding places or finding their way around. Some medical staff forget or don't know how to audio described an environment making the woman unsure what is excepted or needed. Transport is also an issue as there is an anxiety catching a bus because they are not sure which bus to use, cannot see the numbers, don't know what stop etc. There may also be issues in the way that services call the next patient in for screening – if it is done on a screen then there is the possibility they will be missed.

There can be particular problems for Wheelchair users to access health services due to a lack of suitable adjustments both relating to structural barriers, such as poor street design and inaccessible buildings; physical barriers, such as narrow doors, poor toilet access and difficulty getting onto examination tables etc.; systemic barriers, such as appointments that are too short, or lack of planning to cater for their needs; and attitudinal barriers, such as stereotyping and stigmatizing or failure to deliver the same kind of care as given to an able-bodied women (Hanlon and Payne 2018). Similar findings were found in an American study (Stillman et al. 2017) of wheelchair users' experiences of accessing health care, where along with the practical difficulties, there was a perception that they received incomplete care and the physician only had a partial understanding of their needs.

> *"I've known some people who use wheelchairs who've had to struggle on to the bed, with help, and been very uncomfortable and very, very… and had an awful experience. But they wanted to go through with it and that was the only way they could. Because there was no facilities to help them, within their GP surgery. And I don't know whether you can get referred to hospital where they have facilities, but at that point they hadn't." quote from participant in the Women's Voices study* (Thomas and Warwick-Booth 2018)

Ethnic minorities have been found to have lower uptake of screening opportunities, leading to later presentations and poorer outcomes (Macmillan 2014). The sex of the practitioner for cervical cancer tests, language barriers, heath literacy, lack of awareness of religious requirements can all be significant factors in accessing screening opportunities (PHE 2013; Macmillan 2014). Women from the Romany, Gypsy and Traveller community also have access issues with regard to health care, in terms of structural factors, such as not being registered with a GP, cultural factors in relation to perceptions of health, language issues and the ability to understand messages,(Thompson 2013; Warwick-Booth et al. 2017; McFadden et al. 2018).

Lesbians are still at risk of cervical cancer, yet their uptake of PAP screening has been much lower than for heterosexual women (Tracy et al. 2013; Curmi et al. 2014, 2015), in part due to a belief that they are at a lower risk as they are not engaging in heterosexual sex, but also due to a fear of discrimination and other anxieties relating to the procedure. A further study by Johnson et al., (2016a) explored the experiences of lesbians, Bisexual women and transgender men, which found that those who were routine screeners felt more welcome in the health care setting, but for others who did not attend there was a fear of discrimination based on their sexual orientation and gender expression.

The transgender community have specific issues relating to their screening needs specifically trans men and their risk of cervical cancer. For instance the invitation system used for cervical screening is set up automatically to only invite the correct eligible patients, which may exclude male trans who still have a cervix (PHE 2013). In addition, women with a male history, or men with a female history that have developed breast tissue, still need breast screening.

Women who are from the Gypsy and Traveller community have also been found to miss out on screening opportunities, either through problems with access, health literacy, or lack of registration on the appropriate lists (PHE 2013).

12.2.1 Breast cancer screening

Breast cancer screening is offered to women aged between 50 and 70 years every three years. Over England, 75.4% of those eligible for the screening took up the opportunity (2.2 million women), with 41.5% of the cancers detected being too small to have been picked up without the x-ray (7,635 women). Detection is highest in women aged over 70 years (14.6 per 1,000 women tested) and lowest in the 50-54 age bracket (6.2 per 1,000 tested) (NHS Digital 2018). In Leeds we fall below the national average, with 74% of eligible women screened, but this an improvement on previous years and the most current data shows that across Leeds there has been an increase in breast screening uptake, from 66.9% in April 2012 to 70% in August 2017 (Figure 1).

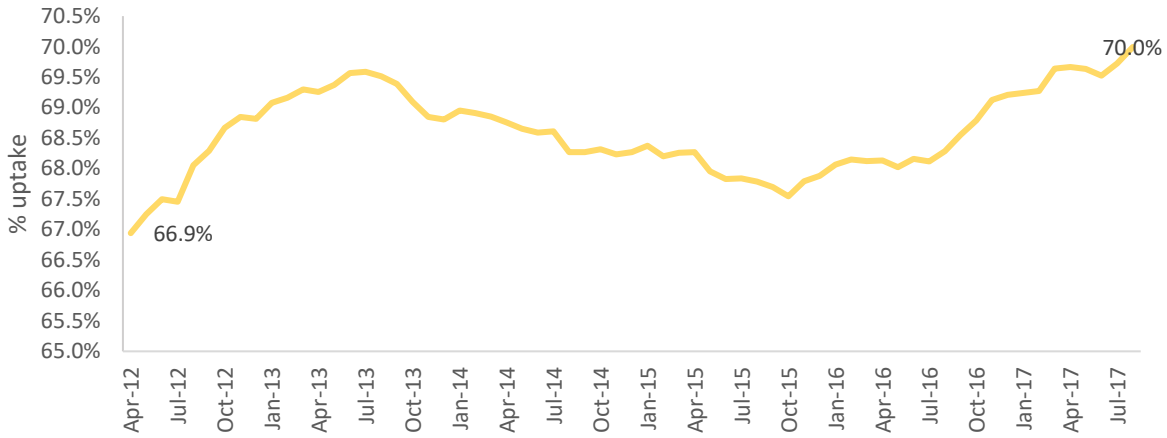

Figure 1 Change in breast screening uptake in Leeds from Apr 2012 to Aug 2017

Cancer screening has been found to be lower in women with mental health problems (Howard et al. 2010; Aggarwal et al. 2013; Woodhead et al. 2016) and in those from ethnic minority backgrounds (Crawford et al. 2016; Hirth et al. 2016). Uptake of breast screening opportunities is also lower in women with intellectual disabilities (Collins et al. 2014) through a complex range of issues, with the role of the carer being of prime importance (Willis 2016).

12.2.2 Cervical Cancer Screening

Cervical cancer screening is effective at reducing advanced cancer in the population (Castle et al. 2017), with regular screening associated with a 67% reduction in stage 3 cancer and preventing 70% of deaths (Landy et al. 2016). Of the ~6% ofwomen across England who tested positive, women aged 25-29 were most likely to have a high-grade abnormality, which reinforces the need for an active marketing programme for this age group (NHS 2017a). There has been a recent push by PHE to improve access to cervical cancer screening, as they recognise the national figures are at a 19 year low (PHE 2017).

Across Leeds, of the 209,200 women eligible for the test, 45,000 have been screened, of which 96% were negative, 1.5% had borderline changes, and 1.1% having moderate to high grade changes (495 women) (NHS 2017b).

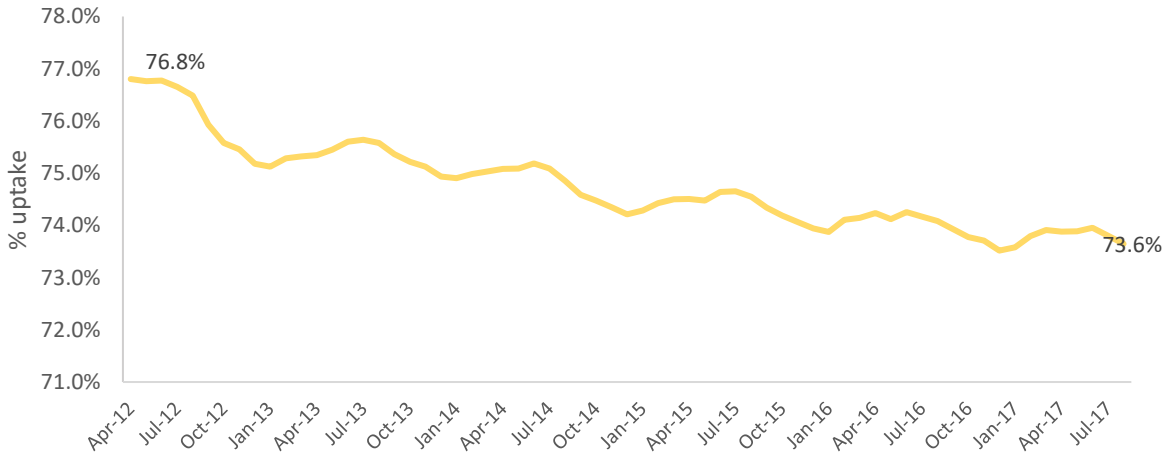

Figure 2 Change in cervical screening uptake in Leeds from Apr 2012 to Aug 2017

There are still women who do not attend screening and there has been a steady reduction in uptake across Leeds with a drop from 76.8% in April 2012 to 73.6% in August 2017 (Figure 2), however this is still above the national average of 72%. Analysis of screening activity tends to suggest that younger women are less aware of the test and older women have decided not to attend (Marlow et al. 2017). Older women that do not take up screening have been found to be affected by embarrassment and logistical issues (Hope et al. 2017). Those at risk of social

isolation (non-English speakers, alcohol abusers, heavy smokers, receiving treatment for psychiatric disease) and those less well educated (Myriokefalitaki et al. 2016; Labeit and Peinemann 2017) are also poor at taking up screening opportunities.

A study of women who did not attend (Marlow et al. 2018) found that they were more likely to be fatalistic and more focused onto the moment rather than thinking about potential future problems; these women were also more likely to avoid information about cancer and be less informed. The role of good quality, focused, and ethnically appropriate information has been suggested as key to getting more women to attend screening (Ghanouni et al. 2017).

There is also a strong argument that for women who have been sexually assaulted, the way the smear test is advertised and the language used to promote the test creates barriers to participation (Cosgrave 2018). With greater awareness of the needs of vulnerable women, the service could be more sensitively promoted and delivered. This work is being promoted by the My Body Back project[4], which is supporting women a year onward following sexual assault.

It is proposed that the current PAP screening be replaced with HPV screening, which would result in an estimated 23.9% reduction in the current cases invited for screening and an estimated reduction of 19% in cervical cancer by 2023 (Castanon et al. 2017). There are worries that the self-sampling required for HPV screening may not be effective due to lack of knowledge, low self confidence in ability to self-sample and a worry over its efficacy amongst other factors (Williams et al. 2017). However, a recent meta-analysis of identifying precancer risk and reaching under-screened women by using HPV self-testing (Arbyn et al. 2018) has found it to be as effective as clinical samples, which may be a positive way forward.

[4] http://www.mybodybackproject.com

12.2.3 Colorectal Cancer Screening

There has been a national bowel cancer screening in place since 2006, aimed at all men and women aged between 60 and 74 years of age. In Leeds this is mostly based on the bowel cancer screening test, which requires the return of three samples of stool (Leeds City Council 2017).

In Leeds those women taking up bowel cancer screening has increased from 55% in April 2012 to 58% in August 2017 (Figure 3).

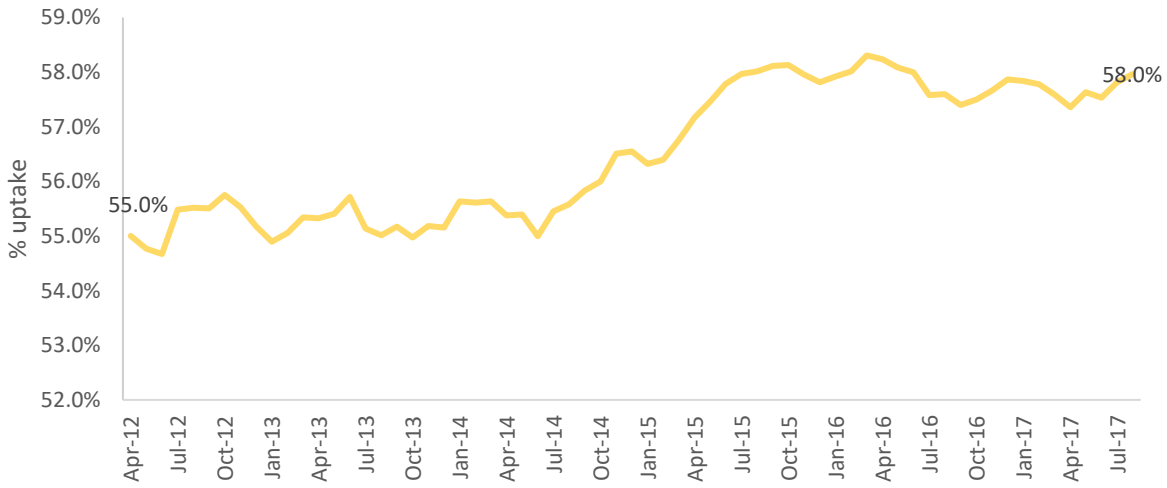

Figure 3 Change in Bowel screening uptake in Leeds from Apr 2012 to Aug 2017

In a review of the national data relating to colorectal cancer (White et al. 2018) a higher proportion of women were found to have taking part in screening (60.9% women as compared to 55.5% of men), with the gap narrowing with age. This review also found that more women are diagnosed through emergency presentation, which was thought to be a consequence of the greater chance of co-morbidity as women tend to be older when they develop the disease.

There are also issues with the way women develop colorectal cancer that can impact on how they are diagnosed and the risk this cancer poses. Women are more likely to develop the disease in the caecum and ascending colon, which is not viewed in the standard Bowel Scope assessment, and are more likely to develop sessile serrated

polyps, which are more likely to be missed via colonoscopy and can lead to more aggressive forms of cancer (Hansen and Jess 2012). Women's bowel cancer has also been found to have a lower level of haemoglobin in the faeces, resulting in a lower pick up on screening (Steele et al. 2012).

Women are as likely as men to prevaricate over screening due to the faecal sampling required (Lo et al. 2015; Clarke et al. 2016) and are embarrassed and have difficulty in reporting symptoms to their GP (Moffat et al. 2016). Greater attention needs to be paid in getting women to be screened, as many think this is a male disease (Friedemann-Sánchez et al. 2007).

One participant from the Leeds Women's Voices study (Thomas and Warwick-Booth 2018) noted that for people with a visual impairment, bowel cancer screening creates difficulties.

12.2.4 NHS Health Check Uptake

The NHS Health Check is a national initiative aimed at preventing Cardiovascular Disease (CVD), through inviting those aged between 40 and 70 years to complete the check every five years. The Leeds approach was to roll out the Health Check in stages, starting in 2009/10 with those most at risk, which included those practices with more than 30% of their population living in the 10% most deprived areas nationally and males.

The latest audit of uptake in 2017 (Turrell *et al*. 2017) shows that between 2011/2012 and 2015/2016, over 90% of those eligible had been invited to be tested. The report notes that women, especially those from deprived areas, are more likely to attend an NHS Health Check than men. It also notes that in Leeds, uptake across ethnicity groups is in proportion to the ethnic composition of local communities and is greater in the older population than the young.

12.3 Mental Health service usage

The primary delivery framework for NICE-recommended psychological treatments for Common Mental Health Disorders is the Improving Access to Psychological Therapies (IAPT) programme. This brings together evidence-based treatments informed by clinical guidelines with the delivery of interventions, in a stepped-care model. Validated patient-reported outcome measures (including GAD7 and PHQ9) are used to assess, monitor and evaluate treatment.

Within Leeds, twice as many women access IAPT services as men (Figure 4).

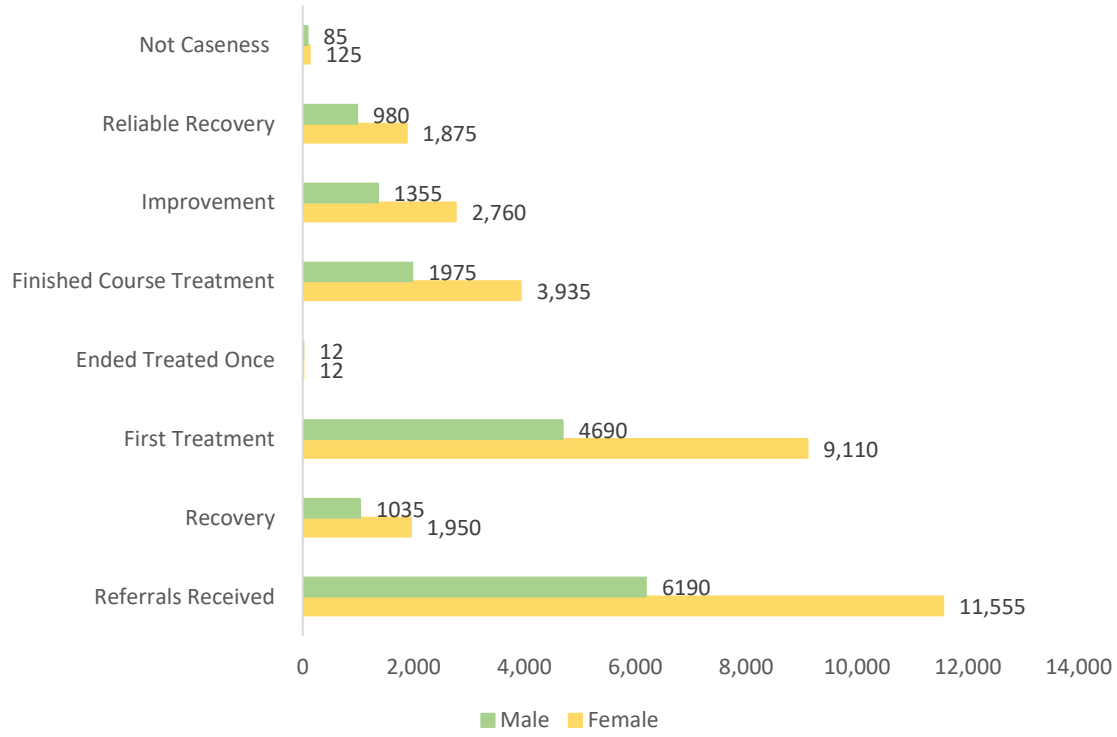

Figure 4 IAPT data by gender. Leeds, CCG Leeds Annual IAPT data return 2017/18

Acute mental health services provide community-based and inpatient treatment for people with moderate to severe mental health disorders, including psychosis. Admissions to acute mental health wards are broadly comparable between males and females, however a greater number of women are referred to community-based mental health teams/primary care mental health than men.

12.3.1 Eating Disorders

Treatments for mild to moderate eating disorders are delivered via the IAPT Service and in Primary Care settings. Information about eating disorders in Primary Care is not consistently recorded. The number of referrals to IAPT between 2016 /17 and 2017/18 with a primary or secondary diagnosis of an eating disorder were at least 15 times more for females compared to males (Table 1).

Table 1 Referrals with a Primary or Secondary Diagnosis of F50 – Eating Disorder

	Female	Male	Total
2016-17	91	6	97
2017-18	143	7	150

Admissions to hospital for physical health conditions related to eating disorders show a similar pattern with at approximately ten times more female patients admitted than males, and nearly 15 times more admissions for female patients than male patients(Table 2).

Table 2 The number of admissions for eating disorders (2013/14 to 2017/18), age 10+ resident in Leeds[5]

	Female	Male	Total
Admissions	721	49	770
Patient Count	346	34	380

The relationship between eating disorders admissions and deprivation appear random, however this may be related to the small overall number of admissions (Figure 5).

Services for severe eating disorders in Leeds are provided by LYPFT via the CONNECT service. This includes a community-based treatment service, inpatient service and FREED (First Episode and Rapid Early Intervention Service). In October 2018 there were 50 Leeds women on their caseload.

[5] Eating Disorders Hospital Admissions (*Admissions data Copyright © 2018, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.)*

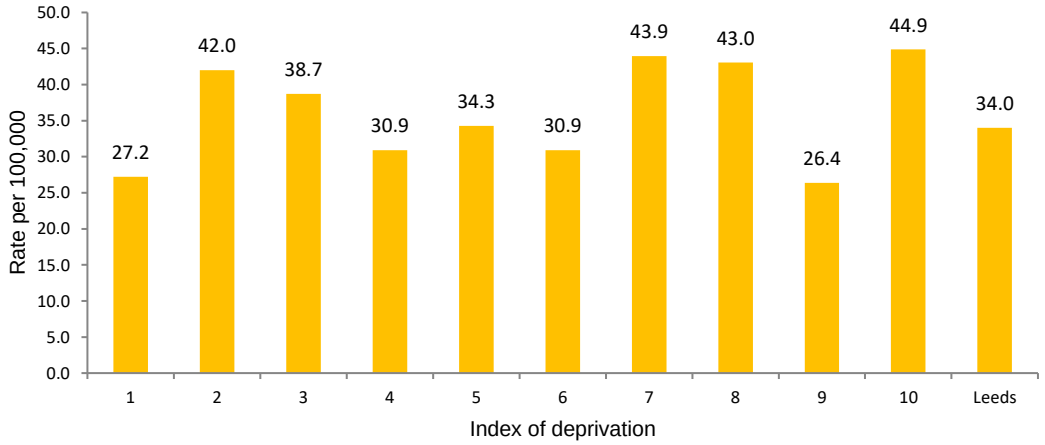

Figure 5 Female admission rates for eating disorders (2013/14 to 2017/18) by Index multiple deprivation deciles, 2015

12.3.2 Self-Harm

Information about self-harm is obtained by collecting data on hospital admissions. It is important to note that this data has limitations - self-harm hospital admissions data does not provide a comprehensive picture about self-harming behaviour in the community.

There are a higher number of admissions for women living in the most deprived two deciles of Leeds, with Leeds rates higher than the national average and greater for women in the deprived areas of the city (Figure 6).

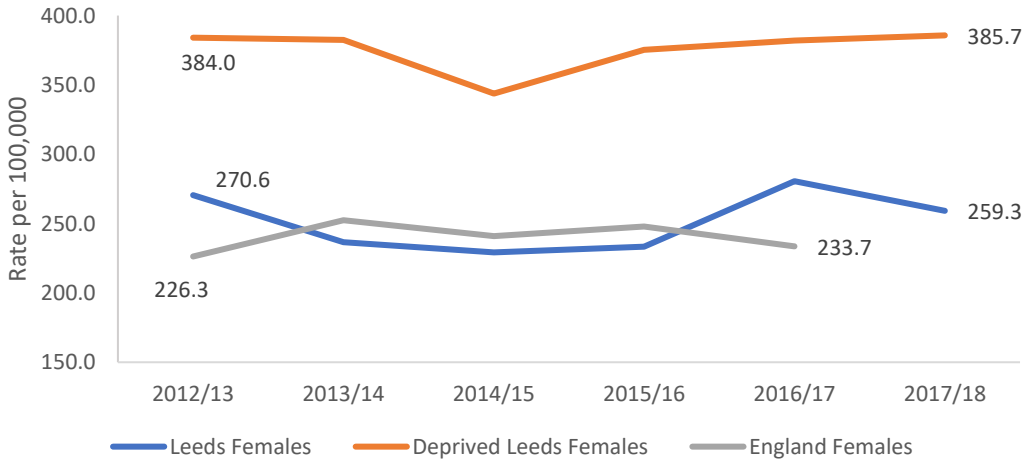

Figure 6 Emergency Admissions for Deliberate Self-Harm All Ages, Persons

12.4 Dental registration

Tooth decay is more of an issue for women than men and has been linked to sex-differences in the composition of saliva, the effect of pregnancy, and different eating habits, especially relating to food production in the home increasing snacking (Lukacs and Largaespada 2006; Ferraro and Vieira 2010). Data was not available for Leeds, but this section has been included as dental health is an important aspect of overall health as women have specific issues to consider.

Obesity is linked to dental caries in children, with more decayed, missing, and filled permanent teeth among obese 18 year old girls than boys (Li et al. 2017). Children from lower socio-economic communities are more at risk of lower oral health quality of life, irrespective of their actual oral health status (Kragt et al. 2017), with the suggestion that self-esteem and self-perception about oral health and body image may be a factor..

A Swedish study (Ericsson et al. 2012) suggests that adolescent girls have more favourable perceptions, attitudes and behaviour with regard to their oral hygiene, which may be influenced, both by a better awareness of the health benefits, but also for cosmetic and aesthetic reasons.

Through pregnancy and whilst breast feeding, it is important to have good oral health as inflammatory gum disease, gingivitis or periodontitis are common problems faced during pregnancy. Increasing midwifery intervention to offer oral hygiene education and guidance on using dental services can improve women's up-take of services (George et al. 2018).

Mental illness can have a negative effect on dentition, as a result of a higher proportion of women smoking, the effect of medication, and anxieties relating to dental services and dental hygiene. There may also be issues relating to competing priorities in their life and difficulties accessing services, especially if there is a felt stigma to using the services (Kisely et al. 2011; Brondani et al. 2017). Eating disorders can damage the enamel of the teeth and result in a poor oral health status due to vomiting (Lourenço et al. 2017).

Women with breast and other cancers can be at increased risk of dental problems (Lo-Fo-Wong et al. 2016) due to the effect of chemotherapy on normal mucosal replacement and also due to use of anti-oestrogen therapy.

Tooth loss in older women may be as a result of osteoporosis and warrant further investigation (Martínez-Maestre et al. 2010). Treatment with bisphosphonates can have a negative effect on oral health and affect bone healing after dental treatment (Grgić et al. 2017).

An Australian study (Riggs et al. 2014) found that migrant women and their children were more likely to access dental services through emergency care as they faced many barriers to using primary dental services.

12.5 Smoking cessation

Across Leeds, between April 2017 and March 2018 there were 944 females and 740 males setting a quit date to stop smoking, of those there were 453 female and 360 male successful self-reported quitters (or approximately 49% of both male and female quitters), with 378 female and 233 male quitters confirmed by CO validation (which is 83% females and 65% of males). There were more women than men attempting to quit and more whose outcome are not known or lost to follow up.

Women usually tend to be less successful at quitting smoking than men (Martin et al. 2016), with especially older White women rating barriers to quitting (such as the risk of weight gain) more difficult to overcome than men. Interestingly a study of nicotine withdrawal showed that although women reported greater negative affect, psychological withdrawal, and sedation after overnight abstinence than did men, they were not influenced by the amount of nicotine in a cigarette when it came to its ‘restorative’ effect (Faulkner et al. 2018). This suggests it was the psychological and affective aspects of withdrawal rather than the nicotine that is the main barrier to cessation.

In part this may be due to women who smoke facing a greater burden of stigma, both from others and ‘self-stigmatizing’ their own behaviour by being very aware of the risks they face,, especially if they are mothers or pregnant (Triandafilidis et al. 2017). This can lead to feelings of shame and having to deal with the emotional bullying that men may not have to endure. With smoking being most prevalent in women from lower social backgrounds and in women with mental health difficulties, this negativity can make their lives all the harder. Focusing on the positive aspects of not smoking may be a more beneficial approach (Triandafilidis et al. 2017), including the effects of smoking on physical appearance, oral hygiene and the health benefits for their children (Memon et al. 2016).

It’s also important to note that attempts to stop smoking during the pre-menstrual period are limited due to increased tobacco dependency and the negative effect of the withdrawal symptoms on top of those experienced by those with elevated affective PMS (e.g. irritability, anger) (Pang et al. 2017).

The Smoking Insight Evaluation carried out in the Leeds East and South CCG areas did not differentiate between male and female smokers, apart from specific reference to pregnant women who smoke (Trigwell et al. 2015). They did note that practitioners felt less successful at reaching into BME Communities.

Lesbian, bisexual, and other sexual minority women have been found to be more resistant to smoking cessation efforts, with the suggestion that they need more targeted interventions that work with them on overcoming the causative factors (Baskerville et al. 2017).

The Stop Smoking Services for Pregnant Women (SSSP) run by the NHS have found that by focusing their services on clinics rather than trying to reach out to the women in their own homes was more effective (Vaz et al. 2017). They also found that they should focus their attention onto the more deprived communities and those with lower educational attainment as they were the most likely to smoke and be the hardest to influence.

The sex and gender differences seen between men and women with regard to tobacco consumption and with regard to problems of cessation warrant more gender aware policies and strategies (Amos et al. 2012).

12.6 Weight loss services

In Leeds 5,994 women (2,868 men) had a hospital admission with a primary or secondary diagnosis of obesity, with 27 females (8 males) having Bariatric surgery in 2016/17 (NHS Direct 2018).

There is evidence to suggest men are more successful at losing weight than women (Stroebele-Benschop 2013). For women there tend to be multiple attempts with a boomerang effect, where weight loss is followed by weight gain. There is a higher proportion of women offered medicinal support by their GP to lose weight, with an increasing number of women are seeking surgical solutions to their weight difficulties, such as stomach bands.

Social stigma and discrimination as a result of obesity has been found to have a greater negative impact on women's ability to lose weight, through many different effects. These include the unwillingness to join exercise groups due to poor self-image, and a lower sense of self-esteem and self-efficacy restricting effort as there is a fear of failure. The stress and depression caused by the stigma can also lead to poorer eating habits. Changing social networks, with the lower likelihood of joining active friends can also be limiting, as can the life-limiting effects of obesity (Brewis 2014), such as reduced job options, lower income and poorer living environments, which limit life choices.

An American study (Ford et al. 2017) found that postmenopausal women with high adherence to a reduced-carbohydrate diet, with moderate fat and high protein intake, were at decreased risk for postmenopausal weight gain.

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