Introduction

We are the Sex-Based Rights Caucus of the Women's Equality Party. Our caucus works on clarifying, protecting, and strengthening the sex-based rights of women and girls. We use our platform to communicate the importance of sex-based rights, with the core aim of increasing understanding and compassion around why women and girls have sex-specific needs and why erosion of our rights impacts on the wellbeing and lived experiences of women.

We represent over 1200 signatories to our petition calling for the protection of sex-based rights. We are part of Women Uniting, a UK collective of organisations with this common aim.

The potential evidence that could be submitted far extends the limits of this document. We have therefore focussed on the issues raised with us by our members.

https://www.womensequality.org.uk/
https://www.wepsbr.com/
https://www.ipetitions.com/petition/wep

Terminology

It is essential that the words used in this document and consultation are used correctly and also clearly understood by everyone.

Woman and Girl: we will be using these words throughout this document to exclusively reference biological sex as understood to be female.

Sex refers to a set of biological attributes in humans and animals. It is primarily associated with physical and physiological features including chromosomes, gene expression, hormone levels and function, and reproductive/sexual anatomy. Sex is binary, male or female, is determined in utero and is immutable.[1] [2]

The 0.02% of people with variations of sexual development, VSD (formerly known as disorders of sexual development DSD, or intersex) are also either male or female.[3]

Gender refers to the socially constructed roles, behaviours and identities of girls, women, boys, men, and gender diverse and gender non-conforming people. There are currently more than 100 published genders in 2021. We do not use the word gender to refer to biological sex in this document.

The two terms 'sex' and 'gender' must not be used interchangeably in health or legal contexts. To conflate the two terms is incorrect and causes miscommunication with poor outcomes.[4]

Gender Identity has been described by Professor Alice Sullivan as "The term refers to some people's sense that they identify psychologically as a member of the male or female sex, particularly when this identity clashes with their biological sex. It refers to how individuals see themselves, rather than how society sees them."[5]

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[1] Kashimada, Kenichi, and Peter Koopman. 2010. "Sry: the master switch in mammalian sex determination." Development 137(23):3921-30.
Sry: the master switch in mammalian sex determination
[2] Sobel, Vivian, Yuan-Shan Zhu, and Julianne Imperato-McGinley. 2004. "Fetal hormones and sexual differentiation." Obstetrics and Gynecology Clinics 31(4):837-56.
Fetal hormones and sexual differentiation
[3] Sax, Leonard. 2002. "How common is Intersex? A response to Anne Fausto-Sterling." Journal of sex research 39(3):174-78
How common is Intersex? A response to Anne Fausto-Sterling
[4] Scott, Joan W. 1986. "Gender: a useful category of historical analysis." The American historical review 91(5):1053-75.
http://ahr.oxfordjournals.org/content/91/5/1053.full.pdf+html
[5] Sex and the Census: Why Surveys Should Not Conflate Sex and Gender Identity by Alice Sullivan :: SSRN

Natal or **biological** woman means a female. Sex is not "assigned at birth" it is observed at birth. For reference, the following articles provide useful analysis of healthcare issues regarding confusing sex and gender:

- Healthcare — Sex Matters
- Health & Disability | WEP Women's Sex-Based Rights Caucus

Evidence

1. Accesibility and single-sex exceptions

In law (*Equality Act*, *2010*), women and girls are currently entitled to the following rights, in order to ensure their privacy, dignity and safety when accessing healthcare:

- The right to ask for female personal caregivers;
- The right to ask for a female nurse or doctor to carry out intimate procedures, including but not limited to: smear tests, sexual health exams, rape suite staff, mammograms, midwives, gynaecologists;
- A right to ask for or expect single-sex hospital wards where women are often in partial undress, vulnerable or sleeping.

These rights are vital in ensuring health care is accessible and safe for women and girls.

Women have clearly responded to the need for same-sex accommodation in recent surveys[6] and have expressed the opinion that if these are not provided they would be and are reluctant to access healthcare. This is a serious clinical risk. The Department of Health's own reports have indicated that single-sex wards are more effective, especially in treatment of mental health conditions, and EMSA policies have been in place since the 1990s, with a view to eliminating mix-sexed wards.[7]

Research conducted by The Women's Budget Group[8] found the majority of women valued women-only services. These include medical services, mental health services, and sex exemptions used to employ female therapists, doctors, nurses and caregivers etc. In a survey of 1000 women:

- 97% said that women should have a choice of women-only support services if they had been a victim of sexual assault;
- 90% believed that women should have the right to report sexual or domestic violence to a woman;
- 87% thought it was important to be able to see a female health professional about sexual or reproductive health matters;
- 78% thought it was important to have the choice of a woman professional for counselling and personal support needs.

A study of women-only services commissioned by the Equality and Human Rights Commission[9] found that, for the majority of service users, the women-only aspect of the service was important in their decision to attend. Reasons for this included safety and security, building trust and confidence, peer support and the ability to talk freely about the issues facing them. These were particularly important for ethnic minority service users.

We ask that the government's Women's Health Strategy protect single-sex provisions and simultaneously expediate EMSA reform in order to ensure it is:

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[6] Poll: Women in Scotland want to retain single-sex facilities

[7] Hawley CJ et al. 2013. "The effect of single-sex wards in mental health." Nursing Times 109: 48, 20-22. The effect of single-sex wards in mental health

[8] Consultation on Reform of the Gender Recognition Act Women's Budget Group response to the Government Equalities Office and Reports

[9] The impact of changes in commissioning and funding on women-only services

- **Trauma Informed**. NHS and social care policies must be informed by understanding that single-sex exceptions exist in significant part to reduce risk of assault and to ensure services are accesible to those women and girls who have experienced/live with sexual trauma, abuse and violence in all of its forms. It is estimated that 31% of women experienced sexual abuse in childhood and 20% in adulthood.[10]

  Single-sex spaces and same-sex clinicians are essential to ensure that women who have experienced or are fearful of assault are confident to access NHS and broader healthcare and wellbeing services and do not self-exclude.

- **Intersectional**. The Women's Health Strategy must look to ensure that providers take account of how sex intersects with other protected characteristics. For example the fact that disabled women and girls are more vulnerable to abuse and need very strong gatekeeping of single-sex provision on their behalf. Women with disabilities (learning disabilities and physical disabilities) are twice as likely to be victims of sexual assault.[11]

  Additionally, women who are detained under section often cannot actively consent to who shares their accommodation. It is imperative that staff should be female to reduce the risk of sexual exploitation and assault. We note that women from BME communities are over-represented in this demographic.[12] Cases of sexual assault in mixed-sex wards are well documented[13]. This is particularly prevalent in mental health wards.[14]

- **Applying the Equality Act 2010**. The Women's Health Strategy must centre women and ensure that guidance and training is given that ensures single-sex exceptions are understood and fully enforced in all service provisions and are applied to the protected characteristic of sex and intersecting protected characteristics.[15]

  The current debates regarding the Equality Act 2010 and the interpretation (and misinterpretation) of its provisions has been very unhelpful with regard to women's healthcare provision.

  A recent report from the House of Commons Women and Equalities Select Committee report '*Enforcing the Equality Act: the law and the role of the Equality and Human Rights Commission*' is useful in understanding this, and discusses 'balancing rights in single-sex services' (pp 46-54).[16]

- **Implementing the NHS strategy on eliminating mixed-sex accommodation (EMSA)**. This includes accommodation in hospitals, hospices, single-sex toilets and changing rooms.[17]

The NHS uses the term "same sex" rather than "single sex". The NHS England and NHS Improvement publication *Delivering Same-Sex Accommodation*[18] (September 2019) explains the duty of healthcare facilities to provide this. It also describes the situations where this is not possible.

We highlight that this publication has a problematic Annex B, which sets out the rights of transgender people and gender variant children. This is a very good example of where the rights of women in the Equality Act 2010 are *not* being upheld, as it suggests that a transgender person's choice overrules the opinions of the other

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[10] Statistics about sexual violence
[11] Spotlight #2: Disabled people and domestic abuse

[12] https://www.reachhealth.org.uk/elibrarary/1465283925BME%20mental%20health%20research.pdf
[13] In Plain Sight: Open Doors, Mixed-sex Wards and Sexual Abuse in English Psychiatric Hospitals, 1950s—Early 1990s
[14] https://www.hsj.co.uk/patient-safety/revealed-hundreds-of-sexual-assaults-each-year-on-mixed-gender-wards/7026629.article
[15] ps://www.legislation.gov.uk/ukpga/2010/15/contents
[16] Enforcing the Equality Act: the law and the role of the Equality and Human Rights Commission
[17] Delivering same-sex accommodation and Supporting note: Mixed sex accomodation
[18] Delivering same-sex accommodation

people in that accommodation. In this instance NHS guidance is clearly misunderstanding and/or misprepresenting the law, which allows discrimination on the basis of sex where is it is appropriate.

Therefore, we would ask that the Women's Health Strategy facilitate this trauma-informed, intersectional approach by amending Annex B of 'Delivering same sex accommodation' in line with the Equality Act 2010. Currently, EMSA is directly undermined by this erroneous Annex B (Sept 2019), which states:

> • *"Trans people should be accommodated according to their presentation: the way they dress, and the name and pronouns they currently use.*
> • *This may not always accord with the physical sex appearance of the chest or genitalia.*
> • *It does not depend on their having a gender recognition certificate (GRC) or legal name change"* - NHS *Delivering same sex accomodation* Annex B (Sept 2019)

This misrepresents equality law. Whilst Annex B correctly states that Gender Reassignment is a protected characteristic (*Equality Act, 2010*), it is not correct that this legislation entitles anyone with that protected characteristic to be treated as the opposite sex in all circumstances.
Sex exemptions exist specifically in order to allow for a service to be entirely single-sex if it is 'proportionate to reaching a legitimate aim' - this is single-sex and not single-gender: possession of a Gender Recognition Certificate does not prevent a person from being excluded from a service on the basis of sex.

Equality legislation is being misrepresented and written without due consideration to the law as is, and to the impact of these policies on women. This is in contravention of Public Sector Equality Duty.
Public bodies are embedding policies that go against the wishes and needs of women, and are in contravention of both the letter and the spirit of the law and the aims of the NHS and Department of Health in eliminating mixed-sex accommodation.

NHS Boards in Scotland confirmed that their NHS services could not guarantee that a woman's request for a female healthcare provider would be honoured, due to the fact that the provisions of the Gender Recognition Act 2004 prevented the disclosure of someone's transgender status.[19] This concern is a real barrier for women accessing healthcare, no matter how much empathy and respect they may feel towards those who identify as having a gender identity they feel is incongruent with their sex.[20]

We call upon the Women's Health Strategy to:

- Ensure the right to request a female (sex) healthcare worker or counsellor and to be assured that the healthcare worker or counsellor is female, with exceptions for genuine emergency care;
- Ensure the right to request only female (sex) midwives;
- Ensure the NHS policy that patients can choose to see a female or male General Practitioner is applied[21];
- Ensure that staff records maintain that the sex of workers is known and is always recorded to ensure obligations towards the needs of women and girls can be met, as outlined above and in line with single-sex exceptions as set out in the Equality Act 2010. This is a major issue for both medical ethics and patient safeguarding[22];
- Actively consider commissioning further specialist and single-sex services to meet particular needs. For example, sex-specific diseases, mental health, drug and alcohol dependency services;
- Fund research and national collection of sex-specific data on women's medical needs and the provision of women-centred healthcare;

[19] https://wgscotland.org.uk/reports/
[20] Women 'risk health over trans NHS workers fear'
[21] https://www.nhs.uk/nhs-services/gps/gp-appointments-and-bookings/
[22] https://a-question-of-consent.net/author/hiyamaya/

- Challenge the bias in design and research - which is based on a male standard[23] [24] [25] - to ensure that the sex-based needs and health and safety of women are properly met;
- Policies across all providers must be audited to ensure legal compliance as described above.

2. Information and education on women's health

Information regarding women and girls' health must be in an accessible format (multiple languages, access for those with reading problems and hearing impairment (British Sign Language, subtitles etc).

It also needs to be available in formats which work for them (social media platforms and videos) and produced with collaboration between healthcare professionals and service users.

Training for healthcare professionals must include understanding of the specific needs of all women and girls relating to ethnic and cultural backgrounds, sexuality and disability. This needs to be part of their continuing professional development programmes.

3. Women's health across the life course

Menopause and Perimenopause

Menopause affects all women, although to a greater or lesser extent. The effective treatment of the menopause and perimenopause is essential for the physical and mental wellbeing of women in addition to their effective functioning in the workplace, and the resultant effect on the economy.

Studies suggest that adverse socio-economic conditions across the lifespan, when measured in terms of economic hardship and low educational attainment, may be associated with a decreased age of entry into perimenopause.[26]

There are 3.5 million female workers in the UK aged over 50. The average age of menopause is 51, although perimenopausal symptoms often begin around six years earlier. Time taken as sickness absence is very common for symptoms such as sleep disturbance, hot flushes leading to problems with concentration, migraines and debilitating irritability and mood swings.[27]

Services and funding for services to support women undergoing menopause should be increased to allow easy access for women via primary care or self-referral.

Pregnancy and Maternity Services

The fact that women from Black and minority ethnicities and their children die or suffer serious health problems during pregnancy is now well documented. This should be carefully explored to see whether lack of access to services or inadequate training of healthcare staff is contributing to this.

Insufficient funds for maternity services and an inadequate supply of midwives are also well-documented problems. Women and children from poorer families have worse health outcomes in this area than others.

Recently, in response to highly publicised failures of care in several areas in England, the *Ockendon Report*[28] advised the following seven immediate and essential actions. These must be implemented as a matter of urgency:

1. Enhanced Safety - Safety must be strengthened by increasing partnerships between Trusts and within local networks;

[23] Sex Bias in Neuroscience and Biomedical Research
[24] Challenging gender bias in research - The BMJ
[25] Gender Bias in Medicine
[26] Lifetime socioeconomic position in relation to onset of perimenopause
[27] https://www.linkedin.com/pulse/what-economic-cost-menopauseand-why-employers-need-more-proddow
[28] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

2. Listening to women and families - Maternity services must ensure that women and their families are listened to with their voices heard;
3. Staff Training and Working Together - Staff who work together must train together;
4. Managing Complex Pregnancy - Must be robust pathways for managing complex pregnancies making sure there is agreed criteria for cases to be discussed/referred to a maternal medicine specialist centre;
5. Risk Assessment Through Pregnancy - Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy;
6. Monitoring Foetal Wellbeing - Maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with expertise to focus on and champion best practice in foetal monitoring;
7. Informed Consent - Trusts must ensure women have easy access to accurate information to enable informed choice of intended place of birth and type of birth, including maternal choice for Caesarean.

Other services for women which need to be expanded include those for early diagnosis of gynaecological cancers, endometriosis and fertility problems.

Migrant populations (refugee, asylum-seeking, trafficked women)
Services must be developed for migrant, refugee, asylum-seeker women and girls, including those who do not have leave to remain and so are living 'under the radar'.

There is evidence of pregnant women not seeking medical care because they are afraid of immigration police and of NHS staff being confused over whether they are allowed to provide medical care. Some women have been turned away from care or being erroneously asked to pay.[29] Concerns over the status of their partners is also a barrier.

It is unacceptable that healthcare services are legally obliged to act as an arm of immigration services as this removes the basic human right of women and girls to access healthcare.[30] There must be an end to the 'hostile environment'.[31]

We also recommend that, where English is a barrier, female interpreters must be made available - especially in relation to domestic abuse, rape crisis, sexual health matters and intimate procedures, eg mammogram and smear screening tests.[32]

We urge the Women's Health Strategy to embed CEDAW within healthcare, ensuring approaches to health provision that recognise female migration should be understood from the perspective of sex inequality, traditional female roles, a sexist labour market, the universal prevalence of violence against women and girls and the worldwide feminisation of poverty and labour migration.[33]

Mental Health
Mental health is often viewed as a medical issue, but inequality and discrimination are also significant contributing factors. Women are more likely to experience violence, to live in poverty, to live alone (particularly in older age) and to be carers for other people, all of which contribute to poorer mental health. Almost twice as many women as men are likely to be diagnosed with anxiety disorders as men.

There are specific risks of mental illness for women and girls which should be highlighted in training of healthcare professionals.

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[29] NHS charging for maternity care in England: Its impact on migrant women - Rayah Feldman, 2020
[30] https://www.project17.org.uk/media/70571/Not-seen-not-heard-1-.pdf
[31] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6733377/
[32] Migrant women's health issues: addressing barriers to access to health care for migrant women with irregular status
[33] Towards inclusive migrant healthcare

This includes the current increase in anxiety and eating disorders in teenage girls, the masking of neurodiversity because of the use of unsuitable diagnostic tests for ASD, ADHD and other conditions in girls, the recent increase in diagnosis of Rapid Onset Gender Dysphoria (see next section, Gender Identity), the risks of experiencing child sexual exploitation or domestic violence or witnessing domestic violence, abuse during childbearing years and elder abuse later in life.

The COVID-19 pandemic has greatly exacerbated mental health problems in women, as well as in children and adolescents.

Suggestions include:

- A mental health lead in every GP practice;
- A mental health nurse in every school;
- Increased, ring-fenced funding for Child and Adolescent Mental Health specialist services which work in conjunction with primary health carers and link into adult services.

Gender Identity

Girls – specifically girls who identify as boys - are being let down by healthcare providers and other institutions.

In recent years there has been a huge increase in girls being referred to Gender Identity Services (GIDS) expressing a trans identity.[34] In 2019 the number of 13-year-olds seeking treatment rose by 30% in a year to 331. Referrals of 14-year-olds went up by a quarter, to 511. The number of 11-year-olds is up by 28%. The youngest patients were three and 12 -17 year-olds make up 80% of referrals. Over 70% of these were girls.[35]

Many of the girls being referred have Rapid Onset Gender Dysphoria. We urge the Government to commission urgent research to respond to this newly emerging clinical trend.[36]

48% of referrals to GIDS are for people who also have autistic traits.[37] This is specifically an issue in referrals for neurodivergent girls who tend to go undiagnosed for longer, and we are concerned that undiagnosed ASD is not being considered when addressing issues of gender dysphoria. We strongly recommend further research in this area.

The most recent study in children desisters (those no longer seeking reassignment as treatment for gender dysphoria) shows that the majority of children desist with the onset of puberty.[38]

We must have further research into care pathways for this demographic to ensure clinicians 'do no harm'. There must adopt an evidence-based approach (not an ideological approach) to both diagnosis and care pathways and look at if and when professionals support social transition and medical intervention (prescribing puberty blockers and cross sex hormones) for children with gender dysphoria (affirmation model).[39] It should be noted that Sweden no longer prescribes puberty blockers or cross-sex hormones to children to treat gender dysphoria because of serious health and developmental concerns.[40]

We urge a review into the adoption of WPATH Standards of Care that promote The Dutch Protocol, that promotes treating gender-dysphoric minors with puberty blockers at age 12 (sometimes interpreted to be upon reaching Tanner stage 2 of puberty, which in girls can occur at age 8), and cross-sex hormones at the age of 16.

Homophobia and transition

Whistleblowing by lead clinicians at the Tavistock Clinic (GIDS) have raised concerns at the number of children referred to the clinic expressing a gender idenity disorder who are in fact same-sex attracted. This is a potential

[34] Tavistock clinic reveals surge in girls switching gender
[35] Why do so many teenage girls want to change gender?
[36] Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria
[37] Autistic Girls : Gender's silent frontier - Transgender TrendTransgender Trend
[38] https://www.transgendertrend.com/wp-content/uploads/2017/10/Steensma-2013_desistance-rates.pdf
[39] gdworkinggroup.org – Paediatric and adolescent gender dysphoria group
[40] https://segm.org/Sweden_ends_use_of_Dutch_protocol

issue around medicalising and pathologising gender non-conformity and same-sex attraction. Whistleblowers have identified a trend of parental and internalised homophobia.[41]

Detransition

There is an increasing number of detransitioners (those who have socially and medically transitioned to live in line with their gender identity, who now regret that transition).

Once a patient has completed their transition, they are discharged by GIDS with no longitudinal care.[42] This is leaving a huge gap in provision for those whose gender dysphoria is not addressed by transition, or who for other reasons suffer mental and physical health detriments after transition.[43] This failure to monitor patients over the long term also results in a data gap, and so the rate of detransition is obscured by a lack of data[44] and quite possibly seriously underestimated.[45]

We recommend an urgent review around detransition, and a service-user-led response to providing healthcare and support for this demographic.[46]

Changing sex markers on medical notes

The General Medical Council's *Trans Confidentiality Guidelines* are also unsound. They state:

> *"Respect a patient's request to change the sex indicated on their medical records; you don't have to wait for a Gender Recognition Certificate or an updated birth certificate.*
>
> *Don't disclose a patient's gender history unless it is directly relevant to the condition or its likely treatment. It's unlawful to disclose a patient's gender history without their consent." -* GMC Trans Confidentiality Guidelines 2016

Furthermore, the current *Trans Healthcare Ethical Advice* from the GMC is at odds with standard ethical considerations and greatly problematic. We consider these ill-advised at best, and are greatly concerned that - if they become standard practice - would potentially place the health of trans-identifying patients presenting with sex-specific health issues at great risk, and go directly against the principles of nonmaleficence.[47] [48]

4. Research, evidence and data

This leads to inaccurate or incomplete record-keeping, making it impossible to accurately measure and address the health gap between the sexes, clearly a crucial information point in informing the Women's Health Strategy and designing healthcare provision.

This was discussed extensively before the Census in England this year, with the result that the guidance for completing the forms was corrected to ensure that data on both sex *and* gender was collected.[49]

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[41] Newsnight Investigation: https://www.youtube.com/watch?v=zTRnrp9pXHY

[42] The Game Plan for when Transition Hasn't Worked Out

[43] Detransition-Related Needs and Support: A Cross-Sectional Online Survey

[44] Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study

[45] https://guideonragingstars.tumblr.com/post/149877706175/female-detransition-and-reidentification-survey

[46] The Ranks of Gender Detransitioners Are Growing. We Need to Understand Why

[47] De-sexing the Medical Record? An Examination of Sex Versus Gender Identity in the General Medical Council's Trans Healthcare Ethical Advice

[48] https://drive.google.com/file/d/1owOCu6J3Pa9Kup4_SMy3pbJglBumiVoB/view

[49] *Sullivan, Alice, Sex and the Census: Why Surveys Should Not Conflate Sex and Gender Identity (March 06, 2020). International Journal of Research Methodology, Forthcoming, Available at SSRN: Sex and the Census: Why Surveys Should Not Conflate Sex and Gender Identity by Alice Sullivan :: SSRN*

Recent studies have shown that the incidence, aetiology and progression of many diseases differ between the sexes, resulting in an increasing amount of interest in the role of biological and socio-cultural factors in medicine. Therefore, genetic and social factors must be taken into account in medicine and research.

Women who smoke have a higher risk of coronary heart disease and lung cancer than do male smokers, overall. Atrial fibrillation is more important as a risk factor for stroke in women than men. Diabetes is a stronger risk factor for coronary heart disease in women than men. Women who have a heart attack are more likely to have shortness of breath or other atypical symptoms and are less likely to report chest discomfort. There are differences in reactions to medications, for example the risk of major bleeding with some anticoagulants is higher in women.

Recording sex in data collection and medical records is also essential for screening programs. Women who are correctly identified on their health records will be called appropriately for breast and cervical screening. The small percentage of the population of biological women who identify as men (trans men) will not be called for screening if their birth sex is not noted on their healthcare records. This poses a significant health risk for them.[50] In diagnosis, in the case of a female presenting as a male with abdominal pain, there would be no reason to do a pregnancy test if records only state gender identity, and so a life-threatening event such as ectopic pregnancy would be missed.

Sex/Gender Considerations in Concussion Research and Treatment

Annually, over 300,000 hospital admissions are associated with Acquired Brain Injuries[51] of which nearly half are caused by concussion-related traumatic injuries, for example associated with contact sports. These numbers include a steadily rising number of females – 61,438 in 2016-17, a 23% increase since 2005 (as compared to a 9% decrease in males over the same period).[52] One major cause of traumatic brain injury in women is domestic violence[53], itself also in the increase[54]: The head and face are common targets of intimate partner assaults, and victims often suffer head, neck and facial injuries.[55]

Research into consequences and treatment for concussions has, to date, been mainly focussed on males (especially male athletes)[56] and the consequent protocols and guidelines of post-concussion advice are almost universally based on these data, and not sex-disaggregated.[57] Yet it is becoming increasingly clear that there is a sex difference in both incidence and outcome of concussion in females.[58] [59] Proportionally, women sustain more concussions at a higher rate than males, have more severe symptoms and more prolonged recovery periods.[60]

The US Government and US-based advocacy groups are calling for increased research into sex differences in concussion and for the development of sex-specific protocols for medical professionals dealing with concussion injuries.[61] This should also form part of advice guidelines for authorities dealing with victims of domestic violence, where concussion injuries are common.

We also urge the Women's Health Strategy to push for the following actions:

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[50] De-sexing the Medical Record? An Examination of Sex Versus Gender Identity in the General Medical Council's Trans Healthcare Ethical Advice

[51] https://commonslibrary.parliament.uk/research-briefings/cdp-2019-0111/

[52] Chris Bryant suggests screening for brain injury is added to the Domestic Abuse Bill - United Kingdom Acquired Brain Injury Forum

[53] Coronavirus: Domestic violence 'increases globally during lockdown'

[54] https://opdv.ny.gov/professionals/tbi/dvandtbi_infoguide.html

[55] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6424660/

[56] https://www.nhs.uk/conditions/concussion/

[57] Dick, R. W. (2009). Is there a gender difference in concussion incidence and outcomes? *British journal of sports medicine*, *43*(Suppl 1), i46-i50.

[58] McGroarty, N.K., Brown, S.M. and Mulcahey, M.K., 2020. Sport-related concussion in female athletes: A systematic review. Orthopaedic journal of sports medicine, 8(7), p.2325967120932306.

[59] https://www.futuremedicine.com/doi/pdf/10.2217/cnc-2017-0015

[60] https://www.openaccessgovernment.org/traumatic-brain-injury-2/100985/

[61] https://www.pinkconcussions.com/

- Ensure sex-disaggregated collection of data and analysis of data. This is a recommendation of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which was adopted in 1979 by the UN General Assembly[62];
- Fully fund research and national collection of sex-specific data on women's medical needs to facilitate the provision of woman-centred healthcare;
- Ensure that trans men (women who identify as men) keep their sex-based rights under the Equality Act protections, and are included in all women's health services to ensure they get appropriate medical expertise in care and safeguarding. This includes essential screening which may be difficult to ensure because their medical notes may record them as male. Any care specific to effects of hormones or surgery relating to trans men's transgender status should be additional to care of trans men within women's health services.

5. Impacts of COVID-19 on women's health

The COVID-19 pandemic has affected women significantly more than men in many instances.

Current studies on the syndrome of Long Covid (symptoms and disability after recovery from the acute episode) will be able to determine whether this is a sex-related issue or not. The evidence suggests that working age women are 50% more likely to be affected than men. The reasons for this are not yet well understood.[63]

The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS-funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient (for example in Intensive Care Units).

From 1st December 2010, the collection of monthly Mixed-Sex Accommodation (MSA) breaches was introduced. NHS organisations submit data on the number of occurrences of unjustified mixing in relation to sleeping accommodation. The collection enables the analysis and publication of consistently defined data to allow patients and members of the public to understand the extent to which MSA is occurring at individual organisations.

The data collected shows a decline in MSA breaches over the years of 2010/11 for seven years then a steady and significant rise to February 2016.[64]

The Department of Health temporarily suspended the monitoring of these breaches in February 2020. As the current hospitalisation rate for patients with COVID-19 has fallen significantly, this should be reinstated as a matter of urgency. This is particularly relevant as most hospitals are currently working to a higher percentage occupancy than the recommended safe level of 85% and therefore breaches are more likely to occur. This specifically impacts on women, as has been discussed above.[65]

(Ends)

62 https://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm?fbclid=IwAR3lQYxyXUHbVdk5i4lhxAIEPZTVdozLZ-yRO8aCu7nsMnJ5NZJjzHJLu3w

63 https://www.kcl.ac.uk/news/study-identifies-those-most-risk-long-covid

64 https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/msa-data

65 https://osr.statisticsauthority.gov.uk/covid-19-and-the-regulation-of-statistics/