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# AN EVALUATION OF THE WOMEN'S HEALTH NETWORK (WHN) IN BRADFORD

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# EXECUTIVE SUMMARY

It is vital to address increasing women's health inequalities by establishing effective models of improving women's health and services. This study aims to address the neglect of women's voices and experiences in healthcare policy and practice by utilising the Women's Health Network (WHN), a collective of women in Bradford District & Craven who have an interest in the health and wellbeing of women and their families, to explore 1) how women, particularly marginalised women, can meaningfully participate in their healthcare and 2) the processes of knowledge transfer across the patient/practitioner boundary; what facilitates and what blocks this. It thus aims to challenge health inequalities by improving equality, inclusion, and diversity in Public Patient Involvement (PPI), as well as widening what and whose knowledge is valued in healthcare policy and practice. In-depth, semi-structured telephone interviews were conducted with 12 members of WHN, including a Clinical Commissioning Groups (CCG) Commissioner, the current Chair of WHN, CNet's Engaging People Project Lead, the previous Chair of WHN, professional and individual members of WHN. WHN is coordinated by CNet Empowering Communities' Engaging People Team and funded by the local CCGs.



## Key findings

- WHN demonstrates the value of addressing women's health holistically as a community issue utilising an asset-based community development and women-centred approach.
- WHN functions as a network of mostly professional and some individual women, who share information and form connections between public, statutory, voluntary and community services, demonstrating successful inter-professional and inter-agency working which benefits service users.
- WHN creates and sustains a bidirectional channel of communication between the micro (ground) level in communities and the macro (institutional) level of NHS CCGs, acting as a bridge or conduit between CCGs, services, and local women.
- The affective dimension of WHN is central to its success and sustainability, including the atmosphere of meetings, solidarity, trust, how the network feels to members, members' passion and pride about WHN, and other intangibles.
- Funders should therefore allow the time and space required to build strong relationships and recognise qualitative measures of impact, not just quantifiable outcomes.
- **Strengths of the network:** consistency and infrastructure with dedicated staff members and well-organised meetings; transparency and open communication with members; diversity and reach across communities; connections to authority; it amplifies lesser heard women and topics; it translates and disseminates information; it is funded by and has a good relationship with the CCGs; it provides female role models; it makes a difference to women and their communities; it has an impact on service design and delivery.
- **Barriers to women accessing healthcare:** language barriers, including a plain English language barrier for native speakers; cultural and religious barriers; fear of speaking out; lack of trust; gendered barriers in healthcare and society (patriarchy; domestic violence); systemic barriers (poverty).
- **Barriers to participating in WHN:** time; finances; travel; internet access; lack of confidence; Covid-19; lack of knowledge and awareness; experiencing domestic violence; geographical barriers; self-imposed barriers (not wanting to participate); communication overload.

### **Next steps and recommendations**

- WHN to go out to specific communities post Covid-19 to build relationships and encourage participation of individual women in WHN, particularly seldom heard women.
- A combination of online and offline engagement post Covid-19 to enhance opportunities for participation.
- Better publicity of WHN in a range of mediums and forums is required to increase local awareness of WHN.
- Continued funding is required to sustain WHN.
- WHN provides a strong model of PPI and knowledge transfer for replication in other localities, taking into account local demographics, and is eager to create links with other women's health networks, nationally.



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# BACKGROUND AND CONTEXT

Research in healthcare has historically neglected to take into account women's lived experiences of health and illness. Women have been underrepresented in medical trials. Health conditions that specifically affect women are under-researched and misunderstood (Howard et. al.2017; Criado Perez, 2019). This has resulted in a lack of sex-disaggregated data and phenomena such as the 'Yentl syndrome' (Healy, 1991) where women are misdiagnosed and poorly treated unless their symptoms or diseases mirror those of men. Health Equity In England: The Marmot Review 10 Years On (2020) identifies a decrease in women's life expectancy in the most deprived areas of England, evidencing the need to pay attention to women's increasing health inequalities. This need is finally being addressed by the British government, who held a consultation in May 2021 to inform the development of England's first Women's Health Strategy, which aims 'to place women's voices at the centre of their healthcare and to improve women's health and well-being'. At the same time, there is a push towards collaboration and integration of community, voluntary, and public services, with recognition of the need for an holistic joined-up approach to addressing health and well-being across communities.

Recent Patient and Public Involvement (PPI) initiatives have emphasised the need to value people's lived experience, investing in partnerships that 'have an ongoing dialogue and avoid tokenism' to prevent the replication of existing health inequalities and exclusions (NHS, 2017: 7). NHS England's (2017) statutory guidance for clinical commissioning groups emphasises seeking involvement from those with protected characteristics under the Equality Act 2010, which includes sex. Yet, there is a lack of research focusing on women's and disadvantaged groups' involvement in PPI initiatives (SERIO, 2018: 34; Stokes et al., 2015).





Furthermore, despite recognising the value of patients' knowledge as 'experts by experience' (NHS, 2017: 6), little attention has been paid to the processes of knowledge transfer across the patient/practitioner boundary. Nevertheless, Ward (2017: 481) identifies a shift towards collaborative or co-productive iterative knowledge mobilisation (the movement of knowledge to where it is most useful [Ward, 2016; Cowdell, 2019]) which is multi-directional and involves the public as stakeholders in their healthcare and representatives of their communities, demonstrating the relationship between knowledge mobilisation and PPI.

The Women's Health Network in Bradford (WHN) is a collective of women living and/or working in Bradford District & Craven who have an interest in the health and wellbeing of women and their families. It was set up in 2016 after 8 months of research and consultation with local and national women and women's groups.

WHN is coordinated by CNet Empowering Communities' Engaging People Team. CNet Empowering Communities is one of the few remaining community empowerment networks in England, giving a voice to local people and groups within local decision-making boards. CNet's Engaging People Team are responsible for the coordination of both the Women's Health Network (WHN) and Bradford District and Craven Maternity Voices Partnership (BD&CMVP).

The Engaging People Project (EPP) commenced as a new project in 2016 and is funded by the then three Clinical Commission Groups (Bradford City; Bradford Districts and Airedale; Wharfedale and Craven). The primary aim of EPP is to undertake engagement on behalf of the three CCGs. The funding was allocated over a three year period. EPP is a voluntary sector partnership project and is made up of CNet, Hale, Bradford Talking Media, and Healthwatch Bradford and District.

WHN members democratically elect an independent chair every two years. The Chair, alongside CNet, sets the direction of the network in relation to strategic and operational delivery. Hence, WHN is delivered by a myriad of organisations all with the aim of ensuring women's health is placed high upon the agenda.

WHN's mission is 'to improve the health and wellbeing of women and their families through effective partnership working, with a particular focus on seldom heard voices' (WHN, 2016). The network therefore provides a unique research context to explore:

1. Effective and meaningful ways of engaging women, particularly marginalised women, in their healthcare.
2. What facilitates and what blocks knowledge transfer between (marginalised) women and healthcare practitioners.

# RESEARCH AIMS

## **The research aims were:**

- To evaluate the extent to which WHN has been successful in engaging marginalised groups of women.
- To identify areas in which WHN can improve, leading to impactful practice and policy changes at the local level.
- To identify what has worked well for WHN in order to learn lessons that can be carried forward in the creation of other local Women's Health Networks.

## **The main research questions were:**

- What enables the development of meaningful PPI that engages marginalised women?
- What facilitates and what blocks knowledge transfer between 'seldom heard' women patients and healthcare practitioners?
- What has worked for WHN in Bradford from the perspectives of different stakeholders?
- What barriers exist to participation?
- How can these barriers be overcome?



# METHODOLOGY

Given the research aim of developing an in-depth understanding of WHN, a qualitative research design was employed.

## Data collection

### Semi-structured interviews

Having undertaken analysis of WHN's documentation which details the network's aims, strategies, and reports of their activities, alongside a scoping literature review to identify key themes in relation to women's health, PPI, and knowledge mobilisation, two interview guides were created. One was for professional members and the other was for members of the public, who participate in WHN in a non-professional capacity (referred to as 'individual members' in this report). These interview guides (see Appendix A) were distributed to the advisory board for comment, ensuring a robust data collection tool.

Given Covid-19 restrictions, semi-structured interviews were conducted over the telephone with 12 members of WHN, including a Clinical Commissioning Groups (CCG) Commissioner, the current Chair of WHN, CNet's Engaging People Project Lead, the previous Chair of WHN, professional and individual members of WHN. As this was a small-scale study without funding for translation, participants were limited to those with sufficient English language ability.

Participants were recruited purposively via WHN, with help from CNet's Engaging People Project Lead and the current chair of WHN who distributed a call for participants to the network's mailing list. The research was also advertised in WHN meetings by the lead researcher and on Twitter (see Appendix B online poster call for participants).

Interviews were recorded and transcribed verbatim. Participants were given a £20 shopping voucher as a thank you for their time; organisers of WHN chose to donate their voucher to charity, preventing any conflict of interest.

## Data analysis

Thematic analysis, as outlined by Braun and Clarke (2006), was utilised to code the data, identify key themes, and group these into wider themes and sub-themes. Despite being the most commonly used form of qualitative data analysis, there are concerns about the credibility of thematic analysis because of its subjective nature.

In order to counter such criticisms and to strengthen the quality of the analysis and subsequent findings, the lead researcher consulted with the advisory board to confirm interpretations.

Quotations from interviews that demonstrate the findings outlined are provided in italics, where relevant and with consent, the participant's role is provided. The majority of quotations are provided without attribution to an individual in order to preserve anonymity and confidentiality.

## Advisory Board

The project involved an advisory board comprising academic experts in community research, women's health, knowledge mobilisation, and health evaluation; members of volunteer community organisations and charities, and WHN organisers. The involvement of a diverse, expert advisory board contributed to producing trustworthy and credible research, as well as fostering collaboration, and mentorship.

## Ethics

Full ethical approval was granted by Birmingham City University (BCU). The research was funded by BCU's pilot project funding scheme. All participants were provided with an information sheet about the research and provided fully informed consent.



# SUMMARY OF KEY FINDINGS



This summary provides an overview of the key findings produced from in-depth interviews with 12 members of WHN. It begins by outlining what was identified by participants as the most pressing healthcare needs for women before providing an overview of the Women's Health Network (WHN), its asset-based and women-centred approach to community working, with a focus on 'seldom heard women'. Following this, it explores how WHN functions as a conduit that bridges communication between women and healthcare professionals about their healthcare needs, and how it creates a safe and inclusive women-centred space that embodies an holistic understanding of health.

The next section outlines the key strengths of WHN that were identified across participants' interviews, and analysed into themes by the main researcher. These include: consistency and infrastructure; transparency; united goal; diversity and reach; enables lesser heard to be heard; well-connected and acts as conduit between professionals and public; passion and pride; the affective dimension; translates and disseminates information; making a difference; funding and relationship with CCGs; female role models.

Having outlined the key strengths of WHN, the next section provides a summary of the key barriers to women's healthcare and to women participating in WHN. Although I have separated these two for analysis purposes in this document, there is overlap between the two types of barriers.

Barriers to women accessing healthcare include: language barriers, including a plain English language barrier for native speakers; cultural and religious barriers; fear of speaking out; lack of trust; gendered barriers in healthcare and society including domestic violence; systemic barriers including the healthcare structure and poverty. Barriers to participating in WHN include: time; finances; travel; no internet access; lack of confidence; Covid-19; lack of knowledge and awareness; experiencing domestic violence; geographical barriers; self-imposed barriers (not wanting to participate); communication overload.

Looking forwards, the penultimate section of this summary of findings considers the sustainability of the network by outlining findings related to funding; the impact of Covid-19; and the future of the network. Finally, key areas identified by participants for improving WHN are outlined including the need to increase: publicity of WHN; participation of individual women and 'seldom heard' women.

## Women's healthcare needs

Participants identified a range of healthcare needs that they considered to be most pressing for women both nationally and locally, based on their own experiences, and their communities' and service users' experiences.

The most commonly reported included:

- Mental health.
- Pre-conception health.
- Menopause.
- Menstrual health, especially "painful periods".
- Endometriosis.
- Cancer screening.
- Domestic violence.
- Loneliness/ isolation.
- Health inequalities related to poverty.
- Access to services and information.
- GPs and commissioning services' lack of awareness of and provision for women's healthcare needs.
- The neglect of women's voices and bodies as a national and local issue.
- The stigma associated with women's health conditions.

*"More awareness with GPs [is needed] because certainly through both Women's Health Network and the work I've done with Bradford Council staff, there's still very little menopause awareness training for GPs. Women are either being fobbed off, told it's your time of life, you should expect it, go away. Or they've been given antidepressants, they're told it's just anxiety, you're being overanxious. The GPs are not aware of the range of symptoms, the sort of ways they can present and they're still relying on just anything to get that patient out of the waiting room. And as I say, we're hearing the same messages, whether it's through the Women's Health Network, across communities, and people at work, women at work. So it's definitely one that needs to be high on the agenda."*

*“I think it’s national. But women’s health, women’s bodies, I feel, as though [they] are very kind of...there isn’t much light on them, there’s not much information around them, there’s not much knowledge around them. And there isn’t, for me, as much research and investigation into that. If you look at, in terms of things like medication, trials, just from my knowledge, and please correct me if I’m wrong, but a lot of them are kind of, they’re created by middle-aged white men, or tested upon middle-aged white men. And I don’t feel that women’s health kind of thing, has come that far. So if you look at some of the things like menopause, things like painful periods, endometriosis, all of these things, there’s very much...there’s not much light on them, I find. There’s not much knowledge around them, and that stigma that’s attached to that, I think that’s a massive thing. Yeah.”*

## **The Women’s Health Network (WHN)**

*“The Women’s Health Network is a group of professionals and women that are not professionals, whose aim is to make sure that all women in Bradford and the Keighley area, so the whole of the area that the Women’s Network covers, have access to screening, for the health needs being met, and beyond that as well, so they know where to go. And also, so that services know where there are hidden voices, so where people are not getting access and looking into why that is. So, for me, that’s what it’s about; expanding proper access for what women need to live a healthy life”.*

The network is commissioned by the local CCGS to deliver a minimum of 6 meetings per year and to improve women’s health outcomes. It has two full time members of staff who work with WHN as part of their remit working for the Engaging People Project and CNet (Bradford & District Community Empowerment Network). Action plans are developed with the CCGs and WHN members to establish areas of focus, short term and medium term goals, and long term vision.



## Asset-Based Community Development and Women-Centred Working

The network utilises an Asset-Based Community Development (Kretzmann and McKnight, 1993) and Women-Centred approach (WomenCentre, n.d.) that recognises and draws on the strengths and skills of individual women, professional women, and their communities, creating a space for open conversation about women's health.

*"So the ethos for me, is kind of firstly about being about women led, and being a safe space for women essentially. And having that kind of approach, that...we want to look at involving communities in their care, and having a bit more of a dialogue and a bottom-up approach, as opposed to that top down approach, that generally happens."*

There is a particular focus on engaging 'seldom heard women':

*"So, what we're asking of them [WHN] is to bring some different perspectives to health issues that we, as commissioners, are trying to solve, to connect and reach into communities of women and individual women in Bradford district whose voices are generally not heard when it comes to decision making around health. So, they enable us to connect to women that we wouldn't, otherwise, hear. And to engage those women in thinking about their own...their own choices, their own health and to becoming more active participants in their communities."*  
**CCG Commissioner.**

### **Seldom heard women**

- There were some groups commonly identified by participants as 'seldom heard' including: South East Asian women; White working class women; single mothers; Eastern European women; African Caribbean women; older women; LGBT women; Black women; the traveller community.
- WHN has been more successful in reaching some of these groups than others and plans to take steps in the future to address this.
- 'Seldom-heard women' is not a fixed category but changes over time and across contexts. Participants highlighted the diversity among 'seldom heard' women.
- Participants problematised the language around 'seldom heard' or 'hard to reach' groups.

*“Specifically, and the seldom heard and hard to reach are ones [terms] that really grate on me, because no one is, if we as professionals are willing to come out of our comfort zone and go to them. But in that context of seldom heard, there’s some of the BAME group, Eastern Europeans are very seldom consulted. There’s a separate Black health network being set up because Black voices are quite seldom heard when it comes to commissioning. In Bradford, with the equalities work we’re doing, I did an engagement piece with a lot of these groups, with the Race Equality Network group, the Black and Minority Ethnic, this were before the national report came out. They very much wanted to be separated from the Asian because they feel that in Bradford, it’s only the Asian voice out of the BAME that’s heard. So we have those links with the other communities and make sure that their voices are heard as well.”*

*“I mean, I am generally against these kind of labels, where they say, seldom heard, or hard to reach, any of those things. Because I feel as though no one is, but they’re made to be. And there’s things, like we...and I say, we, because I’m obviously, you know, part of my job is reaching out to different communities and people. If I’m looking at myself and looking at the role, I look at seldom heard, easy to ignore, but I’m thinking, I’m not doing something right to be reaching these people, because no one’s hard to reach, no one’s seldom heard. It’s just about how you reach out to them, how you go to them and how you present [...]”*

*“It’s basically the groups that statutory services are not reaching because they define that term [seldom heard]. Our communities don’t go around saying, ‘I’m a seldom heard group’, because they’re not aware; it’s the service response and the service term.”*

## Who is WHN?

Despite the network’s aim to include individual members, and particularly ‘seldom heard’ women, attendees tend to mostly be professional women. This includes a range of community leaders, representatives from local organisations that work with women, healthcare professionals, public services, and voluntary and community sector organisations and charities.

*“Yeah, I think there are very few women who attend Women’s Health Network, who are not, in some way, connected to an organisation, or working there. So, they might be there as an individual, you know, there’s a couple of people whose faces are in my mind as I’m speaking to you, so they’re there and they’re talking about their experiences as an individual but actually how they ended up getting involved with Women’s Health Network is often because of the job that they do.”*

Although fewer in attendance than professionals, individual women from the public do attend and are treated as being on equal footing with professionals:

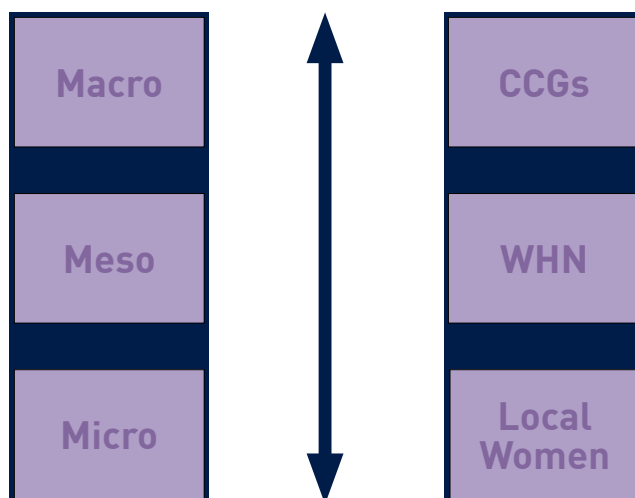
*“And the way I’ve always managed meetings is you leave positions at the door. And I will normally tell this to NHS staff who want to attend for the first time, you leave your position at the door, in this room you are just a woman and we are all equal, everyone’s voice is equal. And that really worked at building it as a women’s network as well as the Women’s Health Network.”*

## WHN as bridge

In practice, the network functions as a web of connections that creates opportunities for professionals to share information and link up, and a source of information which professionals then disseminate to their clients. At the same time, professionals represent their service users and communities by bringing feedback from these groups to the meetings to pass on, or upwards, to the CCGs. In this respect, the network acts as a bridge or conduit between the CCGs, professional services, and women from local communities.

*“So, I suppose our role is always piggy in the middle, Emma: we’re always connecting the dots between this is what we’re hearing at a grass roots level, these are the issues, these are the concerns. And then it’s the agendas and the visions on which local people have been consulted. So, we’re almost that group, that role in the middle. I suppose Women’s Health Network does link to that middle, it’s almost a straddling role between the two.”*

**Engaging People Project Lead.**



**Fig 1. Diagram depicting flow of information and communication between different levels.**

WHN functions as a “two-way mechanism” where the CCGs can pass on health messaging to women and women can feed back their issues and needs to the CCGs:

*“So the two strands of the network are the CCGs will pass down specific pieces of research that they need doing, but they will also then listen to the problems that women are telling us.”*

**Previous Chair of WHN.**

## Creating a safe and inclusive women-centred space

A central element of the network is the creation of a women-centred, safe space where women feel able to speak and are listened to. WHN provides a platform to amplify women’s voices, especially those who are lesser heard. Central to this is the time spent developing trust and relationships with women and their communities, the social element of meetings that creates a fun, warm, and inviting atmosphere, and the use of plain language that increases accessibility.

**Interviewer:** *What do you think makes it a safe space?*

**Participant:** *I think the fact that it’s...I do think it’s because it’s women only and you seem to have a common...that’s obviously the common denominator and it just feels safe because the people that are attending the meetings or the meetings that I’ve attended, generally you have something common with them and that people appear very empathic and it just feels very, very safe.*

*“We need that platform where you feel comfortable, I mean I generally feel comfortable in mixed groups but being able to talk about women’s things doesn’t happen, it just doesn’t happen anywhere, from my experience certainly, over the last two years and certainly before I started attending the meetings and the groups, I haven’t talked about women’s issues since I was a teenager, because there isn’t those platforms.”*

## Holistic health

WHN embodies holistic health with the aim of improving health in the widest terms. This includes providing information and support in relation to finances, domestic violence, bereavement, housing, education, work, mental health, exercise, ageing, children’s health, among others. Attendees are from a wide range of organisations, as well as there in an independent capacity, and are not required to be working directly in women’s health to participate in the network.

*“But it’s really about improving health in its widest sense, so it’s not just that medical sense of cancer, diabetes, heart disease, cervical cancer. So, I think we try and take the approach it’s holistic health, whether it’s mind, body. I suppose soul does come into it as well, although we don’t have that definition.” Engaging People Project Lead.*

## Strengths of the network

Participants spoke highly of the network, highlighting its key strengths, summarised below.

### Consistency and infrastructure

- The presence of key members who developed relationships over time and provide stable support.
- The importance of dedicated admin support, strong leadership, and a strong team.
- Well-organised meetings and events.
- This is enabled by CNet’s Engaging People Project.

*“And so there’s a consistency there in the support, and that’s really important in keeping it going.”*

*“People came and they listened and wanted to keep coming, and that’s the strength, that people stay involved, even if their jobs change, they stay involved in the Network. And so, the other strength is that we have a great administrative support team that keep people, that’s really important in, you know, if anyone was thinking of setting up a similar network, having a stable support is really important.”*

### Transparency

- Open communication.
- WHN is open and honest about aims, shared and developed with members as equal partners.

*“The fact that we are talking to each other, we’re having open communication and we’re going in... Whenever there’s an action, it’s done, it’s actioned. You know? Quite quickly, I might say, and you’ve got some really strong women in that group who take care each other and listen to each other. Who are honest about the challenges that are there, because there are a lot of challenges. There’s a lot of extra work that has to be done to get to where I think they thought they’d be two years ago.”*

## United goal

- Working towards one goal with diverse voices and members.

*“The range of staff, the range of professionals they have on there, there’s such a big range, you know, from the nurses to the midwives to the out there community services, services like us, mental health, and just community centres even, just like development workers. There’s such a range, and I feel like we’re kind of working towards one goal but all on different levels, so it’s really good, but that’s the good thing about it I feel.”*

*“Regardless...the interesting thing for me was that whatever was your culture in the group, in some ways that was irrelevant because like I said, we were as one, it just felt we were all singing from the same song sheet.”*

## Diversity and reach

- Diverse members, representatives from different communities, different professions, different key skills.
- Representative of the local area.
- Wide reach across the local area.
- Breaks down barriers between the statutory and voluntary sectors.

*“The biggest successes for me, are the diversity. The diversity in not only organisations, because we have a mixture of people from the community, people from like church organisations, and people from like CCGs, local authorities. But also around the diversity of voices, because they are different opinions, and they are different viewpoints. But we try and...I think it’s healthy conversation and healthy consideration of that. Another strength is definitely how we’re reaching the diverse communities. We’re constantly looking at, I use the word, recruit, but inviting new people along, which again, aren’t always professionals, but non-professionals as well.”*

*“And I think it’s really good the way that it breaks some of the barriers between the statutory sector and the voluntary sector, so I think you get quite a good mix of organisations represented. And I think in terms of the statutory sector, I think it’s quite good for them to see how vibrant the voluntary sector and how important the voluntary sector is in terms of provision in Bradford.”*

*“And I think the organisations that are attending and that are involved, some of them are really tiny, really small grassroots organisations, and that’s fantastic and we, you know, we absolutely...they are representing and they are connecting to the communities that we want to serve.”*

*“You name it, if it affects women, then there’s somebody there representing them.”*



### **Enables lesser heard to be heard**

- Provides platform for voices that are not usually heard and amplifies them.
- Addresses issues that are often ignored or not discussed and encourages conversation around them e.g. menopause, gender stereotypes.

*“There is a need for Women’s Health Network because I feel like they’re very passionate and you get people that are passionate about their own job that are on this network, which is fantastic, because that’s how things are going to change or that’s how things are going to move on, because if nobody speaks or if no one’s heard... And it’s people...and it’s like the clients that we have that basically wouldn’t speak up for – not all of them, but some of them wouldn’t speak up for themselves. And we are here to support them by asking the right questions, I think eventually they will be heard.”*

*“I think women in general don’t get their voice heard because we’re just...how can I put it? We go along with things, don’t we and just get on with things and we do try to speak out but if it weren’t for things like...if we don’t have those platforms like the Women’s Health Network, there wouldn’t actually be anywhere where I would say, specifically to women, women’s voices wouldn’t get heard”.*

### **Well-connected and acts as conduit between professionals and public**

- Has connections to those above “with clout” and to community leaders.
- Links up services.
- Two-way mechanism of communication:
  - Feeds back from the CCGs to communities and services on the ground.
  - Feeds back to CCGs from those on the ground.

*“I think we’ve been really blessed, Emma, it has been a blessing that we’ve had champions at quite strategic level. And this has been in the council and the NHS. And these are all women.”*

*“I link in with the woman who does a very similar role to me, and she’s from Bradford Council and she might know a load more of service provider users that I wouldn’t even I would know. So these people are sign-posting you to places as well so that you...because of their jobs. But if you were a member of the public, you wouldn’t know. So I would say, yeah, they are very good at it because they’re linking in all these professionals and being able to benefit the individuals in our community from it, by signposting.”*

### **Passion and pride**

- Those involved are very passionate about women’s health and proud of the network.

*“In the past three years I’ve been here what’s really striking is that passion and people actually want to be there. So, it’s not a meeting that you’re told to go and you have to go. People are passionate and they’re wanting to make a difference.”*

*“And the other thing, you know, I need to perhaps say here is that the strength is that the people involved in it are proud of it. So they’re always sort of keen to do more and make sure that they stay proud of it.”*





## The affective dimension

This theme covers a range of emotional, relational, and intangible aspects of WHN which participants highlighted as key strengths, and which are threaded through other themes.

- Social side, fun.
- Relaxed, open atmosphere, comfortable.
- Trust.
- Solidarity.
- Inclusive, safe women-centred space.
- Relationships.

*"[...] people turn up and keep turning up because they're getting something out of it for themselves as well. And people enjoy it, people have a good time. Sometimes we talk about difficult subjects and sometimes the conversations are challenging, but they are rewarding for people and it can be really good fun."*

*I think it's the actual set-up of it's encouraging because it is, it feels like a very safe environment and I think it's the passion of the people that are behind the Women's Health Network and like I said to you, I can't put my finger on the actual word. Like I said, you feel as one really, to me anyway, I felt like I could say anything, and it wouldn't be judged, and it was respected."*

*"For me, it's where people feel valued, people feel welcome to challenge if they need to. People feel welcome to have different opinions. So yes, that's...I think, as well, it's also about...it's hard to explain sometimes, but if you've ever been to any of our events, or even the event that we had on Zoom this year. They feel very warm, there's a lot of laughter, there's a lot of kind, of...you know, before we'd have that [...], for example, we'd have people chatting, we'd have people crying in the meetings, in a good way. So that, for me, also kind of showed, you know, the good vibes in it."*

*"So, for me the key aspect has been that relationship building around trust. And that's really hard to put on paper how you do it, because I think it's over time, it builds up."*

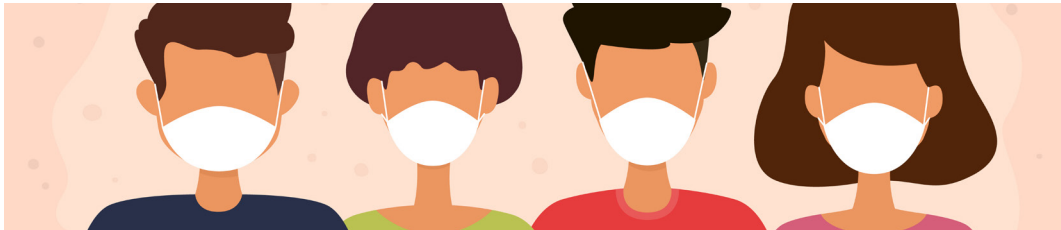
### **Translates and disseminates information**

- WHN gets information to where it needs to be; translates it into different languages and plain English.
- WHN is responsive to what communities need.

*“Empowerment of women to me is women being able to make free choices for themselves and not...and to be able to say, you know, yes to things, no to things, with a genuine yes and no. With a genuine...be able to have the decision making themselves. To be given the information to make informed decisions and that means in their own homes, in the workplace, for themselves in terms of their own health.”*

*“I think it’s always been very supportive of each other and each other’s works and disseminating the messages, getting information out and trying to reach out to those communities that are isolated or not necessarily that they don’t always come forward.”*

*“We really loved that flexibility to set the agenda on things that women wanted information about.”*



### **Making a difference**

- WHN has influenced service design and the language of NHS health communications.
- Makes a difference personally to women members.
- Gives women a sense of ownership.
- Women feel that they are listened to.
- Connects women to services.
- Links services to each other.
- Raises awareness, spreads information, and has conversations that are not typically had.
- Informs and empowers women.
- Produces solidarity and community.
- Amplifies voices that would otherwise be unheard.
- Builds women’s confidence and skills.

*“Then we get to sit round the table with the commissioners and co-design the services. So it’s not just a simple case of passing this piece of work and leave them to deal with it, the Women’s Health Network is then part of that process of the co-design team. An example of that, domestic abuse services were being recommissioned a couple of years ago. They used the Women’s Health Network as a big part of the consultation process. It was being co-commissioned by NHS and Bradford Council. So we were part of the consultation. But then we did another workshop around service design, so that all women involved could have that voice in what the services should look like, how accessible they were, where they should be. It gives women a real sense of ownership when they are listened to.”*

*“Because I think it’s just that evidence has shown it [that WHN makes a difference], in terms of the things that we’ve brought forward. So we’ve brought forward issues like menopause, we’ve brought forward issues around the mental health of women in prison. We’ve brought forward things around, you know, just women feeling shame, or things like stereotypes and conversations. So because we’ve brought all of that forward and acted, you know, tried to do something about it, for me that shows something.” So, it’s not just a case of having a bit of a social gathering, it’s about actually being, what’s the word, it’s proactive. It’s a proactive form of communication, I think for women.”*

*“Making lasting changes. I mean, some of the ones that so far we’re holding strong on, cervical screening letters still say smear test, the recognisable words. They still say woman. Both letters for cervical screening and breast screening both specify you can have a female member of staff dealing with you. So things like that.”*

*“You know, the amount of people that I’ve met through the Women’s Health Network as well, I wouldn’t have met otherwise. That’s been really useful, not only for me individually, in my own kind of development and confidence, but also then, what I’ve been able to do with the community, from there.”*



## Funding and relationship with CCGs

- WHN has the resources that they need – invested in up front by CCGs.
- Not overly prescriptive directive; WHN is trusted to get on with things and given autonomy by the CCGs to set their own agenda.
- The CCGs do not demand solely quantifiable impact but recognise qualitative differences as impact.

*“So, those two, sort of, files of engagement that I describe, that’s stuff that’s about relationships and very organic and free-flowing and the box ticking stuff, actually can work side-by-side, if...but it requires having the foresight to invest upfront in things like the Women’s Health Network.”* **CCG Commissioner.**

## Female role models

- WHN provides role models of strong women and female leaders.

*“I think we’re really lucky. I do think we’re really lucky in the...some of the individuals that we’ve had involved, some of the vision early on from [the GP] that I talked about. The commitment that we’ve had from Chairs of the Women’s Health Network, past and present, and I think I would...I could see that the Women’s Health Network wouldn’t be as positive and as healthy and as vibrant, if different people had been involved at different points in its history. So, I think there’s a huge amount of having, almost, a little bit of luck of having had the right people at the right time, and the right conditions to make it thrive.”*



## Barriers

Participants spoke about two types of barriers; barriers to women's healthcare and barriers to participating in WHN. These are separated below, although there is some overlap between them.

### Barriers to healthcare

- Language barriers, including plain English language barrier for native speakers.
- Cultural and religious barriers and exclusions.
- Fear of speaking out.
- Lack of trust.
- Gendered barriers in healthcare and society (patriarchy; domestic violence).
- Systemic barriers (healthcare structure; poverty).

*"I think maybe [fear of] repercussions or whether...I just feel like...don't know, I'm just trying to think to give you an example. Yeah, maybe where it's going to go, if it's going to come back to them, or if there's going to be any consequences for them or anything like that, so, you know. And with the health side of it, I just feel like maybe speaking up or it's not good for them to speak up and they should be grateful for the service they have and stuff like that, it's that kind of mentality as well, so it's better to keep quiet and not say anything kind of thing, rather than to speak up if they have an issue."*

*"It's almost like [women are] an invisible, you know, species sometimes I do feel. Again, I'm just only speaking from experience, I remember my mother going to the doctor and because English wasn't her first language, it was almost like 'oh no, she's just going through the menopause'. Well, it was more than that. It's dismissive, this dismissive side of things. The language barrier's massive, massive, massive. And not knowing the system is massive. And then you'll easily get lost in it, that's what it is for me."*

*"You know, with some of the women, it's like they just don't want to speak out or speak up or anything like that, this is in mental health I'm talking about. So different obviously ...different women have different cultures, different lives, et cetera, so depending on what they perceive as their religion or culture, it sometimes can be a barrier about, for example, getting out and about, engaging, talking to services, things like that. So it can be quite difficult, I just feel like maybe that trust I think, that trust is kind of hard for women to trust people I think, I don't know. I feel like it is quite hard for us to get women to open up, so yeah, so trust, language [are key barriers]..."*

*“Every time NHS England brings in a new model, it’s gone before they’ve had chance to implement things. So we’re on Community Partnerships at the moment, they’re expected to go soon and something else will take over. So there’s never any chance to implement and evaluate before they’ve already moved on. And that lets down women.” “I don’t think the access to the service is always straightforward, so you get passed around a lot before you get to the service you need, so pathways are not clear always.”*

### **Barriers to participating in WHN**

- Practical attendance barriers (time availability, travel, financial).
- Covid-19 (lack of face to face contact; zoom fatigue).
- No access to the internet (particularly older women and those without English as a first language).
- Confidence and self-worth issues (not feeling they have anything to contribute).
- Lack of knowledge about healthcare.
- Lack of awareness of the network.
- Experiencing domestic violence.
- Geographical barriers (e.g. not living near the city centre).
- Self-imposed barriers (not wanting to participate).
- Competition for attention (communication overload).

*“Some of it is language; some of it is around methods, how to engage; some is the communications put out there; some of it is to do with people having very busy lives; some of it is to do with communication overload because all the services are doing the same thing, and it’s for individuals to decide do I actually want to link in with this or not, do I have the time, do I have the interest, have I got other priorities in my life at the moment, which they have. There’s a variety of factors.”*

*“I think it depends on different communities and something like confidence and language barriers that’s there, but I think it’s understanding the purpose of these kinds of networks and why they exist and what we’re trying to do. Having that kind of grasp, a deeper understanding of stuff like this and that as well. I think what I’ve noticed in the cities is that there are certain pockets who do their own thing and they don’t really want to get involved with other people’s stuff or allow others in, so it’s a bit difficult but we need to tap into that because they’re working with us – at the end of the day we’re all trying to serve the same community, so if we can do it better in a more coordinated approach and serve people better as a community itself. But I think it’s getting over the gatekeeping, people’s insecurities around that, there is that.”*

*“Self-doubt, cultural doubt, where a woman... As it is, I think women second-guess themselves anyway all the time and it will take a while until... I mean, we’re never assertive, are we? We are all aggressive. You can’t be in between. And this is about assertion, this is about learning that you have a voice and to... The historical cultural barriers, especially with male leaders in family structures, et cetera, that includes women in the UK in some quarters. Even in the white population in some quarters, white European population I should say, and to make do with that, to give a woman a voice.”*

*“A bus journey and even a door can be a huge barrier to a woman.” “At the moment, technology might be a massive issue for a lot of people and possibly it’s not just the technology side of things, but I think if women are living in a multi-household, that could be an issue for them actually being able to get, I know it sounds silly but a bit of peace and quiet on their own to be able to attend a meeting or a group.”*

*“I think, you know, there’s that thing around English not being the first language, they’ve not been confident with social media, not being very trustful of social media and what it is.”*

*“Just a sense that it’s not...it’s not for everyone. A sense that you need to know stuff to take part, you need to be connected to something. You need to have a reason to be there.”*

*“I think we need to do more in encouraging more women to come along, and feel as if they’ve got something to give. I think they’ll always feel welcome, but it’s feeling as if they’ve got something to give that we need maybe to work on. Personally, I think that’s a barrier.”*

*“So, I think that’s what one of the main barriers would be and like I said, not having enough knowledge maybe about what the work of the Women’s Health Network. So, it’s important that people are communicated ...the ethos of the Women’s Health Network is communicated well in the first place, I think.”*

*“I think, for me, the outliers, I know there’s a lot of attention being paid into central Bradford City and I’m so worried that when it comes to outliers, such as ourselves, like Shipley and Keighley. We are still outliers, even within this group, because of accessibility, et cetera. So everything happens in the middle of Bradford really and it’s the distance. And especially in COVID, it feels like even more of a distance.”*

## Sustainability

The network was established in September 2016 and is reliant on funding from the local CCGs. At the time of writing (December 2021) it has existed for 5 years. Alongside its many strengths, several key factors contribute to the network's sustainability moving forwards.

### Funding

- There is a need for more funding for community organisations.
  - This is hindered by competition between services and the impact of austerity on services' funding.
- Funding is often 'quick turnaround' which prevents applications, and time-limited, which prevents long term development and evaluation of services.
- The rigidity of funding requirements and how 'impact' is measured is a key barrier for community services, with WHN being held up as a positive example where this had not occurred.

*"There needs to be flexibility with funders if...I mean, I were really fortunate with the one who funded my project that they didn't need numbers in my outcomes, that they wanted to know the difference I'd made, not how many people I'd made a difference to. And they let me do that in the way that I saw best because I knew my community. If I tried something, it didn't work, they were happy for me to stop that and try something else. So the grant funders need to really take on that flexibility and trust, that if someone's applied for the money, it's because they know their community."*

*"And I think it gets away from...because I used to work in the voluntary sector and I do know...I mean, it's natural, because there's an ever decreasing pot of money, that things can become horribly competitive rather than people thinking... I mean, I think that has changed over the years, but it's good if people can be more creative in their thinking, in terms of getting different groups working together to share the pot, rather than having to constantly compete for the pot. And I think something like the Women's Health Network enables that kind of thing because it is about making useful connections, and perhaps recognising, us as an organisation, well, we could do that, but we can't do that. But that organisation over there can do that and let's work together rather than in competition, because none of us can afford to do that anymore."*



*“Community centres are often one of the first places women will go because they already attend a coffee morning or they take their kids to youth group there, they’ve already got that trusted relationship with staff there. And they will talk about their problems and then accept that support, oh, you need to see your GP about that, you need to do this. So there needs to be much better investment in the voluntary community centres because it can have a massive impact on health.”*

*“Firstly that the funding is continued for it [WHN], that adequate funding and resources are put in, because it’s taken four to six years to get to this stage. The momentum is there, so I think it will be conditional on funding and resources. It’s maintaining that passion and commitment and buy-in from women.”*

## Impact of Covid-19

Data collection took place during Covid-19, which had a significant impact on the network.

- Meetings were moved online to zoom and all face-to-face events were cancelled.
- For some women, online meetings are easier to attend as they remove barriers of travel and, to some extent, time.
- For others, a lack of internet access or literacy prevents online participation.
- The lack of face-to-face contact resulted in some women feeling increased loneliness and isolation.
- Nevertheless, new women attended the online meetings and turnout was higher than expected across 20/21.
- Moving forward, the network proposes to use a combination of online and face-to-face meetings.

*“I think the main negative is we’ve not been able to hold those, the workshops and events, we’ve not been able to do in communities. Similar to the last one I mentioned, the cancer one. That’s been the main negative: it’s actually taken some of the workshops and focus groups. Because previously we’d have gone to the mosques, we’d have gone to a community centre, we’d actually gone out and done or hold a large event at the Carlisle Business Centre. That’s been the main negative. But the meetings, as I said, numbers are increasing. And membership is increasing which is a positive. But I think it’s the same for all services, it’s actually going out and talking to real people, that’s been the negative impact of the pandemic.”*

*“Because the other thing that we have, which always encourages people, you know, you put a bit of food on at the end of the event, and it does always encourage people to come along. And they may say, ‘well I’m going, come with me’. And so you might get four or five people coming together, whereas, you know, if you’re sat in your front room or your kitchen, it’s like, oh God, is it ten o’clock? Well, I’m not going to bother. Even if you’ve registered. So, I think that was, definitely I think it was ‘cause it was Zoom.”*

*“Because I think, there are certain issues that you can only deal with by having those trusted relationships and working with people on a face to face basis.”*

*“When looking at the health inequalities around deprivation, poverty has a massive impact. So making sure that people who are living in poverty are able to access meetings. In a lot of ways, this virtual world is helping because it gives that extra strand to how people can attend. So moving forward, I really hope, even if they go back to physical meetings, they retain the virtual element so that people can dial in as well.”*

## Future of the network

Vision and plans for the future of the network include:

- Maintaining the Network’s current activity via continued funding and infrastructure.
- Continuing to be responsive to women and their communities’ needs.
- Expanding the network by increasing the involvement of smaller services and charity organisations.
- Reaching out to more seldom heard women to increase their participation in the network.
- Going out into the community post Covid-19.
- Doing bigger things on a national level by feeding in to the replication of the WHN model in other localities and creating links between future local WHNs.

*“I hope it’s going to continue and grow in strength the way it has. But I also think maybe more of a, I mean, we’ve done some, mind mapping and stuff work around what the future should look like. And I think one of the things is maybe encourage maybe give people targets to encourage and bring along other women who wouldn’t normally attend. That could be a way of growing it and engaging more communities, hopefully the ones that don’t traditionally engage.”*

**Interviewer:** *And what do you hope the future of the network will hold?*

**Participant:** *I hope we get back together in a room...*

**Interviewer:** *Yes.*

**Participant:** *I hope we start to go out into the community more and we see more collaborative projects coming.*

*"I do hope that our like asset-based approach to women centred working, is...it does become the norm, and the Network grows and develops even more. Genuinely, I think it's a brilliant model and I think it works. And I just want to see that pattern growing, developing, and increasing, and it's good if we can use it elsewhere, it would be brilliant."*

*"There needs to be national investment in community services. So national investment in having a women's health network and listening to the voices of women across the country. Because things that Bradford Women's Health Network does wouldn't necessarily be relevant for Leeds, even though we're neighbours, we've got a vastly different demographic. So it does need to be listening to the voices of your community. So one national women's health network wouldn't work, it'd become London centric, it'd be prescriptive. But building up a network of women's networks would. Working in the voluntary sector model is incredibly cost effective because it doesn't have multiple layers of management. So it would be cost effective in terms of NHS engagement work, tackling the women's health inequalities through listening to women. But it would need national investment."*



## Areas for improvement

There were three key areas for improvement highlighted by participants:

1. Raising awareness of the network locally by increasing its visibility and publicity, especially in health services such as hospitals and GPs and local communities.
  - a. Many participants felt that the network was not as visible as it could and should be, and expressed that they would not have heard of it were they not in a particular professional role.
2. Encouraging more individual women to come to meetings and to feel that they have a valuable contribution to make.
  - a. It was suggested that varying the location and times of meetings might enable more women to attend, alongside increasing the network's visibility.
3. Reaching more 'seldom heard' women and under-represented communities such as the Roma community.
  - a. Post Covid-19, it was suggested that going out to local communities to form new connections, targeting specific lesser heard groups, could increase representation of 'seldom heard' women.

*"Reaching out to more, I think and again, from my looking at it from the outside, I think they could do with more funding in that respect, of being able to reach out to more and publicise themselves more, I think is where...that's where the improvements could be made. Shout it from the rooftops, I think, kind of thing. I am aware, like I said, it's the actual infrastructure, funding, and things like that that is the issue, but I do think that's where the improvements could be made."*

*So, I would just say publicise it more, maybe on the internet or something. But there's some women that maybe don't go on the internet, like I said, the older women would they go on Twitter? Would they go on Facebook? Would they go on internet? I don't know if they would. I don't think they would. I think they need to promote it more in local community centres, maybe in doctors' surgeries, things like that. Physically put up the posters, or give it to the children at school because maybe their daughters would tell them about it. They need to publish it where younger women could say to like...it's like, for example, I'm thinking about myself. Excuse me. Would my Mum would have known about it? No, she wouldn't. And the only way she'd know about it is through me. And how would I have known about it as a child, is through school or something like that. So, when I think about it...but I think maybe to get the young girls involved more so that they can..."*

*“To have a buddy system would be really good for every healthcare issue a woman goes through, because it’s holistic health, it isn’t just the period, it is the mental state behind it. It is the psychological, it’s the cultural. For your culture, your mother has told you, ‘oh, every woman has given birth, you’re not the first one’. But, and you know this, if you’ve given birth, not every woman gives birth the same because their bodies are different, everyone is unique. And when you talk to someone and they say, ‘oh, this is the way I brought up my child’. It will not be the same that you brought up your child, every child is unique. So having that ability to have someone you trust.”*

*“Getting more women that are not from professional organisations involved, that would be, you know, if 50 per cent were from the non-professional groups, I think it would be great. Because then you get your word of mouth as well as however else you, I think word of mouth is worth an awful lot in the communities that we haven’t reached as easily as others.”*

*“Maybe kind of doing some more putting themselves out there a bit more in services...in general, so you know like for example domestic violence services or Social Services and things like that, I don’t feel like we have enough representation from that field, I don’t know if it’s the whole timing or whatever or they just don’t want to join, I don’t know if they’ve put themselves out there, so that might be an area for them to target maybe.”*

*“Continuously, for me, [WHN needs to be] reaching new women and hearing new voices. And then, I think it’s, for me, developing upon what we’ve already done, and really, I think...I can’t think of a better word than, hammering it down. But so some of the issues that I’ve mentioned previously around cancer screening, or around women’s health, really kind of holding people accountable, I suppose...holding ourselves accountable for what we’re doing to continue those conversations and to raise them and elevate the voices even more.”*

*“I think, common with lots of similar kind of networks, sometimes the voices that get heard are the voices of voluntary sector organisations or community groups, rather than always the women that they represent and I think it’s important that those groups and organisations are part of the conversation, but that they are bringing the perspective of the communities that they serve and the women that they serve, and not just their own perspectives on an issue. And I think that’s something that Women’s Health Network are aware of and...but could do better at making sure that when we’re capturing conversations, when we’re debating a topic in the forum or when we’re talking about something, that actually we’re able to pull out and distinguish whose voices really are being heard in the room.”*

*“So, for example, we know we seem to be struggling to really engage with Roma communities in Bradford. We don’t have a good grip on who our Roma population are. Public Health struggles to find the data and... to tell us who and where and how many. And that is a group we are particularly interested in health because access to health is a barrier and some of the health behaviours that we are seeking to change across our communities are based in the Roma community. And so, I think, if I was sitting down and I do sometimes, if I was sitting down with Laila [Engaging People Project Lead] and thinking about groups that we need to reach into more and who we need to build those connections with, Roma community would definitely be one of those and there probably are others. But we can’t do it all at once.”*

*“So this is something that we’re looking at actually developing to be fair, so having...instead of being like a conduit in between, seeing if we can have very open, like meet the commissioners type of thing, like a speed dating almost. Where members of the community, I invited directly to have that conversation without us being in between. But generally, I suppose what we do is, we take the conversations that we get from services, from our members, and kind of transform that into kind of a set plan, because, sometimes organisations...I wouldn’t say there’s politics or bureaucraties [sic], but there is like a way of communication isn’t there. Right, okay, the conversation that you might have in a community, is very different to how you might have it with a manager, for example. So it’s just sometimes filtering it through a little bit, to make it easier to read.” Chair of WHN.*

*“But if the meetings were willing to move and not be in one fixed location, I think that would really help more women get involved.”*

*“So, the opportunity for people to engage with the Women’s Health Network, evening time, so I think they don’t do that at the moment, as far as I’m aware. So, maybe introducing the opportunity to people, to run a pilot to see whether there’s more engaging on an evening than there is through the daytime.”*

*“We did a little thing on how lockdown was affecting women’s sleep patterns, you know, just because we’d discussed it at one meeting. So, you know, just coming up with like, little one off things like that as well, and obviously getting more women that are not from professional organisations involved”*

*“So, I think, I’m not sure what more could be done at this time, without more money, you know?”*

*“So, we’ve got to be mindful that we’re not asking the admin support to actually do too much, and that we do a little bit of that ourselves. So, I think we could probably do with getting people involved that know how to do these things, you know?”*

*“I think it’s a case of keep doing what it’s doing. You know, this is... engagement is time consuming, it’s energy consuming. It’s about trust and it’s about building trust and it’s not something that can be achieved quickly if you’re going to do it well. So, I think, where I’m saying it’s not been entirely successful, it’s not that there’s anything they’ve done wrong or shouldn’t have done, it’s just that this is a long process. So, it’s about continuing to build on those successes.”*



# FINAL REFLECTIONS





Women's health is a pressing issue that has long been neglected. There is an urgent need for attention to be paid to women's lived experiences of health and for this experiential knowledge to be taken seriously by healthcare professionals and service providers. WHN demonstrates the value of addressing women's health holistically as a community issue utilising an asset-based community development and women-centred approach.

WHN is a network of mostly professional and some individual women, which creates and sustains a bidirectional channel of communication between the micro (ground) level in communities and the macro (institutional) level of the local CCGs. The network amplifies the voices of 'seldom heard' women by representing their perspectives and feeding this into service design and provision. WHN enables better communication between healthcare and community services, services and service users, resulting in actions that address women's healthcare needs both on the ground in communities and at an institutional, commissioning level. WHN therefore demonstrates successful inter-professional and inter-agency working which benefits service users.

WHN does manage to engage with individual women, albeit less frequently than professional women, and particularly at events that are public-facing such as International Women's Day and focus group workshops. The key areas for improvement identified by WHN participants include reaching out to more 'seldom heard women', especially groups that have historically been lesser involved, and increasing participation of individual women attending the network in a non-professional capacity. Two key strategies for doing so were identified; firstly to increase publicity of WHN in order to raise the public's awareness of its existence and purpose, and secondly to build on existing work in local communities with community leaders who are well-placed to act as a link between WHN and lesser heard communities, reflecting WHN's asset-based community development approach. Covid-19 has posed a significant challenge to WHN's work with local communities as it has prevented outreach and face to face meetings, which have proved successful in the past. At the same time, the advantage of online meetings for overcoming time and geographical barriers to attending has been highlighted during this time, leading to the future network's plans to involve a combination of online and offline engagement.

WHN clearly demonstrates the value of taking time to build strong relationships and trust between professionals and with local communities, alongside the importance of the affective dimension of community engagement where creating a safe, inclusive space that feels welcoming to women is central to the success and sustainability of the network. This has been achieved by CNet, the lead deliverer of WHN, demonstrating the value of community empowerment networks. CNet has a proven track record in delivering community-based projects using an asset-based community development approach, tackling inequalities and connecting Voluntary Community Sector Organisations (VCSOs) (formal and informal) and community stakeholders with strategic partners in Bradford Council, West Yorkshire Police, the NHS, and CCGs.

In order to sustain WHN's vital work with women and communities, continued funding by the CCGs is needed, as is resourcing of community services. VCSOs require not only funding but also the time, space, and autonomy needed to develop networks in a way that reflects meaningful community engagement. WHN provides a strong model of PPI and knowledge transfer between professionals and the public, for replication in other localities, taking into account local demographics and community needs.



## Further reading

Women's Health Network Project Team (2016) Women's Health Network Final Report September 2016, available online at: [https://cnet.org.uk/sites/default/files/2021-12/WHN%20Final%20Report\\_0.pdf](https://cnet.org.uk/sites/default/files/2021-12/WHN%20Final%20Report_0.pdf)

This report details the creation of WHN, focusing particularly on how an Asset-Based Community Development model and Women Centred Working were used to inform the origins of WHN.

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Women's Health Network (2016) Who we are and what we are doing, available at: [www.bradfordcityccg.nhs.uk/get-involved-/what-we-are-doing/womens-health-network/](http://www.bradfordcityccg.nhs.uk/get-involved-/what-we-are-doing/womens-health-network/) (accessed 07/02/2020)

# APPENDIX A

## Professional Stakeholder Interview Guide

### Checklist

Introduced myself	
Participant confirmed they have read Participant Information Sheet	
Answered participant questions	
Obtained verbal consent for study	
Obtained verbal consent to audio-record interview	
Demographic questions complete	

### Demographic Information

Inform participant the following demographic questions are optional and they can respond to as many or as few of the following as they are comfortable with:

Age \_\_\_\_\_ Relationship Status \_\_\_\_\_ Ethnicity (self-defined) \_\_\_\_\_

First language \_\_\_\_\_ Do you speak any other languages fluently ?

Do you consider yourself to have a disability? Y / N

If yes, what disability/ies? \_\_\_\_\_

Do you have children/ dependents? How many and what age?

What do you do to keep busy? Do you work, stay at home mum, etc.

1. What is your role/ involvement with the WHN?
2. What organisation(s) do you work with?
3. What is the WHN?
4. What is the purpose of the WHN?
5. How did you first hear about the WHN?
6. How did you get involved?
7. Why did you get involved?

8. What do you think are the most pressing healthcare needs for women?
  - Locally and nationally
9. What do you feel are the biggest strengths and successes of the network?
10. What areas do you think the network could improve?
11. The network mentions 'seldom heard women' – who are these women?
12. Do you think the network has been successful in engaging seldom heard women?
  - How?
  - How do you think it could improve?
13. How does the network encourage communication between healthcare professionals and women about their healthcare needs?
14. Do you think the network enables meaningful patient and public participation for women?
  - Why/ why not?
  - How has it achieved this?
  - What could be done better?
15. Do you feel the network makes a difference? How?
16. What barriers are there to participation for local women?
  - How do you think these could be overcome?
17. How has the network been affected by Covid?
18. What role does social media play in WHN?
19. What do you hope the future of the network will hold?
20. What advice would you give to someone in another locality wanting to set up a similar WHN?
21. Is there anything else you would like to talk about?

## Members of the Public (individual women) Interview Guide

### Checklist

Introduced myself	
Participant confirmed they have read Participant Information Sheet	
Answered participant questions	
Obtained verbal consent for study	
Obtained verbal consent to audio-record interview	
Demographic questions complete	

### Demographic Information

Inform participant the following demographic questions are optional and they can respond to as many or as few of the following as they are comfortable with:

Age \_\_\_\_\_ Relationship Status \_\_\_\_\_ Ethnicity (self-defined) \_\_\_\_\_

First language \_\_\_\_\_ Do you speak any other languages fluently ?

Do you consider yourself to have a disability? Y / N

If yes, what disability/ies? \_\_\_\_\_

Do you have children/ dependents? How many and what age?

What do you do to keep busy? Do you work, stay at home mum, etc.

1. What is the WHN?
2. What is the purpose of the WHN?
3. How did you first hear about the WHN?
4. How did you get involved?
5. Why did you get involved?
6. What has your involvement been?
7. What do you think are the most pressing healthcare needs for women?
  - a. Locally and nationally
8. Would you identify as being an 'under-represented voice'? Who do you think are 'seldom-heard women'?

9. Do you think the network has been successful in engaging under-represented women?
  - a. how?
  - b. How do you think it could improve?
10. What do you feel are the biggest strengths and successes of the network?
11. What areas do you think the network could improve?
12. Do you feel the network makes a difference? In what ways?
13. What barriers are there to participation for local women? / have you faced
  - a. How do you think these could be overcome?/ how have you overcome these?
14. How has the network been affected by Covid?
15. What role does social media play in WHN?
16. What do you hope the future of the network will hold?
17. What advice would you give to someone in another locality wanting to set up a similar WHN?
18. Is there anything else you would like to talk about?



# APPENDIX B

## Online poster call for participants

The poster features a light purple background with four stylized female figures in orange and purple clothing. The text is centered and reads: 

**Have you been involved with the Women's Health Network in Bradford?**

I am interested in speaking to people about their experiences of the network as part of a research project about the Network and women's healthcare

All responses will be confidential and anonymous.

As a thank you for your time, you will receive a £20 shopping voucher.

If you would like to take part/ find out more, please contact: [emma.craddock@bcu.ac.uk](mailto:emma.craddock@bcu.ac.uk)

