

Women's Experiences of Discrimination and the Impact on Health



HEALTH AND SOCIAL CARE

Women's Health Plan: experiences of discrimination and the impact on health -
research findings

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Executive Summary

Purpose of the project

[The Women's Health Plan for 2021-2024](#) aims to improve health outcomes and health services for all women and girls in Scotland. It is underpinned by the acknowledgement that women face particular health inequalities and disadvantages because they are women. A two-phase research project was developed to address the following medium-term action within the Plan: [To build an evidence base on women's health inequalities, with specific focus on the impact of sexism, racism, ableism, and other forms of discrimination including homophobia and transphobia on women's health.](#)

The purpose of this research was to explore and understand experiences of discrimination among women in Scotland and the impact those experiences have on women's health. Intersectionality, the idea that different aspects of a person's identity overlap to form their unique experience, was used as a theoretical and analytical framework in this study.

There are three parts to this report. The first examines the current evidence base and provides a rationale for the research approach. The second part reports on a series of focus groups with women from different backgrounds. The final part describes the methods and analysis of in-depth interviews with young women aged 16-25 years.

Aims

The overall aim of the project was to develop an initial understanding of how women in Scotland experience discrimination and how it affects their health. The present study had the following underlying research objectives:

- To explore women's experiences and perceptions of health in Scotland, involving women throughout Scotland and from marginalised groups
- To take an intersectional approach to help understand how multiple different aspects of women's identities (e.g. age, disability, race/ethnicity, social class) result in particular experiences of discrimination related to health

Methods

The evidence review involved searching of scientific databases, government reports and grey literature. The qualitative research projects involved fieldwork taking place in August 2022 and between December 2022 and March 2023. The first project comprises four online focus groups with women or people who use women's services residing in Scotland. The overall sample was 14, with each focus group recruiting women from a different population: women aged 16-25 (n=4), women aged over 25 (n=3), women from an ethnic minority background (n=3) and women with a disability or long-term condition (n=4). The second project was

informed by these focus groups. It involved 28 interviews with young women aged 16-25, residing in Scotland. All discussions were transcribed and analysed thematically by two researchers. Findings are not generalisable to the wider population of women in Scotland and interpretation of the findings should be done with this in mind. Nevertheless, the themes reported here provide important insight into how women in Scotland from different backgrounds and population groups experience discrimination in relation to their health.

Key findings

Focus groups

The focus groups were designed to capture a broad range of experiences and direct researchers towards a population or health topic for more in-depth analysis through interviews.

Four themes were identified that revealed several potential ways women in Scotland experience discrimination and how those impact on their health. **Theme 1: “Excuses for not investigating”** describes how women across the focus groups gave many examples of not being listened to, being dismissed and ignored. What’s more, participants noted that various parts of their identity, such as their age, gender identity, weight status, mental health status and relationship status were sometimes used by health professionals as reasons for symptoms they were reporting. They described how these reasons were used against women as “excuses” to not investigate or suggest treatment for a range of mental and physical health concerns.

Theme 2: Health as a concept showed how participants drew on the broader concept of “health” and described how “[the system assumes you’re a man](#)”, resulting in sexist and ableist experiences. This, in turn, fed into perceptions of women’s health not being understood and individuals being held to standards of ‘healthy’ that they were unable to meet.

Theme 3: Navigating racial discrimination provided examples of discrimination from women from ethnic minority backgrounds, who spoke of the exhaustion and mental strain of navigating racism. The healthcare examples given highlighted direct interpersonal and structural racism, resulting in perceptions of unequal access to resources.

Finally, **Theme 4: Self-advocacy** described the ways participants attempted to improve their health and receive appropriate care. These self-advocacy approaches included: extensively researching health conditions and symptoms before seeing doctors, being assertive and articulate, being persistent, challenging healthcare professionals and seeking private or alternative avenues for treatment and support. Women recognised that not everyone has the resources to do this self-advocacy work.

The salience of the findings from the young people’s focus group, coupled with the limited evidence base for this age group, prompted researchers to develop an in-

depth second phase to the research, involving one-to-one interviews with young women.

Interviews

There were four themes that described the interview data. These themes outlined different aspects of the objectives, but all contribute to the identification of different ways in which young women experienced and understood discrimination and health in Scotland. These themes were:

Theme I: Ageist Sexism

Several participants spoke of assumptions about them being “fit and well” as resulting in age discrimination within healthcare. Many participants described how this discrimination intersected with being a woman, producing a specific experience for young women. Sometimes, participants found it a challenge to talk about sexism or ageism as separate things, with many participants claiming their experience of discrimination was likely elements of both. Participants described times where they were made to feel as though young women are “naïve” “overdramatic”, “don’t know about the world”, “stupid”, “hormonal” and “irrational”. Some of these assumptions could be seen as sexist stereotypes experienced by women of any age, others were expressed by participants as amplified because of their young age. These experiences led some participants to pursue private healthcare and for others it discouraged them from seeking health support and treatment at all.

Theme II: Mental Health

Almost all participants in the sample explained how discrimination had affected their mental health or wellbeing. For example, being discriminated against increased their levels of stress and anxiety and negatively impacted their relationships with themselves and others. Almost half of the participants in the sample (n=13) explicitly spoke about having mental health issues and their experiences seeking support. All these participants reported struggling to get their mental health symptoms taken seriously. A common experience related to this was that mental health symptoms, namely anxiety, were at times described by health professionals as a natural female attribute, as opposed to a condition that needed treatment or support. Some women experienced gender stereotypes about mental health that also acted as a barrier for healthcare in other areas. This largely revolved around physical health symptoms being dismissed as psychological. Some of these young women were willing to entertain that a mental health diagnosis was a possibility, but described how the diagnosis often felt like an initial reaction to their gender and age. Participants described how these assumptions were sometimes made with “no tests”, “no investigations” and very few “questions” asked about their health complaint.

Theme III: Hormonal contraception

The intersection of gender and age discrimination becomes especially apparent in participants’ experiences related to contraception. Fourteen participants recounted their “journey” with reproductive technologies when asked to share an experience in which they felt discriminated within or outside a healthcare setting. The most

common experience among these young women was that they felt uninformed about contraception options and the potential side effects of the pill. Following this, some young women in the sample went on to experience mental and physical symptoms while on a form of contraception, and then felt they were met with resistance from medical professionals when they asked to investigate the side effects or consider changing methods. Several participants reported being told to “wait and see”, which left them feeling dismissed and like their “pain was undervalued”. The breakdown in trust between the young women and the healthcare professionals, as well as the lack of information about access to other contraception options, led some participants to “coming off” hormonal contraception all together and being “put off” going to the GP about this and other health complaints.

Theme IV: Racism, structural sexism and socioeconomic disadvantage

Thirteen participants in the sample were from minority ethnic backgrounds. These participants talked about experiences of racism within and outside the health system, using both structural and interpersonal examples of discrimination. One structural experience of discrimination related to participants feeling as though there was little knowledge or understanding about certain health conditions and how they present in people from their ethnic background. Further, some young women described how the systemic racism within the health system and wider society allowed “micro-aggressions” or subtle types of interpersonal discrimination to occur.

Women across the sample also gave examples of structural sexism and socioeconomic disadvantage. For instance, in relation to trying to access physical activity, factors such as financial challenges, safety and general discomfort meant that some young women in the sample face unique challenges. Not only do some young women have to make economic decisions about their health in the current economic climate in Scotland, but they have the added consideration of whether the space is safe and what time they are able to visit. These barriers to health are embedded with wider structural-level discrimination such as gender-based harassment and income inequality.

Conclusion

Women in this research described being discriminated against in multiple ways and through cultural, institutional and interpersonal levels. Participants in these studies described how discrimination has the potential to impact on their health. This includes an impact which is partially linked to their experience of mental health, through the exhaustion and frustration resulting from discriminatory experiences. Discrimination was also described to have tangible impacts on physical and mental health outcomes for women through unequal access to healthcare and delays in referrals, diagnosis and treatment. The discrimination described by women in these studies was almost always intersectional, but usually underpinned by gendered inequalities. Participants in the interview study revealed the unique challenges faced by young women in terms of discrimination and their health. They felt as though stereotypes of the “anxious teenage girl” shaped their experience of healthcare for a range of physical and mental health symptoms. Such stereotypes

were described as manifested in interactions with healthcare professionals to the extent where participants felt discouraged to access healthcare due to the expectation of negative treatment because of their age and their gender. The findings in this project contribute to the evidence base on women's health inequalities, discrimination and young women through in-depth exploration of women in Scotland's intersectional experiences.

Context for the research

[The Women's Health Plan for 2021-2024](#) aims to improve health outcomes and health services for all women and girls in Scotland. It is underpinned by the acknowledgement that women face particular health inequalities and disadvantages because they are women.

The Economic and Social Research Council funded an embedded researcher fellowship, in which an academic fellow from the University of Bristol was appointed between April 2022 and June 2023 to lead a research series on women's health inequalities within the Scottish Government. This research project was developed to address a policy action under **Chapter 9.5. Gender and Health of the Women's Health Plan**, which outlines the priority to 'reduce inequalities in outcomes for women's general health'. The **two-phase qualitative project**, outlined in this report, was developed to contribute to Action 59 in the Plan:

- To build an evidence base on women's health inequalities, with specific focus on the impact of sexism, racism, ableism, and other forms of discrimination including homophobia and transphobia on women's health.

This is a broad action that cannot be fully addressed within the time period of the fellowship. Therefore, the academic fellow developed the research in this report that would provide a meaningful contribution to the action and a steer for future iterations of the Women's Health Plan. The research approach and decisions made around what to focus on in relation to the action are described and justified throughout this report.

This report is split into three parts. **Part 1** (page 18) reviews the current evidence base on women's health inequalities and discrimination and provides a rationale for the qualitative two-phased research approach. **Part 2** (page 18) presents the methods and findings of the first phase of the research – scoping focus groups with women from different backgrounds. **Part 3** (page 30) presents a further, more focused evidence review as well as the methods and findings for the second phase – a more substantive piece of work using in-depth qualitative interviews with a subset of women (women aged 16-25).

All phases of the project were conducted in partnership with a stakeholder group connected to the Women's Health Plan: The Health and Social Care Alliance, hereafter referred to as the ALLIANCE. The work was guided by a Research Advisory Group, made up of policy and research colleagues in the Scottish Government. Regular meetings were held with both the ALLIANCE and the Research Advisory Group and they reviewed all the research documents.

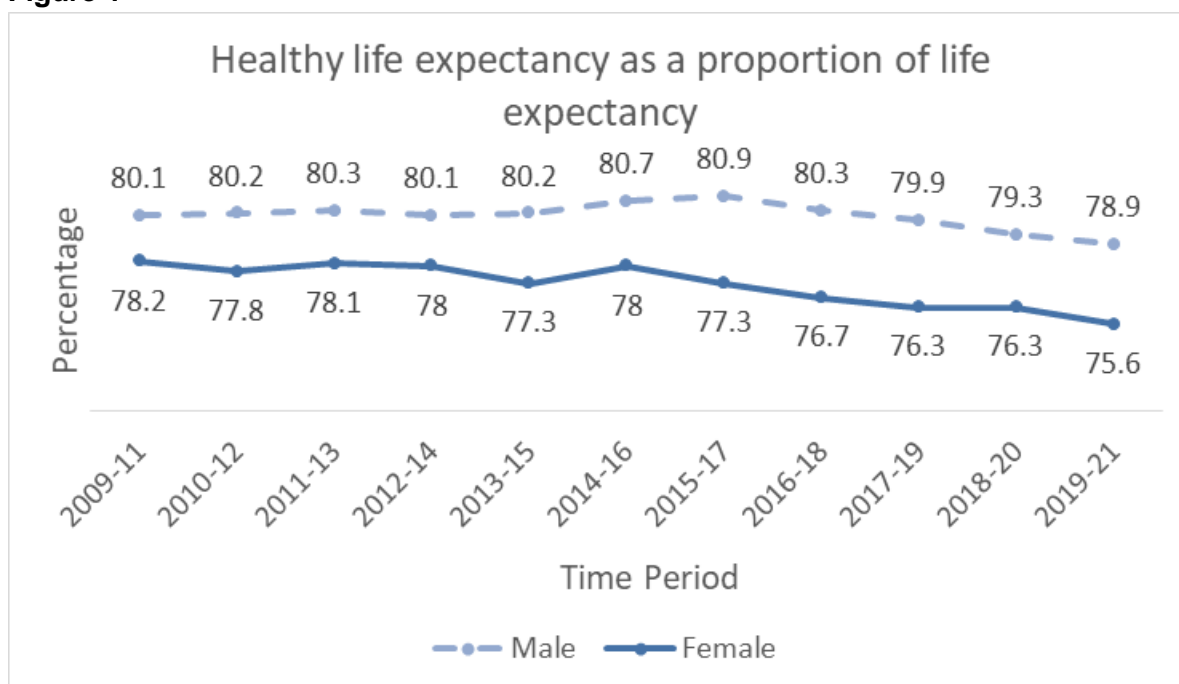
Part 1 - Evidence review and rationale for research

The research began with a review of the current evidence base on women’s health inequalities, discrimination and health, evidence and literature within a Scottish context and intersectionality. The evidence review was used to identify gaps that the research could begin to address and to develop the research approach that would meet the policy action.

Women’s health inequalities

Health inequalities, both across and within countries have been widely described and evidenced in research.¹ Social and environmental conditions are thought to contribute to around 50% of global unfair differences in health outcomes.² Gender is a strong determinant of health with a range of health inequalities particularly disadvantaging women across the life-course.^{3,4} Despite the fact that women globally tend to live longer than men, women suffer to a greater extent from a range of illnesses.⁵ A graph developed from recent [National Records Scotland](#) data as part of our evidence review outlines how this an important consideration for women’s health inequalities in Scotland.

Figure 1



The graph displays that when healthy life expectancy at birth is examined as a proportion of total life expectancy at birth, while women have longer life expectancy and healthy life expectancy than men, **the proportion of their life that is spent in good health is notably and consistently lower than men’s**. The proportion of a woman’s life spent in good health has mainly fluctuated around 78% from 2009-11 to 2014-16 but has since decreased year on year to 75.6% in 2019-21, the lowest since time series began. This compares to men’s whose proportion of healthy life

expectancy remained around 80% from 2009-11 to 2015-17 and has since decreased to 78.9% in 2019-21, again the lowest since time series began.

There is further evidence that women experience greater disability and comorbidities and generally spend fewer years in good health than men.^{6,7,8} In Scotland, data from the Scottish Health Survey 2021 found that women are more likely than men to report living with a limiting long-term health condition.⁹ In 2022, the UK had the largest female health gap of the G20 countries and the 12th largest globally placing it behind other European countries such as France, Germany, and Ireland.¹⁰

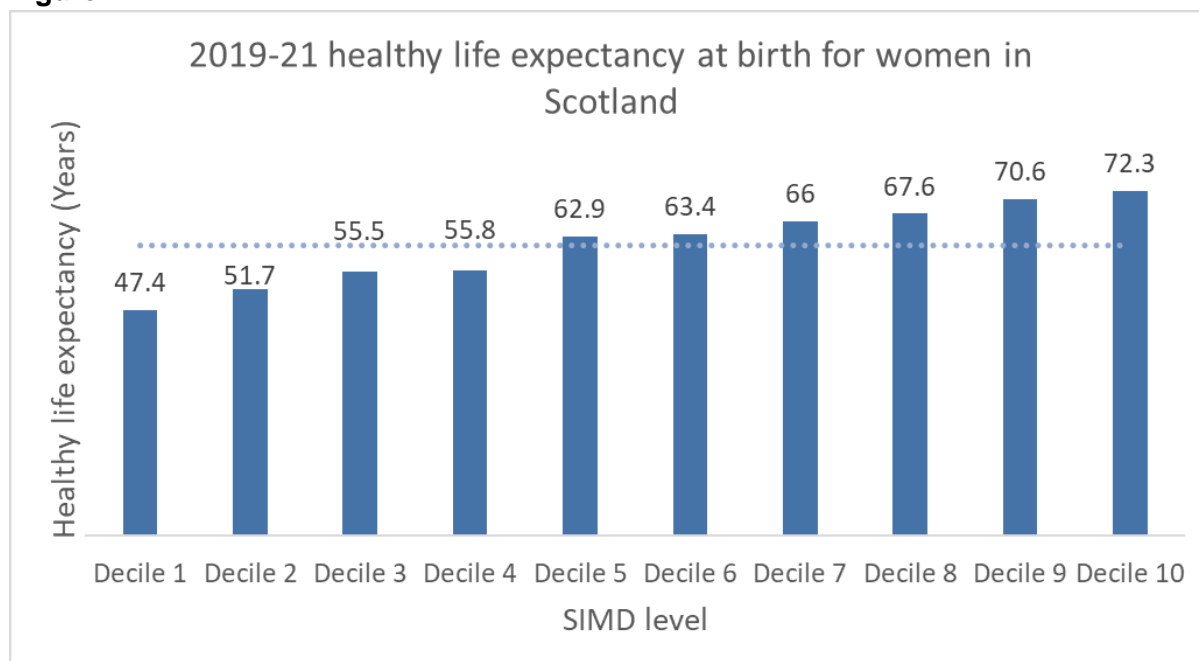
Despite this evidence, there remain significant gender data gaps in medical and public health research, which has been described as further contributing to health inequalities.¹¹ **Women have unique health problems that are under researched, including gynecological conditions which can have severe impacts on health and wellbeing.** For instance, despite endometriosis affecting around 1.5 million women in the UK, and an estimated one in ten women in Scotland, an All Party Parliamentary Group (APPG) Inquiry found that it takes 8.5 years on average from onset of symptoms to be given a diagnosis in Scotland. Further, 58% of women in Scotland visited their GP 10 or more times before being diagnosed, hence its priority in the Women's Health Plan.^{12,13}

Some health issues that affect both men and women can affect women differently and with undesirable outcomes.⁵ Some studies suggest that gender biases in clinical trials are contributing to worse health outcomes for women. For example, a study from the University of Leeds found that women with a total blockage of the coronary artery were 59% more likely to be misdiagnosed than men, and that women had more than double the rate of death in the 30 days following a heart attack in the UK.¹⁴

Women are also more likely to experience mental health conditions than men.¹⁵ While rates have remained relatively stable in men, research has found that prevalence is increasing in women. **In 2021, women's average mental wellbeing scores in Scotland fell by more than those for men.**¹⁶

Individuals can have multiple parts of their identity that lead to disadvantage and to worse consequences for health. Epidemiological studies have outlined that gendered health inequalities can be partly explained by inequalities between women and men in some key social determinants of health, including income, paid and unpaid work.^{17,18} In the most deprived areas of Scotland, women live around 25 less years in good health compared to the most affluent areas (Figure 2).

Figure 2



Disabled women in Scotland also experience specific barriers when accessing a range of services. According to Mencap, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population.¹⁹ Further, [NHS digital statistics indicate](#) that patients with learning disabilities have lower rates of cancer screening than those without and are 8.4 times more likely to experience severe mental illness.

In Scotland, around two thirds (71%) of people experiencing mental health problems report facing stigma and discrimination.²⁰ People describe the stigma and discrimination they experience in services as worse than the diagnosis of a mental health problem. Many also report facing stigma and discrimination for more than one reason, or “dual stigma”, when they experience a mental health issue and have another protected characteristic, for example are LGBTQi+, from an ethnic minority background, in a certain age group, or have a sensory impairment or wider disability.²¹

Further, there is evidence that there are gendered health inequalities in relation to healthcare access and standard of healthcare. Based on more than 400 responses from women in Scotland in 2020, The Health and Social Care Alliance found that across all areas of women’s health, respondents reported not feeling heard, particularly when they then received unclear or incomplete information.²² Based on a survey of 900 young women and people of marginalized genders aged 16-30 (2022-2023), The Status of Young Women report further evidence that young women in Scotland are not taken seriously in healthcare settings. Across every theme, they found that young women are often dismissed, and their experiences are minimised. Overall, the report exposes the intersectional barriers young women and young people of other marginalised genders face in accessing healthcare in Scotland.²³

Similar patterns have been observed in England. Based on 100,000 responses from women across England in 2022, the [Women's Health Strategy](#) found that 4 in 5 (84%) women reported not being listened to by healthcare professionals. Many women recalled their symptoms being dismissed upon first contact with GPs and other professionals. Many felt they had to persistently advocate for themselves to secure a diagnosis, often over multiple visits and found, post-diagnosis, that discussions about treatment options were often limited, and some said their preferences were ignored. In addition, an ethnographic study of women and healthcare professionals in the UK, '[Hysterical Health](#)', revealed how embedded cultural beliefs about women shaped how women were perceived and treated within the health system. The authors concluded that in order to 'level the playing field', assumptions around how women (particularly Black women) experience pain and report their symptoms needs to be reconsidered.

It is widely acknowledged that it is embedded power imbalances between men and women that are likely to be major drivers of these types of health inequalities.⁸ Discrimination that results from these power imbalances is increasingly being highlighted as a key driver contributing to gendered health inequalities that occur in the population.²⁴

What is discrimination?

Discrimination is the unfair or prejudicial treatment of people and groups based on their characteristics.²⁵ Under the Equality Act 2010, direct and indirect discrimination is unlawful. Direct discrimination refers to a person, policy or practice treating someone differently or worse than someone else for certain reasons. Indirect discrimination refers to being treated the same as others, but there being a worse effect on some people because of who they are. The 'protected characteristics' that someone can be discriminated against that come under the Act are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

Discrimination can also occur based on aspects of an individual or group that do not come under protected characteristics. For instance, socioeconomic position, language, geographical location and health status are also aspects that make up an individual's identity and can be used to discriminate against someone.

How can discrimination impact on health and health inequalities?

Discrimination can have an effect on someone's health in many ways. This project was guided by **three levels** at which discrimination can impact on health, outlined in Williams et al's (2019)²⁶ paper on racism and health. Racism has been the principal focus of research on the health effects of discrimination, with a considerable amount of research produced by Professor David R Williams and colleagues in USA populations. While racism may be a particularly detrimental form of unfair treatment, recent evidence suggests that unfair treatment of any type may predict poorer health outcomes in ethnic minority and non-minority populations alike.²⁷ Williams' work has been used to guide research on a broad range of types of discrimination.^{28,29} The three levels are adopted in this report as a useful framework for considering all types of discrimination and how these might impact on women's health and inequalities. The three levels within the framework are:

- (1) **Cultural** –belief systems, images and norms of wider culture are embedded with ideas of which people are inferior, which creates widespread negative beliefs (stereotypes) and attitudes (prejudice) that devalue and marginalise those people. **Cultural racism is the wider context that allows institutional and individual-level discrimination to flourish.** For example, portrayals of negative racial stereotypes in media, such as Black women being more aggressive than White women, can be damaging for health.
- (2) **Institutional/structural** – social policies or structures that limit access to resources and opportunities in society. For example, a workplace may have a promotion policy based on number of days/hours per day spent in the office or ability to attend in-person meetings on certain days. This discriminates against people who are more likely to have flexible or home working patterns, including disabled people and caregivers (who are more likely to be women).
- (3) **Individual or interpersonal** – differential treatment of certain groups of people, instigated by social institutions or individuals. This level is likely what people would talk about when describing sexism, racism, ableism and other 'isms'. These experiences could include more subtle 'micro-aggressions' including misguided comments, being treated as less intelligent, as untrustworthy or with less respect. For example, a woman giving birth in hospital being given less attention by the medical professionals because she is gay.

Discrimination occurs at these three levels, often at the same time and in complex ways. Williams et al (2019) provides some examples of how discrimination can impact on health:

- Health-damaging psychological responses to discrimination, resulting in poorer mental health (e.g. symptoms of anxiety, depression and aggression), low self-esteem and self-worth, low quality of life, psychiatric disorders and conduct disorders.

- Psychological stressors leading to negative health behaviours as a coping mechanism (e.g. drinking alcohol, drug misuse and tobacco smoking).
- Avoidance of health professionals and settings, due to lack of trust and expectation of mistreatment. This can lead to delays in seeking healthcare for medical concerns and lower adherence to medical recommendations.
- Biases among health professionals and systems that restrict access to desirable resources, including referrals, treatment, care and support.

What are the evidence gaps related to discrimination and women's health inequalities?

Our literature search found that the majority of relevant peer-reviewed evidence related to studies examining how particular instances of 'perceived discrimination' impacted on individuals' health. While these studies tell us something that backs up the claim that discrimination is a key determinant of health, it does little to untangle questions around how discrimination plays out at the different levels described by David Williams above. Therefore, the primary evidence gap that we set out to address in this research relates to how and why women experience discrimination.

Secondly, most studies on discrimination tend to focus on one aspect of discrimination, with the majority of evidence and literature exploring racism and health. We were interested in exploring multiple forms of discrimination and how they impact on women's health. While there has been a recent theoretical shift to understanding discrimination and health inequalities in this more complex and nuanced way, through a framework called **intersectionality** (described in a later section), it has seldom been applied within primary research within the UK.

Thirdly, studies on discrimination and health are mostly undertaken in North America. There are far fewer studies within the UK and Scotland. There are the studies mentioned in the previous section that provide some evidence. However, these studies largely had a focus on healthcare access and perceptions of healthcare professionals. The aim of this present study, coming from a public health and social determinants perspective, was to explore discrimination and health in a broader sense, giving participants the opportunity to discuss how work, school, public space and everyday interactions (as well as healthcare settings) might shape their experiences of discrimination and any subsequent impact on their health.

Therefore, the evidence gaps this research begins to address relate to: (1) **how and why** women experience discrimination, beyond descriptions of its existence and effects on health (2) exploration of **multiple forms of discrimination**, and (3) the sparse evidence on discrimination and health within the **UK and Scotland**.

Rationale for qualitative research

The evidence reviewed here complements the Plan's acknowledgement that health inequalities are experienced by women in Scotland. There is a broad evidence base of quantitative data in various fields highlighting that discrimination against women and women's health inequalities exist globally.³⁰ What is less clear is 'how' and 'why' discrimination operates to impact on women's health. [This is a challenge](#)

[within health inequalities research more broadly](#).³¹ Factors that shape health experiences, such as discrimination, are not easily captured and measured through quantitative data. It is only through speaking to women and girls throughout Scotland about discrimination that we will build evidence to support policy action for reducing women's health inequalities. Therefore, through our review of the literature and consultation with policy colleagues, we concluded that what was needed was primary qualitative research. The findings of this qualitative work will not be generalisable, but they will complement quantitative work to begin to plug the gaps in the evidence on women's health inequalities in Scotland.

Rationale for two-phased project

Having identified the need for qualitative evidence in Scotland, the next step was to understand which areas of women's health inequalities and discrimination should be examined. It would not be possible to provide rigorous evidence on all areas and it made sense to focus on one so that a meaningful contribution could be made. In order to choose the area of focus, we wanted to have broad conversations about health inequalities with women from a range of backgrounds. This would help us identify areas of interest from people with lived experience and align those with the needs of the Plan and evidence gaps in Scotland. We were open to the possibility of focusing on a specific area of women's health (e.g. menstruation) or on a sub-population of women (e.g. ethnic minority women), or both.

Focus groups are an established way of conducting this scoping and identification work.³² Therefore, the first phase of the project comprised a series of focus groups as a preliminary scoping phase to support a more in-depth qualitative project on a particular health area and/or a subset of women. The findings from the focus groups aided the development of the research questions and focus of the more substantive second phase of the project. Although the work was intended to be a preliminary scoping exercise, the findings from the focus groups spoke to women's health inequalities and discrimination in a salient and compelling way. Therefore, we thematically analysed the focus group findings and presented them in **Part 2**. These findings should be interpreted with caution due to the small sample size and taken as a pre-cursor to the more substantive and in-depth work on a specific group of women in **Part 3**.

Semi-structured one-to-one interviews allow detailed exploration of complex and difficult topics in greater depth with individuals and are preferable for this kind of research on discrimination and health inequalities.³³ Therefore, individual interviews were chosen to build upon the findings from the focus groups and explore in greater detail an area of women's health inequalities and discrimination. The rationale for the chosen focus for the second phase is provided in **Part 3**.

Overall, this two-phased approach meant that the research focus for the individual interviews was developed with a recent and broad understanding of some experiences of discrimination women in Scotland face. In turn, the preliminary focus groups allowed a level of confidence that we were investigating a relevant area of women's health inequalities through the interview phase. The focus group findings were triangulated with further evidence scoping and conversations with policy

colleagues and the Research Advisory Group to help researchers develop a rigorous and robust qualitative interview project.

Intersectionality

The two-phased project adopted an intersectional approach to research design and analysis. Intersectionality is a term coined by critical legal race scholar Kimberlé Crenshaw (1989). Intersectionality refers to how different aspects of a person's identity overlap to form their unique experience. It is used as an analytical framework in this report. Intersectionality is used to describe how the multiple identities and social positions people hold interact with each other, and how those interactions shape our lives and experiences of inequality. Intersectionality challenges the idea that the experiences of everyone belonging to a group, such as 'women', are the same. The goal is to understand the difference 'within and between' groups of women.

Intersectionality is beginning to be used within policymaking in Scotland. A report by the Poverty and Inequality Commission³⁴ highlighted work since 2020 that is shining a light on intersectional inequalities and how they shape the lives of women and girls in Scotland. The report concluded that more work could be done to extend the intersectional approach beyond the Scottish Government Equalities Unit. Further, The First Minister's National Advisory Council for Women and Girls (NACWG) made a recommendation of "adequate resourcing to enable the collection and analysis of intersectional data to allow policy-makers and influencers to have access to more robust information leading to more effective policy-making", [which was accepted by the Scottish Government in December 2021](#). There has also been an analyst guide to using intersectionality produced by the Scottish Government, which guided this research project³⁵. Crucially, intersectionality is also one of the underlying principles of the Women's Health Plan, which this research was developed to support.

This project used an intersectional approach in three key ways:

- (1) **Recruitment** - We recruited participants from a diverse range of backgrounds. As all participants were women or eligible to use women's services, recruiting based on other characteristics guaranteed at least one intersection of interest.
- (2) **Data collection** - We developed questions for the focus groups that were broad and designed to allow participants to talk about their lives, without undue focus on one element of their identity.
- (3) **Data analysis** - We analysed the data alongside demographic information about the participants and interpreted what they said through an intersectional lens. We regularly discussed our interpretations to uncover the different intersecting identities that were important for discrimination and health. We continually re-read the transcripts to see if our interpretations should be revised and if there were other intersections of interest we may have missed.

Part 2 – Scoping focus groups with women from different backgrounds

Research aims and methods

Aims

The overall aim of the first phase of the project was to develop an initial understanding of how women in Scotland experience discrimination and how it affects their health. The research objectives are:

- To identify areas of women's health inequalities and discrimination for further in-depth investigation
- To explore the use of intersectionality as an analytical framework to help understand how multiple different aspects of women's identities (e.g. age, disability, race/ethnicity, social class) result in particular experiences of discrimination related to health

Research design and recruitment

The research objectives were developed through literature scoping and consultation with stakeholders, colleagues and policy colleagues. The first phase of the research consisted of four online focus groups that took place in August 2022.

Each focus group discussion lasted approximately 90 minutes. Focus groups were advertised to different participant groups to establish diversity in responses and engagement with marginalised groups. It also was a way of incorporating intersectionality in our recruitment strategy. These groups were decided upon through conversations with the Research Advisory Group and the ALLIANCE. The groups and number of participants were:

Group 1: Women over 25 years (n=3)

Group 2: Women aged 16-25 years (n=4)

Group 3: Women from an ethnic minority background (n=3)

Group 4: Women with a disability or a long-term health condition (n=4)

Participants were given the choice of which focus group they wanted to attend, based on how they identified, and were informed at recruitment that they should only attend one focus group. Five participants per focus group were registered, but none of the groups had full attendance on the day. The overall sample was 14 participants.

Recruitment was managed through the ALLIANCE. The ALLIANCE has the networks and connections within the community required to recruit a diverse

sample. It also has experience in communicating with stakeholders about women's health. The ALLIANCE advertised the participation opportunity on their website and telephoned and emailed stakeholders to aid recruitment.

A Research Advisory Group was set up to guide the study through providing comments on written materials and giving advice on recruitment, data collection and analysis.

Data collection

In line with ethical procedures, each participant was given detailed information about the study, a privacy notice and consent form prior to the focus group. Upon registering for the focus group, the participants were also sent a link to an online demographic information survey. This information was collected to monitor recruitment and aid interpretation. The survey included questions from the Scottish Government Collecting Equality Data Guidance³⁶ and the Census³⁷.

A semi-structured topic guide was developed to structure the focus groups. This topic guide was informed by: (1) the underpinning priorities of the Women's Health Plan, (2) discussions with stakeholders and members of a lived experience group, (3) literature on discrimination and women's health and intersectionality frameworks. A pilot focus group was organised in July 2022 with women in England to test the topic guide with individuals not eligible for the study (as not residing in Scotland), but who could speak to the subject matter. Reflections from the pilot were discussed with members of the Research Advisory Group and senior research colleagues. Alterations were made to the topic guide to ensure all participants would understand how the study was interpreting terms such as 'health' and 'discrimination' and to include interactive 'ice-breaker' exercises using Mentimeter software.³⁸

The focus groups began by researchers explaining the research topic again and reading out the consent form. Participants were reminded they were free to withdraw at any time. Researchers then began the audio recording and worked through the topic guide. The topic guide is attached in the appendix.

All participants were sent signposting information provided by the ALLIANCE and a thank you e-voucher, via e-mail immediately after the discussion.

Data analysis

Given the amount of salient and relevant data that came out of the focus groups, we decided to conduct thematic analysis to deliver a set of initial findings from the work, in addition to using them to steer the interview phase.

Audio recordings were transcribed by an external company. Transcripts were then analysed thematically using NVivo 1.6.1 software³⁹ by the two researchers on this project. A three-phase analysis approach was used: (1) open coding, (2) axial coding and (3) theme generation. Open coding involved researchers reading through the transcripts and assigning one-word or short phrase codes to sections of text. Researchers then revisited the transcripts and codes with similar meanings were grouped together and relationships identified between them (axial coding).

The researchers met regularly to compare codes and develop a set of themes. This iterative process resulted in a set of four themes, which are outlined here with quotes from the data to support the findings. Participants are referred to by their participant number and which focus group they attended: '[Participant 14, over 25s group], [Participant 10, ethnic minority group]' and so on.

Limitations

These findings are not generalisable to the wider population of women in Scotland and interpretation of the findings should be done with this in mind. The sample size was also smaller than we expected due to fewer participants attending each focus group than were registered. Input from more women would have strengthened our conclusions. Nevertheless, there was engaging discussion in all the groups, with a wealth of examples related to discrimination and health. The themes reported here provide important insight into how women in Scotland from different backgrounds and population groups experience discrimination in relation to their health.

The focus groups were done online to allow participants across Scotland to attend, but this may have been a barrier to some individuals' participation.

A further limitation related to the intersectional approach, which we were testing as an analytic framework in preparation for the interview phase. Intersectionality aims to treat all identity characteristics as relevant and avoids focus on one experience of discrimination over others. As this project contributes to the Women's Health Plan, unavoidably gender and sex were regularly the focus of participants' experiences.

Findings

This section reports the findings from the focus groups, organised by the themes the researchers developed as part of the data analysis process.

Participant characteristics

There were 14 individuals across the four focus groups. Most identified as women (n=12). One participant identified as non-binary. One participant did not fully complete the demographics survey. They provided specific information regarding their ethnicity and age during the focus group, but the other characteristics remain unknown for this participant. Participants were aged between 17 and 68 years-old (mean age: 42). Just over half the sample had a long-term physical or mental health condition (n=8). The sample was mostly White Scottish/British (n=10) with other racial and ethnic groups including African, Asian and Gypsy Traveller (n=4). Participants represented each quintile on the Scottish Index of Multiple Deprivation⁴⁰, with half of the sample residing in the two most deprived quintiles (n=7).

Theme 1: "Excuses" for not investigating

Participants in all focus groups described how they were "dismissed" [Participant 7, 16-25 group] by healthcare professionals. Women in this study feel as though they are not listened to about their physical and mental health concerns. It goes one

step further than being ignored and there is a clear intersectional element to women being dismissed. A continual theme was that participants claimed that parts of their identity are actively sought out and then used against them as reasons not to pursue avenues of healthcare. This list of “excuses” [Participant 13, over 25 group] included: age (younger and older), trans/non-binary identity, weight, relationship status and mental health status. For example, one participant described her experience trying to get treatment for a mental health condition, but instead her weight became the focus of the appointment:

I went [to the GP] because I was depressed, and I came out with an appointment with a dietician, to weigh me and look at what I was eating... And then, years later, I went back and...I ended up with a diagnosis of borderline personality disorder. It was almost too late [Participant 7, 16-25 group].

In this example, the participant experienced delays in receiving support for their mental health due to the immediate focus on another element that they had not gone to the doctor about in the first place. Some participants highlighted this particular example as a dilemma. They agreed that there was probably reason to suggest losing weight, but the undue focus on this over the original medical complaint often meant their condition got worse. The women in the groups felt that instead of listening to women about what they say about their health, healthcare professionals sometimes pursue avenues about what they think (based on appearance and demographic characteristics) would benefit the patient’s health. These experiences highlight cultural and interpersonal discrimination. Participants felt that healthcare professionals make assumptions about the patient based on stereotypes and norms embedded within wider belief systems. This type of discrimination was not just a pattern in relation to weight. For example, one participant stated that their identity as a non-binary person is a continual barrier to accessing healthcare for a range of health conditions. They found that when trying to access services, they were recommended therapy because of their “identity” [Participant 8, 16-25 group] which was unrelated to what they were seeking medical advice for.

Similar to the experience of Participant 8, most participants saw little connection between the treatment or support they were recommended and what they had told the healthcare professional about their health. Another example of this came from Participant 2, who experienced a physical health issue but found that when the healthcare professional found out about other aspects of her identity (being a single mum), that was instantly used as a reason for her physical pain:

I actually went to a [healthcare professional]... and got a speech about being a single mum. They said: “Are you sure it’s not [stress-related]?” I had broken my hand [Participant 2, long-term condition/disability group].

Participants expressed that while they were experiencing discrimination based on a particular identity characteristic, being a woman was usually the starting point. They outlined this through descriptions of times when men might have experienced the same level of discrimination (e.g. in relation to weight status and age), but did not.

They rationalised that women and girls were subjected to this more than men as they are socialised and stereotyped to be mild mannered, to “not make a fuss” [Participant 6, 16-25 group] and to “get on with it” [Participant 14, over 25 group].

Participants also spoke of being “hormonal” [Participant 8, 16-25 group and Participant 13, over 25 group], as an explanation healthcare professionals give for health complaints. Puberty, pregnancy and menopause were highlighted by women of all ages as reasons medical professionals gave for their experiences of physical or mental health symptoms. For example, one woman from the over-25 group stated: “You reach a certain age, then they say, “How old are you?” ...“42.” Then they say, “Well, it could be the menopause” [Participant 13, over 25 group]. This quote may be surprising given that women in a Lived Experience Group supporting the Women’s Health Plan, for example, feel they are not listened to about their menopause symptoms (see page 24 of the [Women’s Health Plan](#)). However, participants in this present study highlight that menopause is provided as a reason for a range of health symptoms (solely based on the age of the patient) with little support information or hope of further investigation. Participants suggested that these types of diagnoses are ways of dismissing their concerns: “menopause gives them a bit of an excuse not to do anything, I think, to a larger extent. As if to say, “Oh well, love, suck it up”” [Participant 13, over 25 group].

This discrimination takes place at both ends of the age scale, as a participant from the 16-25 group described instances where they were treated as lacking life experience or told their symptoms were related to being a “teenage girl” [Participant 6, 16-25 group]. The age discrimination described here conveys clearly the intersectional experience that is strongly linked to gender. While it is the person’s age that is being used as the point of discrimination, it is the female reproductive milestones (not experienced by men) that allows age to be used as a way of discriminating women and denying them health support.

Participants across the focus groups backed up the claim that being a woman meant their health is not “taken seriously” [Participant 7, 16-25 group]. They used specific examples whereby male family members or friends, with similar or the same symptoms, received different responses from medical professionals and appeared to be referred through the system much quicker. For example, Participant 7 described how her and her male family member had different experiences:

My [male family member] has felt guilty about the care he has got, because he’s male. [I am] at home, with the same, or nearly the same sort of things, with no help...He got support one month after referral. I’ve been waiting years, and I have my assessment tomorrow [Participant 7, 16-25 group].

Adding further understanding of the experience of health services as a woman, some participants described the strategy of “having a man in the room” [Participant 4, disability/chronic condition group] during primary care appointments. One participant highlighted how having a man present meant they received better care and were less likely to be dismissed. As Participant 2 was a single parent, she

would sometimes bring her male son to appointments and found that the consultant would direct questions and listen to her child over her:

I have been in medical appointments and they would speak to my child instead of me. I think there is something wrong if you're believing a child who is male over an adult who is female
[Participant 2, disability/chronic condition group].

This theme details how women in this sample feel dismissed and ignored about their physical and mental health. Participants highlighted a range of identity characteristics that were used as “excuses” to not investigate their health complaints. While these experiences were intersectional and based on a number of different elements of someone’s identity, for many participants, the dismissal was usually underpinned by being a woman.

Theme 2: Health as a concept

Women responded to our question: ‘what comes to mind when you think of the words ‘health’ and ‘being healthy?’ with a range of views related to discrimination. These views in response to this first question mostly relate to ableism. Participants in the disability and chronic condition focus group spoke of ways that they would not be thought of as ‘healthy’, which they see as unfair. Due to her condition, Participant 2 is rarely able to go for a walk for longer than 20 minutes. She said she is treated as “lazy” and “unhealthy” because she is not able to exercise like an able-bodied person:

I think the definition by able-bodied people of the concept of ‘healthy’ is very discriminatory [Participant 2, disability/chronic condition group].

Participant 2, and others in this focus group, talked about how the rigid definition of what it means to be healthy affects how they experience treatment and support. Some women said they were told to pursue physical therapy or exercise programmes to help with their condition. What they experienced when they tried this was a misunderstanding about why they were there and what would help their condition. For example, Participant 3 [disability/chronic condition group] said:

But they put me with a trainer, he has no clue how to deal with a 68 year old with [my conditions], and he does his best, you know. And I couldn't get on the exercise bike and he is shocked by this. He tried get me going up and down stairs, I walk with crutches and that is not going to work either.

Thinking specifically about the intersection of gender and disability, some participants experience real barriers to accessing healthcare. These experiences are forms of structural discrimination embedded within the health system. Participant 14 [over 25 group], who uses a wheelchair and suffers from a number of health problems, described how structural discrimination affects her access to women’s health services. She spoke of being unable to get onto the table for a smear test, with “lack of thought” about her access to such appointments as there

was no hoist to assist her. She also talked about her experience going for a mammogram:

I can't fit in the machine. So, how is that not discriminating against me? Even the last time I went, they expected me to go in a van. I went, "I can't get in a van."

This participant no longer attends women's health appointments because of the ableism she experienced. Discrimination therefore results not only in psychological stress (which participants did highlight), but in reduced access to screenings and appointments that help women maintain a good level of health. These examples of gendered ableism highlight women's experiences are often intersectional.

Participants talked about the concept of 'health' and 'being healthy' as something based on men's health and male bodies. Women spoke about this in relation to gendered expectations about pain:

Women work through difficulty or pain because the system sort of assumes you are a man and your problems aren't there [Participant 13, over 25 group].

There was also discussion across the focus groups about the broader gender discrimination embedded within the health system and health research. Women have a strong awareness of the lack of funding and research for the health conditions that they have. Some of these conditions are disproportionately suffered by more women and therefore have little resource put behind them: *As other people have said, it's a female thing because, as I mentioned, [my condition] mostly affects women* [Participant 3, disability/chronic condition group]. Alternatively, health conditions that are experienced mostly by men, but the symptoms for women are different, mean that women are often left misunderstood and misdiagnosed. Specific examples where this happened were provided related to autism and ADHD.

Participants want healthcare to be more "holistic" and "person-centred". They think that through doing this, the healthcare system would be less discriminatory and result in a better standard of care for everyone:

And I just don't think the joined-up thinking is there or the holistic approach to all the different complex problems that people have [Participant 3, disability/chronic condition group]

It's hard as well because services are supposed to be person-centred [Participant 7, 16-25 group].

Participants acknowledged the huge economic strain on the health service in Scotland. A few women highlighted that, in their experience, some health professionals are trying to adopt a more holistic approach, but they are constrained by financial and capacity limitations in the health system.

The final way that participants talk about the concept of health relates to the financial resources it takes to be 'healthy'. To access appropriate and timely treatment and prevention such as a good diet and exercise, the women talked about how there was a need to have a certain level of financial privilege:

Healthy eating is expensive. People have to choose to get cheaper food and frozen food, because fresh food is really expensive
[Participant 10, race/ethnic minority group].

The data in this theme shows that participants think the very idea of being 'healthy' and the concept of health is in itself discriminatory. What is presented here is mostly institutional/structural examples of discrimination that largely reduce access to current and future opportunities to be healthy for disabled women.

Theme 3: Racial discrimination

Women in the focus groups not only spoke of discrimination within the health system (e.g. interactions with doctors, experiences within hospital and GP surgeries and with NHS systems). They also highlighted broader societal discrimination they face, which is also important to their health. This is something particularly prominent within the experiences of women from an ethnic minority background in the focus groups. Although this focus group did give some gendered examples, the participants' ethnic background was what they continually came back to when discussing discrimination. Women in this focus group spoke of "daily" and "expected" [Participant 11, race/ethnic minority group] acts of racial discrimination that impact on their health. Participants spoke of these non-healthcare specific acts of interpersonal discrimination as occurring in several different spaces such as the workplace, education, public spaces like banks, shops and on the street.

A central theme used to explain the impact of discrimination outside of the healthcare setting was the harmful preconceptions and racialised stereotypes, perpetuated by "media representation" that those from an ethnic minority background are subject to. This reflects the 'cultural discrimination' level described earlier in this report. Participants disclosed that they would sometimes try to "hide" [Participant 11, race/ethnic minority group] their racial or ethnic identity in order to not be subjected to racial discrimination. This was an exhausting practice. Other participants also have daily practices to try and deal with racism:

I will always put my bags down at the front of shops so that the staff can see I'm not stealing stuff. I will always have someone [a staff member] following me [Participant 10, race/ethnic minority group].

People sometimes assume I don't speak English because of how I look. I sometimes just ignore them because you can't always win every battle [Participant 9 race/ethnic minority group].

The women in the focus group from an ethnic minority background described how they expect racism every day. Their daily strategies to try and avoid or prepare themselves for racism have an effect on their mental health. Two participants from this focus group spoke of having to leave jobs because of the stress caused by

racism from their colleagues. One participant felt they were “treated unfairly” [Participant 9 race/ethnic minority group] and had to go off sick. Another participant said she “felt so bad” about her workplace she had to leave as the racism she faced “impacted” [Participant 11, race/ethnic minority group] her to such an extent.

Racism has notable effects on participants’ lives. One participant expressed that the television programme “My Big Fat Gypsy Wedding” airing in the UK caused women in the community to restrict their everyday movements: “Sometimes they don’t even want to take their children to school the next day. So of course it is impacting on people’s health, of course it is” [Participant 11, race/ethnic minority group].

The vast majority of examples given of racial discrimination are outside of healthcare settings. However, Participant 10 provided one experience whereby racism had directly limited her access to healthcare:

I was at the GP [surgery] and the receptionist said “Are you sure if you are eligible for that test?” I said, “Yes.” And he said, “I need to phone somebody,” and it took about an hour to go through checking my IDs, checking they were real. It was unnecessary.

This quote, when viewed alongside evidence in Theme 1, reveals how women from ethnic minority backgrounds may experience barriers to healthcare and intersectional inequalities at stages which are not described by the white women in the groups. In other words, the challenges of entering the health system for women from ethnic minority backgrounds are distinct forms of discrimination that come before entering the doctor’s office. Participant 10 described this experience as expected, based on the “assumption of criminality” attached to being Black.

Notably, these participants were asked the same questions as the other focus groups about discrimination and health. However, instead of sharing experiences that were explicitly related to health, women in this focus group mostly spoke of their daily experiences of racism. There were no examples of being dismissed by healthcare professionals or delays in treatment or referrals, compared to the multitude in the other (mostly White) focus groups. It is this wider societal racism, over and above sexism, that is seen as a priority for health for these women. Data in this theme show that, because of the pervasiveness of daily racism experienced by participants, they rarely separate their experiences into ‘healthcare settings’ and ‘non-healthcare settings’.

There was only one given example of how sexism and racism intersect with a healthcare professional. This example showed a specific discriminatory experience for Black women. It also highlights how there could be real health consequences for the patient:

Someone in my family was pregnant and she went into labour... the paramedics said, “I’m sure you just took the pain where you are from.” He also wasn’t handling her with care. It comes back to how black women are masculinised [Participant 10, race/ethnic minority group].

This excerpt highlights the potential for further racialised gender discrimination from healthcare professionals, when people eventually get access. There were potentially so few of these examples because the race/ethnic minority group had fewer interactions with healthcare professionals in general. This theme informed the interview phase of the research as we sampled so that we would hear the views of ethnic minority women who either had a health condition or more experience of the healthcare system.

Theme 4: Self-advocacy

Many participants spoke of having to constantly “fight” [Participant 14, over 25 group] for the opportunity to be healthy. Women used examples of interpersonal and structural forms of discrimination and described how self-advocacy was one of the few things they do to tackle it. Methods of self-advocacy develop over time through experiences and advice from friends and family. Advocating for oneself includes things like extensively researching symptoms and conditions, being vocal and assertive with medical professionals, seeking out support through private or alternative avenues, learning what to say to health professionals and learning how to complete forms in a way that would mean getting seen by the right person within good time. For example:

I have printed off scientific articles to take to the doctor, to do their work for them so I can get a referral [Participant 8, 16-25 group].

Participants acknowledged that some people are not as able or privileged to advocate for themselves as others. Participants described how they need to know the system and to “know what to ask” [Participant 14, over 25 group], which is a personal resource only available to some people, further amplifying health inequalities. Having the confidence and knowledge to advocate for oneself is likely to be impacted by gender, race/ethnicity, disability, social class, age and sexual orientation. Participants gave many intersecting examples of this, again expressed within the context of being a woman and being expected to not make a fuss, as mentioned previously in this report.

Women in this study also spoke of self-advocacy in relation to expectations of how women are supposed to behave. Even once you know what to ask or how to fill out forms correctly, some participants spoke of how the manner in which they conduct themselves has an impact on how successful their self-advocacy is:

If you're not the person who makes enough noise, you aren't going to be acknowledged and you'll be overlooked [Participant 5, 16-25 group].

So I do think there is a thing about... I am articulate, I am assertive, I am not going to take too much nonsense [Participant 3, disability/chronic condition group].

Expressing levels of assertiveness is not always simple or down to who shouts the loudest. Some participants noted that for some women, being assertive results in further gender stereotyping:

When you advocate for yourself and you kind of get dismissed, then some people then won't continue. But people like myself will get words like 'difficult' in their medical notes [Participant 7, 16-25 group].

Participant 7 described how she has to accept the label of “difficult” or “not nice” as “it was just easier”. She felt it was the only way she would get any health support or treatment, which in itself has an impact on her mental health. Another participant in this group, who is from an ethnic minority background, also outlined having to make decisions about how to behave and how that might lead to different results:

So what do you then do? Do you then choose to be difficult, because sometimes it's the only way to get things done, or do you try and hold back a wee bit more, to see how things pan out? I struggle with that personally, because you don't get the chance to have that balance, because sometimes it's because you're a woman [Participant 5, 16-25 group].

Finally, in the focus groups we also touched more on the financial burden of being healthy, mentioned in Theme 2. Finances also limit participants' ability to advocate for their health. Many participants described long, frustrating and complicated journeys in which they had to advocate for their own health to receive referrals, diagnoses and treatments. Having gone through that experience, they then were usually faced with the reality that the NHS did not offer what they needed. This was evidenced through mentions of extremely long waiting lists or the inability to afford treatment and prevention programmes. For instance, Participant 3 [disability/chronic condition group], after several years of seeking treatment for a chronic physical condition, was told that they have “all the tools”, but what they needed was Cognitive Behavioural Therapy to support them. Participant 3 was told that there was a “fat chance” of receiving that support from the NHS. The private therapists she looked up were “£100 an hour” and so financially, she was not able to get the recommended health support.

Other participants described similar events in which they exercised self-advocacy and that had enabled them to cope with the sexism and other forms of discrimination they experience in relation to their health. However, the result of self-advocacy is not better health outcomes for women, but a path to treatment or support that they are usually unable to take due to structural, predominantly financial, barriers. Participants talked about the “exhaustion” [Participant 7, 16-25 group] and frustration they experience having gone through many years of trying to get referrals and diagnoses, only to then not be able to afford the things that could help them improve their health.

Conclusions

This preliminary phase of research highlighted a number of ways in which women in Scotland may be discriminated against and how those experiences impact on their health. These experiences were almost always intersectional, but largely underpinned by being a woman. The exception to this was for women from ethnic minority backgrounds, who talked about prioritizing navigating racism. The young

people's group described many intersectional experiences of how they felt discriminated against because of their age, gender and other identity characteristics. The salience of the findings from this specific focus group, coupled with the comparative lack of evidence related to young women's experiences, led us to build on the findings from this phase using in-depth one-to-one interviews with young women.

Part 3 – In-depth interviews with women aged 16-25

This section of the report presents the justification and process leading to focusing on young women in this research phase. It then describes the methods taken and the findings from the study.

Why focus on young women?

Adolescence and young adulthood are critical times in the life course for investigating health and social inequalities. Experiences starting at this age can impact on an individual for the rest of their lives, resulting in health outcomes later in life.⁴¹ There is also good reason to focus on young people within public health research where we are taking a prevention perspective. There is broad recognition and support for prevention action to address health outcomes and inequalities within Scotland, as outlined in a discussion paper from Public Health Scotland.⁴² One way of doing that is focusing on individuals earlier in the life course. This prevention approach has been used specifically in relation to women's health in a report by the Royal College of Obstetricians and Gynecologists⁴³, based on the life course approach and the understanding that women experience multiple challenges starting in early life.

The gap in women's health inequalities related to young women prompted the decision to have one of the preliminary focus groups (**Part 2**) aimed at young women aged 16-25 years. Some participants in the ethnic minority focus group and the chronic illness focus group were also within this age range. The experiences and perspectives of the young women in the focus group sample were identified as particularly relevant to the intersectional investigation of discrimination and health. For instance, much of the self-advocacy work described in Theme 4 in of the focus group findings was done by young people, who highlighted their intersectional position of their age and gender as a specific barrier to healthcare access. Further, this group talked about mental health issues where the other groups did not. As mental health is a key priority for Scotland, with a new Mental Health and Wellbeing Strategy being launched in 2023,⁴⁴ and there are gendered inequalities in mental health, focusing on young women provided a potential opportunity to understand discrimination in relation to both physical and mental health in greater detail. Finally, the young people included in the focus groups displayed examples of discrimination that were distinctly intersectional with other dimensions of inequality such as race/ethnicity, disability/chronic illness and gender identity. Therefore, narrowing the age range to young people would still allow the use of an intersectional framework, which had been tested in the focus groups and was applied to recruitment, data collection and analysis of the interview phase.

Therefore, we decided to focus on young women given: (1) the importance of the age group for health inequalities, (2) being an under-researched population within women's health and inequalities (3) the findings from the focus groups highlighting some areas specifically relevant to young women that warranted in-depth

exploration, and (5) the ability to maintain an intersectional framework within the age group.

Current evidence on discrimination and young women

In addition to the evidence review presented in **Part 1**, we conducted a more focused literature search for evidence related to adolescent and young adult women as well as any studies that use intersectionality within young people.

Data in UK and Scotland shows mental wellbeing has decreased over time among children and young adults.⁴⁵ The percentage of children with emotional and behavioural problems has increased, an overall trend driven by a change among girls.⁴⁶ Survey data from 2022 by the Department of Health and Social Care finds that while the rates of a probable mental disorder in England are similar in boys and girls aged 11 to 16 years old, 17 to 24 year old women were almost three times more likely to experience an emotional disorder than young men of the same age (31.2%/13.3%) – a 10% increase from the rate in girls aged 11–16.⁴⁷ This follows research from other countries that finds girls and adolescent young women are likely to display greater prevalence of mental health issues such as anxiety and depression.^{48,49,50}

The Office for National Statistics (ONS) data has shown that since 2012 suicides among females aged 10 to 24 have increased significantly.⁵¹ Young women in particular have been recently identified as a high-risk group, with over a quarter (26%) experiencing a common mental disorder—such as anxiety or depression—compared to 9.1% of young men.

This concerning trend has become exacerbated by the Covid-19 pandemic. Recent data shows young adults, women, people with physical and/or mental health conditions, and people in a lower socio-economic group are more likely to report experiencing poor mental health.⁵² While UK evidence from the pandemic suggests that most children and young people had broadly coped well, girls and young women were more likely to report difficulties with mental health and wellbeing.⁵² In October 2020, 27.2% of young women in Scotland aged 17–22 years in comparison with 13.3% of young men identified as having a probable mental disorder.⁵³ Recent data from the Health and Wellbeing Census (2021-2021) also shows that overall, girls in Scotland report worse physical and mental health. Girls have less positive perceptions than boys across a range of mental health and wellbeing measures.⁵⁴

Discrimination has the potential to have a significant impact on young people, particularly those at positions of multiple disadvantage. Emerging adults who are in higher education may have more access to health care compared to those who are not, although much research on health during this developmental stage focuses on university student samples.⁵⁵

Further, there is a lack of research on adolescent girls' experiences of discrimination and the effects on their health. Researchers have overwhelmingly focused on discrimination among adults. This is surprising given that adolescence ushers in cognitive and psychological advancements that render discrimination

more discernable and more personally relevant.⁵⁶ Children begin to develop an awareness of discrimination by age five.⁵⁷ Early life experiences with discrimination may affect one's health in adulthood, and are associated with poorer mental and physical health.⁵⁸ Given that adolescence is a sensitive period in which mental health difficulties are at their peak for many young women in Scotland⁵⁹, it seems reasonable to expect that more regular experiences with gender discrimination are likely to precipitate emotional and psychological difficulties for girls and young women.

Research finds that discrimination based on race/ethnicity, sexual minority status, and gender is associated with higher rates of drinking, drug use and risky sexual behaviour during adolescence.⁶⁰ However, not all young people who experience discrimination report higher levels of health risk behaviours. While reducing discrimination is important for addressing the consequences of discrimination for health outcomes, better understanding the factors that exacerbate or attenuate the link between discrimination and health risk behaviours is necessary for developing more effective interventions for vulnerable young people currently experiencing discrimination.⁶⁰ Moreover, a more comprehensive assessment of young people's experiences with discrimination may improve our understanding of the discrimination-health relationship in adulthood.

Health condition-specific literature

It is important to note that in both fieldwork phases of this project, researchers had a broad topic guide that asked women about experiences of discrimination both within and outside the health system. Many of the examples and two of the themes (Theme II: Mental Health and Theme III: Contraception) focus on specific areas of health. These areas were not the focus of the topic guide, but were what participants brought up. They serve as examples of ways in which women experienced discrimination and how that impacted on their physical and mental health. For this reason, we did not do an extensive preceding literature review on areas such as mental health and contraception. Throughout the report there are some reflections on previous literature and evidence on these areas and how it relates to what we found.

Methods

Aims

The aim of the second phase of this research was to explore young women's experiences and perspectives of discrimination, with two underlying objectives:

- To understand young women's experiences of discrimination and the ways (and extent to which) those experiences impact on their physical and/or mental health
- To adopt an intersectional approach to understand the complexity of multiple and interconnected forms of discrimination

Research design and recruitment

The study design was a semi-structured qualitative interview project. The ALLIANCE's and the Scottish Government's networks and social media was used to advertise the project. Interested people emailed the researchers and were sent the consent form, participant and privacy information and a demographics survey. The survey meant researchers could assess eligibility and manage recruitment to ensure there was a good spread of experiences, of women from different backgrounds. An interview was arranged via email with those eligible.

Data collection

A topic guide was developed following the focus group phase and discussion with the research advisory group. The topic guide was adapted to be more suitable to one-to-one interaction and remain semi-structured to allow for more in-depth probing about certain topic areas. The following were used to create the topic guide: the core priorities of the Women's Health Plan; discussions with a lived experience group and other interested stakeholders; literature and evidence on young people, intersectionality, discrimination, and women's health. The topic guide was reviewed by the same Research Advisory Group as for Phase 1. The topic guide was tested through an interview with a young woman in England.

Participants were offered a telephone, online video call or face-to-face interview if location and availability allowed. Each interview started with a reminder of the consent form points and obtaining verbal consent. The researcher then worked through the topic guide and used additional questions based on what the participant said. Each interview lasted approximately 45 minutes. Following the interview, everyone was emailed a thank you voucher and a document containing signposting information.

Data analysis

The data analysis process was very similar to the focus group phase. Audio recordings were transcribed by an external company. Transcripts were then analysed thematically using NVivo 1.6.1 software⁶¹ by the two researchers on this project. A three-stage analysis approach was used: (1) open coding, (2) axial

coding and (3) theme generation. Open coding involved researchers reading through the transcripts and assigning one-word or short phrase codes to sections of text. Researchers then revisited the transcripts and codes with similar meanings were grouped together and relationships identified between them (axial coding). The researchers met regularly to compare codes and develop a set of themes. This iterative process resulted in a set of four themes, which are outlined here with quotes from the data to support the findings. Participants are referred to by their participant number: '[Participant 14]', '[Participant 10]' and so on.

Limitations

The findings from this project are limited in a similar way to Phase 1. Even though we spoke to more women in this phase, qualitative research is not generalisable to the wider population of Scotland and should be interpreted with this in mind.

The title of the project 'Discrimination and Health' likely attracted participants who had an interest in the topic or who had significant experience in the topic area. It is possible that this is the reason why we spoke to several young people with chronic physical or mental health conditions.

There were some groups of women within the age bracket we did not speak to. For instance, we did not interview mothers under 25, young women from certain ethnic communities such as the gypsy traveller community and we only spoke to one gender non-conforming person. The sample had considerable ethnic diversity as well as women from urban/rural areas and a range of socioeconomic advantage, so the findings contain experiences and perspectives from a number of, often marginalised, positions. Again, as the findings are not representative and generalisable of the population of women in Scotland, these qualitative findings are intended to explore ways in which discrimination may impact on health using examples from a sample of women's lived experience.

The same limitation related to the intersectionality approach described in the focus groups phase applies here.

Findings

This section reports the findings from the second phase of the project, organised thematically. Each section outlines the researchers' interpretation of the themes, using excerpts of data to exemplify and evidence the finding. Each theme includes a brief reflection on how the findings relate to evidence and literature in the field that the findings either support or challenge.

Participant characteristics

The sample comprised 28 young women aged 16-25 residing in Scotland. The sample captured a range of diverse and intersectional identities. Most identified as women (n=27). One participant was currently questioning their gender identity.

The mean age of the sample was 20 years old, with half the sample aged 21-25 (n=14) and the other half aged 16-20 (n=14) at the time of interview. Just over half the sample had a long-term physical or mental health condition (n=15). Almost half

the sample were White (n=15), with 13 participants belonging to an ethnic minority background. Ethnic groups represented in this sub-sample included Indian, Pakistani, Arab, African, Chinese, and Mixed Race. Just under half of the sample did not practice a religion (n=13) with the remainder identifying as either Muslim, Church of Scotland, Catholic, Sikh and other Christian.

Participants represented each quintile on the Scottish Index of Multiple Deprivation (SIMD)⁶², with 12 participants residing in the two most deprived quintiles. Most of the sample were working as an employee or self-employed (n=17), and eight participants were studying. Just over half of the sample identified as Straight/Heterosexual and nine identified as bisexual.

Theme 1 – Ageist Sexism

The sample were all aged between 16 and 25 years and considered adolescents or young adults. Several participants claimed that their young age meant that assumptions were made by healthcare professionals that they were “*fit and well*” [Participant 28] and would not have “*anything wrong with them*” [Participant 12]. While it is true that adolescence and young adulthood for the majority is the healthiest time of life, participants in this sample spoke of how these assumptions made it a challenge to be “*taken seriously*” [Participant 23, Participant 12] about a range of physical and mental health complaints:

I think that some people make assumptions when they see you, that your health is good. It often felt very much like, “Oh, that is going to be okay. That’ll be fine.” Well actually, now I have a literal metal ankle [Participant 1]

I don’t know whether that’s because I’m a young girl and they have this assumption that all young children, or people in high school are really fit and healthy, and they have no problems whatsoever, and it’s only if you’re older that you have these problems [Participant 12]

I think young people’s health problems can sometimes be, maybe, viewed as lesser because we presume that younger people are healthier than older people, which isn’t necessarily the case [Participant 2].

The first time I went, she was like, “Oh, I don’t think it’s anything like that, like bad, but I’m prescribe you this.” Even though it was concerning to me, because I was now coughing up blood and things [Participant 12].

Some young people in this sample also discussed how there were further assumptions based on stereotypes of young people being undeserving and “delinquents” [Participant 26]:

And age is a big part of it. I think there is a thought among some that, “You’re young, you’re in your 20s, you don’t really know what you’re talking about.” [Participant 22]

She [healthcare professional] was suggesting it would be unfair to give it to me [partially sighted registration] when there could be someone else who needed it more who was older, when I was 18 [Participant 13]

I think, if you're young, it doesn't matter if you're a boy or girl, you'll still be discriminated against, just in different ways [Participant 16]

Several participants saw these assumptions as resulting in age discrimination within in healthcare. As visualized in the network above with the strong connection between age and gender, most participants described how this discrimination was intersectional with being a woman, producing a specific experience for young women. Sometimes, participants found it a challenge to talk about sexism or ageism as separate things, with many participants claiming their experience of discrimination was likely elements of both. This intersectional experience of being a young women led to similar feelings expressed in the focus groups of "*not being listened to*" [Participant 26] or "*taken seriously*" [Participant 14] and being "*patronised*" [Participant 5], both within healthcare settings (e.g. primary care) but also with school, college and work environments:

They are often thinking, "You're a stupid wee girl" or, "She doesn't know what she's talking about." And actually we do, at times women's health issues are just dismissed [Participant 22]

I think gender was a big one, as well, that worked closely in age because it wasn't just, "Oh, you're young and you're dumb." At the same time is was, "Oh, you're a woman and you're blonde so you may not understand." [Participant 24]

It was probably a combination of both because I was so young, I was only 14 and I kind of came in by myself and I'm like, "This is what I want to say." I feel like gender played a part in it as well, it's just like a balance between the two. [Participant 25]

That was one of those ones where I was just a bit like, "I wonder if I had been an 18-, 19-, 20-year-old, athletic boy who needed to go and play football or whatever, if someone would've cared more." [Participant 1]

I've never told anybody my age and if I do tell them, I say I'm over 25...Whether you've been to university, or whether you've worked in a law firm, or whether you've done whatever, nobody will take a female seriously at a young age. [Participant 10]

Further, participants spoke of assumptions that they had issues with "body image" [Participant 11] or "daddy issues" [Participant 21], while others said they were made to feel as though young women are "naïve" [Participant 27], "overdramatic" [Participant 16], "don't know about the world" [Participant 3], "stupid" [Participant 23], "hormonal" [Participant 17] and "irrational" [Participant 21]. Some of these assumptions could be seen as sexist stereotypes experienced by women of any

age, others were expressed by participants as amplified because of their young age.

While for some participants their young age was seen to exaggerate the sexism participants were feeling, for others, these experiences of discrimination were expected to carry on as they got older. Some participants found strategies to navigate this. Those in the sample over 20 years talked about “*learning how to communicate*” [Participant 1] and “*being prepared*” [Participant 23] when going into healthcare consultations.

Some participants who had more serious, complex or chronic conditions decided to “*go private*” [Participant 23] as they were not getting the support they wanted from the NHS:

We had to pay for a shower stool and medications, we also have to pay to get a prescription, consultancy, tests. I think I’m quite lucky we can afford that [Participant 16]

At that stage, I decided to go private because I had no other choice [Participant 21]

The participants who mentioned accessing private healthcare were residing in less disadvantaged areas of Scotland using the SIMD (quintiles 3 and above). This begins to highlight the impact of socioeconomic deprivation on these young women’s health, which will be covered later in Theme IV.

While some participants developed methods of self-advocacy as was mentioned in the focus groups (e.g. being prepared, persistent and assertive) or were able to afford private healthcare, many expressed that the sexism and ageism they had experienced had meant they were “*put off wanting to go to the doctor*” [Participant 2] or “*less likely to go [to the doctor]*” [Participant 25] when they need it:

I think in terms of maybe going and getting reassessed by someone else, it’s put me off, like, asking to do that, because of how, like- it’s just, like, “Oh you are, but I’m not going to.” It’s put me off going back to do that [Participant 13]

I was like, “There’s no point in even going to the doctors, because they clearly don’t care about the health and about this problem that I keep bringing to them. If I’ve been twice or three times already, then you should take it more seriously, but here you were just pushing it away like it’s just a minor thing.” [Participant 12]

Despite little evidence on discrimination among younger populations, as described earlier in this report, there is a [scoping review](#) (2021) that highlights some evidence relevant to this theme that is worth reflecting on. The review explored perceptions of young people and age discrimination within and outside healthcare settings. For instance, studies in the review found that respondents across various countries tended to share similar assumptions about age groups, including that adolescents are impulsive, rebellious and undisciplined.⁶³ Further, another study in the review pointed to younger people regularly feeling patronised by older adults. Finally,

within health and social care settings, one US study in the review found that children and adolescents were regularly viewed negatively by nurses when treating them as patients.

This theme reveals these young women's specific experiences of ageism and sexism within the health system. The intersection of age/gender has been explored through qualitative intersectional analysis previously, but this has often been done in relation to older women's experience. However, there are parallels to this study worth mentioning. For example, Riach and Jack (2021)⁶⁴ conducted a study in Australia of menopausal women's experience in the workplace and found that women experience a 'constellation of aged, gendered and ableist dynamics and normative parameters', which relates to the finding in this report that experiences of discrimination could rarely be separated.

This theme also echoes findings from The Status of Young Women in Scotland survey conducted by The Young Women's Movement research team. Based on a survey of 900 young women and people of marginalized genders aged 16-30 (2022-2023), they find that most of their respondents felt strongly that their negative experiences accessing healthcare were because they were young (55%) and because of their gender (62%).⁶⁵ Our results highlight how these experiences of ageism and sexism are difficult to separate, showing the importance of recognizing that identities and backgrounds such as age, social class and disability traverse gender lines and shape young women's unique lived experiences.

The forms of self-advocacy discussed in this theme (e.g. being prepared, persistent and assertive) have also been documented in previous research. As noted in the focus group findings, for some women, being assertive can at times result in further gender stereotyping. We further find age and previous experience using healthcare to play a key role in these women's attempts of self-advocacy, with only older participants in our sample discussing strategies to navigate discrimination. This is an area that would benefit from further investigation, especially since the Status of Young Women in Scotland survey also found that many women in their sample described feeling exhausted by having to advocate for themselves in healthcare settings to get the support, treatment or follow-up care that they need.

Theme II: Mental Health

Impacts of intersectional discrimination on mental health

Almost all participants in the sample explained how discrimination had affected their mental health or wellbeing. For example, being discriminated against increased their levels of stress and anxiety and negatively impacted their relationships with themselves and others. Participant 16 outlined how ableism, combined with gendered stereotypes, negatively impacted on her mental health and wellbeing:

There will always be people staring, which is stressful, it tires me out... they might see me using a wheelchair, and I'm a teenage girl, they are a bit dubious to begin with, but I then move my legs. Then they obviously think I'm pretending or putting it on, I'm just a spoilt

brat. That itself is also stressful, knowing that people are judging me because I'm using a mobility aid [Participant 16].

Racism was also a common thread through which some participants conveyed the links between discrimination and mental health. This experience was often intersectional with gender, migrant status, language, nationality and religion:

My teacher [in college] was a bit racist... like maybe because I'm I'm Arab or from a different country, I don't know... but she was treating me very bad... And you're over-thinking and you don't eat because of that [Participant 6]

If you were a girl [at school in Scotland], and you wear a hijab, you will certainly get bullied, even more if you do not have English. Sometimes boys take a different view of hijab girls. They think they can't do anything, that she can't talk to anybody, that she has to be alone [Participant 8]

These intersecting stereotypes, for these young women, created a sense of exclusion and isolation that had a negative impact on their mental wellbeing. For these participants, the "bad feeling" was mostly described through their behaviours such as "not eating" [Participant 6], "staying off school" [Participant 7] as opposed to using mental health diagnostic terms such as anxiety and depression, which we found to be terms more commonly used by White participants.

Young women from minority ethnic backgrounds also suggested there was a level of exhaustion in anticipating and expecting racism, even in the absence of any discriminatory acts. This anticipation often meant participants felt they needed to change themselves (e.g. their name [Participant 10], or accent [Participant 15]) or their behaviours (e.g. career choices [Participant 6] and avoiding certain spaces or settings [Participant 15]) to avoid being discriminated against. These expectations of discrimination were expressed across our sample and tied to a range of identities and background (gender, age, religion, race, disability, language):

...actually I am quite worried about my future, because I want to be a nurse and I will be wearing a hijab and the people in the hospital will then see you [Participant 6]

I go by an English name and I it makes me feel sad, because I can't use my birth name, because people will find it difficult to say. I change myself so I'm not discriminated [Participant 10]

Because of that discrimination that I had, I went to the airport four hours early. I did that to make sure that I didn't have to deal with this thing again. And in future I probably would, and try and see what the ethnic, the minority culture of a place is like before I go [Participant 15]

Further, discrimination led some participants to remove themselves from school and college when they experienced discrimination or racial bullying. For example, Participant 8 and Participant 6 share how the discrimination they faced in

educational settings tied to their religious and ethnic backgrounds led to them temporarily or permanently discontinuing education:

I didn't go to school for a week or so...that was the worst week ever
[Participant 8]

I didn't continue with the course, I couldn't really go on with it
because I couldn't learn anything from her with the way she speaks
to me [Participant 6]

These accounts highlight the emotional toll of navigating prejudice and the important consequences intersectional discrimination has on participants' mental health and wellbeing. As Participant 3 notes, "on the grand scale of things, when you're discriminated against for things that you can't change, it does start to have a bit of a knock-on effect, because you remember it." These experiences display not only the mental health impact of discrimination, but how these young women removed themselves from specific spaces and wider society.

Seeking Mental Health support

While the first sub-theme explored the impacts of discrimination on participants' mental health and wellbeing, this theme focuses on the experiences of participants who explicitly spoke about the **process of getting mental health support or treatment**. Almost half of the participants in the interviews sample (n=13) spoke about having mental health issues and their experiences seeking support. All the young women described struggling to get their mental health symptoms taken seriously. Dismissal was often grounded in participants not being believed or being told there is nothing wrong with them:

I told my friend that I was going to student support in school, and telling them how I was feeling. Basically she was, like, "Wait, no, don't do that. Because I know someone who went to them, and they did literally nothing for her." I went and spoke to the school anyway, my friend was pretty much right. It was downplayed, and they were saying things like, "People have it worse than you" [Participant 17]

I have in the past really struggled with my mental health I wasn't given the same support as a boy the same age... Even with just being stressed out, we're just kind of told by the school, 'Oh it's part of life, get over it.' [Participant 4]

Participants who gave examples of when they weren't being heard or taken seriously about their mental health were prompted by researchers to reflect on their identities (e.g. gender, age, sex, race, disability) in those situations (i.e. whether one felt more predominant or not). In all instances, participants identified their gender as predominantly shaping these experiences. They said this was due to their mental health symptoms often being dismissed as a natural part of being a young woman (described by 6 participants):

I did, sort of, see it at school, with, there'd be boys who were being a bit disruptive, who were then being taken to down to pupil support.

But with the girls, we were more told that we were just hormonal, and stuff [Participant 17]

Girls will be seen as moaning, or we'll as like, "Oh, she just wants to add work on [for the NHS]. However, we know as women that we will only make fuss about something when it's needed to be fussed about. We don't just make something out of nothing [Participant 10]

Maybe sometimes women are a wee bit more open to talking about their emotions. So if you say to Uni, "Oh, I've had a rough couple of days, I've been really depressed, I need an extension" they're just like, "Och, you're fine." Whereas I know some of my guy pals have used that for evidence of why they can't hand stuff in. Sometimes it's taken a wee bit more seriously. So you don't know if sometimes it's just- and men are a wee bit more, "Oh, this actually might be a real problem" whereas as a girl they're like, "Och, well, she's just a bit emotional." [Participant 22]

Initial dismissal often meant participants would delay or avoid seeking further support and then their mental health would as a result deteriorate. Various participants expressed frustration at the expectation to "prove" that they need support:

When I had mental health issues, I couldn't say to others, like, "I'm struggling," without giving proof. It then got to a point where I felt like I had to cut myself to show to my work that I'm in pain, because I didn't have the proof that I'm going through something [Participant 10]

...especially for myself I know from a mental health point of view if they can't see it or if you can't prove it with a doctor's note that you've not been well, nobody takes you seriously. [Participant 22]

I think a lot of the time from my experience of being younger, I was really, kind of, just scared after being told no so many times. It just felt like I was, kind of, being judged or just not properly listened to. I just stopped for quite a long time, quite a few years...I don't think I ever went to the doctor's at all, just because I felt a bit scared about going or just felt like what I would be going for wasn't reason enough. It wasn't justified. Anything I had wasn't justified unless I was collapsing or having an infection or something. It's not real. [Participant 21]

While some participants described ways in which stigma around mental health is beginning to be broken down, participants highlighted that increased mental health awareness at times can actually work against young people and become a way of dismissing mental health concerns. While now there is a broad recognition that "there's a mental health crisis", there is a risk of dismissing young people "because it's easily explained by negative societal trends" [Participant 1].

Other participants highlighted how increasing awareness of mental health issues had resulted in a “tick box exercise”, with everything “wrong” with young people being explained by mental health [Participant 16]. The awareness of the extent of poor mental health among young people (i.e. the mental health ‘crisis’), meant that participants felt that it was so commonplace in their age group, with overstretched and limited resources, that it was hardly worth investigating. The attitude from multiple healthcare professionals many had seen was that it was something young people would eventually “get over” [Participant 17].

Health barriers resulting from gender stereotypes

The stereotypes about mental health, young people and women discussed previously not only resulted in barriers accessing support for mental health issues for these women, but difficulty getting treatment for physical health conditions. Several participants in the interview sample gave specific examples of when they were seeking healthcare support for physical symptoms, but they were told it was likely a mental health problem. Some participants reflected on the stereotype of the “anxious teenage girl” [Participant 1], when referring to instances when their physical health concerns were put “down to mental health” [Participant 11] and assumed to be psychological:

I used to get reoccurring UTIs a lot as a teenager. It would always happen at times when I was stressed or down. But, because it was so connected with being an anxious teenage girl, it would almost be treated like a phantom UTI [Participant 1].

The doctor had said anxiety and worrying all the time was the problem, but he also said that I probably have like [low] blood pressure... but even if it was anxiety or worrying, that couldn't last for years and years like this has, you know? I've been like this for two years now, but I don't think it's because it's anxiety [Participant 7].

Some of the young women in the sample were willing to entertain that a mental health diagnosis for their symptoms was a possibility, but described how the diagnosis was often given at a very early stage. Participants described how assumptions about their physical symptoms were made with “no tests” [Participant 11], “no investigations” [Participant 16] and very few “questions” [Participant 15] asked about their health complaint. As one participant explains:

The doctor presumed it was psychological, even though I had loads of physical symptoms and he never discussed it with me, at all. I felt like what he was saying was only to do with my age and me being a girl, it wasn't because of any tests he'd done [Participant 11].

When mental health issues were the suggested diagnosis for these participants, what followed was that little or no mental health support was offered. This left some participants feeling as though their pain was not “real” [Participant 23] and they should “get on with it” [Participant 9] or they were “written off” [Participant 16]. For example:

I went to them for my chronic issues and it was always dismissiveness of it, there was always the talk of it being anxiety and depression. It did also annoy me that they didn't even want to help me, like if it was anxiety and depression like they said, they just wanted to write it down, and write me off, and they weren't offering to help me [Participant 16].

Some of our participants were hesitant about disclosing mental health symptoms to healthcare professionals for fear that would become the focus of the consultation, further leading to their pain not being believed. Participants also felt that such symptoms might be a distraction and reinforce stereotypes as often “they [doctors] just boil it down to one single issue” [Participant 5]. For example, Participant 1 described how she was reluctant to “be honest” about her mental health in case it “automatically discredited” her physical symptoms:

I was concerned that physical symptoms weren't going to be explored properly because they can easily be put down to, “Oh, you've got a history of mental health issues.” ...it's only after about 9, 10 months that I've finally gone to her [doctor], “Maybe it is just really linked to my anxiety.” But, even if I knew that, I wasn't really ready to be honest about that, because then it would be such an easy them to just go, “You just have to manage your anxiety and you'll be fine” [Participant 1].

Participants' intersectional experiences of having their physical symptoms dismissed as psychological (anxiety, stress, depression), and their mental health symptoms dismissed as a gender norm or female attribute further highlights an interplay of their identities, especially, age and gender.

This theme explores how (1) discrimination (e.g. ableism, sexism, racism) impacted on participants' mental health, (2) discrimination acted as a barrier to accessing mental health support and, (3) how assumptions and stereotypes about young women being inherently anxious made it a challenge for participants to access support for both mental health and physical health conditions.

Our findings contribute to growing evidence associating intersectional discrimination with poorer mental and physical health⁶⁶ and highlight the important consequences discrimination had on our participants' mental health and wellbeing. Our findings also support recent results of the ‘Women's Health – Let's talk about it' survey⁶⁷, based on nearly 100,000 responses from women in England. The majority of their respondents reported instances where they were not listened to by healthcare professionals when discussing symptoms, a number that increased for respondents with an existing health condition or disability (89%). They also found that women's symptoms were frequently dismissed as “a natural part of being a woman”. Likewise, our participants reported not being listened to particularly around their mental health, a key area of dismissal also identified by respondents in the survey. This is particularly concerning as, despite evidence showing that stigma around mental health is beginning to be broken down and a greater prevalence of mental health issues among younger people, they further find younger respondents

feel considerably less comfortable talking to healthcare professionals about their mental health than older respondents. Less than half of respondents in their survey aged 16-19 feel comfortable (41%), compared to those aged 80 or above (72%).

The Status of Young Women in Scotland survey (2022-2023)²³ also found that when young women were presenting with any symptoms, mental or physical, medical professionals would suggest hormonal or menstrual issues were the likely cause. Our findings therefore contribute to growing evidence within Scotland highlighting specific health barriers experienced by young women resulting from intersecting age and gender stereotypes.

Theme III: Hormonal contraception

The intersection of gender and age discrimination becomes especially apparent in participants' experiences related to contraception. Fourteen participants recounted their "journey" [Participant 28] with reproductive technologies when asked to share an experience in which they felt discriminated within or outside a healthcare setting. There was a sense among the sample that hormonal contraceptives such as the pill were easily available, readily prescribed and often brought up by healthcare professionals when the participant was seeing them for something other than contraception. This prescription of the pill often occurred in early adolescence and was mentioned as the first (and in many instances, only) drug suggested for birth control. The perceived willingness at which doctors prescribed the pill to adolescent girls did not "sit well" [Participant 3] with a number of participants:

Birth control is actually a really big decision but I think it's treated quite lightly [Participant 2]

Whether it's relevant or not, doctors tend to always ask are you on any form of contraception?... I don't know if young women should be constantly, constantly encouraged to ingest these synthetic hormones from such a young age [Participant 3]

Some participants understood this ease at which the pill is prescribed as reflecting a public health priority for young women to "not get pregnant" [Participant 3]. This focus on pregnancy prevention through the pill left participants feeling they were not trusted or believed to practice safe sex or feeling solely responsible to prevent pregnancy:

I've just always felt I didn't have any control over that part of my health, because everyone's so bothered about me getting pregnant. It feels like young women aren't trusted to practice safe sex [Participant 1]

I feel like it is almost just unfair that we're constantly reminded, like it's only your responsibility as a young woman. That's a type of discrimination that women face very, very regularly and that does not really sit well with me [Participant 3]

Further, participants discussed experiences where the contraceptive pill was prescribed for issues beyond birth control, such as menstrual regulation or pain, and to treat endometriosis or polycystic ovarian syndrome (PCOS): “we’re offered the pill to cure everything” [Participant 14]. The prescription of the pill as a type of medication meant that some participants’ primary concern for which they were going to the GP was at times overshadowed by a focus on preventing pregnancy, despite it being irrelevant to their situation:

It doesn’t necessarily matter to me as much if the birth control is the best contraception... we need to be using the best thing for actually solving the problem [Participant 2]

I think there are often too many things having to do with periods where we think birth control is an answer, which it is not. There was never enough questioning of whether pill they had given me as the solution was helping [Participant 1]

Participants who were prescribed the pill for any reason reflected on the lack of knowledge about potential side effects of the pill. These side-effects (e.g. “vomiting” [Participant 3], “hair loss”, “mental health problems” [Participant 20], “weight change” [Participant 10], “bleeds” [Participant 9]), were often not “properly explained” [Participant 3] when prescribed, sometimes leaving participants feeling as though something else was wrong with them or that they had not “fully consented” [Participant 9] to the prescription:

I was on the pill for around four years and it was only doing me harm [Participant 10]

I’ve had a lot of issues with different contraceptives. Last year I got really unwell and I couldn’t keep food down for several months. I lost about a stone in weight, it made me very, very depressed and it was just an awful time [Participant 3]

I only found out information about the pill after researching myself years after I started taking it [Participant 9]

Following prescription, some young women in the sample went on to experience mental and physical symptoms. Those that sought medical advice were met with resistance to investigate the side effects or consider changing methods. Several participants reported being told to “*wait and see*” [Participant 3], even after long periods of time, which left them feeling dismissed and like their “*pain was undervalued*” [Participant 2]. It was also apparent that mental health issues in particular were not considered valid reasons to change or come off contraception. While participants recognised that it may often take time to adjust to medication or contraception, from their perspective, they were speaking to their doctor about symptoms of concern to them, to which they were told to persevere through the mental and/or physical pain:

Instead of asking, “Are you alright?” they would be like, “Can we put you on more hormones? The worst thing that could happen is that you get pregnant” [Participant 1]

Some participants described their experiences over time with different forms of birth control as an unnecessarily long “journey” [Participant 5]. For those with a reproductive health condition, it took years to figure out how to best treat it or find a suitable form of contraception. Some participants expressed frustration at the length of time it took to find appropriate support and that there was rarely discussion beyond being told to “stick with it” [Participant 20].

I just had the same journey of going to the doctor, trying this one, and going back because it doesn't work for me. And then going back, trying a different one. There was no like trying to offer different things that might be better. And they were all very patronising. I know I was young, and I know I'm not a doctor, but I do know that this thing [the pill] just doesn't work for me, and they keep going, “No, just keep trying it” [Participant 5]

It's still frustrating for me that it took 18 months to get to that point [Participant 2]

One of the consequences of these experiences was that several participants “came off” [Participant 20] hormonal contraception. Some participants felt there was a breakdown in trust in the healthcare professionals due to the lack of information about side effects. The dismissal of suspected symptoms and limited discussion about the available options of contraception intensified that distrust and meant that a few young women we interviewed felt hesitant to engage with healthcare professionals about contraception again.

The dismissal and lack of appreciation of the side effects these women were reporting about their contraception mirrors the mental health theme. Contraception and mental health access are two examples of the healthcare system where young women in this sample describe a feeling dismissed and multiple points of discrimination, primarily related to their age and gender. We therefore interpreted these two themes as two **examples** of areas of the health system where discrimination manifests (rather than highlighting these areas as being of the greatest concern for policy in Scotland). It is unlikely that contraception and mental health support are isolated domains, but in this sample of young women they were the most discussed. Discrimination in the form of dismissal and disbelief of symptoms was also discussed by the focus group participants, related to different areas of health (e.g. surgery, chronic conditions), which illustrates our argument that discrimination is described by women as pervasive in many areas of the health system and wider society.

Many participants in our study brought up experiences with reproductive technologies, most notably the contraceptive pill, as instances when they felt discriminated. The findings in this theme therefore contribute to both the evidence base on discrimination, but also the literature on reproductive technologies. There

is a lack of research exploring women's intersectional experiences of reproductive technologies. In 2018, 28% of women aged 15-49 years in the UK used the birth control pill as their main method of contraception.⁶⁸ Data is however missing on the proportion of women taking the contraceptive pill in the UK or Scotland for issues beyond contraception, including menstrual regulation, lessening menstrual pain and flow and to treat endometriosis and premenstrual syndrome, all of which are primarily treated with the contraceptive pill. Data from the US finds 14% of pill users or 1.5 million women take the pill for non-contraceptive reasons.⁶⁹

Our findings also support evidence from The Health and Social Care Alliance's survey.⁷⁰ Based on more than 400 responses from women in Scotland in 2020, they also found that some respondents felt that they were put on the oral contraceptive pill as a default, which masked symptoms of menstrual health issues such as endometriosis and delayed diagnosis. Similarly, they also found mentions from their respondents of the risks of treatment not being fully discussed before taking place. Evidence from the Women's Health Strategy⁷¹ in England also highlights the oral contraceptive pill and side effects as a key topic where respondents felt they were not listened to by healthcare professionals. Heavy periods and endometriosis, and pain related to menstruation and other gynaecological conditions are also among the top areas where their respondents felt dismissed, mirroring the areas brought up by participants in this study when discussing their experiences with reproductive technologies, especially when prescribed for health issues beyond contraception.

Theme IV: Racism, structural sexism and socioeconomic disadvantage

The way that young women experienced discrimination was often complex, usually intersectional and difficult to untangle. For example, one participant said discrimination was like "a bowl of spaghetti" [Participant 3] in this way. Participant 10's testimony exemplifies this intersectional experience of discrimination. Throughout the conversation, she drew on her racial identity ("people don't take you seriously sometimes with the colour of the skin"), gender ("females, we get seen as we complain a lot, we moan a lot, we just make a fuss out of something"), age ("Because you perceive them as a healthy group...They're not taking them seriously") and language ("you have to speak proper English...Because again, you are discriminated with your terminology").

In this theme, there is a focus on participants' testimonies of structural racism, structural sexism and socioeconomic inequality. While these experiences at times intersect with other forms of discrimination (for example, age, religion, language, disability), these were dominant descriptions and are the focus of this theme.

Thirteen participants in the sample were from minority ethnic backgrounds. These participants talked about experiences of racism within and outside the health system, using both structural and interpersonal examples of discrimination. One structural experience of discrimination related to participants feeling as though there was little knowledge or understanding about certain health conditions and how they present in people from their ethnic background. For example, one participant said "because I was a black, they didn't know much" [Participant 12]. A

specific experience mentioned by a few participants related to skin conditions and how they “show up differently on different coloured skin” [Participant 14]:

My sister and I have eczema sometimes but when we go to the doctors a lot of the time they don't think that's what it is. I think you can notice the effects on White people more than you can on people of colour [Participant 20]

I think, maybe, things like how, in medical textbooks, skin rashes or cancer, are shown on white skin, and not brown skin or black skin. Or they show up differently on different coloured skin [Participant 14]

So, it will be hard to solve these problems when everything is based on White people [Participant 12]

These participants described how the lack of knowledge about non-White skin led to discriminatory experiences that resulted in “repetitive appointments” [Participant 12], delays in diagnosis, which for some participants worsened their condition. One participant incorporated her experience of cultural discrimination and stereotypes attached to the colour of her skin, within her testimony of the lack of research (structural discrimination). The racism this participant experienced at multiple levels, she felt, resulted in the health service being unable to treat her properly but also a lack of care about her as a person:

It felt like they weren't trying to solve the issue. I think that has something to do with the lack of research on Black skin, but I don't think they were probably weren't as bothered or cared as much about what happened to my skin [Participant 12].

Similar to not being “cared” about, some young women described how the systemic racism within the health system and wider society allowed “micro-aggressions” [Participant 12] or subtle types of interpersonal discrimination to occur. Examples included being spoken to “differently or impolitely” by healthcare professionals or administrative staff [Participant 10], having “several repeat appointments” [Participants 12] or “not being gotten back to” [Participant 14], “being ignored” [Participant 9] and being thought to “not speak English” [Participant 10]. While some of these experiences could be understood as resulting from the extreme pressure on the health system (as many participants acknowledged), these participants specifically expressed these as “racist” [Participant 19] experiences and felt that they would be treated differently if they were white. These experiences often related to other axes of discrimination such as language, migrant status, nationality, religion, gender and age, which at times interacted with ethnicity and acted as “additional barriers” [Participant 15] to being treated fairly:

Perhaps it's because I'm from a different country or maybe because I'm Muslim I don't know... but she was treating me really badly [Participant 6].

The fact that I never got the option to decide if I wanted a female or a male doctor when it came to my examining my skin was, I think,

both discrimination against me being a young girl but also because I'm Black [Participant 12]

I'm not sure if it is a woman thing, or a woman of colour thing, or a people of colour thing to really have to exaggerate [symptoms], in order to be heard [Participant 9]

These experiences resulted in feelings of dismissal and frustration for these participants, similar to those explored in relation to age and gender in Theme I. Participant 10 gave a description of her experience of being diagnosed and subsequently managing Polycystic Ovary Syndrome (PCOS). This example shows how complex and connected intersectional structural discrimination, micro-aggressions (inter-personal discrimination) and stigma are for young women from ethnic minority backgrounds. The participant expressed her unique position as a young woman from an ethnic minority background with a 'women's health' condition and the difficulties that come with that:

So you might come from an ethnic minority background, you're more likely to have PCOS. Because women within ethnic minority communities are less likely to get medical advice about it, because of the stigma that comes with that, and then maybe that's why there's a lack of research or information and support to help that person [Participant 10]

As well as experiences of racism, participants across the sample described wider societal sexism. These experiences could be considered 'structural' as they were ways that women were restricted in their opportunities to be healthy aside from interpersonal experiences with healthcare professionals. There were parallels with young women from ethnic minority backgrounds in that many participants described how "women's health" [Participant 20] conditions were under-researched. Specifically, conditions such as PCOS and gynecological issues, with several participants being told there would be little support, treatment or medication for their condition.

A further example of structural sexism related to young women's public health, which some participants suggested limited how they were able to take part in health behaviours such as physical activity. These examples not only related to being a young woman, but also to location (rurality) and socioeconomic disadvantage. For example, some participants mentioned that decisions about exercising outside were inherently different for men and women, with personal safety being a key factor for women:

I always think about this with my partner. When he goes out on a run at night-time, I'm just, like, "Oh, that would be nice to feel safe enough to do that." [Participant 20]

When I live with my parents... they live in a lovely wee village and, that's absolutely fine, I don't feel any issues running at night, I feel safe. If I was to run in [town] at night, where it's quite badly lit, I wouldn't feel safe and there would be a risk there. So that, kind of,

stops me being able to exercise how I like to exercise [Participant 24]

if it's really late at night I'm, like, I have to scoop out a wee bit more money and get an uber home rather than walk through because I know that the route that I'm going is not all perfectly lit or if I feel okay, I'm going to walk home [Participant 25]

It's more likely that I'll just do a 10-minute jog where the street lights are rather than a nice route that I would be used to because I get scared. [Participant 28]

These quotes reveal how structural sexism outside of the health system also have an impact on these young women's health and opportunities to be healthy. The experiences are related to location and socioeconomic disadvantage due to the links between how "safe" women feel in certain places, which in this sample appeared to change depending on how well lit an area was, the perceptions of safety of an area and how familiar they were with it. However, several participants took it as a given that women simply don't run alone at night.

Finally, socioeconomic disadvantage came into these experiences when income was mentioned as an enabler or barrier to safe exercise. Nine participants talked about the funds needed to have a gym membership. Some young women explicitly said they were unable to afford a gym membership. Although many saw the gym as a safer option to exercising outside, there were still safety concerns that related to being a young woman, particularly at cheaper and 24-hour gyms:

Financially, hugely, it's changed, the cost-of-living crisis... I used to go to the gym. I used to live right next to the gym so it wasn't an issue. That's also another thing, it was a 24-hour gym and I didn't feel comfortable going past the dark period at night. I didn't feel safe doing that... You hear stories of people being harassed in the gym [Participant 24].

Sometimes, I'm at the gym and I'm nervous. Like, "Oh, someone's looking at me," or I'm anxious like, "I want to do this exercise, but I'm worried how people will see me. I'll look weird." I don't want- I'm very anxious about people perceiving me- Sexualising me, or anything like that. [Participant 26].

There was someone, this guy. Do you know when you can just feel eyes on you? And it started making me feel uncomfortable about going at that time of night. So, I've started going in the morning but I feel like it's actually better for me now, to go in the morning. But yes, it's so weird because I actually did feel really comfortable there until that happened [Participant 20].

These quotes show one way that public health messages around exercise can be discriminatory, in a structural and intersectional way. Factors such as financial

challenges, safety and general discomfort mean that young women and particularly those on lower incomes face unique challenges. Not only do some young women have to make economic decisions about their health in the current economic climate in Scotland, but they have the added consideration of whether the space is safe and what time they are able to visit. Particularly in Scotland, with the winter months and longer hours of darkness also being said to restrict young women's ability to engage in health behaviours. These challenges are embedded in wider structural discrimination such as gender-based harassment and income inequality.

There was also discussion in the interviews of socioeconomic advantages some young women may have aside from income to afford "private healthcare" [Participant 18], "gym membership" [Participant 28] and "healthy food" [Participant 8]. This related to access to non-monetary resources such as "knowledge" [Participant 12] and "information" [Participant 19] as well as a personal sense of "empowerment" [Participant 22], a sense of "entitlement" [Participant 15] and "confidence" [Participant 5]. These were described as "privileges" that were able to support women in either being healthy or receiving healthcare support. One example that displays this comes from Participant 21 who described her journey receiving an Attention Deficit Hyperactivity Disorder (ADHD) diagnosis in her young adulthood. She outlined her diagnosis as a "privilege" because she claimed she was only in a position to get it because of her increased access to knowledge about health through going to higher education in her early twenties. Being exposed to this new information gave her a sense of empowerment and the skills to navigate the process. She was expecting a level of sexism given that the condition is less well-understood in women, but she highlighted that her newfound education gave her resources to persevere:

It made me feel, like, you know, I was an irrational woman. And I also didn't feel comfortable always to say... the only things that have got me through is this information I've got from doing my course, which is privileged. Most people don't know these things, you know? And being, like, "I know I'm entitled to a referral." So no matter what they say, I'm like, "I know I'm entitled,". Only through being given that language and almost being given- a point in the direction of how to approach things, was I able to, kind of- feel slightly empowered to try and do these things [Participant 21].

This theme presents some examples from the qualitative data which illustrate how structural discrimination (namely racism, sexism and socioeconomic disadvantage) interplay with interpersonal experiences with healthcare professionals and wider society.

There is a wealth of evidence related to structural and systemic racism and how that impacts on health, with the levels of discrimination described in the background of this report having been developed to understand racial health inequalities.¹⁴ The Covid-19 pandemic has not only shone a light on racial health inequalities but may have exacerbated them. Scholars have increasingly turned their attention to examining the significance of racism in producing adverse health outcomes among women specifically, as they are likely to experience a 'double jeopardy'. The focus

group participants in the first phase of this project also highlighted the priority for many ethnic minority women in navigating everyday racism, over and above sexism and other discrimination. However, the interview data from this second phase provide evidence of racism and intersectional discrimination **within** the health system that these young women experienced as patients. A comparative qualitative study with UK ethnic minority women's experiences of maternity care during the pandemic reveals similar patterns.⁷² They revealed that ethnic minority women experienced racism at interpersonal and structural levels. This chimes with the findings in this report that highlights that experiences of racism, operating at these different levels of discrimination, are likely to have major impacts on ethnic minority women. These findings within this theme contribute to the knowledge base around the importance of intersectional analysis to 'help peel back the veil' that the pandemic has begun to reveal.⁷³

Socioeconomic health inequalities within the UK and Scotland are well-documented. Poverty is inherently gendered with the overall pay gap in Scotland currently sitting at 15%.⁷⁴ These gendered economic inequalities were expressed through our participants' testimonies about not being able to afford "safe" health resources like the gym. Barriers to physical activity for women and girls have been explored⁷⁵ and continue to be a policy focus, given that women are less likely to meet physical activity guidelines in Scotland.⁷⁶ Therefore, this project makes a timely contribution to literature and public health strategies by underscoring how key considerations for young women in Scotland in terms of their physical activity are safety and finances.

Conclusions

Conclusions for interview study findings

The findings from the young women in this sample extended those resulting from the focus groups. The participants in the interview study similarly describe how they felt discriminated against in multiple ways and through cultural, institutional and interpersonal levels. Participants revealed the unique challenges faced by young women in terms of discrimination and their health, within and outside healthcare settings. Stereotypes of the "anxious teenage girl" shaped the participants' experience of healthcare for a range of physical and mental symptoms. Such stereotypes manifested in interactions with healthcare professionals to the extent where participants felt discouraged to access healthcare due to the expectation of negative treatment because of their age and their gender. Particular areas of interest for this age group are mental health and contraception, as these were domains where the sample highlighted being dismissed, patronized and unsupported, leaving them feeling frustrated with the health system. Structural experiences of racism, sexism and socioeconomic disadvantage were also highlighted by our participants, indicating that it is not solely negative interactions with individuals that young women are concerned about in relation to their health.

ESRC Fellow reflections

I was brought into the Scottish Government as an ESRC Fellow to develop a package of research to support the Women's Health Plan. Here I reflect on what I see as the main contributions of this programme of work.

1. The challenge of building a robust evidence base for women's health inequalities

The aim was to 'build an evidence base on women's health inequalities, with specific focus on the impact of sexism, racism, ableism, and other forms of discrimination including homophobia and transphobia on women's health.' The evidence review drew upon various projects within the UK that begin to address women's health inequalities. The qualitative findings from the focus groups and interviews begin to give insight into how women experience discrimination in relation to their health,. However, there are still a wide range of gaps related to women's health condition data, ethnicity data and areas of discrimination we were not able to address within the scope of this work (e.g. transphobia, classism). Therefore, one major contribution of this research is highlighting potential avenues for research and policy to continue with the aim of building a robust evidence base.

2. Importance of an intersectional approach to research and policymaking

The findings would have not been as rich and relevant to the policy aims of the Women's Health Plan had an intersectional approach not been embedded within every stage of the research. Through 'thinking intersectionally' when designing the research project and incorporating that into the recruitment plan, we were able to speak to a diverse sample of women in these two projects. Recruitment was monitored throughout using a demographics survey upon registration, allowing researchers to visualize the 'missing' perspectives from the research and where efforts should be focused. For example, through engaging with third sector partners who work with young women who may be marginalised from the research.

Not only has this work highlighted the **importance of intersectionality**, but it provides a case study of **how intersectionality can be operationalized** in research for policymaking. My reflection on this is that there are three key actions we took that resulted in a successful intersectional analysis: (1) incorporating intersectional thinking early in the project development process, (2) being committed to intersectionality as a framework through recruitment, adjusting the recruitment strategy dependent on the developing sample of participants, and (3) structuring (and testing) questions that allow participants the space to reflect on their multiple and interconnected identities. These three steps mean that the data are already set-up for intersectional analysis. We found that there was little interpretation on our part and largely it was clear the different intersections participants were speaking about. Finally, it is important to recognise that there needs to be a starting point when using intersectionality for policymaking (for us, that starting point was women, and subsequently young women). Being comfortable with a certain level of complexity and 'messiness' helped us draw out useful examples of discrimination that should be useful for policy colleagues when it comes to designing strategies.

3. Qualitative research is essential for capturing knowledge for policymaking

This qualitative research project contributes to the evidence base on women's health inequalities and discrimination. While taking account of the limitations of qualitative research related to sample size and generalizability, these projects provide a range of intersectional examples of how some women in Scotland experience discrimination and how that impacts on their health. Without the space to discuss complex and difficult concepts and experiences, these insights would be lost. While survey and quantitative data highlight structural discrimination, what they don't show is how this structural discrimination plays out in women's lives, in often subtle ways. The qualitative approach allowed us to identify potential policy directions for future iterations of the Women's Health Plan, such as mental health and contraception. The added value of qualitative work here is that it demonstrates how those experiences are playing out for women in Scotland. Those in-depth accounts from women are needed to effectively design policies and interventions to improve their health. Therefore, I see the final contribution of this package of work is highlighting that qualitative research should remain a major part of health inequalities research for policymaking.

Annex A: Focus group topic guide

This focus group is on discrimination and health. This research is being carried out as part of the Scottish Government's Women's Health Plan, in which the plan and its associated work is inclusive of women, girls, and all those who access women's health services. We are interested in any and all experiences you are comfortable sharing on this topic. There are no right or wrong answers and if you don't understand anything or we aren't clear, do say, as you probably aren't the only one thinking it.

Let's get started then. We'll begin with a few exercises to get us thinking about what some of these words mean to everyone. We are doing some interactive word clouds, which are anonymous (nobody can see what you write).

For these exercises, we will be using a software called Mentimeter. We will ask you three questions and the answers you give will create a wordcloud.

For each of the questions, you can either do this on the laptop/computer you're on, clicking on to your web-browser while still being in the Zoom call, or you can access it through your mobile phone/tablet/iPad etc. For the browser option, just follow the link we will post into the chat that will take you a form on the Mentimeter website where you can type in and submit words as answers to the questions.

If you are using a separate device, go onto the Mentimeter website and put in the following code in the box at the top of the screen.

I will then share my screen to show the live answers that are being submitted to the question. Just to emphasise that this is all completely anonymous – no-one will know who has submitted what answer. This should all make more sense as we go.

Interactive opener exercises

1. What comes to mind when you think about your health and being 'healthy'?
[Interactive word cloud exercise.](#)

Direct URL for your web browser: <https://www.menti.com/is57s978vu>

OR

go to www.menti.com on your phone and tablet and put in the voting code: 97162215

2. What things do you think impact on your health? [Interactive word cloud exercise.](#)

Direct URL for your web browser URL: <https://www.menti.com/v4dq96i6zc>

OR

go to www.menti.com on your phone and tablet and put in the voting code: 4664 9905

3. One of the things that potentially impacts on your health is discrimination. What does the word 'discrimination' mean to you? [Interactive word cloud exercise](#).

Direct URL for your web browser URL: <https://www.menti.com/xnp7hiqdzf>

OR

go to www.menti.com on your phone and tablet and put in the voting code: 5924 2410

Main focus group questions

Thanks for your input. One definition of discrimination is we found is: the unfair treatment of people based on certain characteristics including their sex, gender, race/ethnicity, disability, age, religion, education level, where you live, language and sexual orientation. This might be something experienced through an interaction with a person, an institution or a public space or environment. So we aren't just talking about explicit instances of discrimination, they might be more subtle or hidden, and someone may experience several forms of discrimination at one time. This doesn't mean all negative experiences you have had, but things that have happened specifically because of your background or belonging to a certain group.

4. Based on what people have noted in the word cloud and the definition we've given, can you think of any examples where you have experienced or witnessed discrimination?

Probing question: do you think that experience impacted on your health in any way?

5. Based on these experiences you have all described, are you able to reflect on any similarities and differences between them?

Probing question: why do you think there are these differing/similar experiences? What do you think is going on there?

6. If there is time: Is discrimination something you thought could impact on your health before this focus group?

General probing questions throughout:

Does anyone have any comments on that question or what others have said?

Do others feel similarly or differently to that?

Why do you think that is?

What do you think might be happening there?

Annex B: One-to-one interviews semi-structured topic guide

This interview is on discrimination and health. This research is being carried out as part of the Scottish Government's Women's Health Plan, in which the plan and its associated work is inclusive of women, girls, and all those who access women's health services. We are interested in any and all experiences you are comfortable sharing on this topic. There are no right or wrong answers and if you don't understand anything or we aren't clear, do say, as you probably aren't the only one thinking it.

Let's get started then. We'll begin with some questions about the terms used.

Definitions questions

What comes to mind when you think about your health and being 'healthy'?

What things do you think impact on your health?

One of the things that potentially impacts on your health is discrimination. What does the word 'discrimination' mean to you?

One definition of discrimination we found is: the unfair treatment of people based on certain characteristics including their sex, gender, race/ethnicity, disability, age, religion, education level, where you live, language and sexual orientation. This might be something experienced through an interaction with a person, an institution (like a workplace, school/college or the NHS) or a public space or environment. So we aren't just talking about obvious instances of discrimination, they might be more subtle or hidden, and someone may experience several forms of discrimination at one time. This doesn't mean *all* the negative experiences you have had, but the things that have happened to you specifically because of your background or belonging to a certain group.

Based on what you've told me and this definition, can tell me about a particular event when you experienced or witnessed discrimination? I won't interrupt, go into as much detail as you like.

Do you think that experience impacted on yours/the person's health in any way?

Probing question: do you have any reflections on why you think that was happening?

Probing question: can you think of any other examples in/out of a healthcare setting? In an education/work setting? (*depending on which area they have focused on*)

Do you think any of these situation of discrimination you've described relate to specific parts of your identity (e.g. gender, race, age, sexual orientation, social class or anything else)?

Probing: Why/why not? What do you think is happening there?

Probing: In the situation you mentioned, is there one identity that is more important than the others? For example, do you think it's because of your [e.g. gender] more so, your [e.g. race] more so, or is it both?

Thinking about your description of health and being healthy, can you tell me what kinds of things you think make it easier or harder to be 'healthy'?

- Location
- Finances
- Options for activities (e.g. different kinds of sports)
- Services (health, education, transport)
- Local environment (green space, air quality)
- Behaviours (activity, diet)
- People (friends, peers, family, community, online influencers etc.)

Do you think the characteristics we spoke about (e.g. gender, race, disability, sexual orientation) have any impact on your ability to do those things/be healthy? Can you give an example?

If there is time: Before the interview, had you thought that discrimination could impact on your health?

General probing questions throughout:

- Why do you think that is?
- What do you think might be happening there?

Examples of different forms of discrimination – only used if nobody can think of any examples themselves:

Certain institutions (e.g. work places, schools, NHS) or places may have policies that discriminate against people. For instance, if NHS mental health support clinics take place every Friday, people who practise certain religions will not be able to attend as this is their day of worship. Or, another example is if a new mothers' social group meets in a centre with no step-free access, this activity discriminates against new mothers with access needs.

Some people may not be listened to, taken seriously or generally treated very well by medical professionals because of who they are (or assumptions about who they are). For instance, a teenager is assumed to be exaggerating their symptoms due to the perception they are inexperienced and unknowledgeable. Another example

might be on a hospital ward, where more attention may be given to white patients than patients from ethnic minority backgrounds.

Discrimination can also occur according to where a person lives. For example, during lockdown restrictions of the COVID-19 pandemic, there were visible inequalities in who had access to green space/outdoor space and who didn't. Those who lived in areas with private gardens were able to access outdoor space at all times during the pandemic, whereas those who live in areas without any private outdoor-space may have had to choose between staying indoors or going to a busy public park (where for a while, these spaces could be used for physical activity only).

Another example of discrimination in relation to neighbourhood/where you live is the accessibility of public transport. For those who rely on public transport to commute to workplaces, education, and healthcare settings, discrimination can occur if the transport system is inaccessible, unaffordable, or unreliable to those who need to use it. This can result in people then missing shifts, school/college/university classes, or healthcare appointments, which directly impacts on their health and opportunities.

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Revisions Table

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Updates Page

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How to access background or source data

The data collected for this <statistical bulletin / social research publication>:

- are available in more detail through Scottish Neighbourhood Statistics
- are available via an alternative route <specify or delete this text>
- may be made available on request, subject to consideration of legal and ethical factors. Please contact <email address> for further information.
- cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.

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