Further reading

Culturally competent care - how to tackle structural inequalities in women's health.

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Fortress NHS

Women from ethnic minority groups often feel that they have to fight their way into care. The healthcare system more like a fortress than a sanctuary; impenetrable, distant, and indifferent.

Not feeling heard isn't just frustrating, it's dangerous. It tells women that their pain isn't real, their stories aren't valid, and their lives aren't valued. This alienation drives women away from us, towards spaces where they feel emotionally safe: family members, friends, healthcare professionals in their countries of origin, local medical traditions, and unregulated sources on social media and the internet. These alternatives can be laced with misinformation, but are seen as safe, in contrast to trained healthcare professionals who may be seen only as gatekeepers.

Consider these three cases – before reading on, think about whether you have similar patients and how your practice manages their care.

Maria is a 34-year-old Black woman living in London, a single mother of three who works long hours at a supermarket. Her long, heavy and painful periods are impacting her health, work, and ability to care for her children, but have regularly been dismissed by healthcare professionals as 'just period pain'. Only after repeated A&E visits with severe pain did her GP finally agree to refer her for an ultrasound, which showed large fibroids and prompted referral to gynaecology. The cost of that delay for Maria wasn't only medical, it was financial, emotional, and deeply personal.

Aisha is a 29-year-old South Asian woman living in Birmingham who has had chronic pelvic pain, fatigue, and irregular bleeding for years. These symptoms of endometriosis touched every part of her life, but in her household, menstrual issues weren't discussed, and pain was something to be borne quietly. That silence followed her into the clinic. She speaks fluent English, but medical language feels cold and inaccessible. She often nodded along, not out of understanding, but to avoid seeming difficult. Her GP, though well-meaning, didn't have the cultural insight to explore her discomfort with hormonal treatments, which Aisha feared might impact her fertility—a common concern in her community, where myths about hormones and reproductive harm still persist. She didn't feel safe enough to say she was worried about her future, about getting married one day, or what people might think. And so, like many women before her, she internalised her symptoms as something she just had to live with.

Aylin is a 51-year-old Turkish woman who recently moved to the UK. She presents with vague, non-specific symptoms of widespread pain, fatigue, mood swings and insomnia. In Turkey, all the good doctors work in the hospital, and they do lots of scans; doctors in the community are seen as second rate. So, she starts every consultation by requesting an MRI, which seems to annoy the doctor, and the consultation goes downhill from there on, often ending soon afterwards. It is never discovered that she can't sleep because of her night sweats and that these symptoms started only a couple of years ago at the same time as her periods started to be irregular. If that had been said, maybe her menopause would have been diagnosed and treated, instead of her being labelled as a 'frequent attender' and a 'heart-sink'. No-one ever explored how disorienting it is to navigate this transition in a new country, in a new language, with no access to culturally appropriate health information.

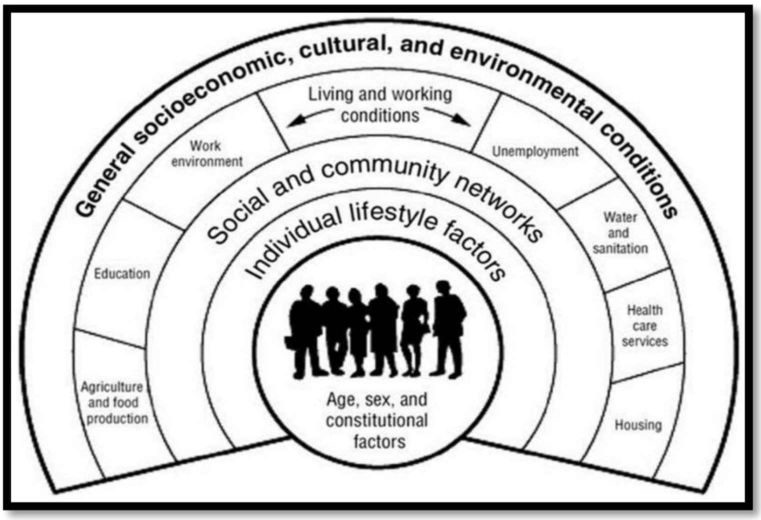
What does the evidence show?

- Up to 80% of Black women have fibroids, often earlier and more severely than White women[1].
- Black women are 50% less likely to receive a prompt diagnosis of endometriosis than White women[1].
- On average, endometriosis takes 7–8 years to diagnose[3,4], but delays are even longer for women from minority backgrounds[3].
- Compared to White women, Black women have a nearly three-fold increased risk of maternal death and the risk for Asian women is nearly double that of White women[5].
- A 2024 report showed that only 5% of Black women and 6% of Asian women use HRT, compared to 23% of White women[6,7].
- People from Black and Asian ethnic groups are over-represented in the cohort of young people with diabetes[8],

A web of disadvantage: how systems undermine women's health before the first appointment

These disparities aren't random. They are rooted in systems.

Social determinants of health are the broad social and economic circumstances that influence health[9]. Where a woman lives, how she earns, what she eats, how safe she feels, and whether she trusts her doctor. All these shape her health, long before she ever books an appointment.



The Dahlgren and Whitehead model of health determinants. From Social determinants of health, used under the Open Government Licence v3.0.

Women from minoritised groups are more likely to live in poverty[10], breathe polluted air[11], and be unemployed[12]. 19% of women in their 30s from ethnic minority groups are out of work due to unpaid caring commitments, compared to 12% of White women and 1% of men[13].

These inequalities are compounded by language barriers, cultural disconnects, and the stress of navigating a healthcare system that often feels alien or unwelcoming. The picture is further complicated by the emerging science of epigenetics[14], which shows that chronic stress, especially from discrimination, can affect gene expression and increase disease risk over time.

Women managing mental health conditions, disabilities, chronic pain, or coming from LGBTQ+ backgrounds face even more complex, layered vulnerabilities. Even well-meaning clinicians may lack the training or time to explore how cultural beliefs, past traumas, or structural barriers shape a woman's health experience.

Rebuilding trust requires more than clinical expertise

We cannot talk our way out of this crisis with good intentions or performative inclusivity. We must become worthy of the trust that has been lost. Cultural competence is not a buzzword, it is a professional obligation, only effective when paired with clinical humility. We may be experts in medicine, but our patients are the experts in their own bodies and lives. A consultation is not a one-way transmission, it is a meeting of two experts.

Cultural competence and clinical humility demand:

- Clinical curiosity and humility – Ask, don't assume. Understand that symptoms are shaped by lived experience and that context matters.
- Trauma-informed, integrated care – recognise the impact of racism, migration, and generational trauma on health.
- Safe, open communication – create non-judgemental spaces where patients can ask questions and express uncertainty.
- Validation of symptoms – have an open mind and listen to what patients tell us, even when their presentations fall outside textbook definitions.
- Culturally sensitive education – explain diagnoses and treatments in ways that resonate with a patient's context and language.
- Continuous learning – Stay receptive and teachable, actively seek out the voices and perspectives of those whose experiences differ from your own.

In practice, this means listening, having an open mind, acting in the patient's interest and sometimes going the extra mile. It means offering interpreters, providing translated, culturally relevant health materials and designing digital tools and safe spaces curated with accurate information that reflect the realities of diverse communities.

A collective responsibility

No single clinician can dismantle health inequality, but every one of us plays a part in it and must be part of the solution. Health equity is not a bonus or a charitable act. It is a baseline of safe and just care.

We need systemic change across policy, funding, education, and service design. That includes:

- Better, disaggregated data collection.
- Inclusive research and representative clinical trials.
- Public health campaigns tailored to underserved communities.
- Workforce diversity and culturally informed medical training.
- Accountability structures that measure outcomes—not just intentions.

Above all, we must start listening to women, believing and validating their concerns with empathy and respect. The NHS needs to change from a fortress to a safe space.

Let us build a system where no woman has to choose between silence and struggle. Where healing begins not with persuasion, but with partnership. Where dignity, empathy, and equity are not optional extras but the very foundation of care.

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