SHE

WOMEN'S HEALTH, MADE EASY.

SHE
WOMEN'S HEALTH
FORUM 2026

OUTCOMES & RECOMMENDATIONS REPORT

PARLIAMENT BUILDINGS,
STORMONT, BELFAST

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PARLIAMENTARY SPONSOR • CLAIRE SUGDEN MLA

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Foreword

SHE Health began with a question.

Growing up, I had a lot of questions about women's health, some personal, some simply out of curiosity. Like many people, I looked for answers in all the places that are now familiar to us: Google searches, Reddit, social media, YouTube and, more recently, AI. What became clear very quickly was not that information was unavailable, but that it was scattered across so many different places and presented in so many different ways that understanding what was reliable, relevant or useful was often difficult.

That became even more apparent during my biochemistry research project, To Investigate the Diversity of β-glucuronidase Among the Gastrointestinal Microbiome of Endometriosis Patients. The project opened me up to the world of women's health in a much more focused way and, through researching endometriosis, I became increasingly aware of how inaccessible much of the language surrounding women's health could be for the average person. Information was often highly technical, difficult to interpret and, depending on the source, slightly different or at times seemingly contradictory.

It made me begin to think beyond one condition and ask a broader question: where is the accessible education for all of women's health?

From there, that question naturally widened. If someone wanted to understand what products were available to them, where could they compare them? If they needed a particular health service, was there somewhere that explained where to go, why that service might be appropriate and what the process would actually involve? The more I looked, the more I realised there was no single place where this information, guidance and navigation came together.

It was fragmented.

And as I continued learning, fragmentation seemed to appear everywhere, in information, in services, in referral pathways, in education and in the wider experience of navigating women's healthcare. That was the starting point for SHE Health: a women's health startup working both digitally and in person to address that fragmentation and make women's health easier to understand and navigate.

As SHE Health developed, I also began to look more closely at the wider systems and policy structures behind women's health. That was when I came across women's health strategies and learned that dedicated approaches had been developed in Ireland, England, Scotland and Wales, while Northern Ireland, where I was based, did not have an equivalent strategy.

That immediately raised another question for me: why?

I began contacting MLAs simply to understand the issue better and to have conversations about what was happening in Northern Ireland. One of those conversations was with Claire Sugden, Independent MLA for East Londonderry. It was an eye-opening discussion and one that moved beyond identifying the gap to asking what could actually be done about it.

From that conversation came the suggestion that this was something worth bringing into Stormont. And that is how the SHE Women's Health Forum came to be. On Wednesday 9 September 2026, after months of planning, the Forum took place in the Long Gallery at Parliament Buildings. It was surreal to see something that had started with a question turn into a room filled with policymakers, clinicians, researchers, community leaders, advocates and others working across women's health.

What was especially striking was how often the conversations in the room returned to the same themes that had led to the creation of SHE Health in the first place: fragmentation, difficulty navigating

services, the importance of being listened to, the need for better education and the value of bringing different parts of the system together.

For that reason, the Forum was never intended to be a one-off event. It was not simply a morning to identify problems, discuss what needs to change and then allow those conversations to end when people left the room. The purpose was to create a space where those conversations could connect, where different perspectives could sit alongside one another and where that shared discussion could become a starting point for further action.

In that sense, the Forum itself was an example of what addressing fragmentation can look like, bringing people from different areas of women's health into the same room and creating the opportunity for those individual perspectives to become part of a much wider conversation.

This document exists because that conversation should not end at Stormont. It brings together what was discussed during the Forum, the themes that emerged, the recommendations raised and the areas in which further action is needed. It is intended to provide a record of the day, but also to carry the discussion beyond it and into the hands of those who can help shape what comes next.

There is now momentum around women's health in Northern Ireland, and there is a clear appetite for a more coordinated approach. The Forum has started a conversation. It has brought voices together, highlighted areas of agreement and made clear that there is willingness across sectors to engage with the question of what better women's healthcare could look like. What happens next will require those conversations to translate into policy, service development and action.

The next step is to make sure that momentum is not lost.

Precious Obasohan
Founder, SHE Health

About the SHE Women’s Health Forum

The SHE Women’s Health Forum took place on 9 September 2026 in the Long Gallery at Parliament Buildings, Stormont.

Parliament Buildings, Stormont

Convened by SHE Health, the Forum brought together people working across women’s health, healthcare, policy, research, advocacy and community support for a focused discussion on the future of women’s health in Northern Ireland.

The programme centred on two panel discussions.

Panel One: Building a Women’s Health Strategy for Northern Ireland focused on the need for a coordinated approach to women’s health and considered what should be prioritised within a future strategy for Northern Ireland.

Panel Two: Women's Health in Practice focused on the practical experience of women's health across services and support systems, bringing together perspectives from healthcare, research, mental health, education, workplaces and community support.

The Forum also included a community contribution from Dawn Shackels, Director of Programmes at Community Foundation Northern Ireland, drawing on the Foundation's Nothing About Us Without Us programme.

Nothing About Us Without Us is a Community Foundation Northern Ireland programme focused on amplifying the voices of grassroots women and supporting their meaningful involvement in decisions that affect their lives. The programme has also undertaken specific work on women's health, including research and advocacy around the development of a Women's Health Strategy for Northern Ireland.

Its inclusion within the Forum ensured that the perspectives and experiences of grassroots women formed part of the wider conversation alongside clinical, political, research and professional voices.

The Forum was designed to bring these different perspectives into one space and provide a foundation for continued discussion beyond the event itself.

Who Was in the Room

The SHE Women's Health Forum brought together representatives from government, healthcare, academia, research, industry, women's health organisations, community and voluntary organisations, advocacy, health innovation and the media.

Dr Alice McGee and Precious Obasohan, SHE Health

Senior health and government representation included Professor Sir Michael McBride, Chief Medical Officer for Northern Ireland, Caroline Keown, Chief Midwifery Officer for Northern Ireland, elected representatives from the Northern Ireland Assembly, and representation from the Departments of Health in both Northern Ireland and the Republic of Ireland.

Precious Obasohan and Junior Minister Joanne Bunting

Laura Dowling, The Fabulous Pharmacist

Forum Moderator

Dr Alice McGee

Senior Medical Advisor at Flo Health. Dr McGee is a medical doctor who graduated from the University of Aberdeen with an MBChB and also holds an MSc in Clinical Education and an MSc in Medical Sciences (Research). She has worked clinically within NHS Grampian, including rotations in obstetrics and gynaecology, and is also the Founder and Managing Director of Mara Health.

Panel One

Building a Women's Health Strategy for Northern Ireland

Claire Sugden MLA

Independent Member of the Northern Ireland Assembly for East Londonderry. She has represented the constituency since 2014 and previously served as Northern Ireland Minister of Justice. She currently sits on the Committee for The Executive Office and the Assembly Business Committee.

Jennifer Murnane O'Connor TD

Minister of State at the Department of Health, Republic of Ireland, with responsibility for Public Health, Wellbeing and the National Drugs Strategy.

Caroline Keown

Chief Midwifery Officer for Northern Ireland at the Department of Health. She is a registered midwife with approximately 30 years' experience across hospital and community settings and has held the Chief Midwifery Officer role since January 2024.

Dr Orla Conlon

Consultant Obstetrician and Gynaecologist and Medical Director of Marble Arch Health. She graduated from Queen's University Belfast, became a Consultant in Obstetrics and Gynaecology in 2007 and is a Fellow of the Royal College of Obstetricians and Gynaecologists. She also has specialist accreditation in menopause, psychosexual medicine, obstetric ultrasound and colposcopy.

Sarah Rose McCann

Health journalist and women's health advocate, with a particular focus on endometriosis. She has worked in health reporting and advocacy around women's experiences of diagnosis and care.

Community Contribution

Dawn Shackels

Director of Programmes at Community Foundation Northern Ireland. She leads programme work across areas including health, poverty, social justice, human rights, peacebuilding, leadership and community capacity-building.

Dawn's contribution drew on the work of Community Foundation Northern Ireland's Nothing About Us Without Us programme, which centres the voices and experiences of grassroots women and seeks to ensure they are meaningfully represented in decisions that affect their lives.

Panel Two

Women's Health in Practice

Breeda Bermingham

Menopause educator, author and Associate Consultant with Henpicked Menopause in the Workplace. She is a former midwife and community/public health nurse, has a background in psychology and sociology, and completed postgraduate research focused on menopause. She is also the Founder of the Midlife Women Rock Project and author of Midlife Women Rock.

Dr Caroline Millar

Visiting Scholar at Queen's Business School, Queen's University Belfast. Her research focuses on maternity-related employment transitions, the motherhood wage penalty, gender pay inequality, female retention and the impact of organisational culture on women returning to work following maternity leave.

Lindsay Robinson MBE

Perinatal mental health campaigner and advocate. She has campaigned for improved perinatal mental health services in Northern Ireland for a number of years and was appointed MBE in the 2024 King's Birthday Honours for her work in this area.

Laura Dowling

Pharmacist, Founder of The Fabulous Pharmacist and Founder of fabÜ Wellness. She graduated in Pharmacy from Trinity College Dublin in 2002 and has more than 20 years' experience in community pharmacy. Her professional background spans pharmacy, pharmacology and public health education.

Catherine McDaid

Student Wellbeing Manager at Ulster University and Deputy Mayor of Derry City and Strabane District Council for 2026,27. She has a professional background in mental health and student wellbeing and also serves as an SDLP councillor for the Ballyarnett DEA.

Additional Political and Health Leadership Representation

The Forum was also attended by senior political and health leaders who were not participating as panellists, including:

- Professor Sir Michael McBride, Chief Medical Officer for Northern Ireland
- Joanne Bunting MLA, Junior Minister, The Executive Office

The presence of senior health leaders, political representatives and officials alongside clinicians, researchers, advocates and community organisations reflected the deliberately cross-sector nature of the Forum.

Organisations Represented

Organisations, institutions, networks and programmes represented across the Forum included:

- Acacium Group
- Aisling Fourie Nutrition
- All About Birth
- Amba Consulting NI
- Antenatal Results and Choices (ARC)
- BBC Northern Ireland
- Belfast Health & Social Care Trust
- Carers NI
- Catalyst
- Community Foundation Northern Ireland
- Connect
- Data Science
- Department of Health, Northern Ireland
- Department of Health, Republic of Ireland
- Derry Well Women
- DigiBio Healthtech Innovation Programme

- Evangelical Alliance
- Flo Health
- fabÜ Wellness
- Happy Women of Belfast
- Health Frontiers
- Henpicked
- Hologic
- IASO Health
- ITV News
- Kingsbridge Healthcare Group
- Kit Day
- Lumifide
- Mara Health
- Marble Arch Health
- Medicines & Healthcare products Regulatory Agency (MHRA)
- Menopause NI
- Midlife Women Rock Project
- Miscarriage UK
- Mná la Grá Podcast
- National Screening Service, HSE
- National Women's Council
- Neula
- Next Chapter Coaching
- NHS
- NHS Clinical Entrepreneur Alumni
- Northern Health & Social Care Trust
- Northern Ireland Assembly
- Northern Ireland Civil Service

- Northern Ireland Rural Women's Network (NIRWN)
- Nourish & Nurture
- Primary Care Research Northern Ireland
- PMDD Project
- PUTTY Consulting
- Queen's University Belfast
- Rathfriland Health Centre
- Real Strong Women
- Roche Diagnostics
- Royal Jubilee Maternity Services
- Shankill Women's Centre
- Southern Health & Social Care Trust
- Southern Trust Gynaecology
- Strategic Planning and Performance Group (SPPG)
- Stroke Association
- The Executive Office
- The Fabulous Pharmacist
- The MenoPal
- The White Butterfly Foundation
- TIYGA Health
- University College London
- University of Glasgow
- University of the West of England
- Ulster University
- Welcome Health Ventures
- Windsor Women's Centre
- Women's Platform
- Women's Resource and Development Agency (WRDA)

- Women’s Support Network

The breadth of representation was central to the design of the Forum. Women’s health spans healthcare, public policy, research, education, employment, technology, community support and everyday life. Bringing these perspectives into one room created an opportunity for conversations that can otherwise take place separately to become part of a shared discussion.

Panel One

Building a Women’s Health Strategy for Northern Ireland

Panel One began with one of the clearest ideas to emerge from the morning: the need to join the dots. Women’s health does not sit within one service, one department, one condition or one stage of life. Yet women often experience a system that is organised in precisely that way. Across the discussion, speakers returned repeatedly to the need for greater coordination between departments, services, healthcare professionals, communities and the women using those services.

Panel One, left to right: Claire Sugden MLA, Minister Jennifer Murane O□Connor, Dr Orla Conlon, Sarah Rose McCann, Chief Midwifery Officer Caroline Keown and Dr Alice McGee, moderator

Claire Sugden MLA


Minister Jennifer Murane O□Connor

Joining the dots

Claire Sugden MLA described women's health in Northern Ireland as operating within a system that can be highly siloed, both between departments and within them. She highlighted how this fragmentation can leave healthcare responding to problems once they have already escalated, rather than intervening earlier and considering what may have contributed to them.

One example raised was the number of osteoporosis-related falls presenting in emergency departments. Rather than viewing the fall only as an isolated acute event, the discussion considered the wider preventative opportunities that may have existed earlier in a woman's life and the need to look at women's health across the full life course.

This idea of moving away from “firefighting” became an important part of the discussion. A more coordinated approach would mean considering not only the immediate health problem in front of the system, but the earlier opportunities for prevention, education and intervention that may reduce the likelihood of women reaching crisis point.

Claire also highlighted the importance of open conversations around periods and contraception, greater understanding of the six-week postnatal check and perimenopause, inequalities in access to treatment, and the need to consider women’s physical and mental health together.

The common thread was that women’s health cannot be treated as a collection of unrelated issues. The experiences a woman has at one point in her life can influence what follows, and a future approach to women’s health needs to recognise those connections.

From an Action Plan to a Strategy

The discussion about fragmentation led naturally to Northern Ireland’s existing Women’s Health Action Plan and the question of what should follow it.

Caroline Keown, Chief Midwifery Officer for Northern Ireland, spoke about the Action Plan and the purpose with which it had been developed. The Department of Health has described the three-year plan as a means of bringing existing activity together, identifying priority actions that can be progressed, and helping pave the way towards a longer-term comprehensive Women’s Health Strategy.

Caroline’s contribution reflected the importance of recognising the work already underway rather than beginning from the assumption that nothing exists. The Action Plan provides a structure through which specific areas of women’s health can be progressed and coordinated.

Claire Sugden emphasised, however, that Northern Ireland has now reached the point where a dedicated Women's Health Strategy is needed. Her focus was not on dismissing the Action Plan, but on what needs to come next. A strategy could provide a longer-term framework around the individual pieces of work already taking place, setting an overarching direction for women's health and establishing clearer coordination and accountability. That distinction became particularly important throughout the panel. An Action Plan can identify and progress immediate priorities; a strategy can articulate the longer-term vision those actions are intended to achieve.

For Claire, Northern Ireland had moved beyond the point of simply identifying that action was needed. The next stage was to establish a broader strategic approach capable of connecting those actions and ensuring that progress is sustained.

Learning from the Republic of Ireland

Minister **Jennifer Murnane O'Connor TD** brought the experience of the Republic of Ireland into the discussion and offered an example of how women's health policy had developed over a number of years. She traced that journey back to the creation of the Women's Health Taskforce in 2019.

The Taskforce was established by the Irish Department of Health in September 2019 to improve women's health outcomes and women's experiences of healthcare. Its model was deliberately collaborative, bringing together policymakers, clinicians, health experts, advocates, international partners and women themselves. Since its establishment, it has engaged with more than 2,000 individuals and organisations representing women across Ireland. Minister Murnane O'Connor placed particular emphasis on the importance of having everyone in the room.

At the centre of that process were women themselves. Women had to be listened to, their experiences understood and their priorities reflected in subsequent policy development. That approach was

embedded early in the work of the Taskforce and later developed through dedicated listening exercises designed specifically to understand women's experiences of the health service. In 2021, the Department of Health published the results of a "radical listening" exercise involving more than 270 women from across Ireland.

The significance of that process was that listening was not treated as something that happened after policy had already been designed. Women's experiences were intended to contribute to deciding what the priorities should be in the first place.

Minister Murnane O'Connor also highlighted the scale of investment that followed this work. By 2025, the Irish Government reported that €180 million had been invested in women's healthcare since 2020, supporting the development and expansion of women's health services. The discussion demonstrated that this investment has extended well beyond the areas traditionally associated with women's health. One of the areas Minister Murnane O'Connor particularly emphasised was period poverty.

Period poverty was discussed not simply as an issue of access to menstrual products, but as a wider health and equality issue. In Ireland, period dignity initiatives have specifically focused on reaching women and girls affected by poverty, homelessness, addiction and other forms of disadvantage. Government data published through the Women's Health Action Plan noted that 24% of women surveyed had experienced at least one indicator of period poverty. This was important within the wider panel discussion because it illustrated how a women's health approach can encompass social circumstances that directly affect whether women are able to manage their health with dignity.

Minister Murnane O'Connor also highlighted women affected by drug and alcohol use. The discussion recognised that women experiencing addiction may face a very different set of barriers to accessing

healthcare, particularly where drug use intersects with poverty, homelessness, mental health difficulties, gender-based violence and other vulnerabilities.

Ireland's Women's Health Action Plan has subsequently funded gender-specific drug treatment services aimed at women with complex needs, including integrated care pathways and measures intended to reduce barriers to accessing and remaining in treatment. The point was broader than addiction alone. It demonstrated the importance of designing women's health policy for women whose lives may not fit neatly within traditional healthcare pathways.

Other areas highlighted during Minister Murnane O'Connor's contribution included free contraception for women under 35, endometriosis, cardiovascular health and social prescribing. She also stressed that funding streams need to recognise poverty and marginalisation and that policy should reflect women across different ages and circumstances.

Her contribution reinforced one of the most important lessons from the Republic of Ireland experience: women's health cannot sit within a single speciality or even a single department. It requires different areas of government and healthcare to work together, while keeping women's experiences at the centre of the process.

Prevention, children and the life course

Caroline Keown developed the life-course element of the discussion further.

She emphasised the importance of thinking about women's health not only in terms of women themselves, but also in terms of children, families and future generations. A recurring point within her

contribution was the importance of doing well for children and giving children the best possible start in life.

This connected women's health with prevention in a much broader sense. Supporting women well before and during pregnancy, through maternity services and into the postnatal period, can have consequences not only for the woman, but for the health and wellbeing of the child and family around her.

Caroline also highlighted gaps in health knowledge across generations. This raised a wider question about how women and families obtain reliable information and whether people are being equipped early enough with the knowledge needed to make informed decisions about their health.

Perinatal support was also identified as an important part of this picture. The discussion therefore placed maternity within the wider continuum of women's health rather than treating pregnancy and childbirth as isolated episodes of care.

Inequality and the postcode lottery

Caroline also drew attention to social inequalities and differences in access depending on where women live. The phrase "postcode lottery" was raised in relation to the variation women can experience across Northern Ireland. This added another dimension to the issue of fragmentation. Even when services exist, they may not be available consistently or equally to every woman.

A coordinated women's health approach therefore needs to consider not only which services are available, but who can access them, where they can access them and whether those opportunities are consistent across Northern Ireland. Caroline also highlighted the role of community networks in supporting women, recognising that formal healthcare services are only one part of the environment in which women manage their health.

Maternity, informed conversations and prevention

Within maternity care, Caroline raised a number of specific issues. She highlighted misinformation and fear among women and spoke about the need for clear, honest conversations around health and maternity.

The discussion included the increasing rate of Caesarean sections and rising induction of labour, alongside the importance of education around obesity, smoking and vaccination. The emphasis was not simply on giving women information, but on ensuring that women have access to reliable information that enables informed conversations and decision-making. This again connected with the broader preventative approach emerging throughout the panel: women should receive support and information early enough for it to meaningfully shape health outcomes.

Being believed

Dr Orla Conlon brought the discussion into the clinical realities experienced by women seeking care. One of the clearest points she raised was the importance of women being believed. She discussed the experiences of women living with conditions including endometriosis and PMDD and the impact that delayed recognition of symptoms can have across a woman's life.

Endometriosis was used as a particularly stark example, with the discussion referencing diagnostic delays of approximately eight to ten years. Those years are not simply a clinical statistic. Diagnostic delay can mean years of managing symptoms without answers, repeatedly seeking help, adapting work and daily life around pain, and trying to navigate a healthcare system without a clear pathway. Dr Conlon linked these experiences to wider consequences for women, including their participation in employment and the broader economic inequalities women may already experience.

Being listened to and believed was therefore presented not as an optional part of good communication, but as something fundamental to whether women are able to progress through the healthcare system in the first place.

Capacity and appropriate pathways

Dr Conlon also highlighted an important limitation to the idea that greater awareness alone will solve women's health problems. Women can recognise symptoms earlier. Healthcare professionals can become more knowledgeable. Public awareness can improve. But those improvements have limited value if the services required once a problem is identified do not have sufficient capacity.

She therefore identified specialist capacity as another essential part of the conversation. This included the need for appropriate referral pathways, access to specialist services and sufficient theatre capacity for women requiring gynaecological treatment.

She also highlighted the significant waits experienced by women within gynaecological services. The discussion demonstrated that improving women's health pathways requires both ends of the system to function: women and healthcare professionals must be able to recognise when specialist care is needed, but specialist services must also have the capacity to respond.

Stopping the normalisation of symptoms

Sarah Rose McCann continued this discussion through the perspective of advocacy and public awareness. She highlighted diagnostic delay and difficulties accessing appropriate care, particularly in relation to endometriosis. A key concern was the normalisation of symptoms. Women and girls may grow up believing that significant pain or disruptive symptoms are simply something they are expected to tolerate.

If a symptom is normalised at home, at school, within wider culture or even within healthcare settings, a woman may be less likely to seek help or may delay returning for further support when an initial interaction does not provide answers. Sarah therefore connected diagnostic delay directly with education. Women need enough knowledge about their bodies to recognise when an experience may warrant further investigation.

Education before crisis

The importance of education became one of the strongest recurring themes within the panel. Sarah highlighted the need for better period education within schools, giving girls the knowledge to understand what is normal, what may not be normal and when they should seek help. She also raised the importance of ensuring conditions such as endometriosis are included appropriately within undergraduate medical education. The lack of education on Menopause within undergraduate medical education was also mentioned in the 2nd panel.

The issue therefore operates at two levels.

- Women and girls need greater health literacy.
- Healthcare professionals also need sufficient education to recognise, investigate and respond appropriately when those women present for care.

Claire Sugden's earlier comments around periods, contraception, postnatal care and perimenopause reinforced this point.

The overall message was not that every woman should become a medical expert. It was that women should have enough accessible information to understand their own health, recognise when something may be wrong and navigate towards appropriate support.

Social media and the changing way women access health information

That led into a discussion about where women now obtain health information. Sarah Rose McCann highlighted the significant role of social media.

Digital platforms increasingly form part of how women discover information about conditions, hear the experiences of other women and sometimes first recognise that symptoms they have been experiencing may have a name. Sarah suggested that this reality needs to be acknowledged within future approaches to women's health rather than treated as separate from the health system. She also highlighted the importance of both patient voices and healthcare professionals being present in these spaces. For many women, the first step towards seeking care may now occur outside the traditional healthcare environment.

The risk of misinformation

Dr Orla Conlon added an important counterpoint. Social media can increase awareness and provide communities for women who might otherwise feel isolated, but it can also expose women to inaccurate or misleading health information.

She therefore highlighted the importance of healthcare professionals communicating reliable information and being visible within the spaces where women are already looking for answers. This again reflected the broader question of accessibility. Reliable information is only useful if women can understand it and find it.

A future women's health approach therefore needs to consider not only what information is produced, but how that information reaches women and whether it can compete with the volume of health information already circulating online.

Working across borders

Dr Conlon also raised the importance of collaborative working across borders. The presence of Minister Murnane O'Connor made that element particularly relevant. Northern Ireland and the Republic of Ireland operate within different health systems, but many of the women's health challenges discussed at the Forum are shared. Cross-border collaboration offers opportunities to learn from policy development, clinical models, public-health initiatives, research and service innovation without assuming that one system can simply be copied into another. The Republic of Ireland experience discussed during the panel provided one example of the potential value of that learning.

Mental health as part of women's health

Mental health also featured within the discussion. Minister Murnane O'Connor emphasised that it is important for people to feel able to talk about mental health and highlighted the value of prevention and early intervention across different groups. This connected with Claire Sugden's earlier emphasis on considering women's physical and mental health together rather than treating them as separate issues. The broader implication was that a comprehensive women's health approach cannot be restricted solely to reproductive or physical health.

Who needs to drive the conversation?

As Panel One moved towards its conclusion, the discussion turned to the question of who needs to drive change. When Claire Sugden was asked who should drive the conversation, her answer was simple: everyone. The responsibility should not sit solely with women, with clinicians or with government. Claire also highlighted the importance of involving men within conversations about women's health, including pregnancy. This point was reinforced during audience discussion, where the importance of educating boys and men, rather than directing women's health education only towards women and girls, was also raised.

That contribution expanded the idea of women's health beyond something women are expected to understand, manage and advocate for alone. Families, communities, workplaces, healthcare professionals, educators, policymakers and men all form part of the environment in which women experience their health.

The final question

Towards the end of the panel, speakers were asked to consider what they saw as the most important next step for women's health in Northern Ireland.

It was a useful question to end on because the discussion had identified a wide range of individual challenges: fragmented services, unequal access, diagnostic delay, specialist capacity, gaps in education, misinformation, prevention, maternity and the need to listen more closely to women.

The question brought those discussions back to implementation. Minister Jennifer Murnane O'Connor's response returned to the central message with which the panel had begun: get everyone around the table and join the dots.

It provided a fitting conclusion to the discussion. The panel had not identified one single women's health problem requiring one single intervention. Instead, it described a series of interconnected issues occurring at different stages of women's lives and across different parts of the system.

- Women need better information, but information needs to connect to services.
- Earlier recognition is important, but recognition needs to connect to specialist capacity.
- Prevention matters, but prevention requires coordination across healthcare, education,
- communities and government.
- Women's voices need to be heard, but listening must ultimately connect to decisions,
- investment and implementation.
- And existing actions need to connect to a longer-term direction.

In many ways, that was the central message of Panel One. The individual pieces already exist. The challenge now is joining them together.

Panel Two

Women's Health in Practice

If Panel One focused on the structures, policy and leadership needed to improve women's health in Northern Ireland, Panel Two brought the conversation closer to women's everyday experiences. The discussion looked at what happens when women try to access support in practice: how they are received when they first ask for help, whether healthcare professionals have the knowledge and time to respond appropriately, what happens when women fall between service thresholds, and how health conditions continue to affect women beyond the healthcare setting itself.

Across the panel, one theme repeatedly resurfaced: women need to feel listened to, believed and supported at the point where they first reach out.

Panel Two, left to right: Dr Caroline Millar, Catherine McDaid, Lindsay Robinson MBE, Breeda Bermingham, Laura Dowling and Dr Alice McGee

When support breaks down

Breeda Bermingham opened the discussion around the points at which support can begin to break down for women, particularly in relation to menopause.

She highlighted the continued stigma surrounding menopause and the importance of creating environments in which women can speak openly about what they are experiencing without feeling that symptoms need to be hidden or minimised.

The workplace featured strongly in this discussion. Breeda emphasised that menopause does not exist separately from women's working lives, and that employers and organisations have an important role in creating cultures where women feel able to ask for support.

Open communication, greater awareness and stronger advocacy within workplaces were all raised as important parts of reducing stigma and improving women's experiences. Her contribution also highlighted the role of women themselves in changing the conversation. Greater visibility and openness can help challenge the idea that menopause is something women should simply manage privately. At the same time, the discussion recognised that awareness alone is not enough. Women also need access to healthcare professionals and services that understand the symptoms they are experiencing.

Gaps in professional knowledge

This led into a discussion about healthcare professional education. **Dr Caroline Millar** raised the issue that some GPs may not have sufficient menopause training.

Laura Dowling later returned to a similar point, highlighting gaps in menopause education among healthcare professionals alongside the reality of short consultation times. Together, those contributions raised an important practical question: what happens when a woman recognises that something is wrong and seeks help, but the first professional she speaks to either does not have the time or the specific knowledge required to respond?

The issue therefore extends beyond encouraging women to seek care. The system also needs to be ready when they do. This linked closely with the discussion in Panel One around education and specialist capacity. Improving public awareness of women's health conditions can increase the number of women recognising symptoms and seeking support, but that needs to be matched by appropriate professional knowledge and clear pathways once women enter the health system.

Listening, stigma and the first consultation

Laura Dowling placed particular emphasis on the importance of the initial consultation and on women feeling listened to when they first present with a concern.

She acknowledged the practical reality of short appointment times and the pressure this can place on both women and healthcare professionals. Laura also spoke about incontinence, particularly the embarrassment and stigma that can make women reluctant to discuss symptoms openly or seek help.

Her contribution highlighted how women can live with symptoms for long periods because they feel uncomfortable raising them, believe they are simply something they have to tolerate, or do not realise that support may be available. That example reinforced a wider point from the panel: women's health problems are not always hidden because services do not exist. Sometimes they remain hidden because the symptoms themselves carry stigma.

For healthcare professionals, that places greater importance on creating consultations in which women feel comfortable discussing issues that may be deeply personal or embarrassing. Laura also raised gaps in menopause knowledge among healthcare professionals, highlighting the need for stronger education so that women are met with appropriate knowledge when they do seek support.

Her contribution therefore brought together several practical barriers to care: limited consultation time, gaps in professional knowledge, stigma and women feeling unable to speak openly about symptoms.

Sarah Rose McCann

The first person a woman tells

Catherine McDaid brought this issue beyond the traditional clinical setting through her experience in student wellbeing. She highlighted how important the response can be when someone first discloses that they are struggling. Her point was that support can fail at the first person they tell. That first person may not be a doctor. It could be someone working in student wellbeing, an employer, a manager, a pharmacist, a community worker, a family member or another trusted person.

How that person responds can influence whether the woman continues to seek support or withdraws from the process altogether. Catherine also highlighted the importance of building a support network around the individual rather than expecting one person or one service to meet every need. This again returned the Forum to the issue of fragmentation.

Women may encounter multiple organisations and professionals before they receive the support they need. The question is whether those individual points of contact operate as disconnected encounters, or whether they can become part of a wider network of support.

Perinatal mental health: beyond physical maternity care

Lindsay Robinson MBE brought the discussion into maternal and perinatal mental health. She highlighted a lack of awareness around mental health and wellbeing during pregnancy and raised concerns that maternity care can place greater emphasis on a woman's physical health than on how she is coping mentally.

Pregnancy involves frequent contact with healthcare services, but that does not automatically mean mental-health difficulties will be recognised. Lindsay spoke about the importance of healthcare workers taking the time to listen and the effect that feeling believed and trusted can have on a woman's willingness to open up about what she is experiencing.

This echoed one of the strongest messages from Panel One: being listened to is itself an important part of access to care. A service may technically exist, but it cannot support a woman if she does not feel safe enough to disclose what she is experiencing.

The importance of continuity

Continuity of care was raised as particularly important within perinatal mental health. Lindsay highlighted the value of women having consistent relationships with those providing their care. When trust develops over time, women may feel more able to speak honestly about their mental health, particularly where symptoms carry fear, shame or uncertainty.

The absence of continuity can require women to repeatedly explain their history and establish trust with new professionals. Within an already fragmented system, that can become another barrier to disclosure and support.

The discussion therefore suggested that continuity is not simply about convenience. It can directly affect the quality of the relationship between women and services and, in turn, whether concerns are identified early.

Specialist services and the women who do not meet the threshold

Towards the end of the panel, Lindsay returned to the need for specialist perinatal mental-health provision. She highlighted the continued campaign for specialist services in Northern Ireland, including the ongoing ambition for a dedicated Mother and Baby Unit. However, she also raised another important gap.

Even where specialist services exist, not every woman who needs help will meet the threshold for specialist intervention. Women experiencing low-to-moderate mental-health difficulties may still be struggling significantly, but can fall between the support available through general services and the eligibility criteria for more specialist care. That creates a gap in which women may be considered not unwell enough for one service while still requiring more support than another is able to provide.

Community support was highlighted as particularly important for women in this position, alongside the need for appropriate funding. This raised a wider issue that applies beyond perinatal mental health: healthcare pathways should not only work for women at the most severe end of need. Support needs to exist across a spectrum.

Maternity transitions and returning to work

Dr Caroline Millar brought a research perspective focused on maternity-related employment transitions and the experience of women returning to work after having children. Her work considers issues including the motherhood wage penalty, female retention, gender equality and the impact that organisational culture can have on women before, during and after maternity leave. This introduced an important dimension to the discussion: women's health does not stop when maternity care ends.

The transition back into employment can take place while women are still adjusting physically and emotionally after pregnancy and birth, alongside new caring responsibilities and changes in family life.The discussion highlighted the need for employers to recognise that the return to work is not always a straightforward transition. Women may be managing physical recovery, changes in mental health, disrupted sleep, caring responsibilities and wider adjustments while simultaneously being expected to resume their previous working role.

Dr Millar's closing point returned particularly to low-to-moderate perinatal mental-health challenges as women move back into the workplace. Not every woman experiencing difficulty will meet the threshold for specialist mental-health services, yet those challenges can still affect wellbeing, confidence, attendance and the experience of returning to employment.

This reinforced the wider discussion around the importance of recognising women whose needs may sit below specialist thresholds, and the role workplaces can play in providing support before difficulties escalate.

It also connected the healthcare and workplace discussions across Panel Two: supporting women's health requires attention not only to clinical treatment, but to the environments women return to and participate in after care.

Menopause beyond the clinic

The discussion around menopause also illustrated the need to think beyond the boundaries of healthcare. Breeda Bermingham highlighted the workplace as an important setting in which women experience the consequences of health conditions. Menopause symptoms can affect concentration, confidence, sleep, emotional wellbeing and the ability to function comfortably at work, but women may still feel reluctant to discuss those experiences with employers or colleagues.

Reducing stigma therefore requires more than clinical treatment. It also requires workplaces to understand the issue and create environments in which women can discuss adjustments or support without embarrassment or fear of being judged.

Breeda highlighted the importance of women's voices in reducing that stigma and of organisations creating more open communication around menopause. Her contribution reflected a wider theme running through the Forum: women experience their health across all parts of their lives, not only during medical appointments. Workplaces, universities, families and communities therefore all have roles within the wider women's health ecosystem.

Research as the foundation for policy

Towards the end of the panel, the relationship between research and policy was raised directly. The message was clear: if the research is not there, policy cannot effectively follow. This linked the practical experiences discussed throughout Panel Two back to the strategic discussion in Panel One.

Women may report difficulties accessing services, gaps in professional knowledge, inadequate workplace support or unmet mental-health needs. But for those experiences to translate into sustainable policy and service change, they also need to be understood through robust research and data.

Research provides a basis for identifying the scale of a problem, understanding which groups are most affected, measuring inequalities and evaluating whether interventions are working. At the same time, the wider Forum discussion suggested that research should not sit separately from women's lived experiences. Evidence needs to reflect what women are actually experiencing within services, workplaces and communities.

The role of organisations working together

The question of how organisations can work better together was also raised during Panel Two. The discussion had already demonstrated why this matters. A woman experiencing menopause may interact with her GP, pharmacist, employer and workplace wellbeing team.

A woman experiencing perinatal mental-health difficulties may interact with maternity services, primary care, specialist mental-health services, community organisations and her workplace. A student experiencing health or wellbeing difficulties may first disclose to a university support service before ever entering a clinical pathway. Women's lives do not follow organisational boundaries. The support around them therefore needs to be sufficiently connected that women are not left to navigate every transition alone.

One action

At the close of Panel Two, each speaker was asked to identify one action they would prioritise. The responses reflected the breadth of the discussion while also showing how many opportunities for intervention exist outside traditional hospital-based healthcare. Laura Dowling prioritised teaching girls about their bodies from a young age. Her response brought the conversation back to prevention and health literacy. If girls grow up with better knowledge of their bodies, they are more likely to recognise changes, understand when something may not be normal and feel confident speaking about symptoms that might otherwise carry embarrassment or stigma.

That recommendation connected directly with Laura's earlier points around incontinence, menopause and the reluctance some women can feel when discussing intimate symptoms. Breeda Bermingham prioritised advocacy within workplaces. Her response reflected the need for women's health to be recognised within employment settings and for women to have both the confidence and organisational support to raise health needs without stigma.

Lindsay Robinson MBE returned to specialist perinatal mental-health services and the continued campaign for a Mother and Baby Unit, while also emphasising the women who fall below specialist thresholds and the need for funded community support.

Catherine McDaid raised the potential value of a multidisciplinary approach around primary care, reflecting the wider discussion about building support around women rather than expecting them to navigate individual services independently.

Dr Caroline Millar highlighted the need to recognise low-to-moderate perinatal mental-health challenges as women transition back into the workplace, reinforcing the importance of support for women whose needs may be significant even where they do not meet specialist clinical thresholds.

Taken together, the closing responses returned to many of the themes that had shaped the panel: education, advocacy, specialist provision, multidisciplinary support and recognition of needs before they escalate.

The audience discussion

The audience discussion again raised the importance of including men within conversations about women's health. One audience contribution highlighted the need for greater involvement of men in these discussions, echoing a similar point raised during Panel One. The recurrence of this issue across both panels reflected a wider recognition that improving women's health cannot be treated as the responsibility of women alone.

Q&A

What Panel Two demonstrated

Panel Two showed how the themes discussed at a strategic level in Panel One are experienced in everyday life.

- Fragmentation can look like a woman moving between services with no clear connection between them.
- A lack of education can look like a healthcare professional being unsure how to respond to menopause symptoms.
- A gap in provision can look like a woman struggling with her mental health but not meeting the threshold for specialist support.
- Stigma can look like a woman living with incontinence without feeling able to raise it.
- A failure to listen can occur in a GP consultation, maternity service, workplace or university support setting.
- And a lack of coordination can leave the woman herself responsible for connecting each of those parts.

The panel also demonstrated that women's health does not begin and end within healthcare. It extends into workplaces, universities, families and communities. Improving outcomes therefore requires not only better clinical services, but better connections between the environments in which women live their lives. Across the panel, there was a consistent emphasis on listening earlier, strengthening professional knowledge, improving continuity, supporting women before difficulties reach crisis point and creating pathways that do not leave women unsupported simply because they do not meet a particular threshold.

If Panel One asked what a future Women's Health Strategy should look like, Panel Two illustrated why that strategy needs to work in practice. A strategy can provide direction. But its success will ultimately be determined by what happens when a woman asks for help.

What Needs to Change

Across both panels, the same issue kept appearing in different forms: women are often expected to navigate a system that is fragmented, inconsistent and difficult to understand. The problems raised were not isolated to one condition, one service or one stage of life. They were connected. What needs to change, therefore, is not one single service. It is the way women's health is approached across the system.

1. Women's health needs to be joined up

Women's health cannot continue to sit in separate boxes. A woman may move between primary care, gynaecology, maternity, mental health, community services, the workplace and other support systems, yet those parts do not always communicate or connect effectively. The Forum repeatedly came back to the need to join the dots between departments, services, professionals and organisations, but also between the different stages of a woman's life. Women should not be left to make those connections themselves.

2. Northern Ireland needs to move from action to long-term strategy

There is already work taking place through the Women's Health Action Plan, and that work matters. But the Forum also made clear that Northern Ireland now needs to look beyond individual actions and towards a longer-term direction for women's health. A strategy would provide the wider framework around the work already underway, connecting priorities, setting direction and creating greater accountability for progress over time. The question is no longer whether women's health requires attention. It is how that attention becomes sustained, coordinated change.

3. Women need to be listened to before decisions are made

Listening cannot happen after policy has already been designed. The experience shared from the Republic of Ireland showed the value of bringing women into the process from the beginning and allowing their experiences to help shape priorities. That same principle appeared throughout the Forum, from the policy discussion in Panel One to the practical examples in Panel Two. Women need to be part of shaping services, pathways and policy, not simply asked for feedback once those decisions have already been made.

4. Women need to be believed earlier

Women should not have to repeatedly return, advocate for themselves or wait until symptoms have significantly affected their lives before concerns are taken seriously. The Forum heard how delayed recognition can affect women living with conditions such as endometriosis and PMDD, but the principle extends much further. The first response matters. Whether that first person is a GP, midwife, pharmacist, student wellbeing professional, employer or another point of contact, women need to feel that what they are saying is being heard and taken seriously.

5. Prevention needs to happen before crisis

Too much of healthcare can become focused on responding once a problem has already escalated. The Forum repeatedly returned to earlier intervention: better education, clearer information, stronger perinatal support, earlier recognition of symptoms and a greater focus on prevention across the life course. The aim should be to support women before they arrive at crisis point, not only once they do. This also means recognising that supporting women's health can have an impact beyond the individual woman, including on children, families and future generations.

6. Education needs to start earlier, and happen on both sides of the consultation

Women and girls need better knowledge of their own bodies. That includes understanding periods, recognising when pain or symptoms may not be normal, knowing when to seek help and having access to information that is clear enough to actually use. But education cannot fall entirely on women. Healthcare professionals also need stronger education in areas of women's health, including conditions that may currently receive limited attention during professional training. The Forum highlighted both sides of that problem: women struggling to recognise when something is wrong, and professionals not always having the knowledge required when women do seek help.

7. Better awareness must be matched by actual capacity

There is little value in encouraging women to recognise symptoms earlier if the next step is an unclear pathway, a long wait or a service without enough capacity to respond. Dr Orla Conlon's contribution made this particularly clear. Awareness and education need to connect to specialist services, appropriate referral pathways and enough capacity within the system to act once a problem has been identified. Women should not become better at recognising problems only to find that there is nowhere appropriate to go next.

8. Access cannot depend on postcode or circumstance

A women's health approach has to work for women living in different places and different circumstances. The Forum raised geographical variation in access across Northern Ireland, alongside the wider effects of poverty, addiction, homelessness and marginalisation on women's ability to access and remain engaged with healthcare. Services may technically exist, but that does not mean every

woman can access them equally. Women's health policy needs to consider not only what is available, but who can realistically reach it and use it.

9. Support cannot begin and end at clinical thresholds

The Forum highlighted what happens when women need help but do not quite meet the threshold for specialist services. This was particularly clear in the discussion around perinatal mental health. Women experiencing low-to-moderate difficulties may still be struggling significantly, yet can find themselves between general support and specialist care. Support should exist across a spectrum. Women should not have to become significantly more unwell before they qualify for meaningful help.

10. Women's health needs to exist outside the clinic too

Women experience their health at work, at university, at home and within their communities. Menopause does not stop when a woman arrives at work. The effects of pregnancy and birth do not end when maternity care finishes. Perinatal mental-health challenges can continue as women return to employment. And the first person a woman speaks to may never be a healthcare professional at all. Employers, universities, community organisations and other support settings need to be recognised as part of the wider women's health system.

11. Stigma needs to be actively reduced

Some women's health problems remain hidden not because women do not need help, but because they feel embarrassed or uncomfortable talking about them. Incontinence was one clear example raised during Panel Two, alongside menopause and mental-health difficulties. If women feel that symptoms

are shameful, private or something they should simply tolerate, they may delay seeking support. Reducing stigma therefore needs to be part of improving access.

12. Trusted information needs to be easier to find

Women are increasingly finding health information through social media and other digital spaces. That can help women recognise symptoms and connect with others, but it also creates a risk of misinformation. Reliable information needs to be accessible, understandable and available in the same places where women are already looking for answers. The answer is not simply to tell women not to use social media. It is to make trustworthy information easier to find and easier to understand.

13. Research and data need to connect directly to policy

The Forum was clear that policy cannot be built properly without research. Better data is needed to understand where women are waiting, where access differs, where services are falling short and which women are being missed. But research should also remain connected to women's lived experiences rather than becoming separate from them. Evidence should tell us not only how many women are affected, but what their experience of the system actually looks like.

14. Women's health cannot be the responsibility of women alone

One of the final points across both panels was the need to involve men and boys in women's health conversations. Women should not be expected to carry the responsibility for understanding, explaining and advocating for women's health on their own. Families, partners, employers, healthcare professionals, educators, communities and policymakers all shape the environment in which women experience their health.

The change is connection

Taken together, the Forum did not point towards one isolated issue that needs to be fixed. It pointed towards a system that needs to become more connected.

- Women need better information, but that information needs to lead somewhere.
- Women need to recognise symptoms earlier, but the services need to be there when they do.
- Women need to be listened to, but listening needs to influence decisions.

Recommendations for Northern Ireland

The Forum identified a clear need to move from fragmented activity towards a coordinated, long-term approach to women's health in Northern Ireland. The existing Women's Health Action Plan was developed as a three-year framework intended to bring current activity together and pave the way towards a longer-term Women's Health Strategy. Based on the issues raised across both panels, the following recommendations are proposed.

1. Develop a comprehensive Women's Health Strategy for Northern Ireland

Build on the Women's Health Action Plan with a long-term strategy that sets clear priorities, responsibilities, timelines, outcomes and accountability measures across the life course.

2. Establish cross-departmental governance for women's health

Create a formal mechanism bringing together health, education, employment, communities and other relevant areas of government, alongside HSC leaders, clinicians, researchers, voluntary and community organisations and women with lived experience.

3. Embed women's voices in policy and service design

Establish a structured and ongoing process for women to contribute to the development, implementation and evaluation of women's health policy. Representation should include women from different ages, geographical areas and socioeconomic circumstances.

4. Review priority women's health pathways from first presentation to specialist care

Identify where women experience unclear referral routes, repeated presentations, diagnostic delay or gaps between services. Priority pathways should have clearly defined routes from recognition and referral through to diagnosis, treatment and follow-up.

5. Align public awareness with service capacity

Education and awareness initiatives should be accompanied by workforce, diagnostic, referral and specialist-service planning so that earlier recognition of symptoms results in timely access to appropriate care.

6. Strengthen prevention and early intervention across the life course

Prevention should be embedded across menstrual and reproductive health, maternity, postnatal care, perinatal mental health, menopause, cardiovascular health and healthy ageing, with greater emphasis on acting before women reach crisis point.

7. Improve women's health education for both the public and healthcare professionals

Strengthen age-appropriate health education for girls and young women, while improving women's health content within undergraduate healthcare education and continuing professional development.

8. Develop support for women who do not meet specialist thresholds

Strengthen community, primary-care and early-intervention support for women whose needs are significant but who do not meet criteria for specialist services, particularly within perinatal mental health.

9. Reduce geographical and socioeconomic inequalities in access

Assess variation in service availability and outcomes across Northern Ireland and address barriers associated with geography, deprivation, poverty, transport, disability, addiction, homelessness and digital exclusion.

10. Recognise workplaces, universities and community settings within women's health planning

Develop stronger links between healthcare and the settings in which women live, study and work, particularly in relation to menopause, maternity transitions, mental health and return to work.

11. Improve access to trusted and accessible women's health information

Provide clear, evidence-based information that is easy to find, understand and act on, with direct signposting to appropriate services and support. Digital communication should form part of this approach.

12. Strengthen women's health research and data collection

Improve data on access, waiting times, diagnostic delay, inequalities, service outcomes and women's experiences of care. Research priorities should be informed by both population-level evidence and lived experience.

13. Introduce clear measures of progress and public accountability

A future strategy should include measurable outcomes and regular reporting on implementation, access, waiting times, inequalities and patient experience.

14. Address stigma as a barrier to care

Public health communication, professional education and workplace initiatives should actively address stigma associated with issues including incontinence, menstrual health, menopause and mental health.

15. Include men and boys appropriately within women's health education

Women should remain at the centre of women's health policy, while recognising that partners, families, employers and wider communities also influence women's experiences and should be included in relevant education and awareness.

Overall recommendation

Northern Ireland does not require another collection of disconnected initiatives. It requires a framework that connects the work already underway. The priority should be to move towards a long-term Women's Health Strategy with clear leadership, measurable outcomes and meaningful involvement from women throughout its development and delivery. The aim is not to start again. It is to connect existing activity, address the gaps identified through the Forum, and create a system in which women can move more clearly from information, to support, to appropriate care.

What’s Next

The Forum was never intended to end with one morning of discussion. The next stage is to take the findings beyond the room, place the recommendations in front of those with the ability to act on them, and create a clear route for continued engagement.

Publish and distribute the Forum report

The first step is to formally publish the outcomes and recommendations from the Forum and circulate them to speakers, attendees, policymakers, the Department of Health, the Executive Office, health and care leaders, professional bodies, universities, community and voluntary organisations, advocacy groups and relevant media.

The purpose is not simply to record what was discussed, but to ensure that the themes and recommendations from the day remain visible and accessible to those involved in shaping women’s health policy and services.

Follow up with key decision-makers

The recommendations should be followed by direct engagement with relevant decision-makers and health leaders. This should include opportunities to discuss the future of women’s health policy in Northern Ireland, the progression from the current Women’s Health Action Plan, and the case for a longer-term Women’s Health Strategy. The aim should be to move the conversation from general agreement towards clearer ownership and next steps.

Build an ongoing women’s health stakeholder network

One of the strengths of the Forum was the range of people and organisations represented in the room.

That network should not disappear after the event.

SHE Health should establish an ongoing stakeholder network bringing together clinicians, researchers, policymakers, community organisations, advocates, employers, universities and others working across women's health. This would create a practical route for sharing information, identifying gaps, supporting collaboration and connecting people who may otherwise continue working separately.

Create a route for further input

The Forum should remain open to further evidence and perspectives. Attendees and wider stakeholders should be invited to contribute additional examples of good practice, emerging needs, research, service gaps and recommendations that can inform future work. This would allow the report to act as a starting point for continued engagement rather than a fixed end point.

Continue cross-border learning

The discussion with Minister Jennifer Murnane O'Connor highlighted the value of learning from the Republic of Ireland's experience in developing women's health policy. That engagement should continue.

The next stage should explore what can be learned from the Women's Health Taskforce, service development, public engagement and investment in the Republic of Ireland, while recognising that Northern Ireland operates within a different health and political system. Cross-border learning should focus on what is transferable, what can be adapted and where collaboration may add value.

Track responses and progress

Follow-up should be visible. A record should be kept of which organisations engage with the recommendations, what commitments are made, which areas progress and where further action is required. This will help ensure that the Forum is not remembered only as an event, but as the beginning of a process that can be reviewed over time.

Keep the conversation public

The issues raised at the Forum should remain part of the wider public conversation. The report should be shared through professional networks, women's health organisations, community groups and media, helping to maintain attention on the need for a more coordinated approach to women's health in Northern Ireland. Public discussion also creates space for more women to contribute experiences and perspectives that may not have been represented in the room.

Sarah Brett, Dr Orla Conlon, Precious Obasohan and Chris Buckler
Good Morning Ulster, BBC NI

Reconvene and review progress

The conversation should be brought back together at an appropriate point. A future roundtable, progress meeting or Forum should review what has changed since September 2026, where recommendations have progressed and where gaps remain.

The purpose should not be to repeat the same conversation, but to ask a more important question:

What has changed since the Forum, and what still needs to happen?

The immediate priority is to ensure that the Forum leads to continued engagement, visible follow-up and measurable progress. The event brought the conversation together. The next stage is to keep it moving.

Conclusion: The Conversation Cannot End Here

The SHE Women's Health Forum was convened because women's health in Northern Ireland is still too often experienced as fragmented, difficult to navigate and disconnected across services, stages of life and settings.

The Forum brought together policymakers, clinicians, researchers, community organisations, advocates and women's health leaders to examine those gaps and, importantly, to consider what needs to happen next. This report is not intended to mark the end of that conversation. For SHE Health, the next stage is to continue working on the problem that led to the Forum in the first place: making women's health easier to understand, easier to navigate and better connected.

That work will continue in two ways.

First, through the development of SHE Health's digital platform. The aim is to create a practical navigation layer for women's health, helping women access trusted information, understand symptoms and conditions, identify relevant services and know what questions to ask next. The digital work will continue to focus on reducing the confusion that can come from fragmented information and unclear pathways.

Second, SHE Health will continue to bring people together in person. Future forums, roundtables and smaller stakeholder discussions will create opportunities to revisit the recommendations in this report, examine specific areas in greater depth, connect organisations working on similar problems and track where progress is being made.

SHE Health also intends to build on the cross-border dimension of the Stormont Forum by exploring a future Women's Health Forum in Dublin. This would create an opportunity to bring together stakeholders from across the island of Ireland, deepen learning between Northern Ireland and the

Republic of Ireland, and continue the conversation around how women's health policy, services and innovation can develop across different systems. The intention is not to repeat the same conversation in a different room. It is to build on it.

Future discussions should become increasingly focused on implementation, specific gaps in services and pathways, cross-border learning, and whether women's experiences are actually improving. The Forum demonstrated the value of bringing different parts of the women's health system into the same room. That will remain central to SHE Health's approach. Progress is more likely when policy, healthcare, research, community organisations, workplaces and women themselves are not working in isolation.

SHE Health will therefore continue to use both its digital work and its convening role to help make those connections. The ambition is simple: that women should not have to work so hard to understand their own health, find the right support, or navigate between disconnected parts of the system.

The conversation at Stormont was a beginning.

The next step is to turn connection into action, continue the conversation across Northern Ireland and Ireland, and keep bringing people back to the table until women can see the difference in practice.

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The Forum was built around a simple idea: that progress in women's health requires people to come together, listen to one another and connect work that too often happens separately.

Thank you for being part of that conversation.

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