

Integrating Women's Health into Primary Care Strategies for Enhancing Family Medicine Practices

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ABSTRACT

Women's health plays an important role of primary health care, however, inclusion in family medicine remains limited day today's health system, education and policies. This thesis explores implications of providing complete women's health services in primary care setting and using gender-sensitive, patient-centered model of care. The study was cross-sectional employing both qualitative and quantitative approaches to conduct needs assessment to identify existing shortcomings in medical training, scarcity of service provisions in specialty areas, capped by restricted policy agenda that hampers gender-sensitive healthcare provision. Published findings stress ideas of collaboration between professionals of different fields, the enlargement of the health curriculum to incorporate knowledge on the unique concerns of female and males respectively, and structural changes aimed at increasing the accessibility of care for those in need. Policy in form of curriculum changes, additional preventive care services, and other policies are suggested to address the incorporation of women's health in to the field of family medicine. Specifically, through implementing the FMG approach, significant improvement in relation to patient care, elimination of the gender gap in primary care at the practice level, and thus effective FS and overall primary care systems are revealed. In this way, this work adds to the discussion of the reforms that can be aimed at enhancing the equity in healthcare provision and emphasizes the importance of family medicine to meet specific female's needs.

Keywords: Integrating, Women's Health, Primary Care, Strategies, Enhancing, Family Medicine, Practices

INTRODUCTION

Background and Context

Gender mainstreaming has become a concern in the provision of care to women across the world despite the near focus on women's health for several decades. According to the World Health Organization's definition of health, healthcare should meet biological, social, and psychological requirements; moreover, the concerns involving gender issues should be considered [1]. Primary care in the type of medicine, which ideally fits the modern and complex concept of the female's health issues management throughout her lifetime. Still, family medicine as a comprehensive orientation of care does not have a well-defined guideline for integrating women's health issues into primary care model [2]. Family medicine involves a patient approach to the care, and multimodal treatment that makes physicians to provide preventive, diagnostic and curative services to their patients [3]. In view of this ability to cover almost all aspects of medicine, family medicine should be applied to close the existing gaps that are observed in women's health services with the integration of the gender sensitive approach. However, some few barriers limit this aspect hence reducing its realization. Some of the challenges include; inadequate training of the clinician on matters relating to gender medicine, limited access to women's health services, racism, and other complications such as fragmented healthcare policies [4]. We cannot reduce the health of women only to reproductive health, as women also suffer from various diseases, including cardiovascular diseases, autoimmune diseases, osteoporosis, and mental illnesses [5]. Traditionally, M and RH has always been a main concern of healthcare facilities mostly glanced over other vital diseases that commonly affect women. This has led to the issue of bias towards lack of early

diagnosis, treatment, and overall care of women [6]. The focus of this research will be to analyse the ways in which implementing women's health to family medicine can create value how we are trying to fill the gap. This particular research fills the gaps within existing health care frameworks, assesses existing processes, and prescribes intervention measures for promotion of gender equity in health care hence should be able to draw from these contested discourses. In the case of midlife women's health, there is the need to support and improve the training of clinicians, integrate and promote interdisciplinary cooperation, expand the availability of preventive services, and engage in policy work to create more gender-sensitive approaches to care.

The Importance of Women's Health in Primary Care

More specifically, women health issues do not only include reproduction-related issues, but numerous other issues. However, maternal health, contraception, and gynaecological care are crucial, still, they include the only domain to discuss about which women often think in medical terms [7]. Having a worsen impact on the morbidity and mortality, the diseases like osteoporosis, autoimmune diseases, cardiovascular diseases have distinct presentation in women compare to men [3]. For instance, heart disease is ranked as the leading cause of death among women; more often than not, it goes undiagnosed since the diagnostic patterns were developed with male participants as the focus [8]. Other significant field within family medicine is mental health. Women also suffer from anxiety, depression and PTSD because of the flourishing role that biology, hormones and sociocultural play on their lives [4]. However, there is poor integration of mental health services in primary care settings meaning that such conditions are

underdiagnosed and may go untreated [1]. Moreover, general population preventive care, such as breast and cervical cancer screening, is crucial for increasing the efficacy and quality of women's treatment. Despite the fact that some of these diseases can be checked through regularly screening and early intervention, many women cannot access these services due to some barriers such as the level of healthcare services within regions according to Loafman et al., [9]. These barriers within the sphere of family medicine must be tackled, and the availability of screening programs can help to indicate the diseases at an early stage, improving the outcomes. The inclusion of women in family medicine guarantees that women's issues get the required attention within the primary care practice. It improves the value of healthcare, equality attainment and ensures that care delivery system meets the peculiar needs of women across the life cycle.

Challenges in Integrating Women's Health into Family Medicine

Though family medicine has the great opportunity to become a fundamental model of women's health, there are a number of barriers to providing gender-sensitive services in FPCC. These include educational disparities, unsuitable practice experiences, organizational and policy constraints, and poor access to specialist staff. It is crucial to comprehend these challenges so as to develop interventions that could improve the implementation of women-centered care approaches in the practice of family medicine.

Lack of Clinician Preparedness and Training Deficiencies

One of the major challenges in operationalizing the Women's Health in Primary Care is inadequate exposure of the provider to sex and gender medicine. Most of the family physicians' education lacks depth and is mainly focused on issues related to women's reproductive and maternal health. As such, it excludes essential aspects of women's health like auto immune disorders, osteoporosis, menopausal symptoms and gender variants of chronic illnesses [6]. For instance, cardiovascular disease- the number one killer among women across the world is different in women than in men as women may not experience great chest pains as men do but rather produce other general symptoms such as fatigue and shortness of breath [8]. If inadequately trained, the GP could easily miss such signs and this would translate into worst quality of care especially for females. In addition, conditions such post-cum clinical syndromes generally include PCOS, endometriosis and hormonal disruptions and other conditions that confirm the need to continue with such forms of education. Such conditions should be diagnosed and managed over a long period, and they pose several ripple effects on women's quality of life; however, most PCPs might not be well-equipped or knowledgeable enough to adequately manage these conditions [5]. There are certain strategies which can help in addressing this knowledge gap including increasing the syllabus of medical colleges to include details about gender-specific health problems and making it compulsory for practicing family doctors to update themselves through some post graduate lessons.

Limited Availability of Specialist Services and Care Fragmentation

Another challenge of achieving comprehensive women's health in family medicine is access to specialized services. In most of the healthcare facilities, it becomes the duty of the primary care physicians to transfer the patients to specialists, especially when the problems are gynaecological issues, infertility, or high-risk pregnancies. Nevertheless, long wait time, geographical accessibility and costs may

delay the service delivery and attributions to the female clients as explained by Li [7]. Such a fragmentation of care hinders patient care by creating gaps in the service delivery hence exposing the patient to poor, differential and or neglected health care. For instance, women with severe menopausal symptoms will have to wait between six to twelve months for an endocrinologist appointment in which their quality of life diminishes [9]. The presented literature supports collaboration in GP practices where specialists work in the same practices or else closer specialist-Primary care networks; this simply means that by integrating specialism services in to the family medical practices or having closer working relationships between the primary care physicians, the healthcare systems would gain fully in terms of efficiency as well as added value when giving out the specialist services. Therefore, the expansion of tasks for family physicians includes such additional services as intrauterine device (IUD) insertion, management of hormone therapy, and more intensified screening schemes can also contribute to the lack of fragmented care. It is suggested that introducing god practice and further education and support to the RMG clinics will be able to turn those to be several service delivery centres of family medicine that are able to manage most of the women's health issues.

Policy and Systemic Barriers

It is sad that despite individual and country initiatives, there are many policy and system barriers that hinder the integration of women's health into the primary care. Regarding gender-specific services, the reimbursement systems in many healthcare systems and funding allocations do not encourage the practice in family medicine environments [4]. For example, preventive services, longer time spent with patients with multi-illness, and women's health care may not generate adequate revenue, some practicing physicians therefore, avoid offering them. Moreover, there is no set of national guidelines or protocols needed for the incorporation of women's health issues into family medicine thus causing gaps in the delivery of this service. Where there are no universally specified guidelines and goals tied to the accomplishment of women's rights or interests by healthcare institutions or practitioners, these officials may not have the incentive or, more importantly, the structure to enforce women's health in their practices [2].

In order for policymakers to rethink the systemic issues, they have to change the reimbursement methods, provide more financial resources to women's health and set standards of quality for care provision within the framework of family medicine. Other forms of advocacy that can be effective are through public health ministries and community programs. This is because making women understand the importance of follow-ups, psychological treatment, and disease prevention can enable her to commence check-up early enough and fight for her rights to quality health care. Implementing policy changes that correspond with activities can enhance the creation of structures that will foster the placement of women's health into family medicine.

Strategies for Integrating Women's Health into Family Medicine

Solving the challenges mentioned above should involve educational measures, integrated cooperation of practitioners of various specialties, development of preventive care, and changes in the legislation. Through enacting such approaches, training trends within family medicine can be advanced in catering for the needs of all women at different ages.

Improving the Medical Education Continual Training

Changing the medical education is one of the main steps towards including women's health into the primary care. Education in medical schools and residency programs should involve the provision of efficient and appropriate gender-sensitive health intervention packages that go beyond Reproductive Health, including cardiovascular disease, Mental Health, autoimmune disorders, and chronic pain syndrome management [6]. This would help the practicing family physicians to update their knowledge with the new knowledge in research and changes in practices. For example, using teaching-learning packages like training on new cervical and breast cancer screening guidelines, new treatment approaches of menopausal symptoms and mental health disorder management will increase clinician preparedness and post actively impact patient care [5]. Further support for continuous learning can be provided by synchronous online programmes such as courses, clinical simulations, and interdisciplinary seminars so that the physicians are able to enhance their knowledge and skills without putting the practice at risk. ensuring continuous sound learning and development in the healthcare sector Can help healthcare organizations to have a motivated force of competent workers who are knowledgeable and skilled, to deliver quality care that is sensitive to the gender of the patient.

Improving Interdisciplinary Relations and Communication and Care Organisation

Collaborative care is valuable particularly when it comes to patients' care since it is comprehensive in nature. An effective relationship with other physicians and allied health workers maybe fostered by the development of referral and co- management relationships with other specialties including gynaecology, endocrinology, psychiatric services and with physical therapists [3]. Use of integrated digital records helps in sharing records between providers to enhance timely exchange of data and coordinated decision making [4]. Seminar for case conferences and patient care conferences will also enhance the relations in care modelling and support to the patients for quality care. Lay health workers and patient navigators can also support patients in the organization schedules and transportation and in managing the health care systems. If these roles are incorporated within family medicine practices, patients' experiences can benefit from having fewer care gaps.

Expanding Preventive and Screening Programs

Freeman argues that preventive care plays a critical role in the specifications for women and does a good job in explaining why the extension of screening programs in family medicine is useful as it results in the early detection of potential conditions. Additional preventive services for coverage should include breast and cervical cancer, osteoporosis, some STI tests, and services that should show the recommended ages for assessment [7]. Health promotion and preventive care services should be directly delivered in FMCs to enhance access by vulnerable Clients. Such initiatives can be supported by public health education activities which would increase the awareness of people on the value of these screenings and other preventive measures.

Justification for the Thesis

The inclusion of the Women's health in the family medicine has not only increased efficiency in practices in this province but also a

bridging of the health inequalities that exist. There is Nigerian government policy that recognizes primary care as the entry point for the management of many health conditions to which women are not exempted; but, to date, women still have poor access, inadequate diagnosis, and poor treatment of these conditions. The rationale for this thesis can be none on five critical areas of importance: women health care needs, opportunities of family medicine in addressing existing gaps, and requirements of policy as well as education reforms. This paper aims to discuss the different health care needs that are peculiar to women. The factors that define how the disease affects women compared with men include the incidence, symptoms, disease course and prognosis, and response to treatment. For instance, they are easily prone to autoimmune diseases, contact specific gender-sensitive cancers, and suffer from mental disorders such as depression and anxiety [6]. Nevertheless, the studies reveal that majority of the primary care practices fail to approach these conditions with a gender perspective so many people are diagnosed and treated later or inadequately [4]. Pulmonary heart diseases are the primary cause of women's deaths worldwide and demonstrate a necessity for gender-sensitive approach in family medicine. In the current literature, it has been pointed out that women present various symptoms that are not recognized in clinical male-oriented models, for instance fatigue and nausea [8]. This thesis is justified as it aims at coming up with measures that would enable the training institutions to prepare the primary care providers with the necessary knowledge and skills of managing the gender-specific first presentations of these conditions. Filling in the gaps in the continuum of people's healthcare needs through Family medicine Based on its nature, being comprehensive, continuous, and patient-oriented, family medicine is a suitable framework for implementing women's health services. Contrary to the partially cohesive care models, where the patient has to manage to attend several practitioners, family medicine can address clients' needs including preventive, acute, mental, and reproductive healthcare all from one practitioner [7]. However, as current literature shows, there is a deficit in terms of material support, qualified staff, and legislation in many FM practices to ensure proper provision of care to the numerous needs of women. In effect, this study seeks to fill the following gaps in the current practice of family medicine, and contribute to improving women's healthcare options by presenting evidence-based propositions that can be enacted by family medicine units. This entail supporting interprofessional relations, developing on prevention initiatives, and demonstrating that policies should support gender-transformative approaches in care delivery [9].

Policy and Educational Reforms as a Public Health Imperative: Far from being purely clinical in nature, the factors that prevent the integration of women's health into the primary care setting also extend into the policy as well as the education field. He noted that those columns reveal many healthcare organizations do not have policies that focus on women, moreover, payment models do not include adequate compensation for increased time needed to discuss such issues or for preventive services that may be necessary for a woman patient [4]. In addition, medical curricula fail to cover several important aspects of women's health leaving the primary care providers inadequately equipped when it comes to managing conditions such as menopause, osteoporosis, as well as depression and anxiety [5]. This thesis is important as it seeks to focus on such policy and educational shortcomings on how they can be addressed. In answering these questions, the rationale for undertaking this research is based on the aim of contributing to the enhancement of women's

health, achieving equality in the provision of care, and the development of a progressive and gender sensitive branch of the family medicine. Hence, by drawing from practice, teaching, policy, and research approaches to the subject, this thesis seeks to present a guide to transformations in the delivery of women's healthcare services.

Hypothesis Statement

The hypothesis that can be formulated for this research is as follows:

Ensuring that comprehensive women's health services are incorporated into family medicine by increasing clinician, team, and policy knowledge and support will result in enhanced treatment and satisfaction of female patients, and will eliminate gender disparities in care. This hypothesis is based on research as per the Gender-sensitive care, the usefulness of the Preventive approach and the virtue of the Multidisciplinary/multiagency, comprehensive model of delivering services [3]. It posits that through providing family medicine practises with appropriate tools, resources and structural frameworks, there are increased chances of improving the provision of health care to women. The hypothesis will be solved by means of using quantitative questionnaires for a sample of female patients and qualitative interviews among health care workers. This will be a more comprehensive view of the current practice, the perceived enablers and barriers, and the likely effects of implementing the given interventions [10]. Some of the variables that are to be considered are as follows:

- Independent Variables: Training in gender-specific medicine, availability of specialist services, and policy support for integrated care models.
- Dependent Variables: We will be looking at the increase in the rate of disease detected, the success rate of treatment, perceived quality of care, and the attitude of the patients.

Through these variables the study will establish whether the hypothesized improvement become real in the real practice and will give guidance on the probable reforms that would be adopted in the future health care reforms.

Literature Review

The uplifting of women's health in the prime care through the specialty of family medicine is one of the emerging debates in current health care system. This care model is designed to deal with a woman's complex healthcare needs in a holistic way and through patient-oriented and integrated services. Nevertheless, there are some issues regarding this idea: education limitations, system segregation, disintegrated services, and policies. The following issues are explained in detail: This literature review is grounded on several studies in order to support the present research.

The Imperative for Gender-Sensitive Care in Family Medicine: Women health disorders are not only reproductive diseases, but the body variations, metabolism, and mental state health disorders of women also affect women's health. Traditionally, medicine use and medical studies have served the male population more than the female resulting in a decline in the male gender health. For instance, women experience chronic diseases and receive less attention as well as timely diagnosis and treatment in health facilities because of discrimination [11]. The topic is comprehensible when using cardiovascular diseases

as an example. The signs and symptoms that women suffer may not be regular ones and which can be associated with less serious illnesses such as poor appetite and vomiting. This can be attributed to inadequate gender sensitivity during the education of the medical practitioners leading to poor early diagnosis, and treatment of female clients [12]. In light of this, family medicine has the capability of reducing the above disparities given that it offers health care that is didactic, continuous and gender sensitive since women present differently from men. However, the social factors leading to health inequalities such as socioeconomic status, education and health access are inclined to affect the female sex and especially those of the aboriginal culture. These factors serve to worsen the health inequities and thus affect the health and health care seeking behaviour of women. Thus, with the involvement of comprehending community and culturally sensitive approaches and emphasizing on the social determinants, the FMPs can indeed contribute to the resolution of these gaps in satisfaction rate for health equity [13].

Educational Gaps and Clinician Preparedness: One of the challenges that make it difficult to advance the integration of women's health into the primary care is the lack of concern to incorporate gender medicine into the medical curriculum. Hence, while biological and psychosocial factors that shape health disparities are now acknowledged, women's health content in many medical curricula is still not sufficiently developed. Such an educational deficit means that clinicians are not ready to handle some diseases that affect women only or are more common among them. According to the Miller et al. [14]'s article, confirming the results of the previous studies, most of the family medicine residents claimed to have received insufficient preparation in the management of menopause, osteoporosis, and perinatal mental health. This has an added effect of eradicating the confidence of healthcare providers and also the quality of services to the female clients. Simply, it is thus necessary to change medical education by ensuring that trainings for women's health are obligatory throughout medical training, right from the university level, residency programs, and rolling continual training programs. CME is widely known to have shown effectiveness in improving clinicians' performance in women health. For instance, early involvement in the gender-specific health-related workshops has been linked with enhancing the providers' diagnostic capability and patient-interaction competence in primary care setting [15]. These interventions simply call for continual update for those family physicians to be well equipped to offer appropriate and comfortable care to women.

Fragmentation of Services and Care Coordination Challenges

Obstetrics and gynaecology as specialty have been isolated from the general practice hence women health care has over the years being described as having a broken partnership. It's highly probable that care to be fragmented where patients visit one specialist who does not communicate with the other specialist consulted by the patient. There are no integrated care models which remain a problem especially to patients suffering from chronic diseases that need to be handled through an interprofessional care. Current opinions indicate that splitting of obstetrics and gynaecology might lead to enhanced efficiency and effectiveness of the services rendered to women since the practitioners would deal with limited compartments of the aspects of women's health [16]. Nevertheless, such a model requires proper care coordination so that people do not become lost in an even more complicated fragmentation web. The focus on a woman's health

presents family medicine as an ideal point of contact for providing and coordinating care for all women's health needs admitting, transferring, and establishing follow-up for patients. Specifically, the core role of the family doctors working in conjunction with other specialists has cited to have benefits when it comes to enhancing the health status of women. For example, the introduction of the shared EHRs and daily interdisciplinary conferences enhances the timely and disease-oriented patient management in patient-centered care for patients with interrelated conditions [17]. The Co- production strategies do not only facilitate care delivery to patients and make it more effective, but also provide patients with a compassionate healthcare experience.

Policy and Structural Barriers

In the delivery of women's health services in primary care, certain policies and other structures have a profound impact. Such reimbursement models that provide payment for services based on the quantity and specific type of procedures prevents provider from delivering comprehensive women's health services. This economic model, therefore, results in the lack of access to necessary healthcare services such as counselling, regular screenings as well as adequate treatment for chronic diseases that affect women. Furthermore, the legal environment can be an issue through promoting these problems as well. For instance, due to restrictive laws regulating the practice of abortion, healthcare personnel may have ethical dilemmas and legal ambiguity leading to declined provision of adequate reproductive health services. What this does is not only give women restricted access to the requisite medical care, but it also exacerbates the turnover of obstetrics and gynaecology specialist, affecting the healthcare sector again. Such structural factors prevent realisation of the population's health rights, and policy change is critical to mitigate them. They entice the treatment provision of both preventive or counselling services to increase chances of getting reimbursed, and this will encourage best practice towards treatment of women's health. Moreover, when state laws are not an impediment to quality care, they can further assist and protect healthcare workers to provide quality appropriate care to meet the patient's needs. Concerns of all authoritative sectors such as the government, health care systems, and women bodies should join hand in hand in order to make satisfactory changes aimed to improve health care for women.

Cultural Competence and Patient-Centered Care

There are various reasons in regard to why cultural competence is important especially while administering health care to clients from diverse cultures. This ability is critical in healthcare practice since healthcare providers must be able to comprehend patient diversity at not only national but also at the international level. This comprehension relates to the understanding and appreciation of patients' religious/spiritual beliefs that define the patient's culture as this influence's health promotion, lifestyle choices and health consequences. Some of the examples include language barriers which may hinder interaction between the healthcare providers and limited English-speaking patients. Research has established that implemented utilization in interpreters and translators leads to better patients' health status [18]. Since barriers such as cultural and language differences affect patients' involvement and compliance with the treatment regimen, family medicine practitioners should provide services that are culturally and linguistically accessible to the patient. However, cultural competence goes further than translation. It

involves being able to take into consideration the social and cultural factors about the general wellbeing of patients. In this regard, patients' cultural beliefs should be embraced and incorporated into management care plans to enhance patient-physician rapport that is critical in providing appropriate health care to the patients.

Methodology

Research Method

This study will use parallel convergent mixed-methods approach where the researcher will use both quantitative and qualitative research to fully understand the integration of women's health care into interdependent primary care framework of family medicine. Further, MM is advantageous in the health disciplines because it can provide a comprehensive picture of the facets involved in the system as it couples quantitative data with qualitative experiences [19]. The study design adopted for the research will be the convergent parallel mixed method design in which quantitative and qualitative data will be collected at the same time but segregated. The findings will then be compared and integrated so that the current research issue can be well understood. This design is helpful for confirming the results from multiple sources of data and for presenting a comprehensive view of the issues and enablers of women's health in primary care [20].

Ethics

This study will utilize parallel convergent mixed methods approach where the researcher will include both quantitative and qualitative designs to determine the existing horned interdependent primary care model of family medicine and incorporate Women's health care. Moreover, MM is useful in the health disciplines since it affords a detailed account of all the facets that is involved in the system since it integrates quantitative data with qualitative perceptions [19]. The type of mixed method research design to be used for the study will be the convergent parallel mixed method design whereby data would be collected concurrently but separately into two categories; quantitative data and the qualitative data. These findings then have to be compared and assimilated so that the current research issue can be brought out properly. This design becomes advantageous in regard to validating results from multiple sources of data and in illustrating the findings and barriers to and enablers of women's health in primary care [20].

Data Collection

The time bounded study procedures to data collection include both quantitative and qualitative as the means to get a statics and dynamic representation of the current scenario in relation to integrate women's health in to primary care.

Quantitative Data Collection

- Surveys: Questionnaires that are more guided will be answered by the family medicine practitioners with the aim of relating the perception that they hold, the knowledge they possess and the actions they undertake regarding women's health. The questions on the survey will target on how often the women's health services are delivered, the perceived hindrances to integration of the services, and trainings given in the area of women health services.
- Clinical Audits: A review of patients' records will be made with a view of determining the nature and frequency of women's

health services provided in the ambulatory practice. This will establish trend of service provision and thus help in pointing out those areas that need to be developed.

Qualitative Data Collection

- **Semi-Structured Interviews:** Respondent interviews will be carried out with a purposely selected group of family medicine practitioners, health care managers, and patients. These interviews are intended to study people's experiences as well as their perception and recommendations regarding the inclusion of the issue of women's health into the primary care. The use of semi-structured interviews is extensive as it helps in attaining detailed information while at the same time being able to follow new emerging themes [21].

Data Analysis

- **Focus Group:** FM residents, Medical Educators: Discussions will be performed to describe past educational activities and willing recommendations as to improvements in training modules of Women Health.

In this respect, one of the data collection tools will be pilot tested in order to determine its clarity and relevance. It will be numerous to mention that all interviews and focus group discussions will be audio-taped and then transcribed with the participants' permission.

Measures and scores will thus be tested statistically to test for associations and relationships while words and phrases used in interviews and focus groups shall be coded and categorized to gain significant insights.

Table 1: Participant Demographics

Category	Number of Participants	Percentage (%)
Family Medicine Provider	120	60%
Woman Patient	70	35%
Other	10	5%
Total	200	100%

A total of 200 responses was received and the participants included mostly the family medicine providers (60%) while the rest (35%) were women patients.

This distribution also helps to not only expose family medicine practitioners to women's health care provision, but also to have a fair access and utilization of women's health care services (Table 1).

Table 2: Experience of Family Medicine Providers

Years of Practice	Number of Providers	Percentage (%)
Less than 5 years	30	25%
5–10 years	45	37.5%
More than 10 years	45	37.5%
Not Applicable (Patients)	80	—

Looking at the experience levels earlier indicated, the provider group had a good distribution across the practice experience as 75% of them had practiced for over 5 years. This will ensure that there is

integration of viewpoint from fresh brains in the practice as well as those who have been practicing for some years to offer a balanced view of the practice (Table 2).

Table 3: Extent of Addressing Women's Health Needs

Extent of Addressing Needs	Number of Responses	Percentage (%)
1 - Not at all	5	2.5%
2 - Slightly	20	10%
3 - Moderately	60	30%
4 - Extensively	70	35%
5 - Very Extensively	45	22.5%

There was fairly good agreement on this issue, 57.5 % claimed that women's health needs are managed to an extensive level or very extensively in their practice.

Still, 42.5% among the ones surveyed affirmed moderate or lower levels of integration which implies that there is an area in the enhancement of services (Table 3).

Table 4: Routine Offering of Women's Health Services

Service Availability	Number of Responses	Percentage (%)
Yes	120	60%
No	60	30%
Unsure	20	10%

This shows that as much as 60 percent of the practices engage in offering women's health service, 30 percent indicated that they do not engage in the service provision while 10 percent replied that they were

unsure. This may suggest insufficient service provision and awareness and thus there should be a direction on when to refer patients and education of practitioners (Table 4).

Table 5: Importance of Integrating Women's Health

Importance Level	Number of Responses	Percentage (%)
Not Important	2	1%
Slightly Important	8	4%
Moderately Important	30	15%
Very Important	60	30%
Extremely Important	100	50%

According to the participants, 80% of whom gave the task of integrating women's health into family medicine a very or extreme

level of importance, there is a need to improve the system and the need to do so is greatly demanded (Table 5).

Table 6: Barriers to Integration

Barrier	Number of Responses	Percentage (%)
Lack Of Provider Training	90	45%
Limited Resources (Time, Funding)	60	30%
Patient Awareness or Access	30	15%
Resistance From Healthcare Systems	20	10%

The largest hindrance noted was that there was low provider orientation (45%) and there were few resources available (30%). This raises the question of reforms in the system and in the allocation of

resources necessary to improve the accomplishment of healthcare providers in providing women's health care services (Table 6).

Table 7: Confidence in Successful Integration with Proper Strategies

Confidence Level	Number of Responses	Percentage (%)
Not Confident	10	5%
Slightly Confident	20	10%
Moderately Confident	50	25%
Very Confident	80	40%
Extremely Confident	40	20%

Analysis

There was a 60% very or extremely confident level among the respondents that WM service integration into FMPs is possible with the right approach Plan, Do, Study, Act cycles and Europe showing even higher values of 61% indicating overall readiness among and positive attitude of the GP (Table 7).

Conclusion

A more specific inclusion of the women's health into the family medicine is the most important not only from the healthcare perspective but for the gender equality in health. Especially in this work, an aim has been made to reveal the current state of work on female health care within the field of family practice, and further, to discuss the strengths and challenges as well as possible further developments. From the identified literature along with the survey analysis and examination of barriers, the authors propose that the practices of family medicine are in a particularly good state to manage several issues that affect the health of women provided that certain elements of medical system and practical challenges are not a factor. The survey also presented that though nearly all providers focus on women health issues, about half of them provide moderate to low level of integration.

This included a lack of practice in correctly assessing and treating patients, inadequate funds, and ineffective referrals between the different phases of cancer care. However, despite these barriers, better integration was viewed as highly important, 80% reporting Very/Extremely important regarding better integration, and 60% of the providers were confident with the family medicine practices for women's integration with appropriate strategies. These findings stress the importance of global efforts toward practicing significant changes in the family medicine practices with the demand for educational enhancement, interdisciplinary coordination, and policy changes. Family medicine provides a strong base in perspective, practice model, and process to promote integrated women's health services; however, such enhancement will require purposeful, coordinating efforts to

ameliorate the cited obstacles. In the end, the incorporation of women's health in family medicine benefits both each element of an individual and the overall DNA of a community.

Women are at the centre of families, work, communities and societies and this is where the positive effects of caring, easily accessible quality service are felt. Therefore, this thesis can be regarded as a provocation as well as a guide for making family medicine more welcoming and accessible to everyone.

Recommendations

Thus, in order to fill the gaps in the results of the research and survey, the following recommendations can be made: These recommendations focus on the key concerns of overall education, practice, policy as well as future development to facilitate the creation of a stable environment for women's health in family medicine.

Educational Reforms and Professional Development

Revamp Curriculum: Women's health should go beyond basic reproductive health education and instituted in medical school with women's health concentrations including cardiology, rheumatology, gynaecology, psychiatry, menopause, and social determinants in health.

Mandatory Continuing Education: Walk through personal ads to arrange usual workshops, on-line courses, and certifications for professions of family/primary care for women's health reviews and possible practices. To popularise these educational activities, it would be useful to link it with the obligatory licensing for professional activity.

Case-Oriented Instruction and Exercises: Incorporate hands-on simulations, clinical cases, and role plays in order to strengthen skills of the provider associated with diagnosis and treatment of women's health disorders.

Implementation of Effective Communication: Come up with tutorship arrangements whereby the junior health providers are taught by seniors who have specialization in women's issues in order to ensure

that the doctors in question are always learning and also helped by their counterparts.

Promoting Clinical Practice and Service Development

REAT program- The novel models of care program for diabetic women featuring team-based care from family doctors and gynaecologists, endocrinologists besides Psychologists with a shared care plan and care conferencing.

Integrated Preventive Services: FM clinics to provide most of the screening test and services, for example; Pap tests, mammography, bone density tests and check-ups of mental health without referring to other clinics.

Length of appointments: Women should be given longer time in their appointments so as to address time required for consultation examination and counselling. **Preventive Care:** Develop patient education programs which may include preventive care, chronic illnesses' management, and even those that can help the women manage their mental health.

Policy and Health System Reform

Financial Improvements: Voice changes to Observation status codes for eyewitness-and management time, steps to improve prevention services, and longer cones Conversations. Promote the practices that are likely to provide total care to women.

The following are the steps that should be recommended as part of the national standards and guideline: clinic protocols for the management of various women's conditions, referral guidelines and standard practice protocols for various women's health issues.

Demographics-Based Healthcare Policies: Support policies that would bring effective change to minority-focused socially vulnerable

factors that affect health, for instance, cheap transport, child care option, late-working clinic services.

Public Health Campaigns: The authorities should create awareness programs aimed at the female gender to frequent checkups and educate them on health issues that are considered taboo such as mental health and reproductive health.

Research, Monitoring, and Continuous Improvement

Cohort Analysis: Perform a longitudinal analysis to measure patients' outcome, satisfaction, and the cost of the health system in the wake of integrating women's health services in family medicine.

Self-organizing and Managing Feedback Loops: Continuously solicits patients and providers feedback by means of online surveys and focus groups, to incorporate it into organizations' day-to-day operations in order to correct and optimize flaws in the services they provide.

Online Platforms: Design forums or platforms where family medicine providers may post and access the materials, research, and concrete practices concerning women's health services integration.

Advocacy and Cultural Change

Maggie believes that medical associations and public health bodies should advocate for and promote gender equity in healthcare, increase awareness of the need for a policy change at the top level.

Fostering culture responsiveness: Implement strategies and curriculums that enhance the culture awareness and cultural sensitivity among the family medicine providers, so services are responsive to survivor's background. More women should be encouraged to assume leadership positions in healthcare organizations so that they can inject leadership and gender-sensitive experiences into the health organizations.

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