Bristol Women's Health 2017

Joint Strategic Needs Assessment Chapter

Public Health Bristol City Council
in conjunction with
Bristol Women's Commission

Bristol JSNA Chapter 2017

Bristol Women's Health 2017

Chapter information	
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Linked JSNA chapters	

Executive Summary

Introduction

This document is about the health of women in Bristol. It covers a range of topics and is guided by both the Chief Medical Officers (CMO) Women's Health Report and the Womanifesto from Bristol Women's Voice. It is designed to present an overview that complements the Bristol Joint Strategic Needs Assessment (JSNA) Data Profile where a gendered approach is taken, plus other JSNA Chapters which include an equalities perspective.

Background

In 2013, the Mayor of Bristol signed the European Charter for Equality of Women and Men in Local Life on behalf of the City of Bristol. A Women's Commission was established to implement the Charter and to draw up an action plan to address areas of discrimination and disadvantage which women face. The Women's Health Task group was set up to tackle the priority of Health and is the reference group for this chapter.

1. Women's Reproductive Life Course

Women have as the backdrop to their lives and all other health conditions their normal reproductive life course including menstruation, avoiding pregnancy, pregnancy, childbirth, breastfeeding, and menopause. Around 80% of women will give birth (CMO, 2015) and many women will also experience termination, miscarriage and stillbirth.

These experiences are unique to women and this section aims to show the extent to which women in Bristol are affected.

Based on the 2015 Bristol population estimates for 16-50 year olds, there are 117,900 females in this age group. With an all-age-all-gender estimate of 449,300 over 25% of the Bristol population as a whole (all ages all genders) are females who are in their fertile years or 64% of adult women in Bristol. Over a quarter of our Bristol residents are therefore experiencing hormonal and mood changes, invasive treatments and pain associated with a number of experiences including:

- Regular menstrual bleeding
- Fertility treatment
- Pregnancy and miscarriage
- Recovery from childbirth
- Abortion
- Breastfeeding
- Hormonal contraceptives
- Symptoms of menopause

The lifecycle experiences of women continue during her fertile lifespan. Even when experienced as healthy and uncomplicated they nevertheless take up time, money, effort and space in women's brains. Furthermore they may complicate or mask symptoms of other conditions.

These experiences should not be exploited to suggest that women are therefore less capable or should not perform roles of responsibility in society. These experiences disadvantage women not because they occur but because they are not fully acknowledged and structures by which women are adequately supported are not in place.

2. Bristol Women who experience poorer health outcomes

This section gives a brief overview of a number of different groups of women including those with Complex Needs, are homeless, Street Based Sex Workers, Disabled Women, Women with Learning Difficulties, Refugee women, and women in a deprived area of the City. It demonstrates that Bristol women are not a homogenous group and shows us that any women in Bristol live in poverty, with life limiting illness or disability, are single parents, experience abusive relationships, do not speak English and/or experience a combination of these or other disadvantages which will all impact on their health.

3. Women and Mental Health

This section looks at both national and local information. It notes that the most recent survey of the mental health of people living in England has highlighted that mental ill health amongst women has increased in recent years (McManus et al, 2016). One woman in five has a common mental disorder, compared with one man in eight.

Young women between the ages of 16 and 24 have emerged as being at high risk, and are almost three times as likely (26%) to experience common mental health problems as their male contemporaries (9%). They also have higher rates of self-harm, post-traumatic stress disorder and bipolar disorder (McManus et al, 2016). These figures are reflected at the local level in the JSNA 2016-17 dataset. In Bristol during 2015-16 there were 1,345 emergency admissions for self-harm; 869 by females and 476 by males. This figure does not include around a third of adults presenting to Bristol's Emergency departments who were discharged without admission.

During the "perinatal period" that lasts from conception to one year after birth, mothers are at greater risk of developing new mental health conditions such as depression and anxiety as well as a worsening of existing psychiatric conditions or a recurrence of a former mental health illness. Untreated and on-going perinatal mental health issues can affect the mother-infant emotional attachment and adversely affect child health outcomes that may last into adulthood. A new perinatal

mental health protocol for Bristol has recently been released, and can be viewed here: https://bristolsafeguarding.org/children-home/news/perinatal-mental-health-protocol-launch/

Whilst there are many factors behind these poor health outcomes, sexual exploitation, abuse and violence are significant.

It is noted that in a 2009 UK study, lifetime prevalence of domestic abuse among women with mental health problems was found to range between 30% and 60% (Howard et al, 2009). Further, 84% of those who experience the most extensive physical and sexual abuse are women and of those, over half have a common mental disorder (Scott and McManus, 2016.)

Alongside this, mental ill health can make women particularly vulnerable, as women with severe mental health problems were 10 times more likely to experience assault than those without (Pettitt et al, 2013).

Bristol's suicide rate is significantly higher than England's average, ranked 130th of 149 local authorities (Public Health England, 2017). However, whilst the majority of suicides are men, the suicide rate for women in Bristol is now significantly higher than nationally and appears to be rising. .

The specific needs of women will be explored in the new 'Thrive' programme where gender specific responses may be required. An example may be supporting care providers to undertake 'routine enquiry' about abuse in their work, and to provide trauma-informed services, as advocated in NICE's Quality Standard on domestic violence and abuse (NICE, 2016).

4. Gender Violence In Bristol

In this section gender violence and especially Domestic Violence and Abuse in Bristol is explored more fully.

Nationally, 27% of women experience domestic abuse in their lifetimes, with negative impacts on mental and physical health and further impact on families including children (CSEW, 2016).

The number of domestic abuse incidents and crimes in Bristol reported to the Police in the year 2015/16 was 18.5 per 1000 population. This is significantly lower than the England average of 22.1 per 1000 population. Furthermore, there are areas of Bristol which have reporting rates far higher than the England or Bristol averages. Hartcliffe and Withywood had the highest rate in Bristol for this time period with 42 reported incidents per 1000 of the population.

Scott and McManus found in their research Hidden Hurt (2016) that: "Overall women are twice as likely as men to experience interpersonal violence and abuse and the

more extensive the violence the more likely it is experienced by women rather than men."

The JSNA dataset tells us that:

- The rate of recorded domestic abuse incidents in Bristol has shown a significant rise over the last 2 years and 74% of victims were female
- Numbers of reported sexual offences rose by 28% in Bristol last year (21% nationally). 84% of victims were female (2015/16).
- Bristol has one of the highest numbers of recorded cases (prevalence) of female genital mutilation (FGM) in England (2015/16).

It is noted that as well as short term injuries, victims of abuse suffer a range of chronic health problems associated with abuse including: chronic pain , neurological disorders, gastrointestinal disorders, migraines/headaches, raised cardiovascular risk, fibromyalgia and increased minor infectious illnesses (Crofford, 2001,Coker et al, 2009, Safe lives 2015). Domestic abuse often leaves victims with reproductive consequences, including gynaecological problems, sexually transmitted infections and difficulties in pregnancy (Coker et al, 2009, CTC, 2014). One in five high-risk victims reported attending A&E as a result of their injuries in the year before getting effective help (Safe lives, 2015). Research has shown clear links between women's experience of domestic abuse and a range of mental health problems, including depression, post-traumatic stress disorder (PTSD) self-harming behaviours and suicidality (Abrahams, 2004; Abrahams, 2010; Humphreys and Thiara, 2003; Stark, and Flitcraft, 1996; Kirkwood, 1993).

There is evidence that women who experience the most extensive abuse and violence (both as children and adults) are more likely to face other adverse circumstances in their lives such as poor mental and physical health, disability, and substance misuse, poverty, debt, poor housing, and homelessness (Scott & McManus, 2016). It is noted that many women have an alcohol problem as a result of abuse where alcohol is used as a coping mechanism (Walby and Allen 2004).

5. Prolapse and incontinence

Incontinence can be seen as a hidden disability. The process of childbirth and menopause put women at a higher risk of prolapse and incontinence. Despite these being widespread issues there has been little attention on them either locally or nationally except via the advertising of incontinence products.

It is estimated that 34% of women are affected (Urinary Incontinence in Women, NICE, Jan 2015) which equates to 60,000 women (19+) in Bristol being affected.

In women over the age of 80, 36% or 3,900 are living with urinary incontinence. Faecal incontinence remains a greater taboo subject than urinary incontinence; it is quite prevalent, with an estimated 1–10% of adults living with this condition.

The exact prevalence for pelvic organ prolapse is difficult to estimate, however in one study of over 27,000 post-menopausal women over 50, 40% had some degree of prolapse.

The Incontinence Service in Bristol suggests pelvic floor exercises are promoted as part of Public Health work. The Chief Medical Officer made recommendations Public Health England convene a group of stakeholders to consider ways of raising awareness of urinary and faecal incontinence and prolapse in women, and improving signposting to resources, self-help information and treatment pathways which alleviate these conditions.

6. JSNA Dataset

This section of the chapter reports on the JSNA 2016-17 Data Profile from a women's health perspective and only includes data from this source. It is intended to give an overview of Bristol women's health issues which have not been covered in previous sections of this chapter.

The full JSNA dataset can be accessed here:
https://www.bristol.gov.uk/documents/20182/34740/JSNA+2016+to+2017+final+version/1ffc45f9-0a75-4e04-8b0d-a1ee86f23bf2

Headline concerns from this section:

- Women live longer in poor health than men
- Bristol female preventable mortality rates are significantly higher than the England rates
- There are more women than men with a "limiting long-term illness or disability" living in Bristol
- Data on smoking is not available by gender for Bristol
- Local women are significantly less likely to be physically active than men
- Bristol rates for admission to hospital for alcohol-related harm are worse than national average for women
- Rates for early deaths due to cancer for women in Bristol are significantly higher than for England and screening coverage for breast and cervical cancer in Bristol between 2010 & 2015 has consistently been significantly lower than the England average (and other cities with a similar population).
- Bristol rates for early deaths due to respiratory disease for women are significantly higher than England (2013-15).
- During 2013-2016 (3 year combined data) there were 1,500 emergency hospital admissions due to asthma. This was 835 females and 660 males
- Nationally more women than men develop dementia over the course of their life and more women than men care for people with dementia
- The majority of falls-related admissions at Bristol Hospitals (2014-2015) (aged 65+) were women
- 2 out of 3 Excess Winter Deaths were women.

7. Conclusions and Recommendations

A number of health concerns for women in Bristol have been identified by using an approach which looks at the topic from a number of different perspectives.

Women's mental health and gender violence and their interconnected nature have been raised and these topics are undoubtedly priorities for Bristol and need further work.

A number of gaps in data collection and reporting were identified including that data on smoking is not available by gender and that getting data which cuts across intersections of inequality is difficult.

Bristol has an aging female population and a number of issues associated with older age including cancer, disability, falls and excess winter deaths have been identified as issues for women in Bristol.

Some of the issues raised or left out of this document will be addressed via other dedicated JSNA chapters taking a gendered approach.

It has been highlighted that account needs to be taken of the fact that women continue with the business of dealing with their reproductive life-course alongside their other life responsibilities and that this may put them at a disadvantage which needs to be addressed. In addition the reproductive life-course may have complications for women and incurs an increased risk of incontinence and prolapse. With many older women in Bristol this may further exacerbate inequalities.

Recommendations:

1. A strategy for Bristol Women's Health is written, led by the Women's Commission and taking into account the content of this document and the other JSNA chapters.
2. A review is conducted of the other JSNA Chapters to ensure they include data for women (and other equality groups, where possible) and that the specific needs of women and girls are highlighted and acted upon as part of the work for that topic e.g. in the commissioning process for services.
3. Ensure that the JSNA chapters on Physical Activity, Substance Misuse / Drugs, Food Poverty, Healthy Urban Place, Falls, Adult Social Care, Healthy Life Expectancy and Healthy Weight and others all include gender disaggregated data and that the content of this document is considered in their development.
4. The Women's Commission lead work across their task groups to increase understanding about the reproductive life course of women and girls and its effect on women's lives as they live them in Bristol. This is both with health professionals regarding, for example, endometriosis, but also with other professionals and the public. It could include campaigns, information for

public and professionals and work in schools on what is considered normal e.g. bleeding monthly and mood changes, and which symptoms or bodily changes need further investigation.

5. Data
    a. Work with health service providers in the city, including GPs to ensure that gender disaggregated data is available, reported and analysed. Encourage use of additional read codes so that the needs of different groups can be analysed.
    b. Explore how intersections of inequality in women's health can be researched though gathering data for gender which also identifies other equalities characteristics e.g. disability, BME women, transsexual women. This could for example, be through a gender health page for the Quality of Life survey and/or a one-off more specific fact finding mission along the lines of the Big Drink Debate.
6. Address the health inequalities faced by women who experience the poorest health outcomes in Bristol by ensuring that services, campaigns and other initiatives are directed appropriately.
7. Continue to support the work of the Bristol Domestic and Sexual Abuse Strategy Group to co-ordinate work across the city to address gender violence in Bristol including work in schools (The Bristol Ideal) and work at community level.
8. The gender differences in mental health experience need to be acknowledged including the effects of gender violence on the mental health of women and girls.
9. Prolapse and incontinence work needs to be explored with Public Health England following Recommendation 15 of the Chief Medical Officer's report on women's health that Public Health England convenes a group of stakeholders to consider ways of
    a. raising awareness of urinary and faecal incontinence and prolapse in women
    b. improving signposting to resources, self-help information and treatment pathways which alleviate these conditions.

Disclaimer

This document focuses on the health needs of women in Bristol and information is included up until July 2017. It is not a comprehensive look at all health needs of all women in Bristol. It is also not an attempt to suggest that the health needs of the local female population are any more or less important than those of people who do not identify as women e.g. Gender Variant people or men whose health is not covered in this Chapter. Some of the information and research cited is quite old. However, the most up to date data and research have been cited and we recognise that in many places more up to date research is needed.

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Appendix 1: Falls Summary of JSNA Chapter - Women

JSNA Chapter report

1. Introduction

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As Dame Sally Davis in the introduction to her Chief Medical Officer's Annual Report 2014 stated,

> "Problems 'below the waist' are not generally seen as attractive topics for public or political discourse. Women are often reluctant to seek help for conditions that are common, disabling and taboo, such as urinary and faecal incontinence and menopausal symptoms. Violence affects women in England's physical and mental health on a scale which demands action across society. We must be able to talk about these issues…"
>
> (CMO 2015 p11)

This chapter is an attempt to start that discourse in Bristol.

It starts with an overview of Women's Reproductive Life-course and goes on to cover women with the poorest health outcomes, women's mental health issues, gender violence, incontinence and prolapse. The final chapter details information from the JSNA data set that has not been captured elsewhere in the document.

The document concludes with a number of recommendations to improve the health and wellbeing of Bristol Women, including the development of a strategy for Bristol Women's Health, led by the Women's Commission and taking into account the content of this document and the other JSNA chapters.

Background

In 2013 the Mayor of Bristol signed the European Charter for Equality of Women and Men in Local Life on behalf of the City of Bristol. In order to implement the charter, a Women's Commission was established to draw up an action plan to address the areas of discrimination and disadvantage which women face. Task groups were established from this as sub-groups of the women's commission, including the Women's Health Task Group.

This JSNA chapter was overseen by the Women's Health task group as part of a piece of work to address Bristol women's health which also included:

- Hosting the Bristol Women's Health Conference on 8 March 2017 (International Women's Day)
- Developing the Joint Strategic Needs Assessment (JSNA) Data Profile 2016-17 to include separate data for women and men (where possible)
- Support with development of a range of JSNA Chapters on priority topics, to include data for women (and other equality groups, where possible) and comment
- A literature review of Women's health
- Research into Young Women's Health undertaken by the University of the West of England.

This document has also been informed by:

- Bristol Women's Voice developed the 'Womanifesto' which includes a chapter on health and social care and made a number of recommendations regarding the JSNA
- The Women's Health and Equality Consortium (WHEC) document "Better Health for Women" guidance on JSNA's
- Women's Health Conference workshops, March 2017
- Community Access Support Service (CASS) workshop on International Women's Day in March 2016
- CASS mental health workshop at the Bristol Big Sisters event October 2016
- Focus groups of local women including:
    - Health Champs Group in Knowle West
    - Refugee Women of Bristol.

2. Women's Reproductive Life Course

Women have as the backdrop to their lives and all other health conditions their normal reproductive life course including menstruation, avoiding pregnancy, pregnancy, childbirth, breastfeeding, and menopause. Around 80% of women will give birth (CMO, 2015) and many women will also experience termination, miscarriage and stillbirth.

These experiences are unique to women and this section aims to show the extent to which women in Bristol are affected.

Based on the 2015 Bristol population estimates for 16-50 year olds, there are 117,900 females in this age group. With an all age all gender estimate of 449,300 it is calculated that over 25% of the Bristol population as a whole (all ages all genders) are females who are in their fertile years or 64% of adult women in Bristol. Over a quarter of our Bristol residents are therefore experiencing hormonal and mood changes, invasive treatments and pain associated with a number of experiences including:

- Regular menstrual bleeding
- Fertility treatment
- Pregnancy
- Recovery from childbirth
- Abortion
- Breastfeeding
- Hormonal contraceptives
- Symptoms of menopause
- Complications of any of the above

2.1 Menstruation

The menstrual cycle varies but the average is to have a period every 28 days and a cycle of anything between 24 to 35 days is normal. Between the ages of 12 and 52, a woman will have around 480 periods, or fewer if she has any pregnancies. Periods last around three to seven days and in total a woman will spend around 6.25 years of her life bleeding (NHS Choices, 2015).

The average age for menstruation to start is 12.9 (12 years and 11 months) for UK girls. A report, from the ESRC International Centre for Life-course Studies in Society and Health found that Indian, Bangladeshi and black African girls were most likely to have started their period at age 11, with Indian girls three-and-a-half-times more likely than their white counterparts to have done so. Girls from the poorest and second poorest groups were one and a half times more likely to have started their periods early. Early onset puberty is linked to a number of conditions including poor mental health in adolescence as well as breast cancer and cardiovascular disease in later life (Kelly et al 2016).

A recent survey of 1000 girls aged 14-21 who were asked about their experiences of menstruation found that the taboos around periods can, and do, have serious consequences. One in seven (14 %) girls admit that they did not know what was happening when they started their period and more than a quarter (26 %) reported that they did not know what to do when they started their period (Plan International UK 2017).

Of those surveyed:

- Only one in five (22%) girls felt comfortable discussing their period with their teacher
- Less than a quarter (24%) of girls felt comfortable discussing their period with their male friends
- Under a third (29%) of girls felt comfortable discussing their period with their fathers
- Four fifths (82 %) of girls admitted they have hidden or concealed their sanitary products
- Almost three quarters (71%) of girls admitted that they have felt embarrassed buying sanitary products.

More than half (59%) of girls revealed that they had received negative remarks about their perceived behaviour and mood whilst on their period and one in ten had been asked not to talk about their periods in front of their mother (12%) or father (11%).

The research also found that girls are feeling the need to make up excuses for when their period has an impact on their day-to-day life. They found that:

- 49 % of girls had missed an entire day of school because of their period, of which 59 % have made up a lie or an alternate excuse
- 64 % of girls had missed PE or sport because of their period, of which 52 % of girls had made up a lie or excuse
- 68 % of girls admitted they felt less able to pay attention at school/college and work and more than half (52 %) had made up a lie or excuse.

This research on the effects of menstruation on girls is backed up by local anecdotal evidence from a number of sources.

Early Help in Bristol,(a service delivered as part of first response safeguarding children service) report that girls they are in contact with show a lack of understanding about issues relating to menstruation including hygiene issues and who to talk to if they feel they can't discuss issues with their parents. For example, they are unsure how to appropriately dispose of sanitary products and have issues with choosing the right sanitary products for them, that parents can also afford. Furthermore, they know little about pre-menstrual tension, their cycle and that they may have heavier days than others, how to manage cramps and the need to carry sanitary products with them.

Elected Members have expressed concern about the number of school absences that are being recorded by girls on the days when they have their period. This is not substantiated because it would be recorded as authorised absences for ill health, not as period related.

Some pain or discomfort from monthly periods is common for all women, with up to 80% of women report having some symptoms prior to menstruation (Biggs et al 2011). Common signs and symptoms include acne, tender breasts, bloating, feeling tired, irritability, and mood changes (Office for Women's Health 2014). These may interfere with normal life, in 20% to 30% of women and in 3% to 8%, symptoms are severe (Biggs et al 2011*)*.

Dysmenorrhoea is one of the commonest gynecological conditions that affects the quality of life of many women in their reproductive years. It is experienced as uterine cramps and can occur a few days prior to menstruation and/or during menstruation, and usually subsides at the end of menstruation. Pain can last 2-3 days after the period and bleeding begins.

Severe period pain has been linked with up to 14% of all women needing time off work each month (BMJ 2017).

In September 2016, a number of UK newspapers reported on the findings of a survey, which questioned 1,000 women for BBC Radio 5 Live's Emma Barnett programme. This survey found that 90 % of the women reported having period pain at some point. More than half (52 %) of women workers taking part said period pains have a negative impact on their ability to work and of that 52 %, nearly a third had taken at least one day's sick leave as a result (Independent 2016).

In 2016, Coexist, a Community Interest Company in Bristol with a large female workforce introduced a "period policy" in an effort to give women more flexibility and "create a happier and healthier working environment". It was the first company in the UK to introduce a policy to allow women leave if they are suffering.

2.2 Conception and Contraception

Whilst pregnancy can be a positive experience and is often planned, a significant percentage of pregnancies are unplanned and unintended. The National Survey of Sexual Attitudes and Lifestyles found that 16.2% of pregnancies among women in Britain aged 16-44 were unplanned and 29% were ambivalent (Natsal, 2013). Some women with unintended and unplanned pregnancies will decide to proceed with their pregnancies. While many of these pregnancies will become wanted, the fact that the pregnancy was unplanned may cause financial, housing and relationship pressures and have impacts on existing children. The study found that pregnancies in young, single women were most likely to be unplanned, with the highest proportion of unplanned pregnancies in the 16-19 age group.

The study also shows how pregnancy prevalence, intention, and contraceptive protection change throughout the life course. In the youngest age group, 16–19 years, sexual inactivity is more common and being pregnant or planning to conceive is rare, but although the use of effective contraception by those who are sexually active is high, a few use less effective methods including methods used after unprotected sex. Through their 20's, many more women are sexually active and pregnancy experience and intention become more common, but use of contraception remains high and effective methods are more commonly used than less effective ones. Intention to conceive peaks in the early 30s and remains high until after age 40 years, when the risk of conception is reduced by use of permanent contraception, post-menopausal status and sexual inactivity.

Women spend an average of 30 years needing to avert an unplanned pregnancy (CMO, 2015). It is essential to ensure that a full range of contraception can be accessed by women during their reproductive years. There are 15 methods of contraception that are available in the UK and free on the NHS to most people. The effectiveness of each method is dependent on a number of factors; the method failure rate; the user failure rate; and the provider failure rate. NICE guidance (NICE, 2005), advises that long acting reversible contraception (LARC), such as contraceptive injections, implants and the intrauterine system or intrauterine device are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. LARCs are only available for use by women. In Bristol, the GP and sexual health service LARC prescribing rate is 65 per 1000 women, which is above the national average of 48.2 per 1000 (Public Health England, 2015a). This may be a possible indicator or wider access to contraceptive methods in Bristol for women and girls.

Emergency contraception data from pharmacies shows us that a total of 4471 women and girls aged 16 and above accessed this type of contraceptive via these venues in the year to March 2017. The most common reason was after unprotected sex with a man.

2.3 Abortions

Abortion rates can provide some indication of the ease of access to, and the quality of contraception services and advice, as well as problems with individual use of contraceptive method. In 2015, the total number of abortions in Bristol was 1,504 and the total abortion rate per 1,000 female population aged 15-44 years was 14.4. In 2016 this rose slightly to 1,615 abortions and a rate of 15.1 per 1,000 but in both years the Bristol rate was significantly lower that the England average.

The conception rate for Bristol women aged under 18 in 2015 (17.3 per 1,000 aged 15-17 years) was the lowest since rates were routinely recorded in the late 1990s, and significantly lower than the national average having fallen by more than half

since 2007. Termination rates for this age group in 2015 were also significantly lower than the national average, as were repeat termination rates for under 19s in 2016, indicating some success in the provision of support and contraception to this age group. The under 19s repeat termination rate for Bristol in 2016 (6%) was the 142nd lowest of 155 areas that had numbers that could be shared, considerably lower than any other city within its peer group of ‘core cities’, and overall there is a picture of fewer unwanted pregnancies in Bristol for this age group than most of the country, and effective intervention with those that have had a termination already.

There are some signs in the data that services may not be quite so effective for slightly older women even though Bristol’s total termination rate is relatively low. Among women under 25 years who had an abortion in 2016, the percentage of those who had had a previous abortion was 24.3%, a figure statistically similar to the national average. By the time they are 45, 1 in 3 women will experience an abortion in her lifetime (NHS Choices, 2016)

The numbers of teenage conceptions in Bristol fell from 360 in 2007 to 113 in 2015. Although the numbers of women conceiving in their teens has fallen markedly in Bristol, data reported by specialist teenage conceptions staff working in the city suggests that those still conceiving are likely to have complex needs and require a high level of support, at a time when falling numbers threaten the sustainability of services designed to support them.

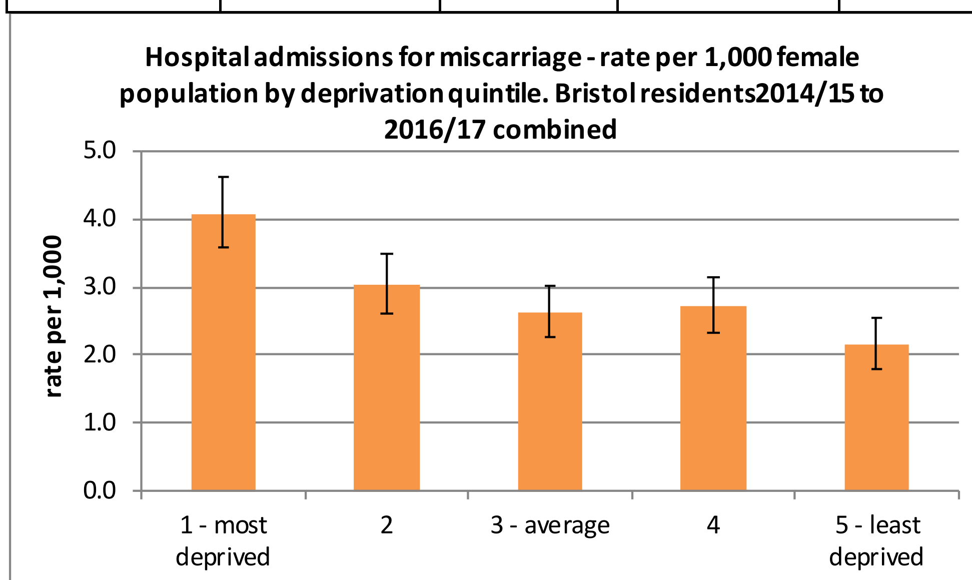
Although only a small proportion of the population are now affected by teenage conceptions, the risk varies widely across the city. In 2014 it was 1 in 45 women in the appropriate age group in Bristol, but in those wards where it is most frequent, around 1 in 15 women aged between 15 and 17 years of age conceived during an average year, while the risk was at least 6 times less in the wards with the lowest incidence. Higher rates of teenage conception tend to be found where deprivation is higher, and teenage conception can be both a cause and symptom of disadvantage, helping to embed and perpetuate poorer outcomes where it is most common.

2.4 Miscarriage

The hospital data for Bristol shows that there is a relationship between women living in deprivation and higher rates of both miscarriage (spontaneous abortion) and ectopic pregnancy.

Number of hospital admission episodes with the primary diagnosis of spontaneous abortion and ectopic pregnancy by deprivation quintile, females, Bristol residents 2014/15 to 2016/17 (combined)

	Number of admissions		Rate per 1,000 female population aged 15 to 44	
IMD quintile	Spontaneous abortion	Ectopic pregnancy	Spontaneous abortion	Ectopic pregnancy
1 - most deprived	245	89	4.1	1.5
2	194	60	3.0	0.9
3 - average	182	61	2.6	0.9
4	171	56	2.7	0.9
5 - least deprived	132	38	2.1	0.6
unknown	85	39		
Grand Total	1009	343	3.2	1.1



2.5 Maternity and Childbirth

Most births in Bristol are to UK-born mothers (4,620 in 2014). 28.3% (1,820) of births in Bristol are to non-UK born mothers, and this figure has fallen slightly since 2012. Somalia and increasingly Poland are the most common countries of the mother's origin for Bristol births to non-UK born mothers (JSNA, 2017).

NHS maternity care in Bristol is provided via the two hospital trusts – North Bristol Trust (NBT) and University Hospital Bristol (UHB). Choices for place of birth include home birth, hospital birth or birth in midwife led units.

2015/2016 data shows there were 6,366 birth episodes for Bristol women that year. Of these, 58% of NBT and 62.7% of UHB births were delivered normally with the remaining births being delivered either by caesarean or using instruments (forceps or a ventouse suction cup) (Maternity Voices, 2016).

Women recovering from childbirth will often experience afterpains (contractions) for several days after childbirth and shrinking of the uterus to its pre-pregnancy size may take 6 to 8 weeks. Sore muscles (especially in the arms, neck, or jaw) are common in the few days after childbirth. This is because of the hard work of labour. Bleeding and vaginal discharge may last for 2 to 4 weeks and can come and go for about 2 months. Vaginal soreness, including pain, discomfort, and numbness, is common after vaginal birth. Soreness may be worse if you had a perineal tear or episiotomy.

Women who have had a caesarean may have pain in their lower belly and may need pain medicine for 1 to 2 weeks. Breast engorgement is common between the third and fourth days after delivery, when the breasts begin to fill with milk and this can cause discomfort and swelling (NHS choices)

Mental illnesses are very common affecting one in five women at some point during the perinatal period (during pregnancy and the first year after birth), (CMO, 2015).

2.6 Breastfeeding

A dedicated JSNA chapter on breastfeeding is due to be published in early 2018.

WHO recommends all mothers should feed their babies only breast milk for the first six months of life, and continue as long as they wish up to 2 years and beyond.

The JSNA Dataset tells us that Bristol has a higher rate of breastfeeding initiation than the national average at 82.2% vs 74. Rates vary across Bristol and between different groups of women. In Bristol rates are lowest for white women living in deprived wards in the city.

Continuation rates are lower than initiation rates as mothers may encounter barriers to successful breastfeeding. Bristol has significantly better breastfeeding continuation rates at 6-8 weeks (58.4% in 2014/15) than England (43.8%) and is highest of the English Core Cities and higher than almost all comparable cities. Within this, Bristol has better rates of exclusive breastfeeding at 6-8 weeks (40%) than nationally (30%).

However, there is variation in breastfeeding continuation rates across Bristol. Rates are generally higher in North and West (inner) locality (up to 84% in Clifton), and much lower in South Bristol (down to 30% in Hengrove & Whitchurch Park and 24% in Hartcliffe & Withywood. Generally, there is a higher rate of breastfeeding in BME communities.

2.7 Menopause

Menopause is a biological stage in a woman's life when menstruation ceases permanently due to the loss of ovarian follicular activity. It occurs with the final menstrual period and is usually diagnosed clinically after 12 months of amenorrhoea.

In the UK, the mean age of the natural menopause is 51 years, although this can vary between different ethnic groups. (NICE 2015)

A range of symptoms are typically associated with the menopause and perimenopausal changes prior to it, and these may last for many years (the average duration of symptoms is 6 years). These symptoms include vasomotor symptoms (hot flushes and night sweats), mood changes, sleep disturbance, musculoskeletal symptoms, urogenital symptoms, and sexual disorders.

Calculating how many women are suffering adverse symptoms of menopause is quite difficult. NICE guidance has a spreadsheet for estimating prevalence of menopause which they suggest is:

50 – 54 years = 60%
55 – 59 = 15%
60 – 69 = 6%
70+ = 3%

Using this a prevalence of **11,186** women with menopause are estimated to currently live in Bristol (based upon mid 2016 population estimates) plus a number of women under 50 that are not included in the NICE calculations. In addition, there are issues of how long menopause lasts, perimenopause and severity of symptoms. Perimenopause begins some years before the menopause itself as the ovaries gradually begin to produce less oestrogen. It usually starts in a woman's 40s, but can sometimes start in her 30s. In the last one or two years of perimenopause, the decline in oestrogen accelerates. At this stage many women experience menopausal symptoms.

An IPSOS MORI survey in 2016 found that 80% of women aged between 45 and 65 were currently experiencing menopausal symptoms or had done in the previous 10 years, some of which may be painful or distressing, yet just half had consulted a healthcare professional for help with these symptoms. Half of those surveyed reported that these symptoms had affected their ‘home life’ and more than a third reported an impact on their social and/or work life.

Based on this survey’s findings and other sources it is estimated that approximately 38,000 women in Bristol aged between 45 and 65 will have experienced such symptoms in the last 10 years, and up to one-third of them will currently be experiencing symptoms (11,000 – 15,000).

The numbers of older women in employment have been rising for a number of years and as a result, many more women will now experience adverse menopausal symptoms whilst in employment.

A report on women’s participation in the labour market during menopause transition (GEO 2017) notes that whilst the evidence identifies many negative effects on

participation, the quality of evidence is mixed for the most part, and significant gaps exist (p 75). For example, costs the evidence base does not quantify at all include:

- decreases in household income or costs borne by family members having to earn more income
- symptom-related lateness to work
- lost productivity due to medical appointments during working hours
- women who reduce their working hours due to symptoms
- dynamic effects on career – eg, losing out on promotion opportunities
- increased symptoms due to work
- women feeling they are treated negatively by colleagues and managers as a result of transition.

They conclude that given the lack of evidence it is not possible to determine the economic costs of menopause transition in the UK.

Many women are able to manage their symptoms with lifestyle changes such as taking regular exercise, avoiding possible triggers for hot flushes, and ensuring good sleep hygiene. For some women, hormone replacement therapy (HRT) may be useful.

In the *Time of our Lives* study (de Salis 2017) 49 women from Bristol and surrounding area, were interviewed about their experiences and perceptions of midlife and menopause. Although women had diverse experiences of this process, they described menopause in three dominant ways: as normal and natural; as struggle and distress; as transformation, liberation and new beginnings. Many women also looked forward to no periods or risk of pregnancy. So, menopause can be both a positive time and a difficult one.

The shame, taboo and stigma of menopause exacerbated women's distress. This meant some women couldn't share experiences with friends, tell their bosses they were menopausal for fear of appearing incompetent or 'passed it', or seek support from health care professionals.

Women in the study had varying levels of needs and experiences of support. Some women had been well supported by the health service or other health practitioners:

> "I am just feeling more like me (after taking HRT) …that I am not quite as bonkers as I was feeling."

> "I've been having monthly shiatsu for years to keep my energy balanced and I think this has helped me a lot during my menopause."

But too often some women felt uncomfortable seeking help and that their GPs did not take menopause seriously. Others wanted a place to share experiences and gain information:

> "Well I could go and see the doctor, but I, you just feel like such a fool really."
>
> "I wish there was a Well Woman clinic I could go to just talk through my symptoms."

The Menopause was also a workshop topic at the Women's Health Conference held in Bristol's City Hall on March 8th (International Women's Day) 2017. This event for professionals made the following recommendations for further action:

1. Information hub to provide and ensure widespread access to accurate, up-to-date and appropriate information on full range of approaches and options for the management of the menopause

2. Consultant-led specialist menopause service for Bristol:

   - support Primary Care to implement NICE guidance and to fully appreciate the range of needs for women experiencing the menopause

   - care for women with complex health needs requiring management of menopausal symptoms

   - partnering with local organisations to provide support groups, information on other therapies and promoting choice in menopausal care

3. Encourage employers to implement the TUC/Faculty of Occupational Medicine guidelines on supporting women in the workforce going through menopause.

These suggestions were re-visited at 'Our Menopauses', an event for women to learn and share experiences and ideas about menopause in City Hall on 18th November 2017.

2.8 Complications of the reproductive Lifecycle

The Women's Health All- Party Parliamentary Group raised concerns around endometriosis and Fibroids via a report published in March 2017. This used information collected using an online survey and freedom of information requests to hospital trusts.

As well as some specific recommendations around the conditions, the report also recommends that menstrual health education is undertaken in secondary schools and includes wider awareness about what is normal pain and what is not. Women

still feel stigmatised about discussing “women’s problems” and put up with incredible pain because they are not aware of what is “normal”(APPG, 2017).

2.9 Intersections of Reproductive Life course with inequalities, conditions and behaviours

Some women experience particularly poor health outcomes around the reproductive life course. An example is women from Gypsy, Roma & Traveller communities who experience higher infant mortality rates (up to five times higher), lower birth weights, lower levels of breastfeeding, higher maternal death rates and higher prevalence of miscarriage (16% vs 8%), (JSNA, 2017).

Homeless women have issues with getting access to sanitary towels and tampons with no Government funding currently going towards providing these. Bristol shelters have small supplies of products. In Bristol there are also issues with access to washing facilities like public toilets. Staff at Bristol’s women’s night shelter – Spring of Hope, report that security staff at the Galleries and Cabot Circus stop homeless women from accessing toilets there (Bristol Women’s Voice , 2015. The Homeless Period, 2016).

Pregnancy can interact with other health conditions and result in further complications.

Diabetes and hypertension can be revealed during pregnancy and manifest due to gestational changes in physiology, years ahead of when they might otherwise have shown up (CMO, 2015).

Obese women have lower fertility rates and greater risk of early miscarriage (Gillman and Poston, 2012). During pregnancy, obesity confers greater risk of metabolic disease such as gestational diabetes, of perinatal complications and of later Non-Communicable Diseases (NCD) such as diabetes and hypertension in both the mother and her child (O’Reilly and Reynolds 2013).

The trend in Bristol seems to be towards increasing numbers of overweight and obese mothers and a reduction in mothers of healthy weight when measured at booking for antenatal care. Within the Bristol/North Somerset/South Gloucestershire (BNSSG) area, nearly half of pregnant women have a BMI of over 25 at booking, with 20% being classified as obese with a BMI of 30 or over (Bhattacharjee and Mytton 2014).

The JSNA dataset details data for smoking in pregnancy. This is because whilst all smoking is harmful, smoking during pregnancy is harmful for the baby as well as the mother.

For several years, Bristol mothers’ rate of smoking at the time of delivery had been lower than the national average, down to 10.3% in 2010/11. This rose 2012- 2014,

but has been falling since and is in line with the national average. Over 630 pregnant mothers (10.1%) in Bristol self-reported as smokers (BCC 2016). This is broadly similar to the England average (10.6%), but is one of the lowest rates for Core Cities, and for other comparable cities. Further analysis of local data up to 2012 (by Bristol Public Health Knowledge Service, 2014) showed that the rates of smoking in pregnancy were highest in areas of greatest deprivation.

2.10 Conclusions

The reproductive lifecycle experiences of women continue during her fertile lifespan. Even when experienced as healthy and uncomplicated they nevertheless take up time, money, effort and space in women's brains. Further they may complicate or mask symptoms of other conditions.

These experiences should not be exploited to suggest that women are therefore less capable or should not perform roles of responsibility in society. These experiences disadvantage women not because they occur but because they are not fully acknowledged and structures to adequately support women are not in place.

3. Bristol Women who Experience Poorer Health Outcomes

Bristol women are not a homogenous group and this section looks at some examples of women in Bristol who experience poorer health outcomes in order to help us move away from a model of Bristol women as white, well-educated cis-gender mothers in loving relationships (with a man) a stable home, a job and enough money to cover their everyday needs.

An important element of the Public Health Outcomes Framework is to reduce inequalities in health. In order to do this it is necessary to identify those who have the poorest health outcomes and ensure that our services and interventions are targeted and accessible as appropriate.

Many women in Bristol live in poverty; may have life limiting illness or disability; be single parents; experience abusive relationships; do not speak English and/or experience a combination of these or other disadvantages.

The following should be considered as examples, both of the groups of women and of their health inequalities. This is not an exhaustive or comprehensive view of either.

3.1 Women with Complex Needs

Women with complex needs are those women who are experiencing multiple issues in their lives which can include physical or mental health and/or addictions, involvement in the Criminal Justice system and problems finding and maintaining housing.

The essence of complex needs implies both:

- breadth - multiple needs (more than one) that are interrelated or interconnected
- depth of need - profound, severe, serious or intense needs.

Deterioration in physical and mental health can be the result of other problems, such as homelessness. It can also be the case that chronic or persistent physical ill health can give rise to other and more complex problems. (Rankin and Regan 2004).

- **Women and homelessness**

The organisation Crisis reported in 2011 that nationally homeless people are more likely to die young, with an average age of death of 47 years. Homeless women at 43 die younger than homeless men (Crisis 2011) however, they note that this is not life expectancy; it is the average age of death of those who die on the streets or while resident in homeless accommodation.

Locally, the TARA Project has researched the health and social care needs of homeless women. Conducted over 2 years with a cohort of 38 homeless women in Bristol, the study was undertaken by researchers from the School for Policy Studies, University of Bristol, led by Dr Emma Williamson and funded by the NIHR School for Social Care Research.

The study found that many have experienced high levels of childhood abuse, domestic violence and sexual violence. Findings stress the need for safe housing, co-ordinated support for multiple problems and the importance of being listened to.

One of the factors that has been identified as resulting in episodes of homelessness for women is abuse and violence within their sexual and emotional relationships (McNaughton and Saunders, 2007).

Women who are homeless or at risk of becoming homeless often have complex social care and health needs and once a woman becomes homeless, many existing problems are made more difficult.

Mental health issues develop further with the insecurity of homeless life on the streets or in unsafe accommodation. The ability to self-care e.g. eat, sleep, attend to personal hygiene regularly or to take medication or attend appointments is affected and this puts further pressure on both mental and physical health

Reliance on drugs or alcohol as a mechanism for coping with daily life may develop or worsen as a result.

Previous research shows that there is a lack of physical and emotional safety and that women are at risk of further abuse (Williamson et al, 2010; Henry et al, 2010).

Women often feel that mixed hostels are not safe for them and are more likely to resort to other options to get shelter which could include staying with family or friends, using crack houses or selling sex in return for shelter (survival sex). Whilst women feel these are safer options, they may still open up further risks.

Service providers may find it hard to find, engage and maintain contact with homeless women and in part, this is because of the often hidden nature of women's homelessness.

In addition, there are often barriers to accessing services for women including an inability to access appropriate information and support systems, inability to remember or attend appointments, confusion at being passed from one agency to another, poor mental and physical health and a lack of resources (such as a lack of money to make phone contact).

The table overleaf shows the extremely high level of complex and gendered issues impacting on the participants' lives. The final column shows the total number, and percentage, of the original 38 participating women who either disclosed experience

of the issues within any of the interviews or where it was apparent - to both the interviewer and key worker - that this was an issue.

Table: Presence of difficult experiences in the lives of homeless women

Issue	Interview 1 (n=38)	Interview 2 (n=28)	Interview 3 (n=22)	Total and apparent N (%)
Sex work	7	8	5	12 (32%)
Drug abuse issues	21	16	14	23 (61%)
Alcohol abuse issues	25	15	11	23 (61%)
Mental health issues	33	26	19	37 (97%)
Criminal Justice involvement	16	11	8	27 (71%)
Child abuse/neglect/sexual abuse	14/13/13	16/15/14	11/10/9	24 (63%)
Domestic violence past	16	11	8	30 (79%)
Domestic violence current/recent	6	3	5	9 (24%)
Sexual violence past	10	9	7	21 (55%)
Sexual violence current/recent	2	1	0	5 (13%)

Only 5 of the women (13%) reported having to deal with 1 or 2 of these issues, 34% had between 3 and 5 issues to address, and almost half (47%) mentioned 6-8 problem areas. Two women (5%) identified dealing with 9-10 of the listed difficulties.

Street Based Sex Workers

Certain groups of women are more likely to experience violence. For example, sex workers have an increased risk of physical and sexual violence and have a higher mortality than the general population (Watts and Zimmermann, 2002; Hester and Westmarland, 2004).

There are estimated to be 80,000 sex workers in the UK, of whom 70% have a history of local authority care and nearly half have a history of childhood sexual abuse (Home Office, 2014). National figures show that 85%– 90% of sex workers are women, although the proportion is 60%–70% in central London (Scambler, 2007). The Association of Chief Police Officers has estimated that 30,000 women are involved in off-street prostitution in England and Wales (ACPO, 2010).

Female street sex workers are 12 times more likely to be murdered than the general female population in the UK (Salfati, 2009).

The charity One25 supports around 230 sex working women in Bristol per year with an age range of 18-55. 100% of these women report childhood abuse or neglect. Of the women they support who are currently in street sex work, 80% experience homelessness within any given year and 92% suffer malnutrition (One25, 2017).

In 2011, the police estimated 280 women were working in the sex market in Bristol, and an estimated 126 women working in 25 parlours in Bristol. This does not include women working from their own homes (Safer Bristol 2012).

Interviews with 71 street based sex workers in the Inner City of Bristol about their access to health services revealed that 83% of the women had registered with a GP but most (62%) had not disclosed their work to them. Only 38% had had cervical screening in line with guidance and fewer than half (46%) had been screened for STI's. Six of the 47 women who had been pregnant had not attended antenatal care until they presented for labour and only 14 had booked in their first trimester. (Jeal and Salisbury, 2004).

Forty-four per cent of the women in this study had experienced sexual abuse; 97% had been offered more money for unprotected sex and 51% had had unprotected sex in the last week. All had drug or alcohol dependency problems. In the previous week, 22% of injecting drug users had shared needles and 59% had shared injecting equipment.

In 2008, in-depth interviews were conducted with 22 street sex workers in Bristol who described their lives as cycle of selling sex, buying and using drugs and then going back to selling sex. Most of the women injected drugs with all using either crack cocaine, heroin or both. They reported that they did not sleep, drink or eat regularly. These factors combined to result in weight loss and poor mental and physical health (Jeal et al 2008).

They described themselves as stuck in this cycle with each element presenting health risks. The sex work put them at direct risk of harm both of being physically hurt directly by clients (e.g. beaten up, which some women described) and at risk of Sexually Transmitted Infections.

Buying drugs also presented risks as the women were seen as easy targets for other drug users to attack and rob and more likely to have either money or drugs. They were also at risk of being sold empty wrappers or other materials (e.g. candle wax) instead of drugs leaving them without money or drugs and meaning they would need to go back to work sooner to avoid withdrawal symptoms and thus put themselves at further associated risks.

The research highlighted that drug taking presented further health risks; 15 of the 22 women were injecting drug users with, for example, abscesses, septicaemia, deep vein thrombosis, pulmonary emboli and risk of blood born viruses. Women who smoked drugs were worried about their wheeziness and coughs.

At the time of the research, only 5 of the women had stable accommodation and for the others this presented issues with sleeping on friends floors and in crack houses. As the women were seen as able to make money, they were forced to support others' drug habits as well as their own and this meant they had to work more,

putting them at increased risk. The majority of the women had partners whose habit they were also supporting.

3.2 Disabled Women

Disabled people are more likely to experience health inequalities and major health conditions, and are likely to die younger than other people. The extent of these health inequalities is difficult to assess because of limited data on outcomes for disabled people collected by NHS providers and commissioners. Accessibility of services is problematic, and disabled people are less likely to report positive experiences in accessing healthcare services. (Equality and Human Rights Commission, 2017 p11).

Data on Disabled Women in Bristol

There are 38,379 females (18% of the Bristol female population) who describe themselves as having their day to day lives limited a little to a lot by their condition. Of these, 835 (2%) are aged 0-15, with the remaining 37,544 aged 16 and over. This compares with 16% of the Bristol male population with life limiting conditions of which 6 % are in the 0-15 age group (estimates based on ONS 2011 Census).

Quality of life data for the local population shows us that those women who identify as Disabled are less likely to report that their health has been good or fairly good in the last 12 months. Only 41.2% compared to 92.9% of non-disabled women (BCC 2016)

In addition, far more Disabled women rate themselves as having below average wellbeing compared to non-disabled women. 38.4% of Disabled women report below average mental wellbeing compared to only 8.4% of non-disabled women.

The Disability Equality Forum in Bristol suggests that figures for those reporting their ‘lives are limited a little to a lot’ will be an under-estimate. This is because there are certain types of difficulty that are stigmatised, which means that many people won't admit that they experience them. Mental health is one such difficulty, but there are many others, e.g. incontinence.

In addition, there are those who, because they have the support and treatment they need, would respond “No” to questions about their life being limited because they don't now experience difficulty.

Women with Learning Difficulties

The Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD) found that on average women died 20 years sooner than women in the general population. This compared to 13 years sooner for males.

Health and Care of People with Learning Disabilities 2014-15 was published in December 2016. This found that women with Learning Disabilities were found to

have a life expectancy 18 years lower than those without (for men this was 14 years). It also explains that 1 in 2 eligible women with Learning Disabilities receive breast screening compared to 2 in 3 for other women.

A number of studies (summarised by Emerson et al., 2012) have reported low uptake of health promotion or screening activities among people with a Learning Disability, such as: assessment for vision or hearing impairments; routine dental care; cervical smear tests; breast self-examinations and mammography; and bowel and prostate screening. Access is especially poor for people with more severe learning disabilities.

Disabled Women and Gender Based Violence

Disabled women are twice as likely to experience domestic violence and abuse as non-disabled women. They are also likely to experience abuse over a longer period of time and to suffer more severe injuries as a result of the violence (Women's Aid, 2009).

People with Learning Difficulties are also more likely to experience domestic violence and abuse than the general population (Martin et al, 2006).

Those with Learning Difficulties are also at a heighted risk of forced marriage (Foreign and Commonwealth Office, 2014; Chantler et al 2009).

Whilst victims of domestic violence are often dependent on their abuser and fear disclosing abuse as well as lacking the means to be economically independent. These issues may be heightened for a woman who also has a disability (Harpur P, Douglas H. 2014).

In 2008-09 and 2012/13, disabled respondents (4.3% and 3.7%) were about twice as likely as non-disabled respondents (2.1% and 1.8%) to report that they had experienced emotional or financial abuse in the last 12 months, of which their partner or ex-partner was the perpetrator (Equality and Human Rights Commission. 2016).

Crown Prosecution data shows that disability hate crime evidence shows high levels of sexual violence (CPS, 2016).

Disabled Women, Social Isolation and Poverty

In Bristol, the Disability Equality Forum has raised issues around social isolation and exclusion as well as poverty for disabled people and the links between these and poorer physical and mental health outcomes.

Social Isolation

Loneliness and social isolation are linked to an increase in risky health behaviours like smoking and physical in-activity (Shankar et al, 2011) as well as a number of

health conditions including coronary heart disease (CHD) and stroke(Valtorta et al , 2016). These conditions in turn can lead to further disability and social isolation.

There are barriers to social inclusion for Disabled people, especially for people with mental health conditions because they are particularly likely to be stigmatised (Abrams, Swift and Mahmood, 2016). A series of research projects commissioned by disability charity Scope showed that negative attitudes towards disabled people remain quite common in Britain (Aiden and McCarthy, 2014).

In one study, disabled women were more likely to say they have faced a challenge in transport (28% compared to 22% of men). Those with physical and/or sensory impairment reported that the places and spaces they wished to visit were often inaccessible to them creating a barrier to independence and adding to feelings of Isolation. In the same study over a third (35%) of disabled people said they found leisure a challenging area of life. The ability to get out and about was felt to be essential to mental health, a sense of independence and happiness, but reduced funding and other pressures limit the ability of Disabled people to maintain social connections (Copestake et al, 2014).

Poverty

In Britain in 2015/16, less than half of disabled adults were in employment (47.6%), compared with almost 80% of the non-disabled adult population, and since then the gap between these groups has widened and continues to widen. There is also a difference in levels of pay. In 2015-16, there was a gap in median hourly earnings with disabled people earned £9.85 compared with £11.41 for non-disabled people. Disabled young people and disabled women had the lowest median hourly earnings (Equality and Human Rights Commission, 2016).

Across the UK, 18.4% of disabled people aged 16-64 were considered to be in food poverty in 2014 compared with just 7.5% of non-disabled people. Disabled people over the age of 65 were twice as likely as non-disabled people in the same age group to be in food poverty: 6.8% compared with 3.3% (Equality and Human Rights Commission, 2016).

Data

In England, the NHS Outcomes Framework and Public Health Outcomes Framework were designed to enable disaggregation of outcome data by protected characteristic. However, there is very limited data being collected by NHS providers and commissioners about outcomes for disabled people. The Department of Health's Adult Social Care Outcomes Framework does not currently disaggregate data by disability (Equality and Human Rights Commission, 2016).

Obesity

Although the Government's call to action on obesity sets out the national ambition for a sustained downward trend in obesity by 2020, equality analysis highlights that there is no population-level data on obesity prevalence in physically disabled people and that monitoring can be problematic because of difficulties with weighing and measuring disabled people (DH, 2011a).

In a 2014 study, participants with physical impairments reported difficulties in accessing activities such as swimming with many feeling they were unable to take part in sessions open to the public or that they needed help and support to participate and that this was unavailable. For some, swimming was felt to be crucial for keeping weight down and maintaining wellbeing and the only option accessible to them (Copestake et al, 2014).

3.3 Women of Refugee Background

2011 census data shows that there were 5,965 Black African Women in Bristol at that time. The age profile of the Black African population (all genders) living in Bristol is much younger than that the general population with 82% aged under 40 compared to 60% of the total population. There are more children, with 38.2% of local Black Africans aged under 16, compared to the Bristol average of 18.4%. As women are more likely to be the main or sole carer for children, this means that Black African women are more likely to have care of more children per woman than other women. Black African women are also less likely to have support from their own parents or other community elders for informal childcare because less than 2% of Black Africans are aged 65 and over compared to 13% of the total population. According to 2011 census data there were only 217 individuals (all genders) who identified as Black African over 65 with an under 16 population of 4,614.

The Chief Medical Officer's Women's Health Report mentions refugees, asylum seekers and travellers as groups of women who are being failed by cervical screening and HPV vaccination programmes.

There are theories that migrant populations adopt unhealthy lifestyles whilst living in the UK. This includes higher levels of smoking, lower levels of breastfeeding, and diets with high fat content and these lifestyle effects on diabetes, cardiovascular disease and cancer. (Hawkins et al. 2008).

Barriers to access and use of healthcare have been found to be insufficient translation and interpreting services, lack of access to reliable transport because of poverty and poor services in many areas where migrants live. There is also confusion around entitlement to some types of services and some cultural insensitivity of some frontline medical staff (Phillimore et al, 2010; Johnson, 2006).

The Confidential Enquiry into Maternal Deaths 2006-2008, found that Black African mothers had mortality rates nearly four times that of white women (Lewis 2011). The latest report in 2016 suggests that this remains unchanged (Knight et al, 2016 p25).

In a survey of women asylum seekers, detained at Yarl's Wood (Girma et al,2014), three quarters reported having been raped and nearly half said they had been tortured. Physical and mental health deteriorates as people are kept in detention centres, particularly for those with Post Traumatic Stress Disorder (PTSD). This is made worse by lack of access to reproductive healthcare and mental health services. In 2014, Women for Refugee Women published the results of a survey of 46 women who had sought asylum and had been detained. 72% said that they had been raped and 41% said that they had been tortured. A systematic review of asylum seekers' experiences of violence reported greater than 30% exposure to violence, but emphasised the enormous gap in good-quality, policy-relevant information on asylum, violence and health (CMO, 2015).

Statistical ward profiles show that whilst across Bristol the population is 77.9% White British, there are areas where the percentage of BME communities is far higher. Of these, Lawrence Hill ward has the highest percentage of BME people recorded with 59.6% identifying as BME. Of these, the largest group is Black African at 20.2% followed by other Black and Mixed.

Interestingly, the area has a higher- than-Bristol average life expectancy for women with 84.1years compared with Bristol 82.8 years. Premature mortality (all genders) is far higher than the Bristol average with 575.5 per 100, 000 of the population compared to 390 per 100, 00 for Bristol. Cardiovascular and respiratory disease deaths are well above average. The area also has a far higher than Bristol average percentage of people born outside the UK with 39.2% compared to 14.7%. In addition, 29.8% speak a language other than English as a main language.

Qualitative information was gathered on this topic from a discussion with women at the Refugee Women of Bristol drop in in January 2017. Around 55 women attended this session with an age range of 21 – 60.

The women in the group highlighted the following:

- Children's health
- Parenting and stress
- Support outside the time of pregnancy
- Language barriers
- Mental health.

The following quotes are all taken from this session.

Children's health

'As a Mum I do not allow fizzy drinks, only water in our house. You have to start at home to feel healthy.'

Parenting and stress

'Women have more stress than men due to childcare, they feel no one looks after them. I feel like we look after the whole community and no one looks after us, it would help if someone cooked for us and helped wash up. I have no family but I do have friends.'

'Being a woman especially a Mum you feel tired and like you cannot do everything by yourself, especially a single Mum as it is so hard raising children.'

Support outside the time of pregnancy

'Health visitors come to you and midwives come to you and then after the baby is born nothing and women then struggle'

Language barriers

'You have to learn the language to benefit you and your health, the more you talk the more you learn. Once you learn you can do anything.'

'With the Doctor, language can be a barrier so it can be hard to discuss something private because there is no translation, sometimes there is an interpreter but the woman may not feel comfortable with that other person there.'

Mental health

'If you are not feeling happy inside, to me you are sick'

'If you have a Mother or best friend to talk to you can trust them not to take your words outside, that network is not necessarily here as they come from a different country'

3.4 Women in Hartcliffe and Withywood

There are geographical areas in Bristol where women's health is worse than average and these overlap with areas with high levels of poverty and multiple deprivation. Hartcliffe and Withywood women are discussed here as one example of the effect of deprivation on women's health. Other deprived areas of the City could equally have been used.

The statistical ward profile for the area shows that the area is in the most deprived 10% in the UK for multiple deprivation.

Quality of Life data for the area shows that:

- Those reporting health as being good or fairly good for the last 12 months is 75% compared to 88% for Bristol
- 48% took recommended levels of exercise compared to 65% for Bristol
- 34% live with a smoker compared to 18% for Bristol
- 12% agree that domestic violence and abuse is a private matter compared to Bristol at 7%
- 42% with life limiting long term illness, health problem or disability compared to Bristol at 24%
- 66% are overweight or obese compared to 45% for Bristol
- Life expectancy is 80.4 years compared to the city average of 82.8 years
- Premature mortality 524.1 per 100, 000 compared to the Bristol average of 390
- Premature cancer deaths is 223.8 compared to 157.1 per 100,000
- Percentage of respondents who say disability prevents them from leaving their house when they want to is 17% compared to 6 percent for Bristol
- There is 52.4% social housing compared to a city average of 20.3%
- 41.2% have no car or van in the household compared to 28.9% for Bristol.

Avon and Somerset Police data shows that there were a very high number of reported incidents of domestic violence in the area compared to anywhere else in the city for the 2015-16 period. The police recorded domestic abuse incidents rates by ward for the year ending March 2016 for Hartcliffe and Withywood, as 42 per 1000 of the population which is the highest in the city. This compares to the Bristol average of 14 per 1000 and the next highest ward in neighbouring Filwood at 32 per 1000.

In total there were 579 incidents reported during 2015-16 in the area. This is far higher than anywhere else in the city with the next highest being Filwood with 318 reported incidents.

What do women in the area think?

In 2016 a knitting group were asked about the health of women in their area. The group meet at the @Symes building in Hartcliffe. Eight local women aged between 29 to 80 contributed to the discussion.

The following themes were identified from the conversations in the group

- Cancer
- Dementia
- Care homes and women as carers
- Lack of availability of healthy food.

Cancer

Women in the group were concerned about young women not attending cervical screening checks.

"I think the young girls are not going for their screening – for their smear checks"

Screening for breast cancer was also discussed and there was experience of cancer in the group and one person commented:

"We've had people that go in for surgery and people pass away from cancer"

This is consistent with data for the area which shows there are higher levels of premature cancer deaths in the area (for all genders). 223.8 cancer death rate per 100, 000 which is the third highest rate of wards in the city (Public Health Intelligence Unit, Bristol City Council 2016).

Data from the two main surgeries shows that cervical screening rates are below target for both and that one also falls below the average rate for Bristol.

Dementia

There were people with dementia at the knitting group. One individual whose husband had dementia recounted,

"I'm actually my hubby's carer now. He's got early dementia. It's not too bad. He gets his up and down days. I try to get him out as much as I can. I don't know if this makes sense but he's different to when he's out to when he's in. He's more his old self when he's out. He used to be a builder and he got wet a lot. And he's got knee replacements, he's got arthritis – he's got a lot of problems."

Care homes and women as carers

One woman described during the course of conversations that she had been her mother's carer – indeed had moved to Hartcliffe to be with her mother in 1969. She described how she is now her husband's carer.

Another individual described her job as going to Callington Rd hospital to do craft activities with those staying there.

In the knitting group itself, the women described there being a lot of disabled people who came and how they enjoyed the mix.

At the end of March 2017 there were 62 people living in "Care Homes" in Hartcliffe & Withywood, mainly these were older people in Nursing homes (PHIU 2017).

Lack of availability of healthy food

One individual talked about the lack of healthy cheap food locally. She talked about all the offers being on low nutrition food and not on fruit and veg. People in the area are likely to be on lower income and therefore buy whichever food is cheapest.

The work of Food for All and the People's Kitchen was acknowledged but it was also noted that because of limited resources, Food for All is only open very short hours in the day – usually from 10am-2pm and a lot of people may not know about it.

"People's Kitchen are really good and they've made a massive difference".

Conclusions

The examples shown above demonstrate that women who experience poor health outcomes are likely to be subject to multiple disadvantage. For example, many women of refugee background, with complex needs and who live in Hartcliffe and Withywood will also be Disabled.

Mental Health as well as gender violence issues are apparent for all four groups and these will be explored further in the following sections.

4. Women and Mental Health

This section looks at women's mental health and the following section looks at gender violence. However, due to the interrelationship between these two there will be some overlap and discussion of the same issues in both sections.

4.1 Women and Mental Health: National Picture

The most recent survey of the mental health of people living in England highlighted that mental ill health amongst women has increased in recent years (McManus et al, 2016). One woman in five has a common mental disorder, compared with one man in eight. Since 2000, there has been a slight steady increase in the proportion of women with symptoms of common mental health problems, with this increase in prevalence mostly evident at the severe end of the scale. Men overall have remained relatively stable.

Young women between the ages of 16 and 24 have emerged as being at high risk, and are almost three times as likely (26%) to experience common mental health problems as their male contemporaries (9%). They also have higher rates of self-harm, post-traumatic stress disorder and bipolar disorder (McManus et al, 2016).

Whilst there are many factors behind these poor health outcomes, sexual exploitation, abuse and violence are significant.

Both women and men need help to improve their mental wellbeing, but there are gender-related differences which need to be understood and acted upon. Some of these are outlined below.

4.2 Prevalence differences by gender

- 43.4% of adults think that they have had a diagnosable mental health condition at some point in their life (35.2% of men and 51.2% of women), and a fifth of men (19.5%) and a third of women (33.7%) have had diagnoses confirmed by professionals (Stansfeld et al, 2016).
- In the UK, women are almost twice as likely as men to be diagnosed with anxiety disorders (Martin-Merino et al, 2009).
- Women and girls comprise the majority (62%) of hospital admissions for intentional self-harm in the UK (Winter, 2015). The highest rates of self-harm were reported by women aged 16–24, in which one in four (25.7%) reported having self-harmed, compared to 9.7% of men in this age group (McManus et al, 2016).
- Approximately one in eight women experiences moderate to severe postnatal depression (Knapp et al, 2011).
- Eating disorders are more common in women than men, with young women most likely to develop one: 1.9% of women and 0.2% of men experience anorexia in any year, and between 0.5% and 1% of young women experience bulimia at any one time (Mental Health Foundation, 2017).

- Worldwide, more women are affected by Post Traumatic Stress Disorder than men, largely because women are exposed to more sexual violence. The risk of developing PTSD after any traumatic event is 20.4% for women and 8.1% for men (Mental Health Foundation, 2017).

4.3 Gender-Related Risk Factors: Domestic and Sexual Abuse

Gender differences in rates of mental ill-health are closely linked to women experiencing more abuse, both physical and sexual, than men (Scott et al, 2016).

An estimated 1.4 million women are subject to domestic abuse annually (Home Office 2013). The Crime Survey for England and Wales report that women were more likely to report having experienced domestic abuse than men (CSEW 2016) and girls are more likely than boys, with young adolescents just as likely to experience abuse as older teenagers (Barter et al, 2009).

About 66% of girls and 32% of boys aged 14 – 17 report having experienced one or more types of abuse from an intimate partner (Barter et al, 2015). For young people including those below 16, the likelihood of experiencing high severity abuse is no different to adults (Safe Lives, 2017).

This has a significant impact as women experiencing domestic abuse are at a greater risk of mental ill health, and having a mental health condition makes one more vulnerable to abuse (Devries et al, 2013):

- In a 2009 UK study, lifetime prevalence of domestic violence among women with mental health problems was found to range between 30% and 60% (Howard et al, 2009)
- 84% of those who experience the most extensive physical and sexual abuse are women and of those, over half have a common mental disorder (Scott and McManus, 2016)
- In a study conducted in England and Wales in 2015, women with experience of domestic violence had high rates of depression, anxiety and PTSD (Ferrari et al, 2016)
- 70% of women in psychiatric inpatient settings and 80% of those in secure settings have histories of physical or sexual abuse(Phillips, K, 2000)
- Women affected by abuse are five times more likely to attempt suicide, and one third of all female suicide attempts can be attributed to current or past experience of domestic violence (Stark and Flitcraft, 1996)
- The figures for Black and minority ethnic women are even higher. For example, research has found 50% of women of Asian origin who have attempted suicide or self-harm to be domestic violence survivors (Chantler, K, et al., 2001).

Alongside this, mental ill-health can make women particularly vulnerable, as women with severe mental health problems are 10 times more likely to experience assault than those without (Pettitt et al, 2013).

Women are also disproportionately affected by other risk factors that detrimentally affect mental health, including social and economic disadvantage, low income and income inequality and they have major responsibility for the care of others.

4.4 Treatment Differences

Demographic inequalities in the prevalence of mental illness are also reflected in treatment. For example, white British, females, or females in mid-life are more likely to receive treatment, while people from black ethic groups have particularly low treatment rates. Also, people with low incomes are more likely to have requested but not received mental health treatment (Mental Health Foundation, 2016).

4.5 Women and Mental Health: Bristol picture

The JSNA 2016-17 data profile reports the following:

- Mental health disorders are up to three times more prevalent in women than men. The overall prevalence estimate for all mental health disorders is 28.2% in females, 10% in males and 18.9% overall.
- Girls report worse mental wellbeing than boys. 42% girls and 27% boys had a low or medium low wellbeing score (Bristol Pupil Voice, 2015).
- In Bristol during 2015-16 there were 1,345 emergency admissions for self-harm; 869 by females and 476 by males.
- Around a third of those presenting to Bristol's Emergency Departments (adults) were discharged without admission after being treated for relatively minor self-inflicted injuries and therefore they are not included in the admission statistics.
- Rates of self-harm vary considerably across Bristol and as well as being more prevalent in women and girls, there is a link between self-harm and deprivation.
- The number of female suicides (45 in Bristol) is lower than for males. However, the female rate in Bristol (7.7 per 100,000) is significantly higher than the England average for women (4.7 per 100,000) and appears to be rising.

During the "perinatal period" that lasts from conception to one year after birth, mothers are at greater risk of developing new mental health conditions such as depression and anxiety. They are also at greater risk of experiencing a worsening of existing psychiatric conditions or a recurrence of a former mental health illness. Up to one in five women and one in ten men are affected by mental health problems in

the perinatal period. Unfortunately, only 50% of these are diagnosed. Untreated and on-going perinatal mental health issues can affect the mother-infant emotional attachment and adversely affect child health outcomes that may last into adulthood.

The Confidential Enquiry into Maternal Deaths in the UK shows that nationally suicide continues to be a leading cause of maternal death with psychiatric causes as a whole accounting for 25% of all maternal deaths or 3.7 deaths per 100,000 maternities. Nationally 101 women died from suicide during the perinatal period in 2009-13 and a further 58 died as a result of substance abuse.

Community Access Support Service (CASS) facilitated a workshop on International Women's Day March 2016 which involved at least 45 women. The issues that were discussed included access issues for women using mental health services, barriers for women and suggestions for service improvements. Access issues raised included the general lack of services targeting women's mental health, including perinatal services and women only secure services, the high number of male staff in secure services or male staff supervising women patients in inpatient services around, for example, using toilets. Lack of awareness of services, the impact on their children or from caring responsibilities, fear of children being taken into care if mother identifies mental health issues and services not childcare or children friendly are all barriers to accessing services. Women attending the workshop wanted to see a range of service improvements including more women advocates, wider range of services targeting women available, but not just though GPs and more training for mental health staff to better understand needs and issues for women, for example, the impact of domestic abuse and sexual violence.

In October 2016, CASS held a mental health workshop at the Bristol Big Sisters event targeting Muslim women; 25 women attended the workshop and 10 women completed a survey. Women identified the key issues facing Muslim women around mental health and wellbeing, as stigma; shame and fear of gossip; cultural understanding and impact on family and honour. Particular triggers identified for Muslim women affecting their mental health were Islamophobia and racism, finding self-identity and poor self-esteem and pressure from peers, family or community. Emotional wellbeing issues raised included adapting or balancing between cultures, pressure to able to manage it all with little support and lack of knowledge of services and how to access them.

Suicide

Bristol's suicide rate is significantly higher than England's average, ranked 130th of 149 local authorities (Public Health England, 2017). However, whilst the majority of suicides are men, the suicide rate for women in Bristol is now significantly higher than nationally and appears to be rising. For the period 2013-15, Bristol's average mortality from suicide rate was 12.9 per 100,000 population compared with England is 10.1 and is the highest of core cities.

4.6 Self-harm

The data below is from the Bristol Self-Harm Surveillance Register Annual Report 2016 (Knipe, D, 2017):

- Of the 1536 episodes of self-harm presenting to Bristol Royal Infirmary in 2016, the ratio of men to women was 1:9. This was an increase from 1:5 in 2015.
- Self-harm patients in the BRI: 62.6% female v's 37.4% male.
- Female patients were on average younger than male patients (median age males v's females 34 years v 27 years).
- The three wards with the highest rates of self-harm (not broken down by gender) were Whitchurch Park, Filwood and Hartcliffe.
- In January 2016 an additional domestic violence question was added to the data collection form. An estimated 10% of episodes were indicated to be in patients who had experienced domestic violence and abuse. A larger proportion of these were seen in women than men.
- There were 994 episodes of self-harm in students between 2010-16. These episodes account for 11% of self-harm attendances in the BRI. The majority of students were aged <25 years (90%) and were female (81%).

4.7 How Could Bristol Better Respond to the Mental Health Needs of Women?

Bristol is developing a city-wide programme to improve mental health and wellbeing, called 'Thrive Bristol'. The specific needs of women affected by mental ill health, and possibly the needs of young women and those from black and ethnic minority backgrounds, may be prioritised within this work.

Through this the gender-related differences between men and women's mental health and the need for gender-specific responses will be highlighted. An example may be supporting care providers to undertake 'routine enquiry' about abuse in their work, and to provide trauma-informed services, as advocated in NICE's Quality Standard on domestic violence and abuse (NICE, 2016)

5. Gender Violence in Bristol

In this section gender violence and especially Domestic Violence and Abuse are explored more fully.

5.1 Domestic Violence and Abuse figures for Bristol – the current picture

Nationally, 27% of women experience domestic abuse in their lifetimes, with negative impacts on mental and physical health and further impact on families including children (CSEW, 2016). More than 30% of domestic abuse starts in pregnancy (NHS Choices 2017).

The number of domestic abuse incidents and crimes in Bristol reported to the Police in the year 2015/16 was 18.5 per 1000 population. This is significantly lower than the England average of 22.1 per 1000 population. This figure cannot be compared to previous years because a new method of recording has been introduced which includes the addition of data relating to 16 and 17year olds. However, as discussed in previous sections, there are areas of Bristol which have reporting rates far higher than the England or Bristol averages. Hartcliffe and Withywood had the highest rate in Bristol for this time period with 42 reported incidents per 1000 of the population.

Scott and McManus found in their research Hidden Hurt (2016) that: "Overall women are twice as likely as men to experience interpersonal violence and abuse and the more extensive the violence the more likely it is experienced by women rather than men."

The JSNA dataset tells us that:

- Police data for victims of 'domestic abuse' offences in Bristol for 2015/16 reveals that during that reporting period 74% of victims were female and 20% were male (with 6% unknown).
- The rate of recorded domestic abuse incidents in Bristol has shown a significant rise over the last 2 years
- There has been a rise in the proportion of people who feel that "sexual harassment is an issue in Bristol" (22%)
- Numbers of reported sexual offences rose by 28% in Bristol during 2015 (21% nationally) 84% of victims were female (2015/16).
- Bristol has one of the highest numbers of recorded cases of female genital mutilation (FGM) in England (2015/16).
- Police data for "violence against the person" (2015/16): 47% of victims were female and 43% male (10% unknown).

5.2 Physical Health Consequences of Domestic Violence and Abuse (DVA)

One in five high-risk victims reported attending the Emergency Department as a result of their injuries in the year before getting effective help (Safe lives, 2015).

Domestic abuse often leaves victims with reproductive consequences, including gynaecological problems, sexually transmitted infections and difficulties in pregnancy (Coker et al, 2009, CTC, 2014)

As well as injuries, victims of abuse suffer a range of chronic health problems associated with abuse including: fibromyalgia, chronic pain , neurological disorders, gastrointestinal disorders, migraines/headaches, raised cardiovascular risk and increased minor infectious illnesses (Crofford, 2001,Coker et al, 2009, Safelives 2015).

5.3 Mental Health Consequences of Domestic Violence and Abuse (DVA)

Research has shown clear links between women's experience of domestic abuse and a range of mental health problems, including depression, post-traumatic stress disorder (PTSD), self-harming behaviours and suicidality (Abrahams, 2004; Abrahams, 2010; Humphreys and Thiara, 2003; Stark, and Flitcraft, 1996; Kirkwood, 1993).

In figures:

• 40% of high-risk victims report having mental health issues (Safe Lives, 2015a)

• 16% of victims report that they have considered or attempted suicide as a result of the abuse, and 13% report self-harming (Safe Lives, 2015b)

• Domestic abuse victims are at risk of post-traumatic stress disorder (PTSD), as many as two-thirds of victims of abuse (64%) developed PTSD in one study (Golding, 1999)

• Between 30% and 60% of psychiatric in-patients had experienced severe domestic abuse (Howard et al, 2010)

Cessation of abuse does not necessarily mean that women are no longer affected by mental health problems. The influence of abuse can continue long after the abuse itself has stopped and the more severe the abuse, the greater its impact on physical and mental health.

5.4 Intersectionality

There is evidence that women who experience the most extensive abuse and violence (both as children and adults) are more likely to face other adverse circumstances in their lives such as poor mental and physical health, disability, substance misuse, poverty, debt, poor housing and homelessness (Scott & McManus, 2016).

Gender violence has already been raised in previous sections of this chapter for:

- Women with Complex Needs

- Women with Disabilities
- Women living in areas of poverty and deprivation
- Refugee women
- Women with poor mental health (as both a determinant and result of)

In addition:

- Women who suffer gender violence and abuse are over 5 times more likely to abuse alcohol (OR=5.6) (Golding 1999) many women have an alcohol problem as a result of abuse where alcohol is used as a coping mechanism (Walby and Allen 2004).
- Women with a long-term illness or disability were more likely to be victims of any domestic abuse in the last year (16%), compared with those without a long-term illness or disability (Public Health England, 2015). Disabled women are significantly more likely to experience domestic abuse than disabled men and the abuse is more severe and with more frequent episodes. (Hague et al , 2007)
- Domestic abuse is a notable issue for Gypsy Roma Traveller women with an estimated 60%-80% of women from these communities experiencing domestic abuse during their lives (JSNA, 2017).

6. Prolapse and incontinence

In some women pregnancy and childbirth impacts adversely on the pelvic floor leading to disturbances of the bladder, bowel, and sexual function and from these incontinence and prolapse may arise. Multiple births, larger babies, aging, menopause and obesity further increase risk. Women may play down symptoms and be unwilling to consult their doctor believing that they will not be taken seriously. Longer term this failure to get help early on may result in long- term medication and/or surgery (CMO, 2015 p123).

It is difficult to estimate the prevalence of urinary incontinence (UI) due to differences in study populations, definitions, measurement methods, and the methodology used. The severity or frequency of symptoms being measured can have a significant effect on the estimate given. Where the most inclusive definitions have been used ('ever', 'any', 'at least once in the last 12 months'), prevalence estimates in the general population range from 5% to 69% in women 15 years and older, with most studies in the range 25–45% (Hunskaar et al. 2005). In one study cited in the NICE 2015 guidance (Perry et al. 2000) 34.2% of women reported UI at times, only 3.5% experienced the symptom on a daily basis, 11.8% weekly, 7.3% monthly and 11.6% yearly (NICE 2015) which equates to an estimated 60,000 women (19+) and 3,900 or 36% of women over the age of 80 in Bristol being affected by all types of UI.

Faecal incontinence remains a greater taboo subject than urinary incontinence and again prevalence is difficult to estimate. The CMO 2014 report suggests that an estimated 1-10% of all adults live with this condition (CMO 2015 p125).

The exact prevalence for pelvic organ prolapse is also difficult to estimate, however it is common in women, affecting around 30% of women who have given birth and are over 50 years of age, with a lifetime prevalence risk estimated at 30–50% (Subak LL, et al.2001).

6.1 Women's Incontinence key statistics for Bristol

The Bladder and Bowel Service in North Bristol Trust works with people aged 19 plus. In Bristol there are 176,400 women 19 plus based on ONS Mid-Year Estimate 2015. Taking NICE estimates of around 34% of women affected (NICE 2015) would mean there are 60,000 women aged 19 and over in Bristol affected.

In women over the age of 80, 36% are living with urinary incontinence which would extrapolate to 3,900 of women of this age group in Bristol being affected (Foley AL, et al. 2012).

The CMO reported that:

- 50% of women between 18 and 65 years of age reporting incontinence are moderately or greatly bothered by it.

- 27% perform ‘toilet mapping’ and will avoid areas where access to toilets may be limited.
- Approximately 23% state that it affects their sex life, 23% say that it reduces and 25% feel embarrassed or frustrated.
- 31% dress differently because of their symptoms.
- Urinary incontinence adversely impacts on other co-morbidities and workplace absences.
- Incontinence is associated with falls and strokes in women over 80 years of age.

CMO Report 2015 (p123)

6.2 Prolapse Prevalence in Bristol

The exact prevalence for pelvic organ prolapse is difficult to estimate, however in one study of over 27,000 post-menopausal women over 50, 40% had some degree of prolapse

There are 65,600 women aged 50 & over and taking the estimated cut off of 55 as average age to be “post-menopausal”, there are 53,000 women 55 & over so 40% of these would suggest that there could be 21,200 with prolapse in Bristol.

6.3 What do Local Women Think about Incontinence?

The eight Health Champions in Knowle West discussed incontinence. These women felt they may talk with friends about it if they were their age and/or if they had to suddenly rush to the toilet.

Pelvic floor exercises were known about but not done regularly by anyone in the group.

“I don’t think you think about it until you have a problem. I think people don’t take notice until then.”

Even though there was an understanding you should do pelvic floor exercises, there was perhaps some lack of understanding about how much help they can be and whether there was time or age limit on this.

Many women recalled being told after childbirth to do pelvic floor exercises and did them for a while then stopped. They reported that it was difficult to absorb information when you have just had a baby especially if you also have other children and commitments.

During the conversation more than one woman in the room disclosed she had had some sort of operation on her pelvic floor.

6.4 Conclusions

Incontinence is a hidden disability. The process of childbirth and menopause put women at a higher risk of prolapse and incontinence. Despite being widespread there has been little attention on them either locally or nationally.

Preventative strategies are recommended as they can be effective and it is possible to substantially improve quality of life. The Incontinence Service in Bristol suggest pelvic floor exercises are promoted as part of Public Health work. The Chief Medical Officer made recommendations for Public Health England to raise awareness of urinary and faecal incontinence and prolapse in women, and to improve signposting to resources, self-help information and treatment pathways.

7. JSNA Dataset

This section of the chapter reports on the JSNA 2016-17 Data Profile from a women's health perspective and only includes data from this source. It is intended to give an overview of Bristol women's health issues which have not been covered in previous sections of this chapter.

Please note – on some points more recent data may now be available, and will be released in a subsequent JSNA Data Profile. This Chapter is not able to provide the latest data on all indicators for women.

The Bristol JSNA is at www.bristol.gov.uk/jsna and the JSNA dataset used here can be accessed at JSNA 2016-17 data profile .

The headline concerns from this section:

- Women live longer in poor health than men
- Bristol female preventable mortality rates are significantly higher than the England rates
- There are more women than men with a "limiting long-term illness or disability" living in Bristol
- Data on smoking is not available by gender for Bristol
- Local women are significantly less likely to be physically active than men
- Bristol rates for admission to hospital for alcohol-related harm are worse than national average for women.
- Rates for early deaths due to cancer for women in Bristol are significantly higher than for England and screening coverage for breast and cervical cancer in Bristol between 2010 & 2015 has consistently been significantly lower than the England average (and other cities with a similar population).
- Bristol rates for early deaths due to respiratory disease for women are significantly higher than England (2013-15).
- During 2013-2016 (3 year combined data) there were 1,500 emergency hospital admissions due to asthma. This was 835 females and 660 males
- Nationally more women than men develop dementia over the course of their life and more women than men care for people with dementia
- The majority of falls-related admissions at Bristol Hospitals (2014-2015) (aged 65+) were women
- Two out of three excess winter deaths were women.

7.1 Population, Life Expectancy and Mortality

There are 224,600 females and 224,800 males in Bristol which is an almost exact 50/50 split. However there are differences within age groups and there are more women than men aged 65 and over and more men than women in the 25-49 year age group.

Healthy life expectancy is broadly similar for women (64.2 years) and men (63.3 years) in Bristol. The gap in healthy life expectancy (between the most deprived 10% and the least deprived 10% in Bristol) is similar for females (16.7 years gap) and males (16.3 years gap).

Life expectancy for women in Bristol (82.8 years) is broadly similar to the England average (83.1 years). Within Bristol, Bristol North West (inner) has the highest life expectancy for women (85.2 years). The neighbouring sub-locality of Bristol North West (Outer) has the worst female life expectancy (81.5 years) in Bristol. At ward level, Clifton has the highest female life expectancy (90.1 years) and Southville (77.2 years) is lowest.

The main cause of the gap in life expectancy in Bristol for women and men is cancer.

Bristol women live an average of 18.6 years in poor health and this figure is similar to England as a whole. Within Bristol three areas fall within the lowest 5% for female healthy life expectancy (Withywood, Hartcliffe and Barton Hill). The gap in healthy life expectancy between the most deprived 10% and the least deprived 10% for females is 16.7 years. The numbers of years women are living in ill health ranges from 11 years to 31 years. Bristol's healthy life expectancy gap for women does not compare well with other local authorities, out of 149 local authorities in England it is 23rd worst.

Whilst nationally rates of premature (fewer than 75 years) mortality in women are falling, Bristol's premature mortality rates, for women are significantly worse than the England rates. Where there are reductions, these are due to fewer early deaths from cardiovascular diseases and a smaller contribution of cancer deaths. At a sub-locality level North & West Bristol (outer) females have significantly higher premature mortality rates than Bristol and North & West (inner) has significantly lower rates.

At wards level there are also differences with Clifton having the lowest rate of female premature mortality and Southville the highest.

The top 4 causes of premature mortality in Bristol (for all genders) are cancer, cardiovascular disease, respiratory disease and liver disease.

Bristol's female preventable mortality rates (151.6 per 100,000) are significantly higher than national average (139.6).

There are more women than men with a "limiting long-term illness or disability" living in Bristol –17.8% of women and 15.6% of men.

7.2 Autistic Spectrum Conditions

There were estimated to be 3,570 adults in Bristol with some level of autistic spectrum condition in 2016 (18+, including 560 people over 65) with an estimated 360 females and 3,210 males.

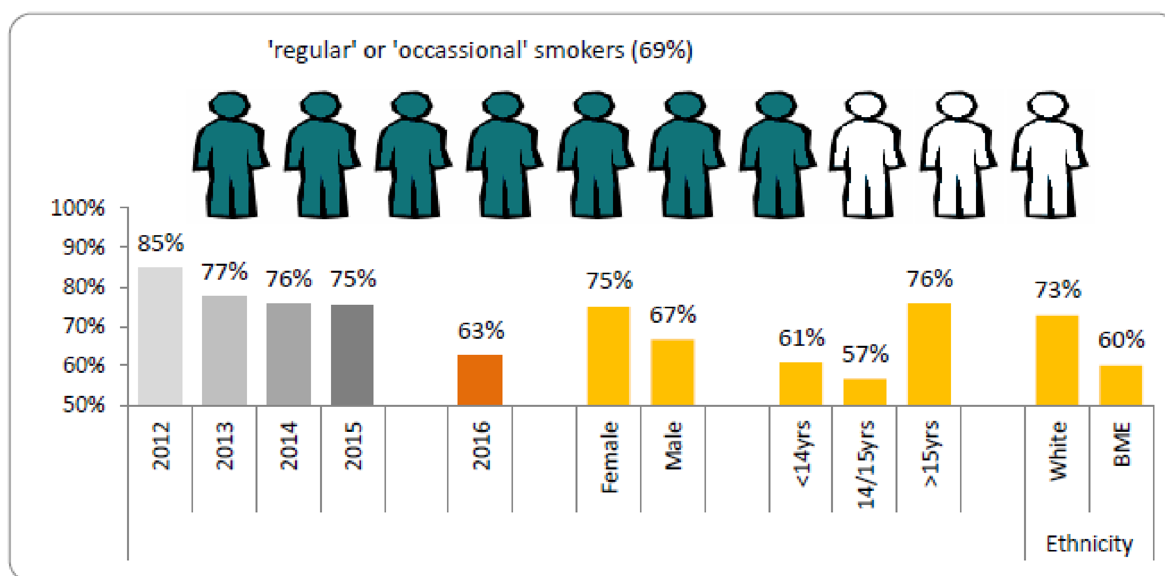
It is widely acknowledged that the diagnostic models for Autistic Spectrum Conditions are based on studies of males and male presentation of the condition and these fail to identify many females. As a result many women remain undiagnosed throughout their life. Many Autistic women are diagnosed only after it has been recognised in their children and may have experienced a lifetime of mis-diagnoses e.g. bio-polar, depression, anxiety (Tierney and Burns, 2017).

7.3 Young Women‘s and Adult Women’s Lifestyle

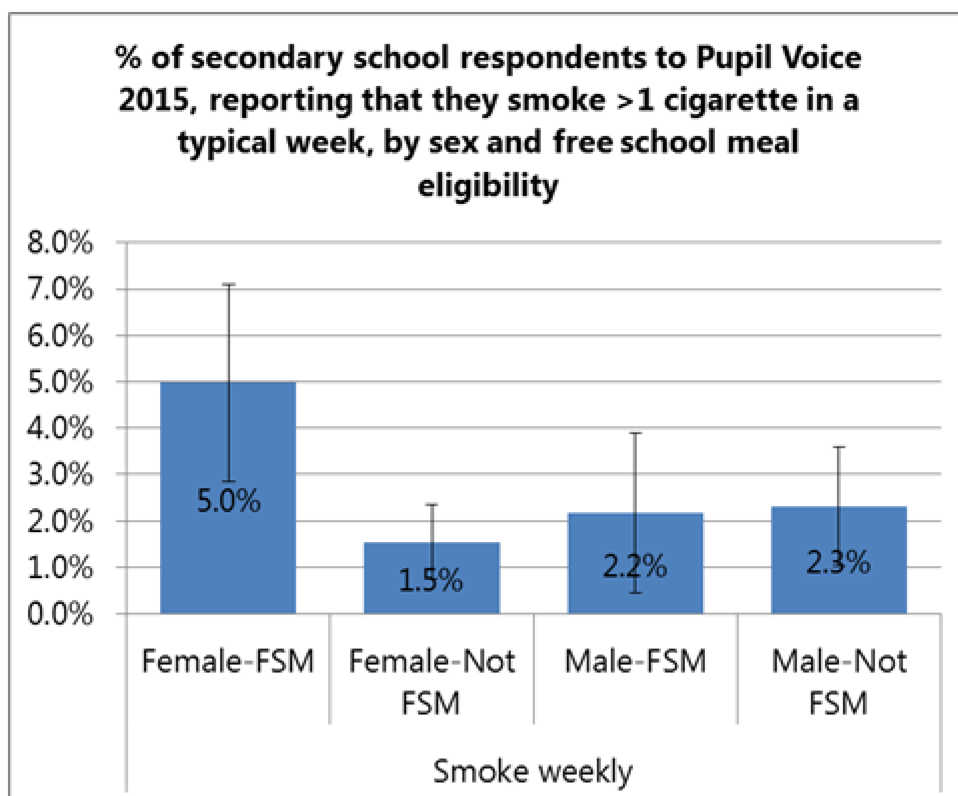
Nationally, females at age 15 are significantly more likely to be a smoker than males, which is very different to the adult picture. However, the local “Pupil Voice” 2015-16 survey of more than 5,000 year 4, 6, 8 and 10 pupils across Bristol would suggest that there is little difference between smoking behaviours for boys and girls, although in year 10 girls are more likely to have ‘tried’ smoking than boys, and more likely to be very occasional smokers (i.e. less than 1 per week).

Smoking prevalence can be much higher in certain groups within the population, even at a relatively young age. An analysis of local data about young offenders in contact with services in Bristol indicated that 63% of those aged 15 or less were current smokers. Again, girls in this cohort were more likely to smoke.(The Youth Offending Team (YOT) health survey provides data for the cohort of young people (aged 11 to 18) in contact with the YO service.)

Respondents (Jan 15 - Dec 16) reporting they are **'regular' or 'occasional' smokers**:



This gender difference is also reflected in secondary school pupils in receipt of free school meals.



Source Pupil Voice 2015/6

Nationally, 15 year old females are significantly more likely to have had an alcoholic drink than males, and to report being drunk in the previous 4 weeks, although males are more likely to drink regularly.

Nationally, 15 year old females and males are equally likely to have ever tried cannabis and to have used it in the previous month. However, girls are more likely to have taken drugs other than cannabis in the previous month, although the proportions that use these substances are very small.

Nationally, women (14.9%) are significantly less likely to smoke than men (19.1%). However, the data is not available by gender for Bristol.

Local JSNA data tells us that:

- Women (63%) are significantly less likely to be physically active than men (68%).
- Women are significantly less likely to be overweight than men but women have higher levels of obesity.
- Women (55%) are significantly more likely to eat 5-aday than men (46%). Women (52%) are significantly more likely to eat food produced by themselves or people they know than men (45%).

- Women (47%) were significantly more likely to abstain from drinking for at least two days in a row than men (32%).
- Bristol rates for admission to hospital for alcohol-related harm are worse than national average for women and men. Of the 3,020 alcohol-related hospital stays in Bristol in 2014/15, 1160 were women (a rate of 576 per 100,000, significantly worse than the national average for women).
- The rate of alcohol related mortality in females in Bristol is 7.9 per 100,000, which is similar to the national rate.

7.4 Sexual Health

Sexual ill-health contributes to health inequalities in Bristol. Strong links exist between deprivation and sexually transmitted infections, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), young people, certain black and minority ethnic groups, people involved in sex work, people with learning difficulties and homeless people.

7.5 Non Communicable Disease

Rates for early deaths due to cancer for women in Bristol (136 per 100,000) are significantly higher than for England (123.9 per 100,000). Screening coverage for breast and cervical cancer in Bristol between 2010 & 2015 has consistently been significantly lower than the England average, (and other cities with a similar population). In 2015, Bristol's screening rates were 73.2% for Breast cancer (England 75.4%) and 70.9% for cervical cancer (England 73.5%).

Rates of early deaths due to respiratory disease are significantly higher in Bristol than nationally for both women and men. Locally, rates for women had been rising, but not during 2014-15.

The Cardiovascular Disease (CVD) death rate for women in Bristol (53 per 100,000) is similar to national average, and heart disease early death rates are 3 times lower for women than men in Bristol.

In 2013-2016 (3 year combined data) there were 1,500 emergency hospital admissions due to asthma. This was 835 females and 660 males. Admission rates to hospital for Chronic Obstructive Pulmonary Disease (COPD) and for Asthma are both significantly lower in Bristol than England.

Bristol rates of early death from liver disease in females (11.1 per 100,000) are similar to England (12.5 per 100,000).

7.6 Older Women - Dementia, Falls and Excess Winter Deaths

Nationally, more women than men develop dementia over the course of their life and more women than men care for people with dementia. 60%-70% of carers of people with dementia nationally are women. Carers report that this affects them economically (20% of working-age give up work or reduce their hours), physically (50%) and emotionally (62%).

The majority, (68%), of falls-related admissions at Bristol Hospitals (2014-2015) (aged 65+) were females.

Two out of three excess winter deaths (EWD) were women. The EWD index for Bristol women rose significantly from 5.9 in 2013/14 to 38.2 in 2014/15, in line with the England rise. This means there were 38.2% more women dying in the winter months in 2014/15 compared with the non-winter months.

8. Conclusions and Recommendations

This needs assessment has identified a number of health concerns for women in Bristol by using an approach which looks at the topic from a number of different perspectives.

Women's mental health and gender violence and their interconnected nature have been raised and these topics are priorities for Bristol and need further work.

A number of gaps in data collection and reporting have been identified including that data on smoking is not available by gender and that getting data which cuts across intersections of inequality is difficult.

Bristol has an aging female population and a number of issues associated with older age including cancer, disability, falls and excess winter deaths have been identified as issues for women in Bristol.

Some of the issues raised or left out of this document will be addressed via other dedicated JSNA chapters taking a gendered approach. Specifically, physical activity was raised by the Task Group as an important issue for women. An example summary of a JSNA chapter looking at women and falls in Bristol is included as Appendix 1 to show how this might be picked up.

Finally, it was not the intention of this Chapter solely to focus on gynaecological health topics or "women's issues". However, it is important to take into account that women continue with the business of dealing with their reproductive life-course alongside their other life responsibilities and that this may put them at a disadvantage which needs to be addressed. In addition the reproductive life-course may have complications for women and incurs an increased risk of incontinence and prolapse. With many older women in Bristol, this may further exacerbate inequalities.

Recommendations:

1. A strategy for Bristol Women's Health is written, led by the Women's Commission and taking into account the content of this document and the other JSNA chapters.
2. A review is conducted of the other JSNA Chapters to ensure they include data for women (and other equality groups, where possible) and that the specific needs of women and girls are highlighted and acted upon as part of the work for that topic e.g. in the commissioning process for services.
3. Ensure that the JSNA chapters on Physical Activity, Substance Misuse / Drugs, Food Poverty, Healthy Urban Place, Falls, Adult Social Care, Healthy Life Expectancy and Healthy Weight and others all include gender disaggregated data and that the content of this document is considered in their development.
4. The Women's Commission lead work across their task groups to increase understanding about the reproductive life course of women and girls and its

effect on women's lives as they live them in Bristol. This is both with health professionals regarding, for example, endometriosis, but also with other professionals and the public. It could include campaigns, information for public and professionals and work in schools on what is considered normal e.g. bleeding monthly and mood changes, and which symptoms or bodily changes need further investigation.

5. Data
   a. Work with health service providers in the city, including GPs to ensure that gender disaggregated data is available, reported and analysed. Encourage use of additional read codes so that the needs of different groups can be analysed.
   b. Explore how intersections of inequality in women's health can be researched though gathering data for gender which also identifies other equalities characteristics e.g. disability, BME women, transsexual women. This could for example, be through a gender health page for the Quality of Life survey and/or a one-off more specific fact finding mission along the lines of the Big Drink Debate.
6. Address the health inequalities faced by women who experience the poorest health outcomes in Bristol by ensuring that services, campaigns and other initiatives are directed appropriately.
7. Continue to support the work of the Bristol Domestic and Sexual Abuse Strategy Group to co-ordinate work across the city to address gender violence in Bristol including work in schools (The Bristol Ideal) and work at community level.
8. The gender differences in mental health experience need to be acknowledged including the effects of gender violence on the mental health of women and girls.
9. Prolapse and incontinence work needs to be explored with Public Health England following Recommendation 15 of the Chief Medical Officer's report on women's health that Public Health England convenes a group of stakeholders to consider ways of
   a. raising awareness of urinary and faecal incontinence and prolapse in women
   b. improving signposting to resources, self-help information and treatment pathways which alleviate these conditions.

Disclaimer

This document focuses on the health needs of women in Bristol and information is included up until July 2017. It is not a comprehensive look at all health needs of all women in Bristol. It is also not an attempt to suggest that the health needs of the local female population are any more or less important than those of people who do not identify as women e.g. Gender Variant people or men whose health is not covered in this Chapter. Some of the information and research cited is quite old.

However, the most up to date data and research have been cited and we recognise that in many places more up to date research is needed.

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10. Appendices

Appendix 1 - Falls summary of JSNA chapter: women

1. Introduction

Although not an inevitable consequence of old age, increased rates of falling are associated with growing older. Falls are not only associated with greater morbidity and mortality in older people, but are also linked to reduced overall functioning and quality of life, and early admission to long-term care facilities (Department of Health, 2012).

1 in 3 people aged 65+ and 1 in 2 people aged 80+ falls at least once each year (NICE, 2013). Approximately 7% of those who fall attend A&E, 4% result in a serious injury, and 3% are admitted to an inpatient bed (Department of Health, 2009).

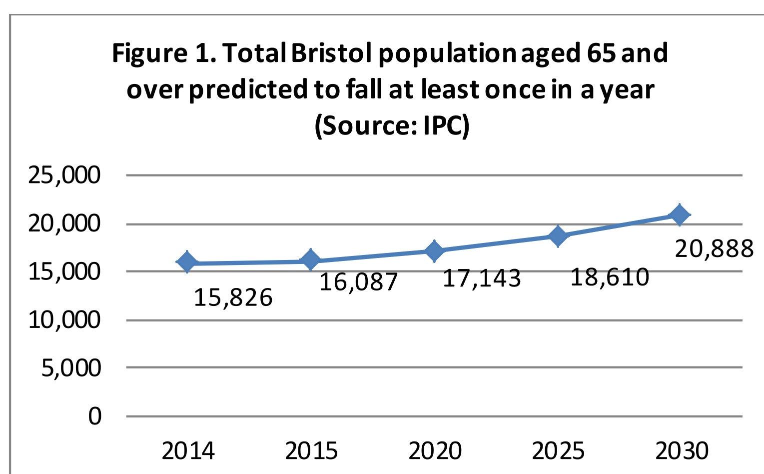
2. Who is at risk and why?

- Age is one of the key risk factors for falls
- Older women are especially prone to falls and increased injury severity (World Health Organisation, 2012).
- *Intrinsic risk factors include:* weakness in leg, hip, thigh, ankle or foot; previous falls; problems with walking and balance; visual impairment; depression; functional and cognitive impairment; dizziness; low body mass index; urinary incontinence; postural hypotension (drop in blood pressure on standing or stretching); female gender and those aged 80+.
- Extrinsic factors include: polypharmacy (taking more than 4 prescription medications), psychotropic medications (affecting a person's mental state), and environmental hazards such as poor lighting, loose carpets, and lack of bathroom safety equipment.
- Physical activity is important, not only as people age but over the lifespan. Age-adjusted risk of hip fractures is up to 40% lower in the most active compared to the least active adults (Gregg, 2000). Epidemiological studies have found that a lifetime's history of regular physical activity can reduce the risk of hip fracture by up to 50% and much of this benefit is thought to result from a reduction in falls (Law, 1991)
- Fear of falling is the most commonly reported anxiety among older people (Skelton, 2004). Falls and fear of falling are associated with anxiety and depressions, decreased mobility, reduced social contact, higher medication use and increased dependence on medical and social services and informal carers (Yardley, 2003).
- People with dementia are four to five times more likely to experience falls than older people without significant cognitive impairment (Van Doom, 2003). There are 2,856 people aged 65+ with a recorded diagnosis of Dementia on GP Practices in Bristol (Public Health England, 2016).
- Those with osteoporosis are more likely to experience a bone fracture if they fall. Fractures that that occur because of reduced bone strength are described

as fragility fractures and many will be caused by osteoporosis. Women are more at risk than men of osteoporosis because the condition often develops as a result of hormonal changes following the menopause. Those with osteoporosis are more likely to experience a bone fracture if they fall. Fractures that that occur because of reduced bone strength are described as fragility fractures and many will be caused by osteoporosis (National Osteoporosis Society, 2016). There are 767 people aged 50+ with a Recorded diagnosis of Dementia on GP Practices in Bristol (Public health England, 2015/16).

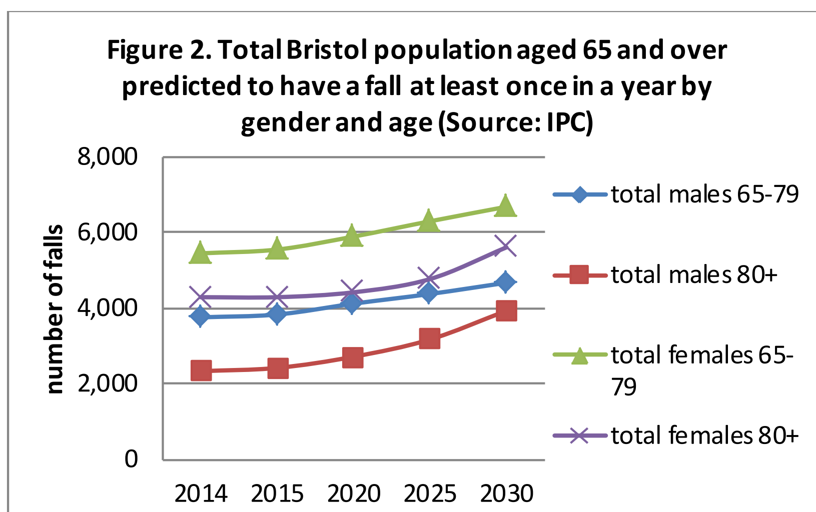
3. Size of the Issue in Bristol

An estimated 16,000 people aged 65 and over in Bristol, fell at least once in 2015. The number falling is expected to rise to an estimated 18,000 in 2025 and 21,000 in 2030 (figure 1). Of those estimated 16,000 who fell, 6,700 were estimated to be people aged 80 (42%). This number is expected to rise to an estimated 8,000 in 2025 and 9,500 in 2030 (figure 1) (Institute of Public Care: Projecting Older People Population Information System, ONS figures , 2016).



Females

In Bristol, in those aged 65+ more females fall then men. The numbers of women aged 80+ who fall in Bristol, is predicted to rise more sharply than in those aged 65-79, by 2030 (figure 2) (Institute of Public Care: Projecting Older People Population Information System, ONS figures , 2016).



Emergency Admissions for injuries due to falls – females

In Bristol, 65% of falls related emergency admissions (aged 65+) are in females. The rate of falls related emergency admissions per 100,000 population aged 65+ is significantly higher in females than in males (the female rate is 20% higher than the male rate). In those aged 80+, the rate per 100,000 population is also significantly higher in females than in males. The difference is more pronounced (female rate is 36% higher than the male rate) (table 1) (PHE, PHOF, 2015/16).

Table 1. Emergency hospital admissions for injuries due to falls in people over 65 (Source: PHOF)

Indicator (emergency admissions) 2015/16	Bristol		Region	England
	Number	Rate / 100,000	Rate/ 100,000	Rate/ 100,000
Injuries due to falls in people aged 65+ (Persons)	1669	2631	2072	2169
Injuries due to falls in people aged 65+(Male)	577	2304	1657	1733
Injuries due to falls in people aged 65+ (Female)	**1092**	**2805**	**2362**	**2471**
Injuries due to falls in people aged 65-79 (Persons)	537	1325	946	1012
Injuries due to falls in people aged 65-79 (Male)	251	1314	775	825
Injuries due to falls in people aged 65-79 (Female)	**286**	**1336**	**1100**	**1177**
Injuries due to falls in people aged 80+ (Persons)	1132	6416	5339	5526

Injuries due to falls in people aged 80+ (Male)	326	5175	4216	4367
Injuries due to falls in people aged 80+ (Female)	**806**	**7065**	**6019**	**6223**

Emergency admissions for fractured neck of femur (hip fracture)

In Bristol, the rate of emergency admissions for hip fractures per 100,000 population aged 65+ is higher in females than males, albeit the difference is not significant (table 2) (PHE, PHOF, 2015/16).

Table 2. Number of emergency admissions for fractured neck of femur (hip fracture). Source: PHOF

Indicator (emergency admissions) 2014/15	Bristol		Region	England
	Number	Rate / 100,000	Rate/ 100,000	Rate/ 100,000
Hip fractures in people aged 65+ Persons)	406	636	598	589
Hip fractures in people aged 65+ (Male)	134	551	431	416
Hip fractures in people aged 65+ (Female)	**272**	**704**	**716**	**710**
Hip fractures in people aged 65-79 (Persons)	126	309	240	244
Hip fractures in people aged 65-79 (Male)	49	254	170	168
Hip fractures in people aged 65-79 (Female)	**77**	**359**	**304**	**311**
Hip fractures in people aged 80+ (Persons)	280	1587	1634	1591
Hip fractures in people aged 80+ (Male)	85	1412	1186	1136
Hip fractures in people aged 80+ (Female)	**195**	**1702**	**1910**	**1868**

Trends over time

The number and rate of emergency admissions due to injuries from falls in people aged 65+ are consistently highest in females, perhaps explained by females living longer than males (figures 2 and 3).