Bristol City Council

Women's Health in Bristol

Joint Strategic Needs Assessment
November 2022

Contents

1. Executive Summary

The role of this paper is to understand the health needs of women in Bristol. It has been produced in light of the first ever national Women's Health Strategy and seeks to fulfil three key aims:

1. To build a comprehensive view of women's health needs in Bristol – *what do we know?*
2. To recognise current initiatives with regards to women's health – *what are we doing?*
3. To identify any gaps and make recommendations for future work – *where are the gaps?*

Women's Health in Bristol – what do we know?

Cross-cutting themes

This section discusses cross-cutting themes that span across women's health issues, including voice, access and disparities. Women frequently express not being listened to when it comes to healthcare, and this can impact upon health outcomes as well as their experience of healthcare services more broadly (DHSC, 2022a, p.15). There are also often barriers to women accessing healthcare services. Moreover, access to and uptake of services also differs between women.

There are significant disparities between women within Bristol relating to health outcomes, access to services and experience of services. This is further exacerbated by intersectionality, as a woman's various identities may combine to potentially create multiple disadvantage.

To tackle these health inequalities across the female population in Bristol, we first need to better understand the disadvantages that different women face and refrain from viewing our female population as a homogenous group. Different groups that are at increased risk of poor health are discussed. Inequalities data has also been integrated throughout.

Reproductive Life Course

This paper is guided by the life course approach, which focuses on understanding the changing health and care needs of women across their lives to identify key areas in order to both promote good health and prevent poor health outcomes (DHSC, 2022a, p.13).

Key Findings

The size of the issue in Bristol

- There are 237,900 women and 234,500 men in Bristol, meaning that women account for 50.4% of the population.
- In Bristol, female life expectancy is 82.7 years, just below the England average of 83.1 (Office for National Statistics (ONS), 2021).

- Women in Bristol live an average of 21.2 years in poor health. This is higher than the national average for women (19.2) and over 2.5 years higher than the Bristol average for men (Office for Health Improvement and Disparities (OHID), 2022a).
- The number of years that women live in ill health ranges from 11 to 31 years across Bristol, which means a healthy life expectancy gap of 16.7 years between the most and least deprived women in the city (Bristol City Council, 2022c). This is wider than the gap for men (16.3).
- In Bristol, around 1 in 3 women (30.3%) reported having an illness or health condition which limits their day-to-day activities at least a little, compared with around 1 in 5 men (21.2%) (Bristol Quality of Life Survey, 2022).

Who is at Risk

Age

- The Bristol rate for under 75 mortality from cancer in women (130 per 100,000) is higher than the national average for women (113.5 per 100,000) (Bristol City Council, 2022g).
- Bristol has a statistically significantly higher mortality rate from breast cancer in under 75s than the England average, with a rate of 25.9 per 100,000 compared to England's 20.3 using 2017-19 data (OHID, 2022a).
- Almost two thirds of falls-related admissions in the over 65s in Bristol are amongst females. Bristol rates have increased slightly in females since 2018/19 and remain significantly higher than the England rate (Bristol City Council, 2022s).
- Of patients 65 and over, 4.43% in Bristol are recorded as having dementia, which is higher than the England average of 3.97% (Bristol City Council, 2021d).

Ethnicity

- Local data shows that age, ethnicity and deprivation impact upon birth outcomes such as premature birth and low birth weight. Mothers under 20 and over 40, Black women and women living in deprived areas at higher risk (Healthier Together, 2021).
- Bristol's breastfeeding initiation rates (71%) compare favourably with the England average (55%) and is the highest of all core cities. Although, there are substantial differences between age groups, ethnicities and different levels of deprivation. For example, initiation rates ranged from 99% in Westbury on Trym and Henleaze to 45% in Hartcliffe and Withywood during 2021/22 (BCC, 2022j).

Disability

- Bristol's rate of cervical screening coverage for all women does not compare favourably with England (69.4% v 70.2% in 2021) (NHS Digital, 2021a). Bristol, North Somerset and South Gloucestershire (BNSSG) data shows that women with learning disabilities have consistently and substantially lower screening rates (NHS Digital, 2021b).

- Those with learning disabilities have consistently lower rates of breast cancer screening in BNSSG (NHS Digital, 2021b) which means they are more likely to die from breast cancer (Macmillan, 2019; OHID, 2020; NHS England, 2022d).

Health Conditions

- Bristol is well below the national average for Human Papilloma Virus (HPV) vaccination uptake in both boys (51.6% v 71%) and girls (51.4% v 76.7%), and substantially worse when looking at figures for those who have received both doses (12% v 54.7% for boys and 13.1% v 60.6% for girls) (BCC, 2022f).
- Rates of breast cancer are 16% higher in Bristol than the England average (OHID, 2021a). Bristol screening coverage for breast cancer is consistently significantly worse than the England average, at 62.7% for Bristol and 64.1% for England in 2021 (Bristol City Council, 2022g).
- In Bristol prevalence of osteoporosis is rising much faster than in England (BCC, 2022o), and 72% of hip fractures, a common consequence of osteoporosis, were women (Bristol City Council, 2022s).
- Nationally, more than 1 in 4 women are affected by perinatal mental illness (NHSE, 2022b) and "maternal suicide remains the leading cause of direct deaths occurring within a year after the end of pregnancy" (MBRRACE, 2021). It is estimated that, in Bristol, there are between 500 and 800 women each year that will develop mild to moderate depression and/or anxiety in the perinatal period (Bristol City Council, 2022i).
- The overlap between mental health and other women's health topics discussed in this paper is significant. A few areas of particular note include the perinatal period, menopause, long-term conditions and violence against women and girls.
- There are varying estimates on the prevalence of chronic pain, ranging from about one third and one half of the population, though research is unanimous that it disproportionately affects women (Bristol Health Partners, 2022; Versus Arthritis, 2021a, p.10).

What are we doing?

This section recognises current initiatives and core pieces of work that relate to women's health, so that any subsequent gaps can be identified. It is not an exhaustive list, though does demonstrate current areas of focus. This is not to suggest that any of the associated issues have been resolved, rather that they have already been identified as issues and work is already underway. It includes narrative on domestic abuse and sexual violence, sexual health, maternity, menopause, mental health, healthy lifestyles, period dignity and incontinence.

Where are the gaps?

Areas in need of further attention have been identified, and largely fall into the following three categories:

- **Areas which we have limited local data** on and would therefore benefit from further local research in order to give a fuller understanding of the issues in Bristol - including: menstrual health and gynaecological conditions; menopause; pelvic floor health, prolapse and incontinence; and long-term conditions, disability and chronic pain.
- **Areas where we have some local data** but currently lack sufficient inequalities data that is crucial in tackling the issue and reducing health inequalities. Including: HPV vaccination and cervical screening; pregnancy loss and fertility; breast cancer; mental health, including perinatal mental health; osteoporosis and bone health; dementia and ageing well.
- **Areas where local data identifies issues** that are in need of further attention, including: HPV vaccination uptake; breast cancer; long-term conditions, disability and chronic pain; osteoporosis and bone health; dementia and ageing well.

Recommendations

Full recommendations, setting out areas for future focused action or where further research is needed can be found on page 67, but in summary, they are:

Areas for focused action:

- Ensure that increasing HPV vaccination uptake is a priority for Bristol
- Consider how Women's Health Hubs could best work in Bristol
- Ensure that clear learning and actions are taken from the recent BNSSG Maternity Health Equity Audit
- Continue work to reduce inequalities relating to breastfeeding
- Take action on the findings of the upcoming Healthwatch menopause project
- Continue work to improve women's wellbeing and lifestyle across Bristol.
- Ensure that system-level work on dementia and ageing well includes a women's health perspective.

Areas for future research:

- Investigate the experience of menstrual health and gynaecological conditions for women in Bristol
- Explore ways of improving cervical cancer screening uptake, with a focus on inequalities
- Conduct research to better understand pregnancy loss and fertility, with a focus on inequalities
- Undertake research on pelvic floor health, prolapse and incontinence in Bristol
- Support national work on increasing uptake of breast cancer screening
- Research to better understand mental health across the female life course, from adolescence, the perinatal period, and the menopause
- Conduct research into how long-term conditions, disability and chronic pain affects women in Bristol
- Conduct further research into osteoporosis and bone health in Bristol.

2. Introduction

The role of this paper is to understand the health needs of women in Bristol. It has been produced in light of the first ever national Women's Health Strategy and seeks to fulfil three key aims:

4. To build a comprehensive view of women's health needs in Bristol – *what do we know?*
5. To recognise current initiatives with regards to women's health – *what are we doing?*
6. To identify any gaps and make recommendations for future work – *where are the gaps?*

This paper is structured around the above questions, and looks into cross-cutting themes, the reproductive life course and general health needs of women. This approach aligns with the national Women's Health Strategy and includes the identified topics below.

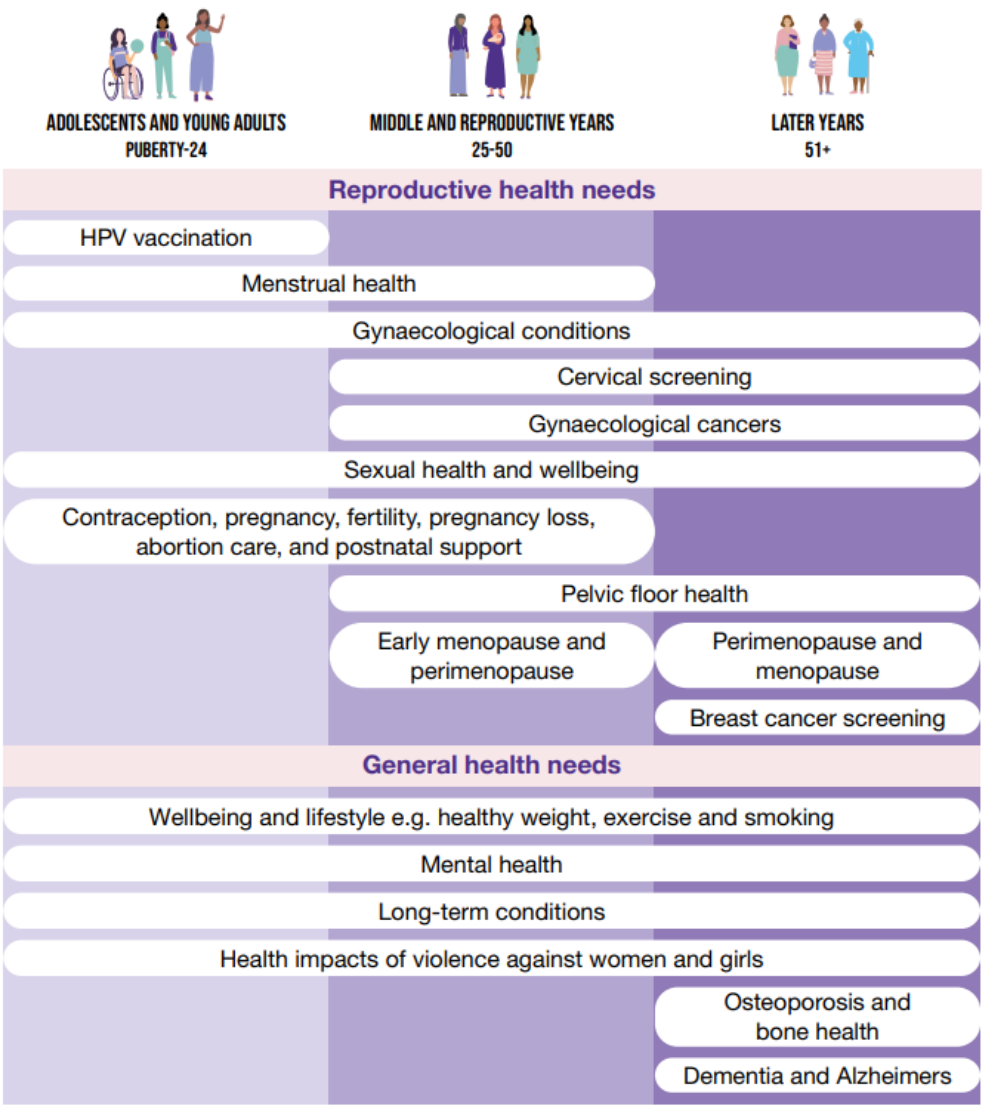

Figure 1: The Women's Health Life Course (Source: DHSC, 2022a)

Reducing health inequalities is a key aim of Bristol City Council's Health and Wellbeing Strategy (BCC, 2022a) and the One City plan (Bristol One City, 2019). This paper will contribute to achieving that aim by providing data and evidence on women's health – involving disparities for women and between women.

It is crucial to note that -

- Although women usually live longer than men, they spend considerably more time in poor health (DHSC, 2022a, p.5)
- Women make up 51% of the population, yet the system is largely designed by men and for men as default (DoH, 2015)
- Health needs that are specific to women, or that disproportionately affect women, have historically not received appropriate focus

Key demographics and statistics

Population

There are approximately 237,900 women and 234,500 men in Bristol, meaning that women account for 50.4% of the population. This broadly aligns with national 51:49 split (ONS, 2022a).

Life expectancy

Female life expectancy in Bristol is 82.7 years, just below the England average of 83.1. Male life expectancy is 78.5 in Bristol and averages 79.4 in England (ONS, 2021).

Healthy life expectancy

Healthy life expectancy is the average number of years that a person would expect to live in good health based on current mortality rates and self-reported good health. Women in Bristol live an average of 21.2 years in poor health. This is higher than the national average for women (19.2) and over 2.5 years higher than the Bristol average for men (OHID, 2022a).

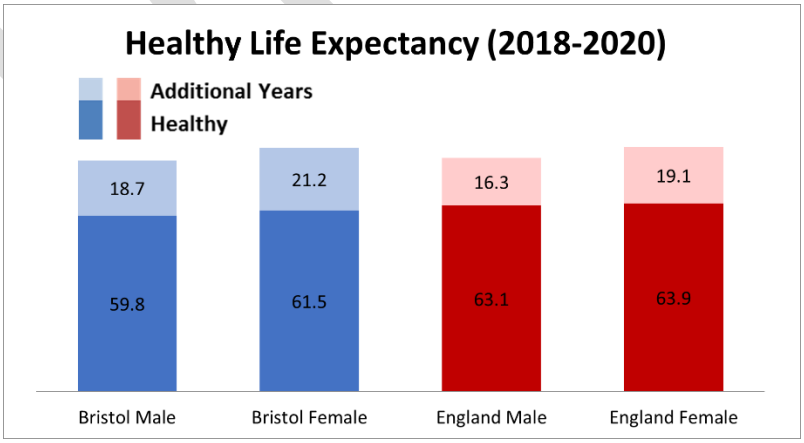

Figure 2: Healthy Life Expectancy in Bristol and England, 2018-2020
(Source: OHID, 2022a)

Equalities statement

We recognise that solely referencing cisgender women (women who identify with the sex they were assigned at birth) in the context of women's health, particularly in relation to sexual and reproductive health needs, may exclude transgender and non-binary people who have needs and experiences that can be similar to but also unique from those of cisgender women.

Covid-19 impact statement

The impact of the Covid-19 pandemic on women's health cannot be ignored. This report has highlighted specific issues that have been impacted, for example, the decrease in breast cancer screening which will have health ramifications for years to come. It is still too early to understand the full impact across the entire health system and close monitoring will be key to enabling improvement plans and actions to be put into place.

Upcoming Cost of Living crisis?

3. Women's Health in Bristol – what do we know?

This section will firstly consider cross-cutting themes that span wider than one specific health area, and then provide detail on various health aspects of the reproductive life course as well as the more general health needs of women.

3.1. Cross-cutting Themes

3.1.1. Voice

Women frequently express not being listened to when it comes to healthcare. In fact, in the national call for evidence for the Women's Health Strategy, 84% of respondents said there had been instances where they had not been listened to by healthcare professionals (DHSC, 2022a, p.15). There have been several recent papers that support this, including the First Do No Harm report (DHSC, 2020) and the Ockenden Report (DHSC, 2022b), among others. This can impact upon health outcomes, for example, leading to a delayed diagnosis, as well as negatively impacting upon their experience of healthcare services more broadly. The concept of women's voices (and often a lack thereof) should be considered throughout this document.

3.1.2. Access

Access to healthcare services is a critical component of the NHS constitution (DHSC, 2012). However, we know that people often face barriers in doing so.

Fragmentation of women's health services is a key example that negatively impacts upon access, with women facing difficulties in navigating the complex web of different services and providers to get the help or support that they require. The national Women's Health Strategy cites sexual and reproductive services as a prime example, and the work around Women's Health Hubs will contribute to lessening this problem through providing a 'one-stop shop' to serve an array of women's health needs (DHSC, 2022a).

Access to and uptake of services also differs between women. This differential uptake of healthcare services is largely influenced by disparities, and both evidences and exacerbates inequalities in health. A key means of resolving health inequalities is therefore to also focus on access.

3.1.3. Disparities

It is not enough to look at generalised data. There are significant disparities between women within Bristol relating to health outcomes, access to services and experience of services, and it is important to apply this critical lens to women's health.

To tackle these health inequalities across the female population in Bristol, we first need to better understand the disadvantages that different women face and refrain from viewing our female population as a homogenous group. Understanding the differences allows us to tailor our approach in order to reduce inequalities between women whilst improving health for all.

Understanding of intersectionality, i.e., how a woman's various identities combine to create discrimination and privilege, is pivotal to this, as many women face multiple disadvantages. For example, we know that disabled women are at higher risk of domestic abuse, are more likely to live in poverty, and are more likely to develop poor mental health, among other factors that can impact upon their health (Breckenridge, 2018; Joseph Rowntree Foundation, 2022; Mental Health Foundation, 2022a).

Strategic context

Various local and national strategic commitments also recognise that understanding disparities in health is fundamental, including:

- Bristol City Council's Health and Wellbeing Strategy (2022), which cites reducing health inequalities as a key approach.
- The national Women's Health Strategy, which sets out a 10-year commitment to resolve inequalities, with a vision that - *"disparities in access to services, experiences of services and outcomes are tackled. Women with additional risk factors or who face additional barriers have equitable access to services. All women can access health and care services that are free from stigma and discrimination."* (DHSC, 2022a, p.31). Each local system has a critical part to play in achieving this.
- NHS England's Core20PLUS5 approach to inequalities, which considers the most deprived 20% of the population, as well as population groups that we would expect to see identified (for example, minority ethnic communities and inclusion health groups, among others). It focuses on five key areas – maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension (NHSE, 2021).
- The government's commitment to 'Levelling up' holds health as a key aspect, with goals to narrow gaps in healthy life expectancy by 2030, as well as improving healthy life expectancy across the board (DLUHC, 2022).

In recognition of this, information highlighting disparities between women is integrated throughout this document. It is not exhaustive of all inequalities but goes some way in understanding how health issues affect women differently. Local data will be given where possible, though it is important to note that it is lacking in many cases, and addressing these gaps are a key recommendation of this paper. Where local data is unavailable, information on what we know nationally will be given.

To provide some context and highlight key inequalities that we know to exist, the remainder of this section will give some general information for groups of women that are disadvantaged in terms of health.

Women of an minority ethnic background

In this report, we use the phrase minority ethnic groups to refer to those who, through a lack of power, are often disadvantaged in society, experiencing social and economic exclusion and racism. We acknowledge that these groups (on their own and combined) are diverse, and include people with a range of experiences, circumstances and identities.

In England, health inequalities exist between minority ethnic groups and white groups, as well as between different minority ethnic groups. People from minority ethnic groups are more likely to report poor health outcomes and poor experiences of health services than their white counterparts (King's Fund, 2021). Gypsy, Roma and Traveller communities have some of the worst health outcomes across the country (Women and Equalities Commission, 2019).

Bristol is increasingly diverse. The 2011 Census showed that 16% of the population were from minority ethnic backgrounds but for children this figure was 28%. More recent data shows that the proportion of pupils who are not 'White British' has increased from 31% in 2011 to 38% in 2021 (BCC, 2021a). This means that a growing proportion of our female population are of an minority ethnic background and are therefore more likely to face disadvantages in terms of health.

Women living in areas of high deprivation

Recent research shows that, nationally, 1 in 5 of our population live in poverty. It also shows that women are more likely to live in poverty (Joseph Rountree Foundation, 2022).

The Index of Multiple Deprivation uses several indicators, such as income and employment, to relatively rank areas in England from most deprived to least deprived (Ministry of Housing, Communities and Local Government, 2019). This is used as an indicator of deprivation throughout this document.

In Bristol, 15% of the population live in the most deprived 10% of areas in England – equating to 70,400 people (BCC, 2020a). Figure 3 shows deprivation levels by ward.

There is a significant link between deprivation and health outcomes. Within Bristol, the life expectancy gap between the most and least deprived areas for women is 6.9 years (BCC, 2022b).

The inequality is even more stark when looking at the difference in healthy life expectancy. The number of years that women live in ill health ranges from 11 to 31 years across Bristol, meaning that there is a healthy life expectancy gap of 16.7 years between the most and least deprived women in the city (BCC, 2022c).

This is wider than the gap for men (16.3) and, of the 149 local authorities, is the 23rd worst female healthy life expectancy gap in England (BCC, 2022c).

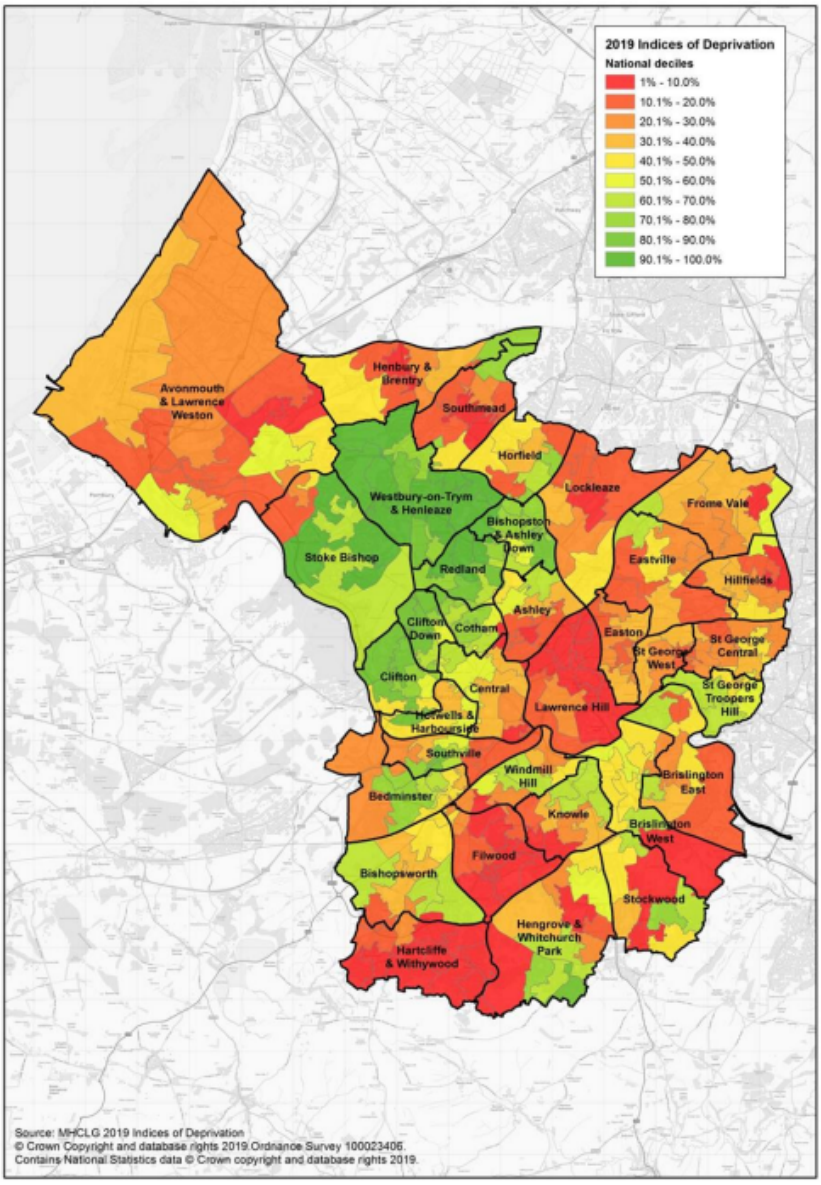

Figure 3: Deprivation Deciles in Bristol, 2019 (Source: BCC, 2020a)

Disabled women

The Bristol Quality of Life Survey (2022) found that:

- Women are much more likely to have 'an illness or health condition which limits day-to-day activities at least a little', with 30.3% reporting so, representing almost 1 in 3 women, compared to 21.2%, or 1 in 5, men.
- Those with disabilities are more likely to have poor health. An average of 84.9% of people across Bristol reported good health compared to just 36.9% of disabled people.

As well as having additional and often more complex health needs, disabled people also have more difficulty accessing services. The recent UK Disability Survey found that 46% of

disabled people were unable to access, or had extreme difficulty accessing, medical facilities (Disability Unit, 2021).

Moreover, disabled people are at higher risk of poverty and therefore also the health risk that are associated with deprivation. This is partly due to the additional costs associated with disability and ill health, and partly due to disabled people being less able to access work. In the UK, 36% of working-age disabled women live in poverty, compared to 18% of non-disabled working-age women (Joseph Rowntree Foundation, 2022), meaning that disabled women of this age category are twice as likely to live in poverty. Research also shows that nearly half of those in poverty were from families in which someone had a disability (Institute of Health Equity, 2020).

Women experiencing multiple disadvantage

Women experiencing multiple disadvantage includes those experiencing homelessness, those with substance misuse problems and those involved in the criminal justice system, among other socially excluded groups such as street sex workers. Often, women experience a combination of these issues concurrently; they seldom exist in isolation and experiencing one of the issues increases the likelihood of poor physical and mental health. Complexity therefore implies both breadth (multiple and often interconnected needs) as well as depth (profound and severe need).

We know that women experiencing multiple disadvantage are more likely to have poorer health outcomes and will also face additional barriers to accessing healthcare than women in general (DHSC, 2022a). Structural barriers that can prevent access include not having the money or support to attend appointments, or being refused registration (Groundswell, 2020). Even when women overcome these barriers and access services, they often experience stigma and discrimination (DHSC, 2022a) resulting in poor experiences that mean they are less likely to attend in the future.

Homelessness

In 2020/21, Bristol City Council received 5,508 homeless applications, demonstrating the size of the issue (BCC, 2022d). It is important to note that not all homeless people are rough sleepers, and that much of the issue is hidden. On average, women that sleep rough die almost 40 years earlier than women in the general population (ONS, 2020a). Moreover, women who are homeless often have other health and social care needs. Recent research has found that 74% of homeless women had a physical health issue and 64% were experiencing mental health issues (Groundswell, 2020). In fact, poor health is often a cause of homelessness, with 59% of women in a recent study either agreeing or strongly agreeing that their health contributed to them becoming homeless (Groundswell, 2020).

Street sex workers

Estimating the prevalence of sex work is challenging due to its hidden nature (Bristol University, 2019). National research suggests that a substantial proportion are selling sex to get by financially (University of Bristol, 2019a). Street sex workers specifically are highly marginalised and carry an “extremely high burden of unmet health need” (Potter *et al.,* 2022). Despite high levels of need, there is little evidence that healthcare is effective for this

group and access is variable across the UK, especially with regards to primary care and mental health provision (Potter *et al.,* 2022).

Substance misuse

There are an estimated 4,940 opiate and/or crack users in Bristol (BCC, 2022e), and though this is a small proportion of the population, the burden of ill health among this population is extensive. This equates to roughly 1 in 100 people and is the second highest number among the core cities. Crucially, a significant amount of those in treatment have experience of the criminal justice system and homelessness, demonstrating the intersectionality between these issues (BCC, 2022e).

Women in prison

There is growing evidence that prisons are not only unable to meet women's health needs but in fact have a damaging impact on women's physical and mental health (Howard League, 2022).

The intersectionality and overlapping nature of the above factors mean that these groups of women are incredibly vulnerable and at a significant disadvantage in terms of access, experience and outcomes relating to health.

Refugee and asylum-seeking women

Female refugees and asylum seekers are likely to have experienced trauma along with physical and mental health pain that led to forced migration, representing unique and complex health needs. Moreover, whilst refugee women can often theoretically access health services, they face many challenges in doing so, including insufficient support to access services, language barriers, cultural differences, limited health literacy, digital exclusion, transport issues, limited financial capacity and even fear of being deported (Rogers *et al*., 2020; Refugee Council, 2021). The Women's Health Strategy also recognises the difficulties that refugee and asylum-seeking women face, and the poorer health outcomes that result (DHSC, 2022a).

Neurodiverse women and women with learning difficulties

Mencap estimates that around 1.5 million people in the UK have a learning disability (Mencap, 2020). Nationally, the life expectancy gap for women with a learning disability is 27 years (University of Bristol, 2019b). These women often experience poorer outcomes in terms of diagnoses, for example, in relation to the under-identification of autism in women and girls (DHSC, 2022a, p.34). Barriers to access also pose problems and include a lack of staff understanding around learning disabilities, anxiety of those with learning disabilities, inadequate follow-up care, a lack of joined up working between providers and failure to make a correct diagnosis (Mencap, 2022).

Women who are serving, or have served in the armed forces

Women who have served in the armed forces will often face a unique set of challenges in accessing healthcare that are different from their male counterparts (DHSC, 2022a, p.33).

This, in conjunction with their potential physical and mental combat related injuries, means that they are particularly vulnerable to ill health (DHSC, 2022a, p.34).

LGBTQ+

LGBTQ+ people have disproportionately worse health outcomes and experiences of healthcare services (NHSE, 2022a; DHSC, 2022a). Research has also found that LGBTQ+ people feel their specific needs go unaddressed and that they have great difficulty accessing services, as well as facing stigma and discrimination (Government Equalities Office, 2018a).

The Bristol Quality of Life Survey found that approximately 9.1% of the Bristol population identify as Lesbian, Gay, or Bi-sexual (BCC, 2021). It is not possible to give robust population estimates for the trans community due to the small number of responses.

We know that these groups of women are particularly vulnerable to poorer health and these disparities must be central to our understanding of women's health in Bristol. Subsequent sections include disparities data where possible and highlight where it is missing.

3.2. Reproductive Life Course

This paper is guided by the life course approach. Unlike a disease-oriented approach that looks at singular issues, it focuses on understanding the changing health and care needs of women across their lives to identify key areas in order to both promote good health and prevent poor health outcomes (DHSC, 2022a, p.13). This is particularly useful when looking at women's health; women have predictable and long-term reproductive health needs (RCOG, 2019).

These needs do not equate to women being less capable; they disadvantage women not because they occur, but rather because they are not fully acknowledged or supported.

3.2.1. Menstrual health and gynaecological conditions

Menstrual cycles vary between women, though estimates show that on average a woman will have 480 periods in her lifetime, or fewer due to pregnancies (NHS, 2019a).

Understanding of menstrual health is crucial, especially when considering its impact upon identifying gynaecological conditions; those who menstruate need to understand what is normal and what is not so that they can access help when necessary. However, consultation with the British public found that there is a lack of information and awareness, with only 8% of women having enough information on gynaecological conditions and 17% of women having enough information on menstrual wellbeing (DHSC, 2022a, p.60).

Stigma around menstrual health also acts as a barrier to women seeking help. In the UK, research has found that "nearly 80% of adolescent girls have experienced *concerning* menstrual symptoms (such as unusually heavy or irregular bleeding) but hadn't consulted a health professional; 27% of those said they were too embarrassed to discuss the topic" (The Lancet, 2018).

In Bristol, the Pupil Voice Survey (BCC, 2019) found that 10% of secondary school age girls had missed school in the last month due to their period and it was the third highest reason for absence. Menstrual health and wellbeing also relates to having access to period products (DHSC, 2022a, p.60). In 2018, research found that 1 in 10 girls aged 14-21 couldn't regularly afford menstrual products, and this has implications on school attendance (The Lancet, 2018). Now, all schools and colleges can access free period products, though a recent report has found that a third of girls can't access them (The Guardian, 2022).

Dysmenorrhoea (painful cramping experienced before and during menstruation) is the most commonly reported gynaecological symptom, though prevalence estimates range nationally between 16-91% of women of reproductive age due to differing definitions (NICE, 2018). Despite the high prevalence and impact on quality of life, few women seek treatment (NICE, 2018).

Normalisation of symptoms like period pain also means that diagnoses are often missed. In England, it is estimated that endometriosis (a condition where endometrial tissue is present

outside of the uterus, often causing extreme pain and even infertility) affects between 6 and 10% of women (Dixon *et al.,* 2021). Yet, the average diagnosis for this condition takes 7 to 8 years (RCOG, 2019).

There is limited data available on the prevalence of gynaecological conditions in Bristol. There is some data on hospital admissions due to endometriosis and we can compare these figures with national data (Figure 4). However, it is important to emphasise that hospital admissions will only show part of the picture, and the prevalence of endometriosis (diagnosed and undiagnosed) will be much higher. The dip of planned admissions in 2020/21 is likely to be a reflection of the impact of Covid-19.

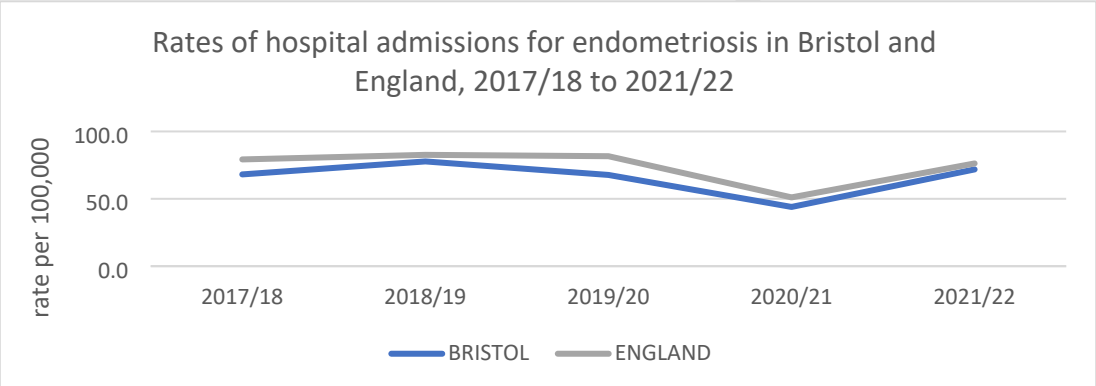

Figure 4: Rates of Hospital Admissions for Endometriosis in Bristol and England 2017-22 (Source: Hospital Episodes Statistics via NHS Digital)

Figure 5 shows the admissions data by age group per 100,000, comparing Bristol with England for the 5 year period 2017-22, using data from Hospital Episodes Statistics via NHS Digital (collated by Public Health Bristol City Council). Admissions due to endometriosis are highest in women aged 35-39. This may show that symptoms are more extreme for this age group, but this is heavily caveated with the knowledge of how long it takes to achieve a diagnosis and therefore receive treatment. The average crude rate per 100,000 for the 5 year period 2017/18 - 2021/22 across all age groups in Bristol is 74.6, compared to 100.5 nationally.

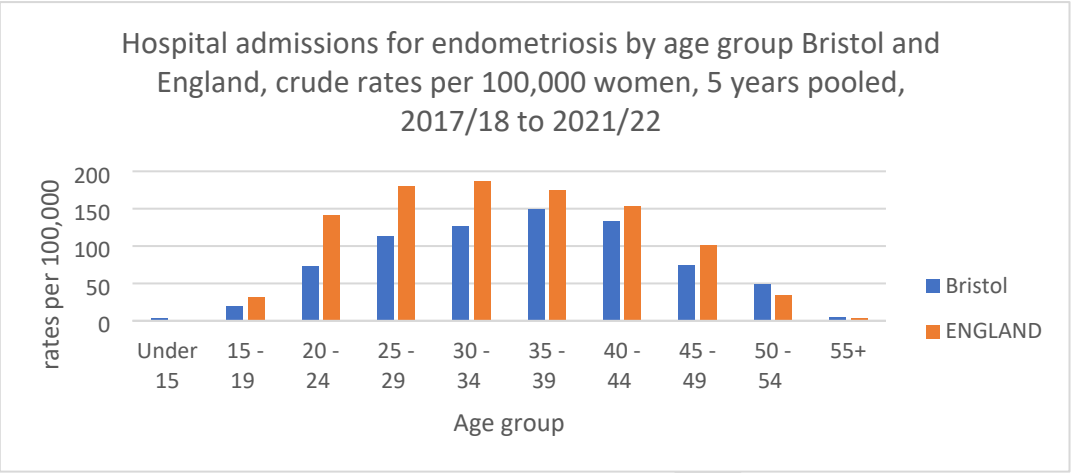

Figure 5: Rates of Hospital Admissions for Endometriosis by Age Group in Bristol and England, 5 years pooled 2017-22 (Source: Hospital Episodes Statistics via NHS Digital)

The NHS has seen gynaecology waiting lists increase by 60% since the pandemic, the largest growth in percentage terms of all elective specialities (RCOG, 2022).

Disparities

Local data on disparities among women and girls in terms of menstrual health and gynaecological conditions is limited.

However, national research has suggested that menstrual problems may be experienced differently by women with learning disabilities, and that problems may not be appropriately recognised (Rodgers *et al.,* 2006). There is also a clear relationship between deprivation generally and period poverty.

NB: prolapse and other pelvic floor health issues will be discussed in section 3.2.8.

3.2.2. HPV vaccination, cervical screening and gynaecological cancers

HPV vaccination

The HPV vaccine helps to prevent cancers caused by human papillomavirus (HPV), including cervical cancers and some cancers of the mouth, throat, anus and genitals. It also helps to protect against genital warts. High risk types of HPV can be found in more than 99% of cervical cancers, Gardasil 9 (the latest vaccine) protects against 95% of cervical cancers (NHS, 2019b).

Since 2008, school-age girls have been offered the vaccine, and in 2018 it extended to also include school-age boys. As HPV is spread through skin-to-skin contact, usually found on fingers, hands, mouth and genitals, it is crucial for girls and boys of this age to have the vaccination – before they become sexually active. The vaccine entails two doses, to be taken between 6 and 24 months apart.

Nationally, up to 80% of women ages 15-24 have received the vaccine and there is early evidence of its impact i.e., a reduction in high-risk infections, genital warts and pre-cancerous lesions (DHSC, 2022a, p.94). A recent study found that women who had the HPV

vaccine between the ages of 12 and 13 years had 87% lower cervical cancer rates than previous generations (Falcaro *et al.*, 2021). The Women's Health Strategy sets out a 10-year ambition to reach 90% uptake for both doses (DHSC, 2022a, p.93).

Figure 6 compares the uptake of school-age immunisations, comparing Bristol with national averages. It shows that Bristol is well below the national average for HPV vaccination uptake in both boys and girls, and substantially worse when looking at figures for those who have received both doses (BCC, 2022f).

It also shows that HPV vaccination uptake has decreased far more substantially than other school-age immunisations when accounting for the impact of the Covid-19 pandemic.

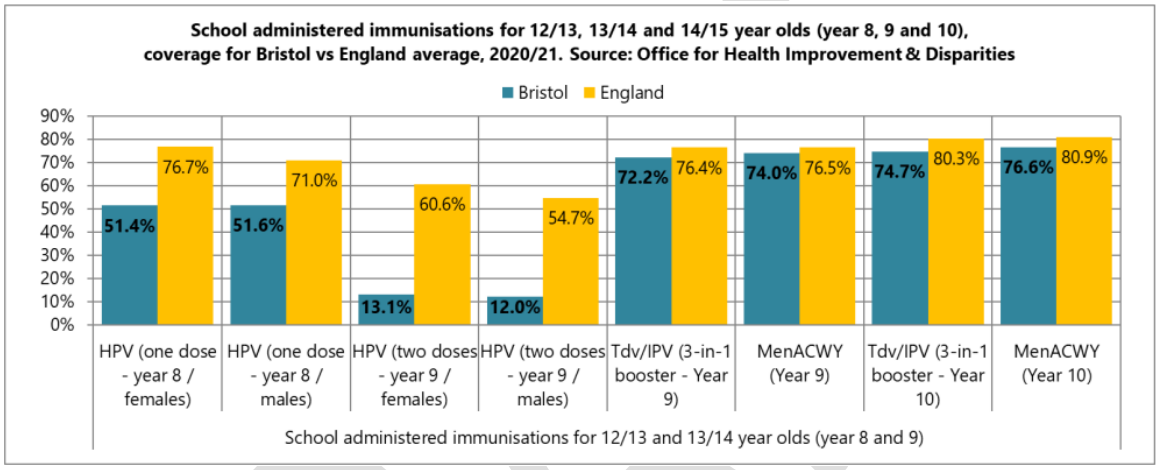

Figure 6: School Immunisations Coverage in Bristol and England 2020/21 (Source: BCC, 2022f)

It is important to look at the trend over the past few years, which shows that the HPV vaccination uptake took a huge dip in 2019/20, likely due to the disruption caused by the Covid-19 pandemic in early 2020. Though the national picture also saw a decrease in uptake, Figure 7 shows that this was far more significant in Bristol, substantially widening the gap between Bristol and the national average.

The further drop that we see for second doses in 2020/2021 is in part due to the limited uptake of first doses the year before, and is also likely to have been impacted by the pandemic. Though, we have early signs that uptake is increasing.

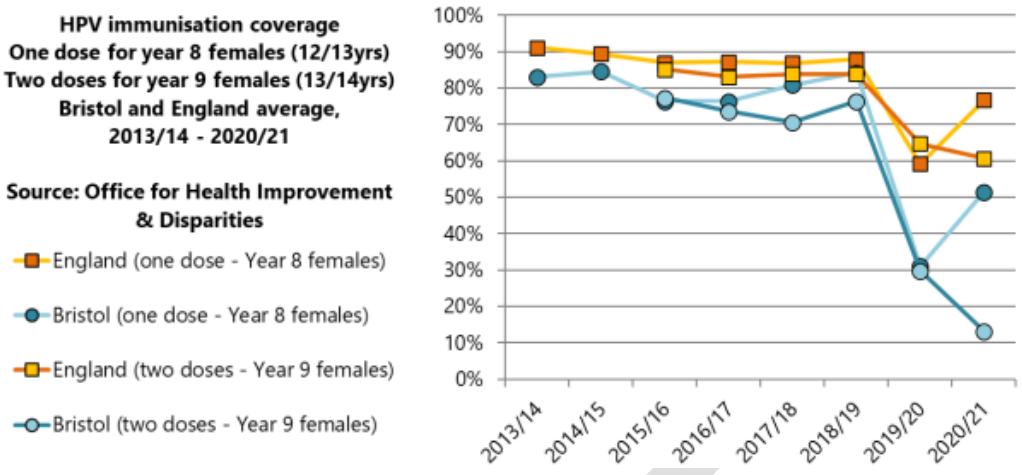

Figure 7: HPV Immunisation Coverage in Bristol and England 2020/21 (Source: BCC, 2022f)

Disparities

Our current understanding of disparities in uptake is limited. Though national studies have shown that deprivation and ethnicity play a role in HPV vaccination uptake (Kumar & Whynes, 2011). Moreover, a recent local study by Bristol University has found that written consent forms can act as a barrier to HPV vaccination uptake, especially for those from non-white British groups and more deprived areas (Fisher *et al.,* 2021).

Cervical screening

There are a variety of gynaecological cancers including of the womb, uterus, ovaries, cervix, vulva and vagina. Diagnosis at an early stage is associated with much greater chances of survival and NHSE's Core20PLUS5 approach aims to diagnose 75% of cancers by stage 1 or 2 by 2028 (NHSE, 2021). Screening programmes and information campaigns are therefore crucial. In 2019, an estimated 56.6% of *all* (i.e., not specific to gynaecological cancers) new cases of cancer in Bristol were diagnosed at an early stage, similar to the national average of 55.0% (OHID, 2022a).

The HPV vaccine does not eradicate the risk of cervical cancer completely and it is hence important that even vaccinated women continue to have regular cervical screening (RCN, 2020, p.6). Moreover, the full impact of the HPV vaccination is unlikely to have been felt among the population yet; there is still a large proportion of the female population that would not have benefited from having the vaccine due to when it was brought in and their age at that time.

Figure 8 shows Bristol's cervical cancer screening rates in comparison with the South West and England. It shows that Bristol's 2021 rate of 69.4% does not compare favourably with England's 70.2%, though the differences are not significant and both rates are below acceptable performance levels (NHS Digital, 2021a).

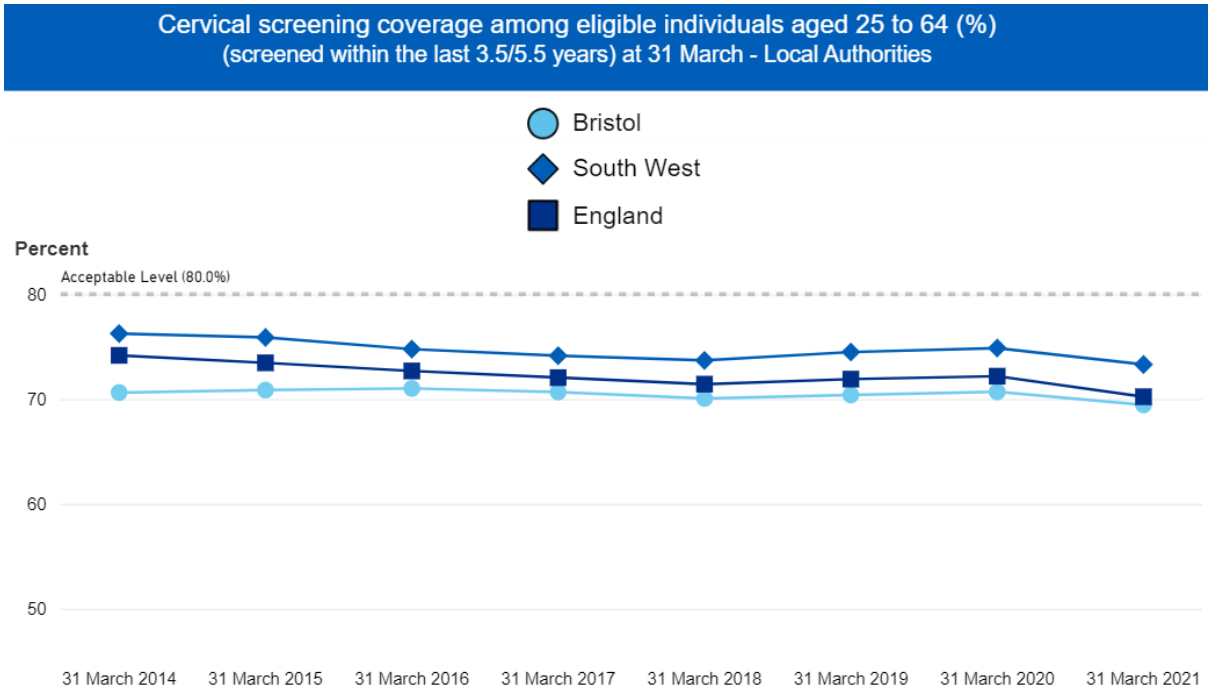

Figure 8: Cervical Screening Coverage in Bristol, the South-West and England 2014-2021 (Source: NHS Digital, 2021a)

In the UK, cervical cancer rates are highest in females aged 30-34 (Cancer Research, 2018), this age group are therefore of particular concern when it comes to screening.

When separating the 2021 cervical cancer screening rates into two ages categories (ages 25-49 and 50-64), we can see that screening uptake is lower generally for the younger age group.

It also indicates that whilst screening uptake in the younger age group (ages 25-49) is slightly higher than the England average – 68.4% and 68.0% respectively, screening for 50–64-year-old women is slightly lower in Bristol (72.7%) than the England average (74.7%) (OHID, 2022a).

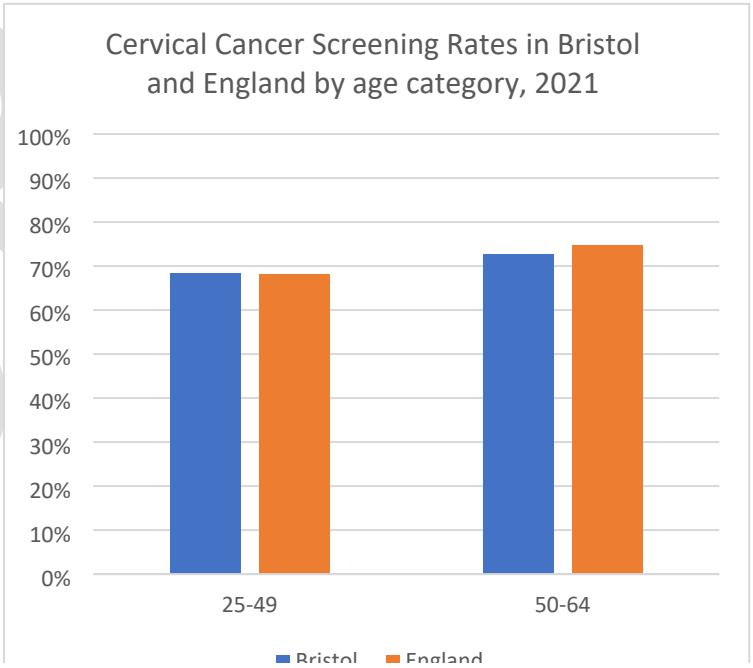

Figure 9: Cervical Screening Rates in Bristol and England by age 2021 (Source: OHID, 2022a)

Gynaecological cancers

Nationally, cervical cancer rates have remained relatively stable since the turn of the century - meanwhile, mortality rates have gradually decreased. Figure 10 displays this using age-standardised data on the number of tumours and number of mortalities per 100,000

population in England between 2001 and 2019. The equivalent data for BNSSG is displayed in Figure 11, though it should be noted that this data is not as reliable (NCRAS, 2021). Though we see more fluctuation in prevalence in Bristol, due to the smaller numbers involved, it is reasonable to deduce that mortality rates are similar to the England average.

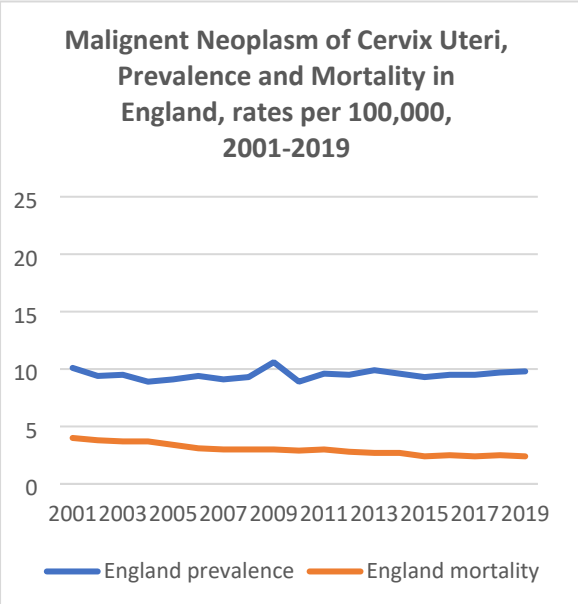

Figure 10: Cervical Cancer Prevalence and Mortality in England 2001-2019 (Source: NCRAS, 2021)

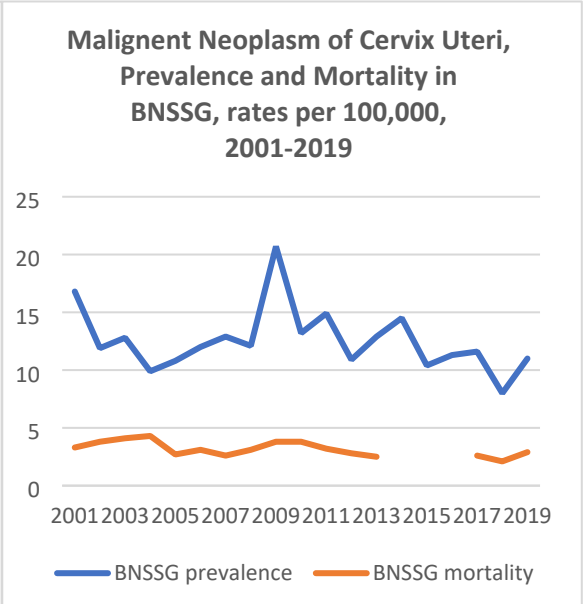

Figure 11: Cervical Cancer Prevalence and Mortality in BNSSG 2001-2019 (Source: NCRAS, 2021)

Figure 12 shows the combined prevalence of cancer of the Cervix Uteri, Corpus Uteri, Uterus, Ovary and other unspecified female genital organs. The data has been age-standardised and reflects the number of cancerous tumours per 100,000 population, comparing Bristol, North Somerset and South Gloucestershire (BNSSG) with England. It shows that, of these gynaecological cancers, BNSSG averages a slightly higher rate than England, though it is not statistically significant (NCRAS, 2021).

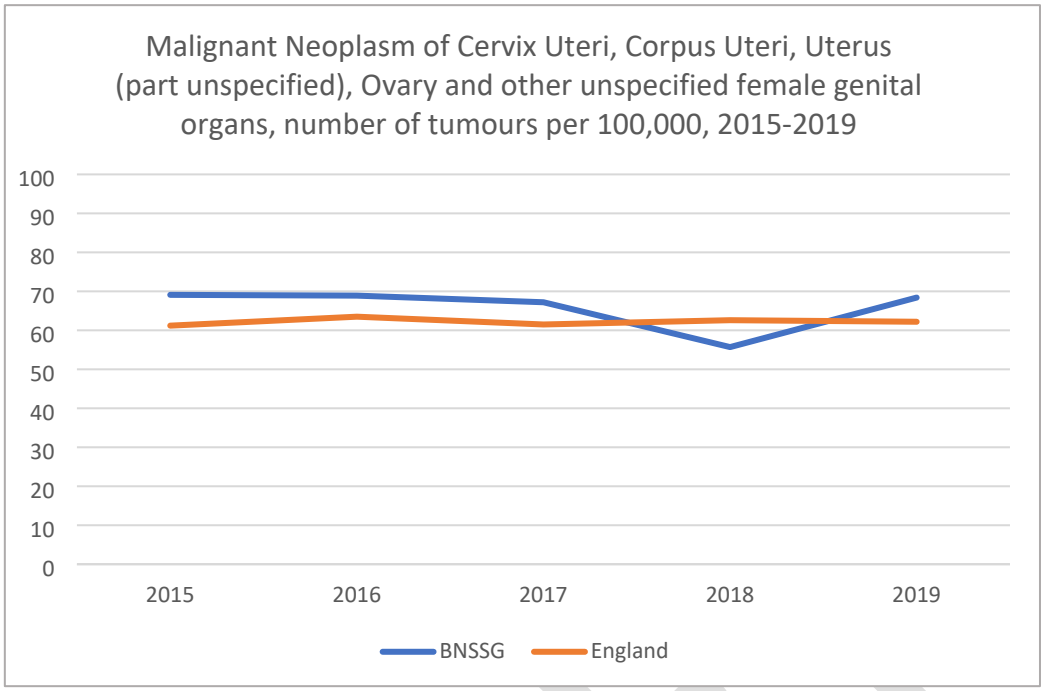

Figure 12: Combined Prevalence of Multiple Gynaecological Cancers in BNSSG and England 2015-2019 (Source: NCRAS, 2021)

The aforementioned cancers are the only types of gynaecological cancers that we have local (BNSSG) data for. Two other types (vulval and vaginal) have national data, though the rates of both are low (4.1 and 0.8 per 100,000 respectively) and it would therefore likely be difficult to draw local conclusions.

Disparities

National reports cite that survivors of sexual abuse, minority ethnic women, disabled women, LGBTQ+ women, women living in deprivation, refugee and asylum-seeking women, homeless women, female prisoners and travellers are less likely to attend cervical screening (RCOG, 2019, p.103).

Locally, BNSSG data shows that women with learning disabilities have consistently and substantially lower screening rates for cervical cancers (NHS Digital, 2021b).

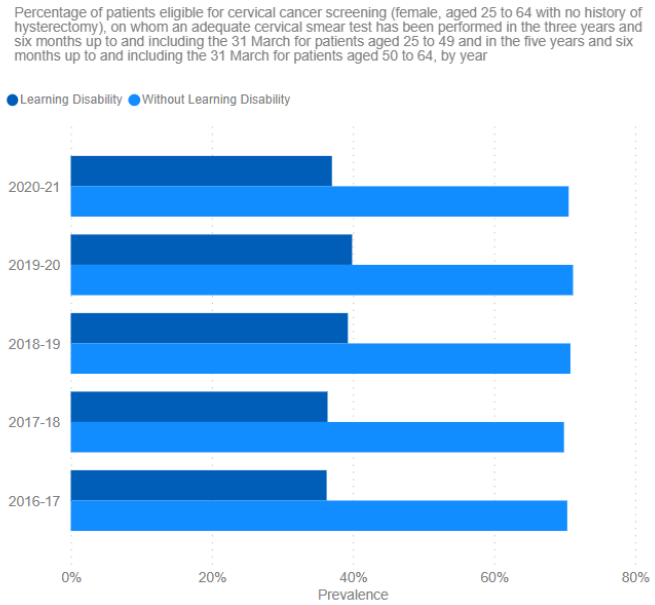

Figure 13: Cervical Screening Coverage Comparing those with a Learning Disability to those without in BNSSG 2016/17-2020/21 (Source: NHS Digital, 2021b)

Nationally, it has been found that cervical cancer incidence rates are 65% higher in the most deprived quintile of the population compared with the least (Cancer Research, 2018).

Local data on disparities in terms of gynaecological cancers is limited. However, there is local data that evidences a clear relationship between deprivation and cancers generally, with rates of under 75 mortality due to cancer twice as high in the most deprived areas of the city compared to the least (BCC, 2022g).

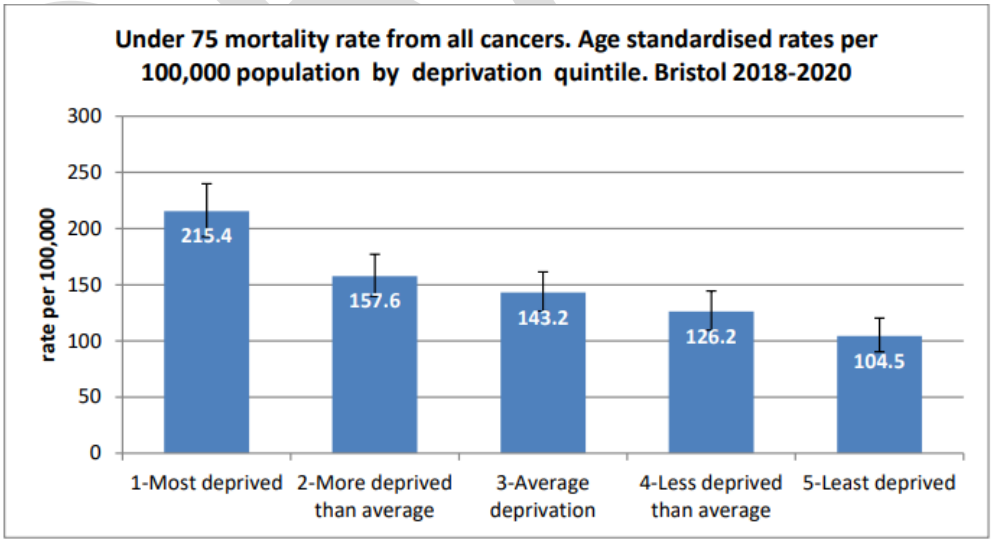

Figure 14: Under 75 Mortality Rate from all Cancers by Deprivation in Bristol 2018-20 (Source: BCC, 2022g)

3.2.3. Sexual health, contraception and abortion

The World Health Organisation defines sexual health as '*an integral part of overall health, wellbeing and quality of life. It is a state of physical, emotional, mental and social wellbeing in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity.*' (DHSC, 2022a, p.124).

It covers the provision of advice and services around contraception, relationships, sexually transmitted infections and abortion (BCC, 2016), and is a public health priority included in Bristol City Council's Health and Wellbeing Strategy.

Sexual Health services are commissioned by Bristol City Council, NHS England and the BNSSG ICB and this can lead to fragmented commissioning – an issue identified within the national Women's Health Strategy, with the concept of Women's Health Hubs presented as a potential solution to such by providing a one-stop-shop for women to access sexual and reproductive health services.

Sexually Transmitted Infections (STIs)

Bristol continues to have relatively high crude rates of diagnosed STIs. However, this is likely due to Bristol's young population; when age and sex are taken into account, the rate of STIs in women are similar to England's rate (BCC, 2021c). Figure 15 shows that rates are higher for females than males, the inverse of the national trend, though this should be interpreted with some caution as it only relates to the *diagnoses* of STIs and could reflect higher screening rates among women, and not necessarily the full picture of prevalence among the population.

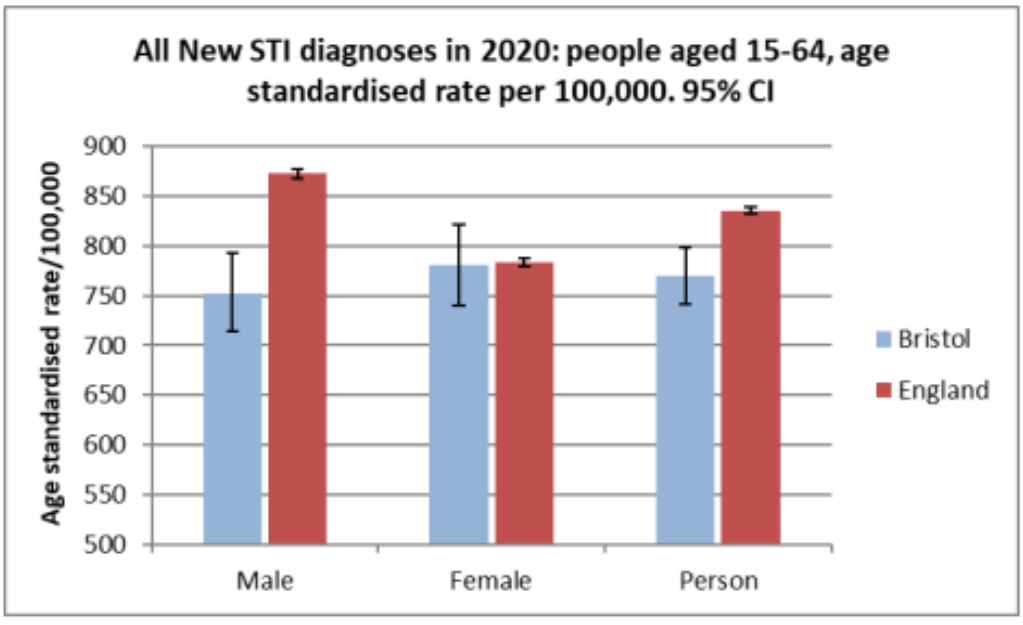

Figure 15: STI Diagnoses by Gender in Bristol 2020 (Source: BCC, 2021c)

Pelvic Inflammatory Disease (PID), an infection of the upper female genital tract, is of particular note when considering women's health as it can lead to serious implications such as ectopic pregnancy, infertility and chronic pelvic pain. STIs are a common cause of PID. In

Bristol, there were 360 hospital admission for PID in 2019/20: a 7% increase upon the previous year. The resultant rate of 319 per 100,000 for women aged 15-44 is significantly higher than the England rate of 254.7 (BCC, 2021c). Opportunistic chlamydia screening of asymptomatic young people is now being focused on young women only, in order to address these adverse outcomes of undiagnosed chlamydia infections.

Contraception

Heterosexual women need contraception for an average of 30 to 40 years of their lives (DHSC, 2022a, p.69).

Long Acting Reversible Contraception (LARC), such as coils and implants, is the most effective form of contraception. Bristol has high rates of LARC uptake in primary care, though this saw a significant reduction in 2020 due to the pandemic – falling from 8360 in 2019 to 5850 in 2020 (BCC, 2021c). Figure 16 shows that this trend is apparent across England.

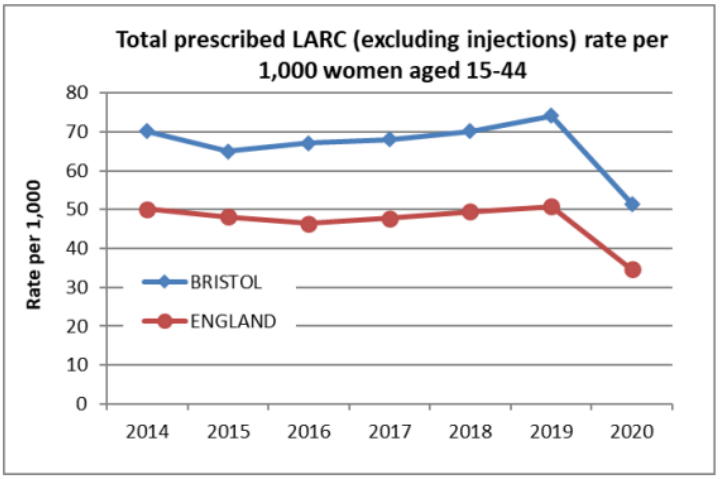

Figure 16: LARC Prescriptions in Bristol and England 2014-2020 (Source: BCC, 2021c)

Nationally, 2020/21 data shows a 44% drop in emergency contraception provided by sexual and reproductive health services compared to the previous year. Other providers of emergency contraception in the community saw an 18% drop (NHS Digital, 2021c). This is likely another impact of the Covid-19 pandemic and further data will need to be analysed in order to track ongoing uptake.

Contraception availability at maternity services has been highlighted as an integral part of maternity care, though it is often a missed opportunity (DHSC, 2022a, p.78). It is an effective way of avoiding short intervals between pregnancies – an interval of less than six months presents a risk factor for the next pregnancy (RCOG, 2019, p.80).

Abortion

Abortion rates provide an indication of the ease of access to contraception services, as well as issues relating to individual use of contraceptive methods. In Bristol, abortion rates remained relatively stable in 2020 and lower than the England rate (BCC, 2021c).

Teenage pregnancy

As Figures 17 shows, under 18 conception rates have significantly reduced over time, and Bristol rates remain lower than the England average.

In 2020, 45.5% of all teenage pregnancies ended in an abortion, an increase of 3.7% on the previous year and compared to 53% across England (BCC, 2021c).

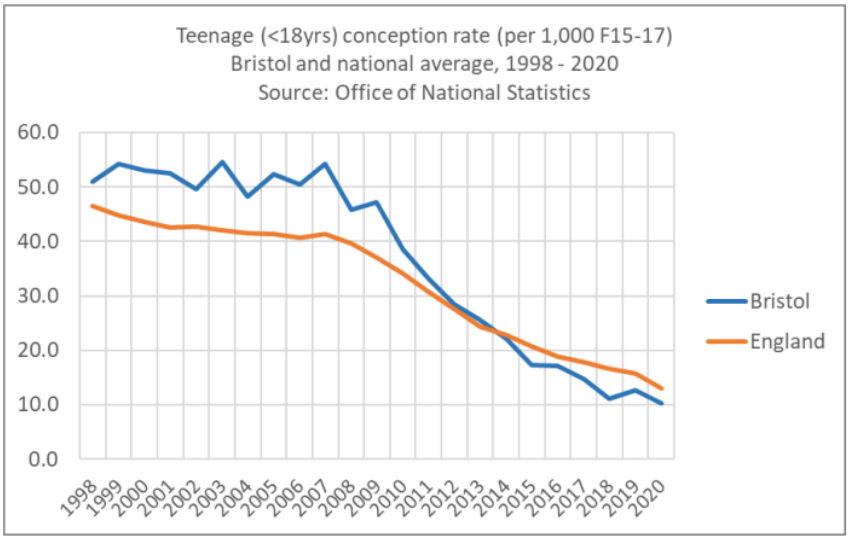

Figure 17: Teenage Conception Rates in Bristol and England 1998-2020 (Source: BCC, 2021c)

Disparities

In Bristol, we know that sexual ill health contributes to health inequalities. There are strong links between deprivation and STIs, under age 18conceptions and abortions. Hartcliffe & Withywood, Southmead and Filwood wards, which have higher levels of deprivation, have the highest teenage conception rates (BCC, 2021c).

Women are disproportionately affected in comparison to men, as well as further disparities for certain minority ethnic groups, people involved in sex work, people with learning difficulties and homeless people (BCC, 2021c, p.6). Bristol has relatively high rates of HIV, and HIV acquired through heterosexual sex disproportionately impacts women of Black African heritage (BCC, 2020b).

Furthermore, the reduced availability of sexual health services throughout the pandemic has had a negative impact upon access, and it is likely that this disproportionately affected vulnerable groups (BCC, 2021c, p.8).

3.2.4. Pregnancy loss and fertility

Miscarriage is a common, yet often considered taboo complication of pregnancy that can have a devastating impact on a woman's mental wellbeing. It is rarely discussed due to distress, embarrassment and even shame (DHSC, 2022a, p.5).

National research shows that, among those who know they're pregnant, around 1 in 8 pregnancies end in miscarriage (NHS, 2022a).

Recently published data (Figure 18) shows stillbirth rates, neonatal mortality rates and extended perinatal mortality rates across the UK over the last decade (MBRRACE, 2022). *NB: extended perinatal mortality refers to the combination of stillbirth and neonatal mortality.*

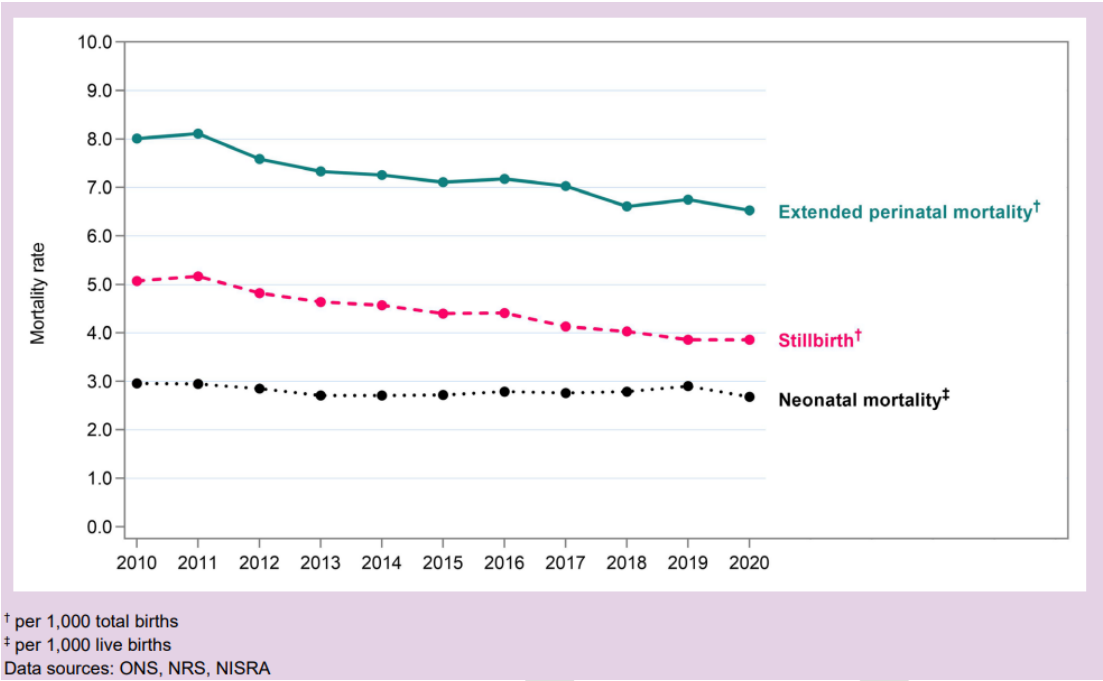

Figure 18: Stillbirth, Neonatal and Extended Perinatal Mortality in the UK 2010-20 (Source: MBRRACE, 2022)

Figure 19 shows that Bristol rates for stillbirth rates, neonatal mortality rates and extended perinatal mortality are similar to the England (using MBRRACE stabilised data, rates per 1,000 births, based on mother's postcode at time of delivery).

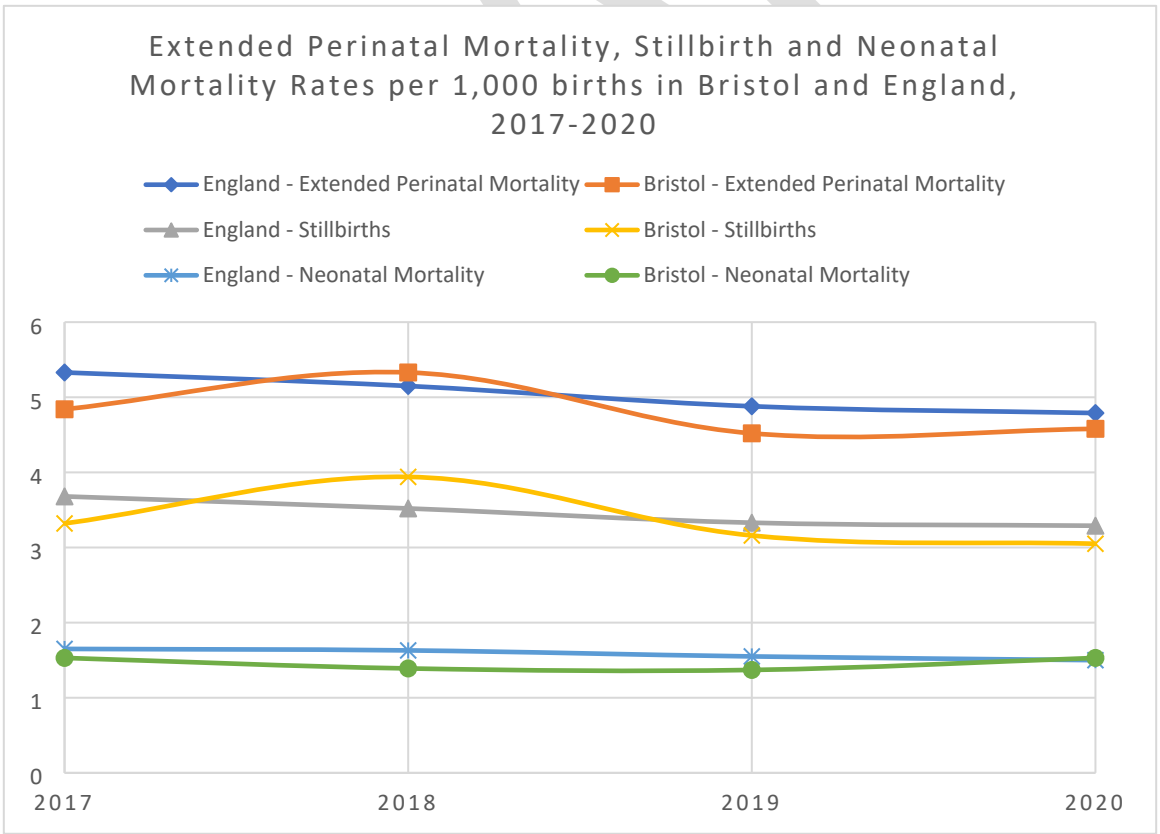

Figure 19: Stillbirth, Neonatal and Extended Perinatal Mortality in Bristol and England 2017-2020 (Source: MBRRACE, 2022)

We are limited in our understanding of miscarriage more broadly, as not all women affected will be in contact with health services.

Disparities

Figure 20 uses national data to show that there is an intersectional relationship between ethnicity, deprivation and stillbirth rates. For all ethnicities, stillbirth rates rise with increased levels of deprivation (MBRRACE, 2022).

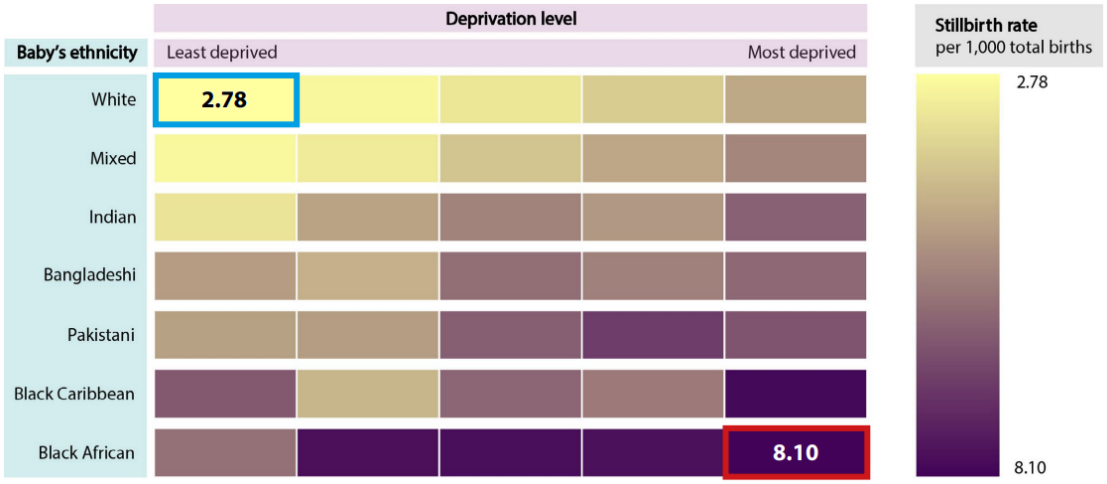

Figure 20: Stillbirth Rates by Ethnicity and Deprivation in the UK 2020 (Source: MBRRACE, 2022)

Local BNSSG data shows that women under 20 have the highest risk of stillbirth (8%), followed by women over the age of 40 (6.2%), compared to an average of 4.9% for all age groups – see Figure 21 (Healthier Together, 2021, p.36).

BNSSG data also shows that women from 'Other' ethnic categories have the highest stillbirth rate of 7.8%, compared to an average of 4.7% across all ethnicities – see Figure 22 (Healthier Together, 2021, p.37).

BNSSG	Stillbirth rate (per 1,000 births)
<20yrs	8
20-24yrs	4.2
25-29yrs	3.4
30-34yrs	2.9
35-39yrs	4.7
40yrs+	6.2

Figure 21: Stillbirth Rates in BNSSG by Age 2020 (Source: Healthier Together, 2021)

BNSSG	Stillbirth rate (per 1,000 births)
Asian	5.8
Black	5.2
Mixed	1.4
Other	7.8
White	3.5

Figure 22: Stillbirth Rates in BNSSG by Ethnicity 2020 (Source: Healthier Together, 2021)

We also know that Gypsy, Roma and Traveller Communities have a significantly higher prevalence of miscarriage than other communities (BCC, 2022h).

Moreover, there is national variation in the level of support offered by healthcare services, as well as inconsistency with regards to fertility treatments, especially for the LGBTQ+ population (DHSC, 2022a). Readily available local data on this is limited.

3.2.5. Pregnancy and childbirth

Maternity is a key aspect of the NHS Core20PLUS5 approach and is a key area of focus nationally. A recent Maternity Health Equity Audit was undertaken across BNSSG – much of the data detailed below is taken from this audit.

Pregnancy

Preconception health refers to the "behaviours, risk factors and wider determinants for women and men of reproductive age which impact on maternal, infant and child outcomes" (PHE, 2018, p.7). Preconception health influences health and behaviours during pregnancy. Key maternal risk factors during pregnancy include late booking for antenatal care, smoking, obesity, alcohol consumption and poor mental health (Healthier Together, 2021, p.14). This is not an exhaustive list, but these areas have been focussed on due to their potential impact and the availability of data.

Late booking for antenatal care i.e., booking after 12 weeks gestation, smoking and drinking in pregnancy have reduced in Bristol since 2013. However, maternal obesity has increased, and there is some limited evidence that mental health needs among pregnant women could be increasing, although the data is very limited and should be interpreted with caution (Healthier Together, 2021, p.1).

Early booking for antenatal care enables health promotion at the earliest opportunity and late booking is associated with poor birth outcomes. Figure 23 shows that rates have gradually reduced in Bristol since 2013 (Healthier Together, 2021, p.14).

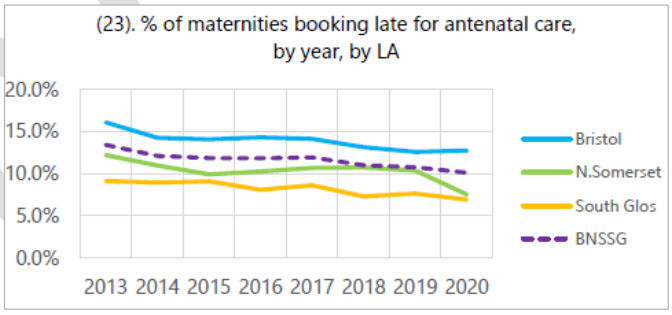

Figure 23: % of Maternities Booking Late for Antenatal Care in BNSSG 2013-2020 (Source: Healthier Together, 2021)

Smoking is the single biggest modifiable risk factor for poor birth outcomes. Figure 24 shows the declining rates of Smoking at Time of Booking (SATOB) and Delivery (SATOD) in Bristol. This compares favourably with regional and national averages (Healthier Together, 2021, p.15).

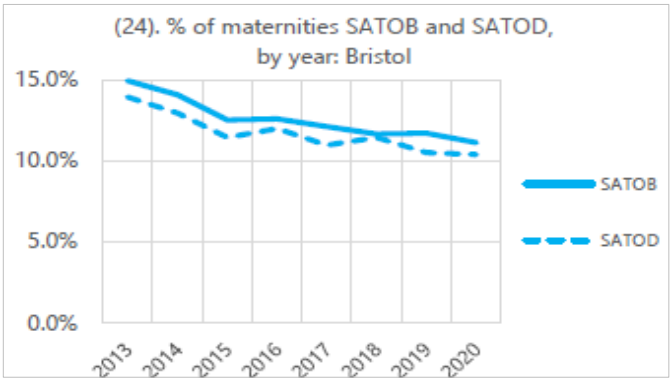

Figure 24: % of Maternities SATOB and SATOD in Bristol 2013-2020 (Source: Healthier Together, 2021)

Mothers who are overweight have increased risk of complications during pregnancy. Figure 25 shows the increase of maternities with a BMI above or equal to 30 at time of booking in Bristol since 2013 (Healthier Together, 2021, p.16).

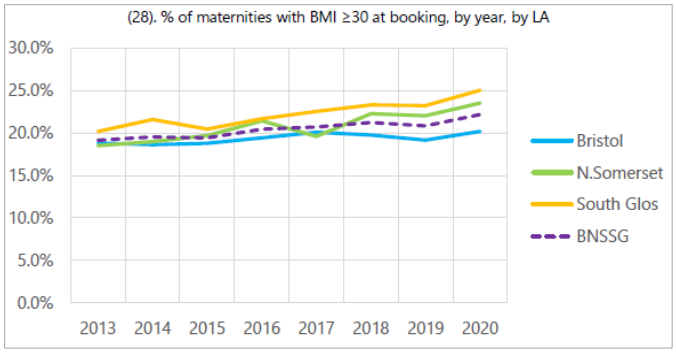

Figure 25: % of Maternities with BMI equal to or above 30 at Booking in BNSSG 2013-2020 (Source: Healthier Together, 2021)

Drinking in pregnancy can affect foetal development and cause birth defects as well as pregnancy complications. The greater the alcohol intake, the higher the risk (Healthier Together, 2021, p.17). Figure 26 shows that Bristol's rate of maternities with alcohol intake is higher than the BNSSG average. Figure 27 shows a slight reduction since 2013, from 2% to 1% of maternities.

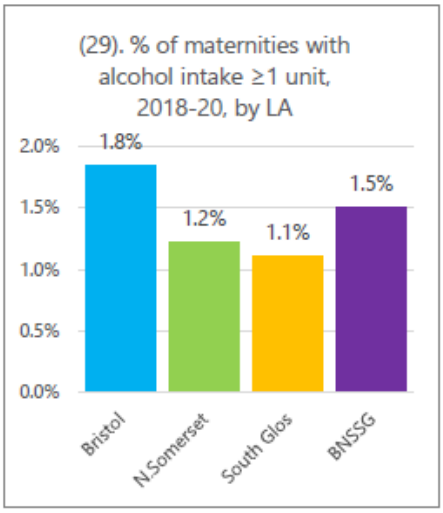

Figure 26: % of Maternities with Alcohol Intake above 1 unit in BNSSG 2018-2020 (Source: Healthier Together, 2021)

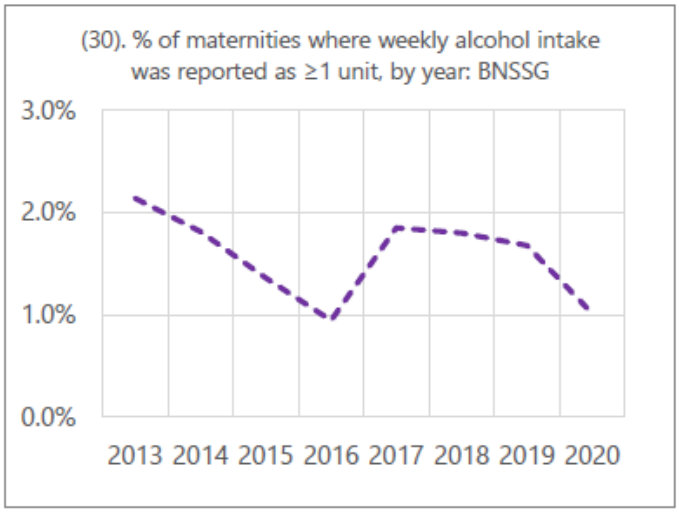

Figure 27: % of Maternities with Alcohol Intake above 1 unit in BNSSG 2013-2020 (Source: Healthier Together, 2021)

Mental wellbeing is as important as physical health during the perinatal period (Healthier Together, 2021, p.18). Figure 28 shows that an increasing proportion of maternities could be experiencing poor mental health across BNSSG, though the data only reflects maternities at University Hospitals Bristol and Weston and so only represents approximately half of all maternities across BNSSG. Perinatal mental health more broadly will be discussed in more detail below.

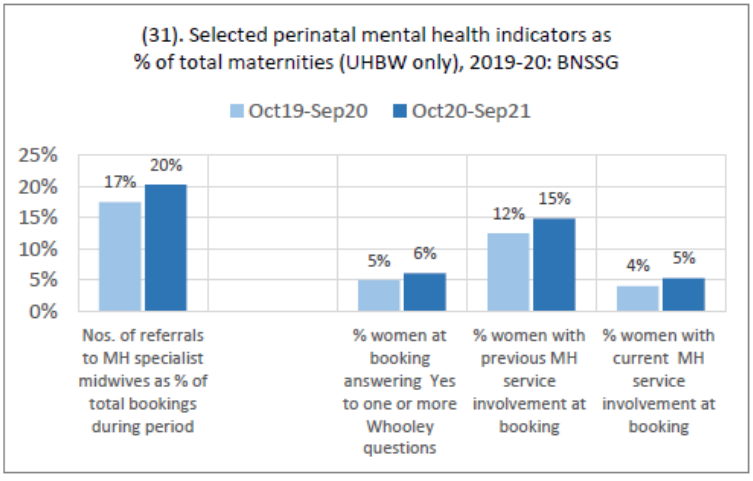

Figure 28: Perinatal Mental Health in BNSSG – UHBW only – 2019/20-2020/21 (Source: Healthier Together, 2021)

Disparities

Local data from 2020 shows that there are disparities in terms of age, ethnicity and deprivation with the aforementioned preconception health risk factors (Healthier Together, 2021).

Age

Figure 29 shows disparities in relation to maternal age. Across BNSSG, younger mothers, particularly those under 20 years of age, are at a higher risk of late booking for antenatal care and smoking during pregnancy. Conversely, trends show that as age increases, mothers are more likely to consume alcohol whilst pregnant. It also shows that the most common maternal age in BNSSG is 30-34 years.

BNSSG	% of all maternities	% of maternities = late bookings	% of maternities = SATOB	% of maternities = SATOD	% of maternities = BMI>30	% of maternities = alc units>1pw
<20yrs	2.1%	21.8%	34.0%	31.8%	17.8%	0.7%
20-24yrs	10.5%	15.7%	26.1%	24.2%	26.6%	0.9%
25-29yrs	23.8%	10.2%	13.9%	12.5%	25.3%	0.9%
30-34yrs	36.5%	9.2%	7.0%	6.3%	18.4%	1.5%
35-39yrs	22.2%	9.7%	5.8%	5.4%	19.3%	2.3%
40yrs+	4.8%	12.2%	5.7%	5.4%	25.1%	3.0%

Figure 29: Maternal Risk Factors by Age across BNSSG 2020 (Source: Healthier Together, 2021)

Ethnicity

Figure 30 shows disparities in terms of ethnicity. It shows that Black mothers are at higher risk of late booking for antenatal care and a higher maternal weight. Mothers of a mixed ethnicity are at higher risk of smoking and drinking during pregnancy. White mothers are also at higher risk of smoking during pregnancy.

BNSSG	% of all maternities	% of maternities = late bookings	% of maternities = SATOB	% of maternities = SATOD	% of maternities = BMI>30	% of maternities = alc units>1pw
Asian	5.2%	14.0%	1.0%	0.8%	17.1%	0.3%
Black	5.1%	28.0%	3.7%	3.3%	34.1%	0.9%
Mixed	2.7%	15.0%	15.5%	14.6%	24.6%	2.4%
Other	2.9%	19.3%	4.4%	3.8%	13.3%	0.7%
White	84.1%	8.3%	12.4%	11.5%	21.6%	1.6%

Figure 30: Maternal Risk Factors by Ethnicity across BNSSG 2020 (Source: Healthier Together, 2021)

Deprivation

Figure 31 shows disparities in relation to deprivation. It shows a clear correlation between higher levels of deprivation and higher rates of most risk factors – for all bar alcohol consumption.

Bristol	% of all maternities	% of maternities = late bookings	% of maternities = SATOB	% of maternities = SATOD	% of maternities = BMI>30	% of maternities = alc units>1pw
1=Most deprived	25.8%	17.9%	20.9%	20%	29.3%	1.4%
2	22.1%	12.7%	14.2%	13.5%	22.1%	1.8%
3	20.9%	11.0%	8.9%	8.2%	18.3%	2.3%
4	17.3%	10.5%	4.5%	4.0%	12.3%	1.8%
5=Least deprived	13.9%	9.5%	2.2%	1.6%	9.3%	2.1%

Figure 31: Maternal Risk Factors by Deprivation across BNSSG 2020 (Source: Healthier Together, 2021)

Maternal and birth outcomes

Since 2010, there has been a 36% reduction in the neonatal mortality rate and a 17% reduction in maternal mortality nationally (DHSC, 2022a, p.72).

National data shows that between 2017 and 2019, there were 191 maternal deaths among 2,173,810 maternities. This equates to 8.8 per 100,000 maternities (MBRRACE, 2021). The confidential nature of the topic means that the low numbers locally are suppressed.

Across Bristol, rates of stillbirths and low birth weight compare favourably with national averages (Healthier Together, 2021).

Disparities

National reports show that women and babies of black or Asian ethnicity, as well as those living in the most deprived areas, are more likely to die during pregnancy and birth, as shown by Figure 32 (MBRRACE, 2021; DHSC, 2022a, p.72).

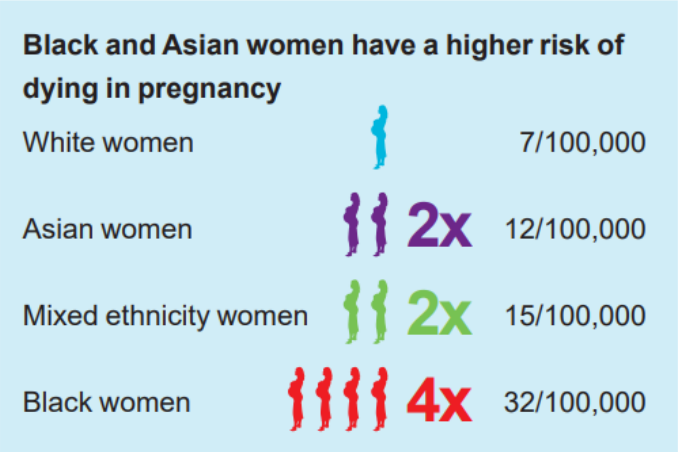

Figure 32: Maternal Mortality Rates by Ethnicity (Source: MBRRACE, 2021)

Moreover, national research shows that Gypsy, Roma and Traveller women have higher maternal death rates, and that those of a migrant or refugee background are at an increased risk of various poor birth outcomes (BCC, 2022h; Rogers *et al.*, 2020).

It is not possible to go into such granular detail with local data due to the small numbers involved, but this national data gives us an indication of how disparities are likely also impacting Bristol in this regard.

Locally, we know that women under 20 and over 40, minority ethnic women and women living in deprived areas are more likely to experience poor birth outcomes (Healthier

Together, 2021). Stillbirth data has been included within the pregnancy loss section; this section refers to premature births and low birth weight.

Age
In BNSSG, women under 20 are most likely to have a premature baby (11.8%), followed by over 40 year olds (8.8%), and compared with 7.8% among all age groups. Women under 20 are also most likely to have a baby with a low birth rate (12.4%), compared with 8% among all age groups (Healthier Together, 2021 p.36).

Ethnicity
Local BNSSG data shows that Black women are most likely to have a premature baby (8.5%), compared to 6.7% of white women. Black women are also most likely to have a baby with a low birth rate (10.7%), compared with 6.4% of white women (Healthier Together, 2021, p. 37).

Deprivation
Bristol data shows a clear relationship between deprivation and premature births, with 8% of maternities being premature in the most deprived areas, compared with 4.3% in the least deprived. This pattern also applies to low birth weight, where 9.7% of births in the most deprived areas of Bristol had a low birth weight, compared with 4.1% in the least deprived (Healthier Together, 2021, p.39).

Perinatal mental health
The perinatal period lasts from conception to one year after birth. During this period, mothers are at greater risk of developing new mental health conditions, as well as a recurrence of a former mental health illness. Mental wellbeing during this period is as important as physical health. Nationally, more than 1 in 4 women are affected by perinatal mental illness (NHSE, 2022b).

'Maternal suicide remains the leading cause of direct deaths occurring within a year after the end of pregnancy.' (MBRRACE, 2021)

It is estimated that, in Bristol, there are between 500 and 800 women each year that will develop mild to moderate depression and/or anxiety in the perinatal period (BCC, 2022i).

Women often also face difficulties in accessing mental health support during this period. This can be due to a variety of reasons, including stigma, a lack of resources e.g., for childcare, service fragmentation and language barriers, among others (Smith *et al.,* 2019).

Disparities
Local data on this topic is limited. Though, we know nationally that various risk factors are associated with perinatal mental health illness, including poverty, migrant or refugee status, extreme stress, exposure to violence, experience of adverse childhood events and previous pregnancy loss (PHE, 2019; Rogers *et al.,* 2020). These risk factors often also equate to additional barriers to accessing support.

3.2.6. Breastfeeding

Breastfeeding not only provides optimal nutrition for babies, but also has health benefits for mothers. Mothers who breastfeed have lower rates of breast and ovarian cancer, postnatal depression and diabetes (BCC, 2022j).

Nationally, 3 in 4 mothers start breastfeeding. In Bristol, the rate has increased gradually for several years and has been above 80% since 2018/19 (BCC, 2022j).

Figure 33 shows breastfeeding rates at the 6-8 week point, comparing Bristol with England and other core cities.

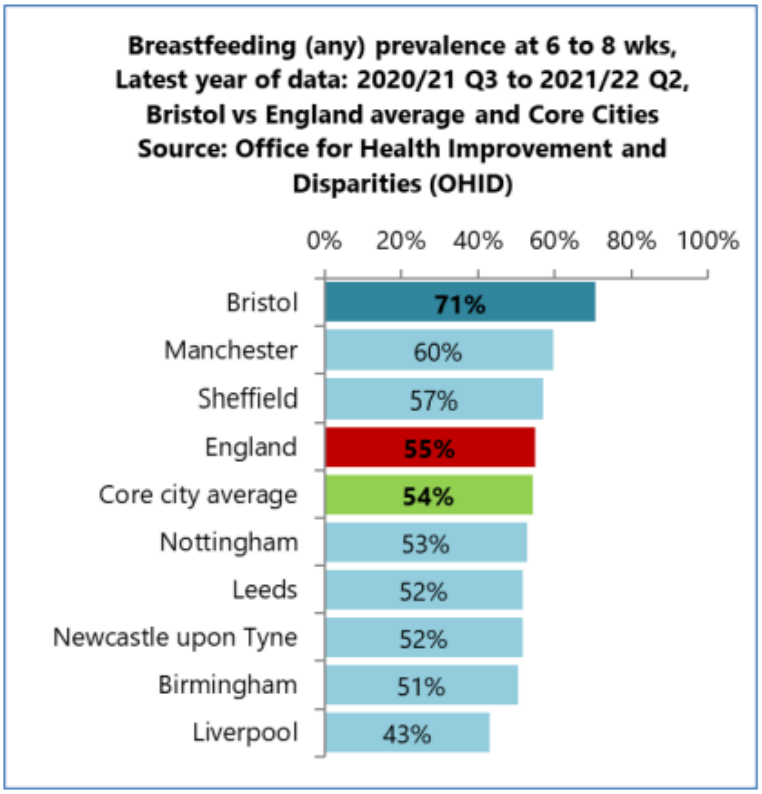

Figure 33: Breastfeeding Initiation Rates among the Core Cities and England 2020/21 (Source: BCC, 2022j)

Disparities

Local data shows that there are differences in breastfeeding uptake in relation to age, ethnicity and deprivation in Bristol (BCC, 2022j).

Age

Figure 34 shows that there is a relationship between maternal age and breastfeeding initiation within 48 hours in Bristol, with mothers under 20 years of age the least likely to breastfeed (BCC, 2022j).

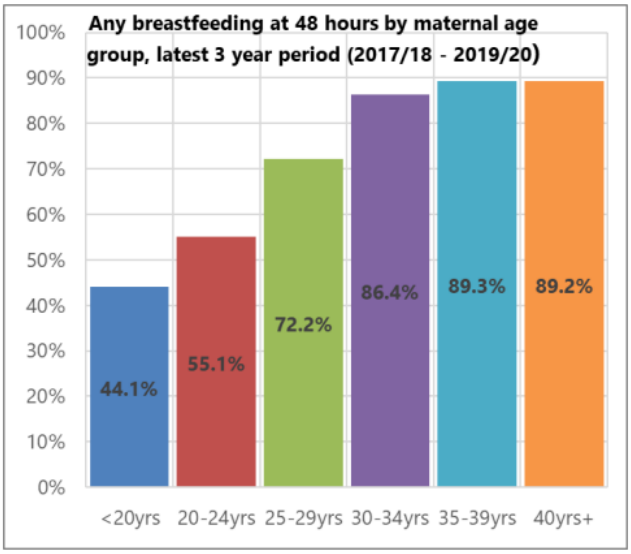

Figure 34: Breastfeeding Initiation Rates in Bristol by Age 2017/18-2019/20 (Source: BCC, 2022j)

Ethnicity

Figure 35 shows that, in Bristol, white women are least likely to initiate breastfeeding within 48 hours whereas black women are the most likely to (BCC, 2022j).

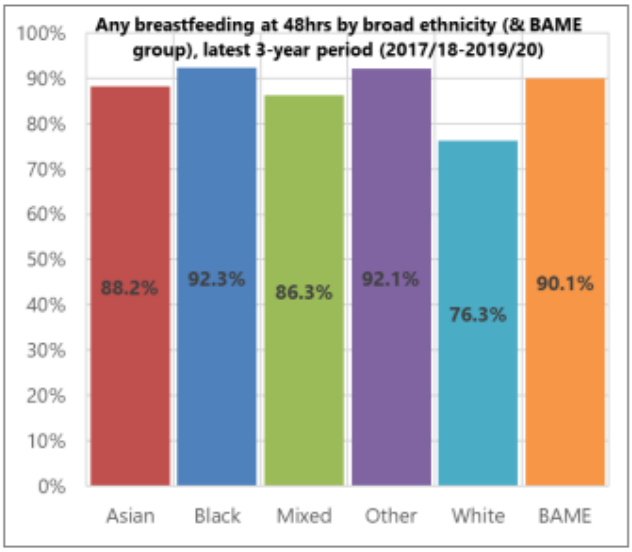

Figure 35: Breastfeeding Initiation Rates in Bristol by Ethnicity 2017/18-2019/20 (Source: BCC, 2022j)

Deprivation

There is a significant relationship between deprivation and breastfeeding uptake.

Figure 36 shows that whilst the gap between the most and least deprived areas has narrowed over time, significant inequalities remain.

For example, initiation rates ranged from 99% in Westbury on Trym and Henleaze to 45% in Hartcliffe and Withywood during 2021/22 (BCC, 2022j).

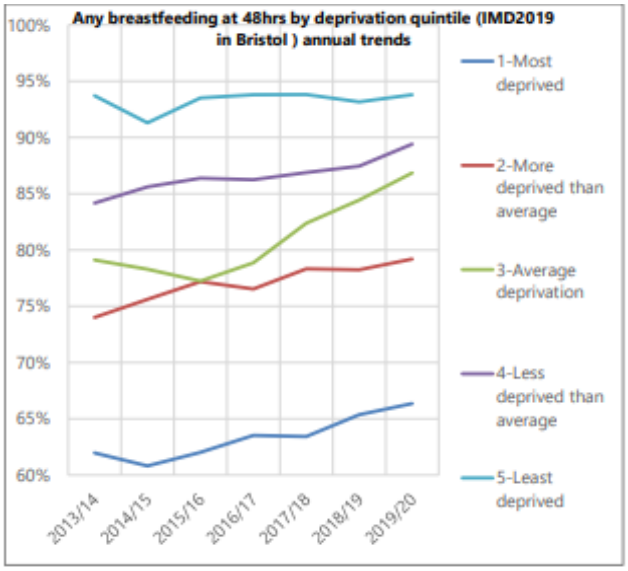

Figure 36: Breastfeeding Initiation Rates in Bristol by Deprivation 2013/14-2019/20 (Source: BCC, 2022j)

3.2.7. Menopause

Menopause is where menstruation ceases permanently due to lower hormone levels. A woman reaches menopause when they have not had a period for 12 months (NHS, 2022b). The average age that women reach menopause in the UK is 51, though this ranges from 45-55 usually (Health in Menopause, 2021).

It is estimated that around 13 million people are peri or menopausal in the UK, which is equivalent to a third of the entire female population (NHSE, 2022c). Though the menopause is a natural stage in every woman's life, open conversations around menopause have only fairly recently begun.

Symptoms of the menopause and perimenopause include anxiety, mood swings, brain fog, hot flushes and irregular periods, among others. These symptoms can start years before periods end and carry on afterwards (NHS, 2022b).

The national Women's Health Strategy recognises that women often face difficulty accessing care and are often given antidepressants where Hormone Replacement Therapy (HRT) may be more appropriate (DHSC, 2022a, p.79). The menopause has mental health impacts, owing to the change of hormone levels, but these are distinct from depression and NICE guidance states that antidepressants should not be the first line of treatment (Mental Health Foundation, 2021).

There are, nonetheless, significant links between the perimenopause and mental health. Research suggests that this could be a factor in the increased suicide rates of women of perimenopausal age (Newson Health Menopause Society, 2022). By broad age group, Figure 37 shows that women aged 45-64 have consistently higher rates of suicide than any other age group (ONS, 2022b). Additionally, ONS states that women aged 45-49 have the highest suicide rate of all, with a rate of 7.8 per 100,000 in 2021 (ONS, 2022b).

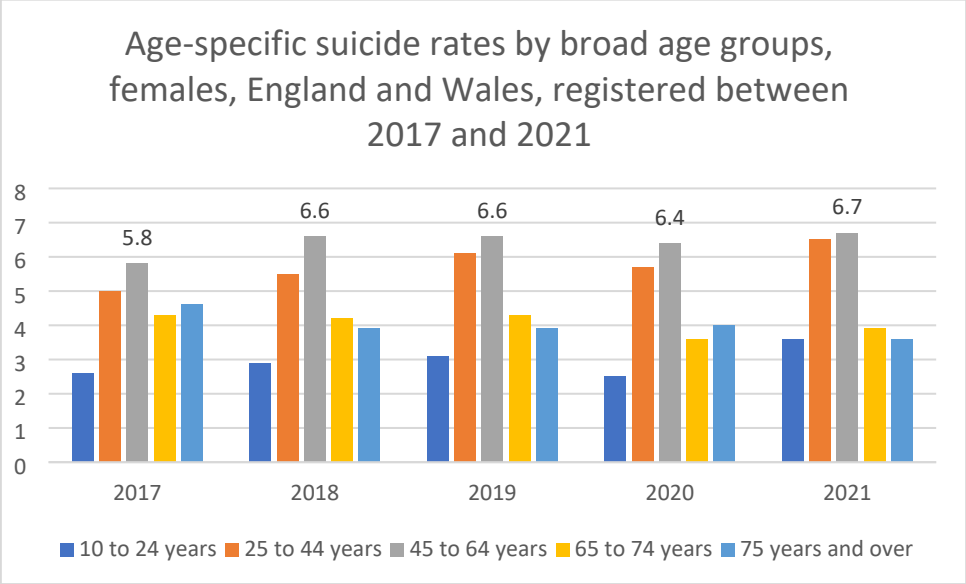

Figure 37: Age-specific suicide rates in females, 2017-2021 (Source: ONS, 2022b).

Support for women experiencing menopause in the workplace is also a key theme within the literature; there are over 3.5 million female workers aged 50 and over in the UK and the recent Royal College of Obstetricians and Gynaecologists report on women's health, as well as the national Women's Health Strategy, call for it to be seen as a 'health and work' issue (RCOG, 2019, p.104; DHSC, 2022a, p.80). A lack of menopause support in the workplace can lead to women reducing their hours, passing up promotions and even quitting their jobs (Wellbeing of Women, 2022).

Locally, research by the Bristol City Listening Project revealed that many women are concerned about the availability and quality of menopause support services (Bristol Women's Voice, 2020).

Disparities

Local data on this topic is limited. However, the national picture shows that women from lower socio-economic backgrounds are more likely to experience early menopause (DHSC, 2022a). Moreover, social factors such as socio-economic status, as well as lifestyle factors such as smoking and diet, can influence a woman's experience of the menopause – including the nature of severity of symptoms (Hickey *et al.*, 2022).

3.2.8. Pelvic floor health, prolapse and incontinence

Pregnancy and childbirth can adversely impact on pelvic floor health, leading to disturbances of the bladder, bowel and sexual function, as well as incontinence and prolapse. Multiple births, larger babies, menopause, ageing and obesity can further increase risk (DoH, 2015, p.123). It should not, however, be seen as a 'normal' consequence of childbirth (DHSC, 2022a, p.60).

Prolapse accounts for 20% of the women on gynaecological surgery waiting lists in the UK, and pelvic organ prolapse affects around 40% of women over the age of 40 (Abbas & Reid, 2022). By the age of 80, estimates show that more than 1 in 10 women will have undergone some form of surgery for prolapse (RCOG, 2019, p.109).

Estimating the prevalence of incontinence is difficult; it is reliant on disclosure, and many are reluctant to discuss it due to feelings of embarrassment. However, it is known that over 14 million adults experience urinary incontinence (NHSE, 2018). Faecal incontinence remains to be an even more taboo subject and it is therefore also difficult to measure its prevalence. However, NHS England have estimated around 6.5 million people experience bowel control difficulties in the UK (2018). We also know that incontinence affects roughly twice as many women as men (Incontinence UK, 2019).

Locally, there is no readily available empirical data on pelvic floor health, prolapse and incontinence.

A recent project conducted by Bristol Health Partners and the West of England Academic Health Science Network highlighted six key opportunities for improving the lives of people living with bladder and bowel incontinence: perception, communication, environmental (largely focussed on toilet accessibility in public places), improved health services, recognition and support for its impact on mental health and anxiety, and enabling increased participation in society (West of England Academic Health Science Network, 2022).

Furthermore, in 2020, Bristol Health Partners also conducted a project in collaboration with Healthwatch to investigate the service user experience for people with incontinence during the pandemic. A key finding was that participants reported they feel 'it is a rather neglected condition', that 'services remain overstretched', and 'symptoms are overlooked or deprioritised' (Healthwatch, 2022, pp.12-13).

Moreover, safety concerns around the use of pelvic mesh implants (used to surgically repair pelvic organ prolapse and manage incontinence in women) have recently come to light. The procedure has been linked with chronic pain, recurrent infections, mobility issues, sexual

difficulties, autoimmune issues and mental health issues (DHSC, 2020). At the heart of the First Do No Harm review are stories of women not being listened to about their concerns (DHSC, 2020).

Disparities

Whilst there is no local disparities data on this topic, we know nationally that physical activity and a good diet can prevent pelvic floor dysfunction (NICE, 2021). Groups that are less likely to have good diets and reasonable levels of physical activity are therefore likely at increased risk of poor pelvic floor health.

A recent report has also found inequalities in access to pelvic floor health services due to expertise being dispersed around the country (The Pelvic Floor Society, 2021).

3.2.9. Breast cancer

Prevalence

1 in 8 women are diagnosed with breast cancer during their lifetime (DHSC, 2022a, p.98).

Breast cancer remains to be the most commonly diagnosed cancer in England and accounts for 30% of all female cancer diagnoses.

Recent data shows that rates of breast cancer are 16% higher in Bristol than the England average (OHID, 2021a).

Screening

Screening programmes are important in aiding early diagnosis, which ultimately leads to better chances of survival. Breast cancer is more prevalent in older women, and screening is offered to women aged 50-70 every three years to reflect this.

However, in recent years there has been a significant drop in breast cancer screening nationally. In 2020/21, 1.19 million women were screened – a 44% decrease from the previous year. In the same time period, diagnoses through screening decreased by 39.2% (NHS Digital, 2022). It must be stated that during this period, the NHS Breast Screening Programme was seriously impacted by the Covid-19 pandemic. Screening was paused, leading to backlogs, and fewer women presented for screening when invited, potentially due to shielding and self-isolation (NHS Digital, 2022).

Bristol screening coverage for breast cancer is consistently significantly worse than the England average – see Figure 38 (NHS Digital, 2022). In 2021, screening rates were 62.7% for Bristol and 64.1% for England (BCC, 2022g).

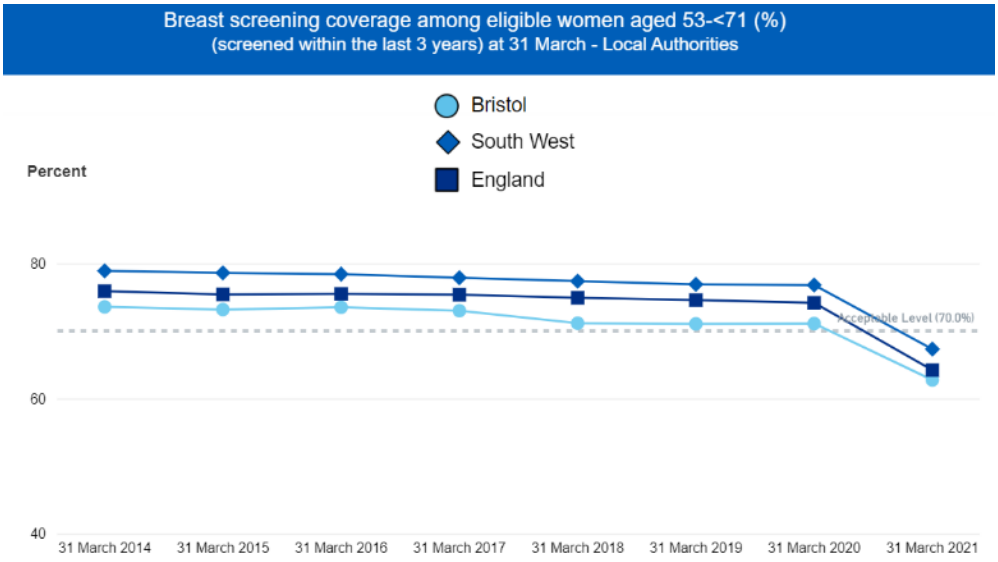

Figure 38: Breast Screening Coverage in Bristol, the South-West and England 2014-2021 (Source: NHS Digital, 2022)

Treatment

National research into women over 50 shows that treatment of breast cancer was also impacted by Covid. Between April and December 2020, 79% of women with breast cancer received surgery, compared to 86% for the same period in 2019 (National Audit of Breast Cancer in Older Patients, 2022).

Locally, internal 2019/20 data from NHS Futures shows that 84% of those with breast cancer received treatment within 2 months in BNSSG, compared to an average of 89% in England and 88.14% among BNSSG's 10 most similar CCGs (now ICBs).

Mortality

Bristol has a statistically significantly higher mortality rate from breast cancer in under 75s than the England average. Directly standardised pooled data between 2017-19 shows Bristol's mortality rate to be 25.9 per 100,000 compared to England's 20.3 (OHID, 2022a).

For further context, at an international level, the UK continues to lag behind other developed countries. The UK ranks 21st of 34 countries in the Organisation for Economic Co-operation and Development for breast cancer survival rates, despite screening programmes that are not freely available in some other countries (King's Fund, 2022).

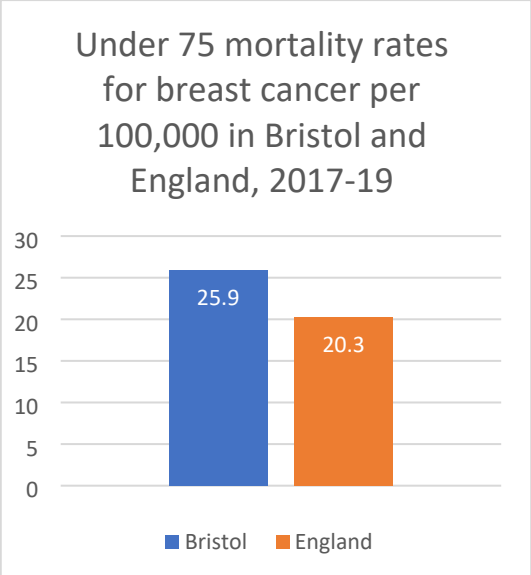

Figure 39: Under 75 Mortality Rates for Breast Cancer in Bristol and England 2017-19 (Source: OHID, 2022a)

Disparities

Locally, we know that those with learning disabilities have consistently lower rates of breast cancer screening in BNSSG – see Figure 40 (NHS Digital, 2021b).

In the absence of readily available local data, we also know that in the UK, women in the most deprived areas are less likely to participate in breast screening and are more likely to die from breast cancer (Macmillan, 2019; OHID, 2020; NHSE, 2022d).

However, we also know that early diagnosis only partially accounts for inequalities in survival outcomes (Macmillan, 2019); inequalities must therefore be understood from a wider perspective than just breast cancer screening.

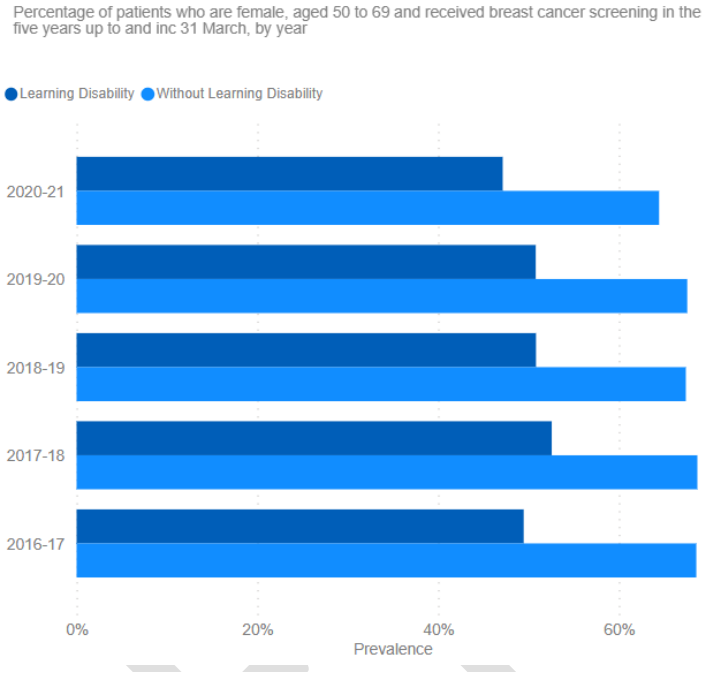

Figure 40: Breast Screening Coverage Comparing those with a Learning Disability to those without in BNSSG 2016/17-2020/21 (Source: NHS Digital, 2021b)

3.3. General Health Needs

Women's health relates to more than simply women's reproductive health needs. Women also have various health needs that, whilst may not be specifically tied to their reproductive life course, are either more pertinent to women, or affect women in a different way.

3.3.1. Wellbeing and lifestyle

The importance of having a healthy lifestyle in determining wider health outcomes cannot be overstated. There are several lifestyle factors that influence women's health, and a few factors of note are highlighted below.

Smoking

Though rates of smoking are generally higher in men, women in Bristol smoke more than the national average - around 13% of women in Bristol smoke, compared to 10.4% of women nationally (BCC, 2022k). *Smoking during pregnancy is also a concern for women's health – please see section 3.2.5 for more detail.*

Healthy weight and diet

In Bristol, whilst men are more likely to have excess weight than women (51% and 41% respectively), women are more likely to be obese i.e., with a BMI higher than or equal to 30, with a rate of 16.1% of women and 14.9% of men (Bristol Quality of Life Survey, 2022).

Physical activity

In Bristol, women are less likely to be physically active than men. The Bristol Quality of Life Survey found that 63.8% of women were active compared with 70.4% of men, and that this gap has significantly increased in the last year (2022). This trend is also true of school-age children; the Pupil Voice Survey consistently shows that boys are more likely to be physically active than girls (BCC, 2019). Research shows that motherhood has a hugely significant, and mostly negative, impact on women's physical activity levels (Sport England, 2019).

Disparities

Looking through an inequalities lens allows us to better understand differences in lifestyle behaviours that lead to poorer health outcomes for certain communities. Perhaps the most influential inequality to consider here is around deprivation. Local data shows us that women (and men) living in areas of high deprivation are substantially more likely to smoke (BCC, 2022k).

Figure 41 shows the prevalence of households with a smoker by ward in Bristol, evidencing the link between higher levels of deprivation.

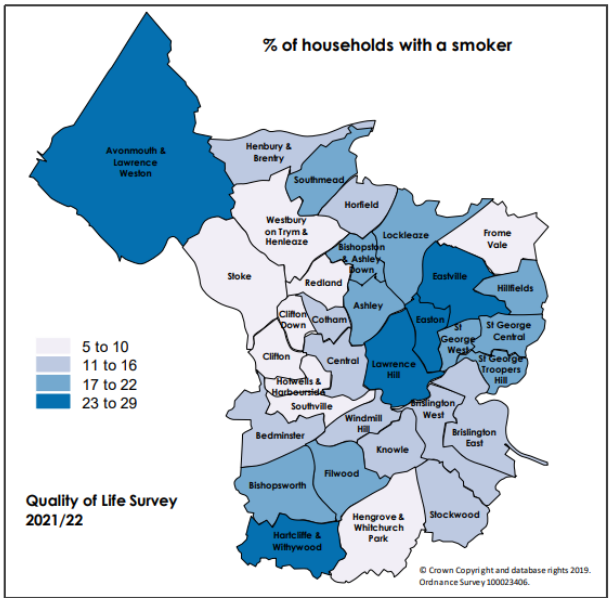

Figure 41: % of Households with a Smoker by Ward in Bristol 2021/22 (Source: BCC, 2022k)

Moreover, poverty is associated with a higher risk of excess weight in Bristol. The relationship is complex but seems to affect women more so than men (BCC, 2022l). Figure 42, though not specific to women, depicts levels of healthy weight by ward in Bristol.

There is also a clear relationship between higher levels of deprivation and poorer diets, as shown by Figures 43 and 44, as well as physical activity, show by Figure 45.

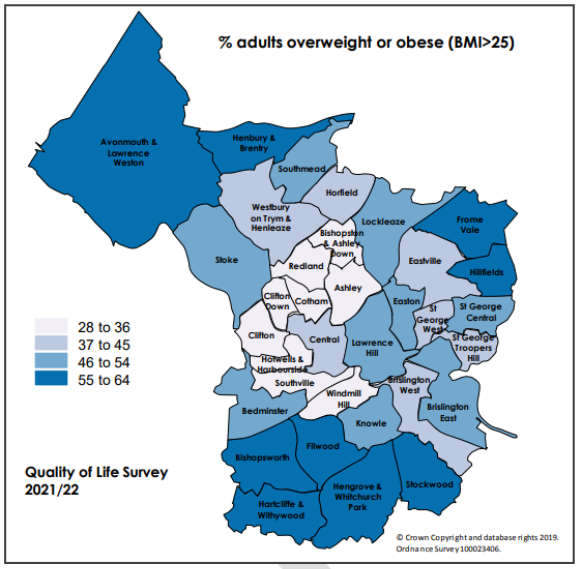

Figure 42: % of Adults Overweight or Obese by Ward in Bristol 2021/22 (Source: BCC, 2022l)

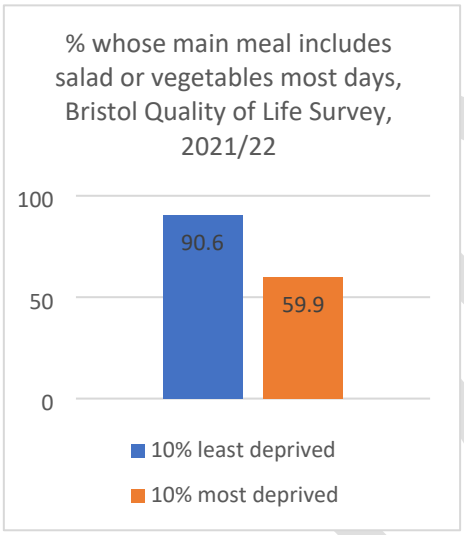

Figure 43: Diet including Vegetables by Deprivation in Bristol 2021/22 (Source: Quality of Life Survey,

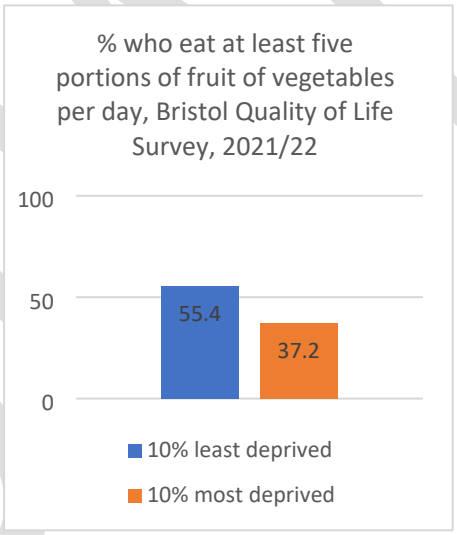

Figure 44: 5 a day by Deprivation in Bristol 2021/22 (Source: Quality of Life Survey, 2022)

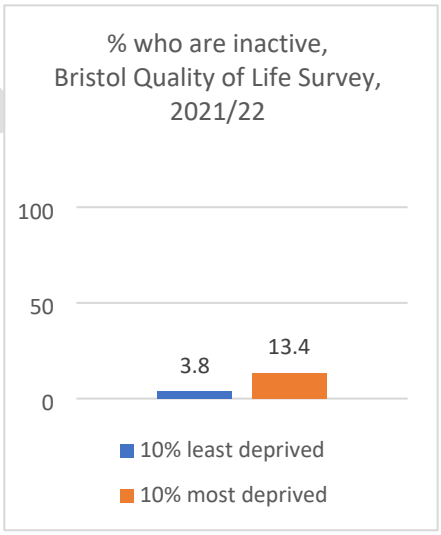

Figure 45: Inactivity by Deprivation in Bristol 2021/22 (Source: Quality of Life Survey, 2022)

3.3.2. Mental health

'Mental health problems affect both men and women, but not in equal measure.'
(Mental Health Foundation, 2022b)

Common mental health disorders

Nationally, 1 in 5 women have a common mental disorder, compared with 1 in 8 men (McManus *et al.*, 2016). Between the ages of 16 and 24, women are almost 3 times as likely

to experience a common mental health issue as men - 26% and 9% respectively (McManus *et al.*, 2016).

Moreover, young women and girls are reporting increasing levels of mental disorders (NHS Digital, 2021e). Rates are likely worse since the pandemic, and research shows an increased prevalence of clinically significant levels of mental distress during lockdown (18.9% 2018/19 to 27.3% in April 2020). Crucially, increases were the greatest in women and young people (Pierce *et al.*, 2020).

The Bristol Quality of Life Survey shows that 19.1% of women reported that their mental health prevents them from leaving their home when they want to, compared with 11% of men (2022).

Though not specific to women, we know that in BNSSG, the recorded prevalence of depression in over 18s in 2021 was higher than England, with an average of 13.5% compared to an England average of 12.3% (OHID, 2022b).

It is important, however, to recognise that suicide rates are substantially higher in males than female, though further discussion of this is out of scope of this paper.

Disparities

Locally, there is a relationship between poor mental health and deprivation. In 2021/22, 20% of respondents to the Quality of Life Survey had below average mental wellbeing. However, in the most deprived areas this rose to 32%; ranging from 10% in Stoke Bishop to 35% in Lawrence Hill (BCC, 2022m). It is also likely that the cost-of-living crisis will disproportionately impact the mental health and wellbeing of those in deprived areas, with poverty being both a cause and consequence of mental ill health and a further 1.3 million likely to be driven into poverty in England in the next year (BCC, 2022m).

BNSSG data also shows that severe mental illnesses are much more prevalent in those with learning disabilities, as shown by Figure 46 (NHS Digital, 2021b). Though this data is not specific to women, it is nevertheless a useful indicator of how women with learning disabilities face significant inequalities in mental health.

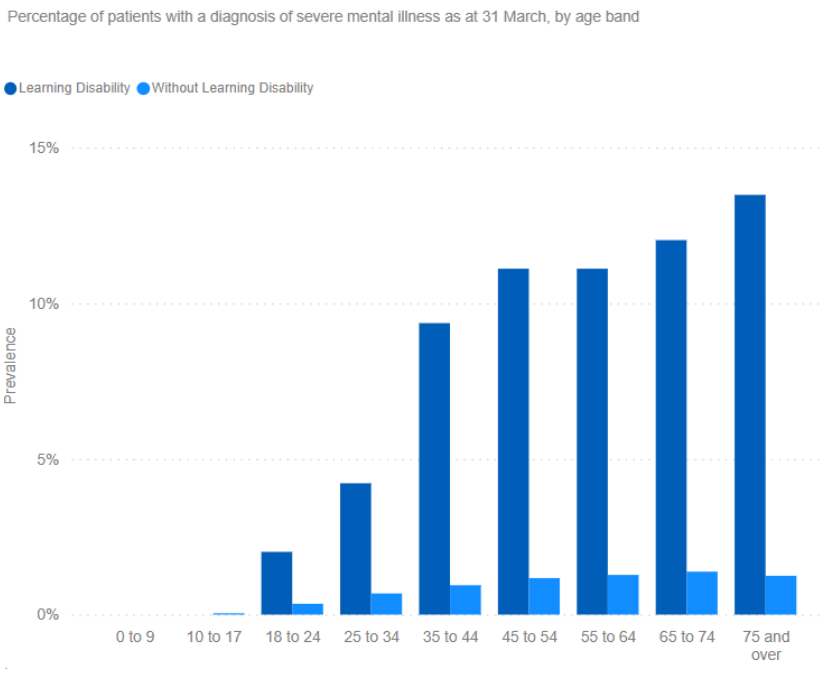

Figure 46: Severe Mental Illness comparing those with Learning Disabilities to those without in BNSSG 2020/21 (Source: NHS Digital, 2021b)

National research has also found that there are differences between ethnicities, with black women more likely to have mental health issues compared to white women (DHSC, 2018). Particular concerns have also been raised about the impact of the pandemic on the mental health of minority ethnic young women (Agenda, 2020).

Furthermore, national research has found that women in the armed forces face additional barriers to accessing mental health support than their male counterparts, representing a health inequality for this group of women, often with complex mental health needs (Godier-McBard *et al*., 2022).

Self-harm

Women and girls are more likely to self-harm. Nationally, 25.7% of women and 9.7% of men aged 16-24 report having self-harmed at some point in their life (Mental Health Foundation, 2022b).

In Bristol, 11% of secondary school girls who responded to the Bristol Pupil Voice Survey said that they harm or cut themselves as a means of dealing with their problems, compared with 5% of secondary school boys (BCC, 2019).

There were 1,717 emergency admissions for self-harm in Bristol in 2020/21, of these, 68% were female. Bristol also had the highest rate of emergency admissions for self-harm in women among other core cities in 2019/20 (BCC, 2022n).

Disparities

Critically, self-harm admissions for males and females were 2.7 times higher in the most deprived areas of Bristol compared to the least, as Figure 47 shows (BCC, 2022n).

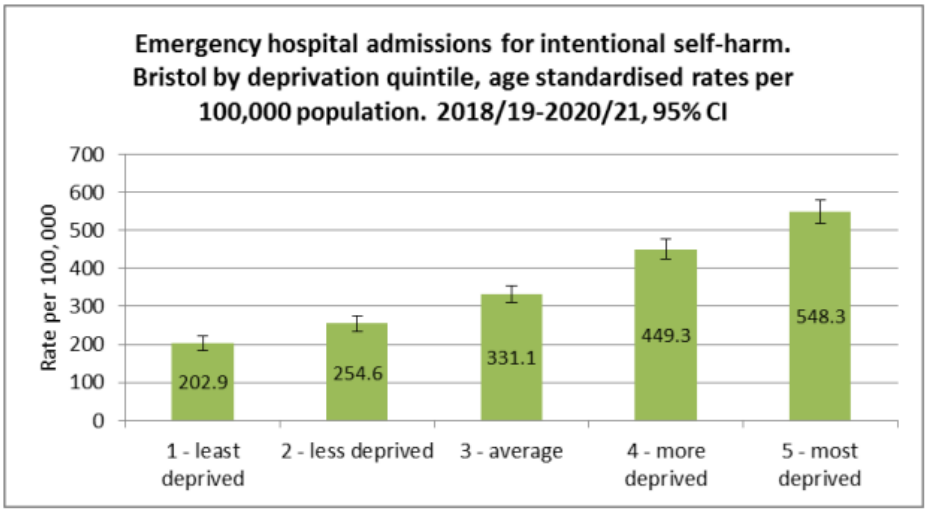

Figure 47: Hospital Admissions due to Self-harm by Deprivation in Bristol 2018/19-2020/21 (Source: BCC, 2022n)

Moreover, national research shows that rates of self-harm are highest among young black women, but they are less likely to receive support, and that South Asian young women are significantly more likely to self-harm than white women (Agenda, 2020, p.5).

Body image and eating disorders
Body image and eating disorders are another area of mental health where women and girls are disproportionately affected (DHSC, 2018). Over half of 15-year-old girls think "their body is not about the 'right size'" (DHSC, 2022a, p.88). Recent research has also found that 61% of adults and 66% of children feel negatively about the way they look most of the time, with even higher rates for women, those with disabilities and transgender people (Women and Equalities Commission, 2021, p.5).

Furthermore, eating disorder charity Beat estimate that approximately 3 in 4 of the estimated 1.25 million people affected by an eating disorder in the UK are female (Beat, 2022).

Disparities
National research shows that there are disparities in relation to body image and eating disorders. For example, LGBT adults are more likely to experience poor body image, as well as those with physical disabilities (Women and Equalities Commission, 2021, p.9).

Research into intersectionality shows that LGBT people of colour are twice as likely to have an eating disorder than white LGBT people (22% and 11% respectively). Furthermore, evidence from the Bristol-based Centre for Appearance Research demonstrated that black women, for example, can have body image pressures due to both gender and racial oppression (Women and Equalities Commission, 2021, p.10).

Intersectionality between mental health and other women's health issues
The overlap between mental health and other women's health topics discussed in this paper is significant. That is, several issues relating to women's health have subsequent impacts upon women's mental health.

A few areas of particular note include the perinatal period, menopause, long-term conditions and violence against women and girls. More detail on the relationship with mental health is provided in the relevant section.

3.3.3. Long-term conditions, disability and chronic pain

Long-term conditions
A long-term condition is an illness that cannot be cured, though it can usually be controlled using medicines and treatments. According to the Patients Association, about 15 million people in England have a long-term condition (2022).

In Bristol, around 1 in 3 women (30.3%) reported having an illness or health condition which limits their day-to-day activities at least a little, compared with around 1 in 5 men (21.2%) (Bristol Quality of Life Survey, 2022).

Crucially, long-term conditions often present differently in women and diagnostics are less effective, given that much of the research is based on men (DHSC, 2022a, p.106). Below are just a few long-term conditions that are pertinent to women's health, though it should be

recognised that this is by no means an exhaustive list and much more research is needed, both nationally and locally.

Musculoskeletal (MSK) conditions are more common in women. The national Women's Health Strategy cites that 35% of women are affected, compared with 28% of men (DHSC, 2022a, p.110; Versus Arthritis, 2021a, p.7). These estimates differ quite substantially to data from GP surveys, which are used to inform Bristol City Council's JSNA data profiles, which state 19.3% and 14.6% for women and men respectively, with an average of 17% overall (BCC, 2022o). However, the trend still stands – women are more likely to be affected by an MSK condition. In Bristol, an average of 13.8% of adults reported having an MSK condition, though a gender breakdown is not given. We can deduce that MSK conditions are perhaps less prevalent in Bristol, whilst recognising that this may not give a true picture of the issue when considering the higher prevalence quoted elsewhere.

Though cardiovascular disease is often considered to be more of a problem for men, the 2019 Better for Women report found that it was the leading cause of mortality in postmenopausal women, and that coronary heart disease kills twice as many women as breast cancer in the UK (RCOG, 2019). It adds that women are twice as likely to have an initial misdiagnosis, increasing their risk of death by 70%, as well as being less likely to receive standard treatments such as bypass surgery and stents (RCOG, 2019, p.110).

Moreover, though the under 75 mortality rate from cancer is higher in men than women, the Bristol rate for women (130 per 100,000) is higher than the national average for women (113.5 per 100,000) (BCC, 2022g).

Disability

Figure 48 uses data from the national government-led Family Resources Survey to compare the proportion of men and women with a disability in the UK (Department for Work and Pensions, 2022). It shows that disabilites are consistently more prevalent in women.

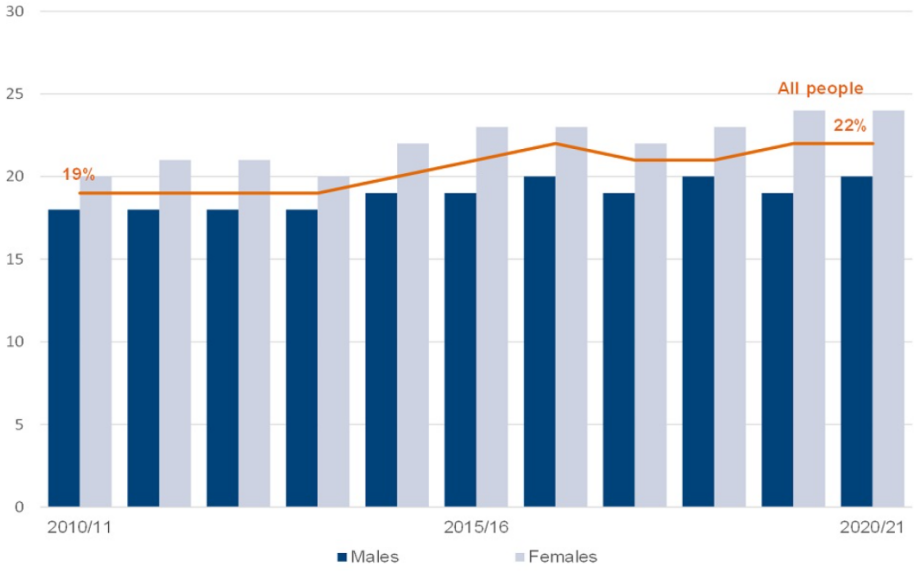

Figure 48: Proportion of Men and Women with a Disability in the UK 2010/11-2020/21 (Source: Department for Work and Pensions, 2022)

In Bristol, the disability free life expectancy is 58.3 for men and only 56 for women, compared with 62.4 and 60.9 in nationally. Whilst is it significantly lower Bristol, the trend remains; women have fewer years disability free despite living longer (OHID, 2022a).

Not only do women in Bristol have 2+ fewer years disability free than men in Bristol, they also have around 5 fewer years disability free than the national average for women.

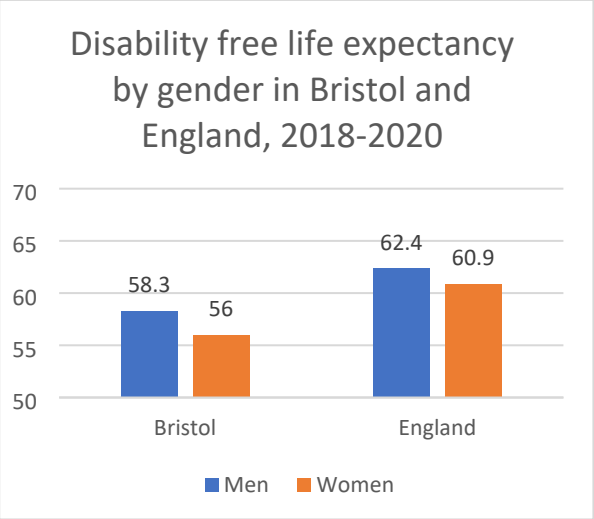

Figure 49: Disability Free Life Expectancy by Gender in Bristol and England 2018-20 (Source: OHID, 2022a)

Chronic pain

> *"Chronic pain has been called an invisible condition. Although often devastating to the millions who have it, to others it cannot be seen." (Versus Arthritis, 2021b, p.15)*

Chronic pain is defined as pain lasting for more than 3 months and can be highly debilitating. Chronic pain, often caused by musculoskeletal conditions, can affect all aspects of a person's life, including their mood, sense of wellbeing and quality of life more broadly (Versus Arthritis, 2021b, p.8).

There are varying estimates on the prevalence of chronic pain, ranging from about one third and one half of the population, though research is unanimous that it disproportionately affects women (Bristol Health Partners, 2022; Versus Arthritis, 2021a, p.10). According to a recent report by Versus Arthritis, chronic pain affects 38% of women and 30% of men, whilst high-impact chronic pain affects 14% of women and 9% of men (2021a, p.10).

For example, fibromyalgia, a long-term condition that causes chronic pain all over the body, affects about 7 times as many women as men (NHS Inform, 2022). What is more, this is likely to only tell us part of the story; it is hard to decipher its true prevalence as it is a difficult condition to diagnose, with no specific test for the condition (NHS, 2022c).

Not only do women suffer with almost all chronic pain conditions to a greater extent than men, but they also suffer from female-specific causes of chronic pain, such as endometriosis (Nuffield Department of Women's and Reproductive Health, 2022).

Readily available local data is limited, and more research is required into chronic pain in Bristol. However, the Bristol City Listening Project heard that women with chronic health conditions spoke of a lack of support and often being passed between services without receiving treatment (Bristol Women's Voice, 2020, p.33).

Long-term conditions and mental health

There is a clear intersectional link between women that suffer from long-term conditions and mental health. Long-term conditions can lead to social isolation, low self-esteem, stigma and discrimination, meaning that women with long-term conditions are more likely to develop a mental health problem. Research shows that people with long-term physical conditions are more than twice as likely to develop mental ill-health (Mental Health Foundation, 2022a).

Data from the Quality of Life Survey (2022) highlights how this affects disabled people and women in Bristol:

- 10.6% of women reported that their physical health prevents them from leaving their home when they want to, compared to 6.9% of men
- 12% of women reported that poor health stops them from getting involved in their community, compared with 8.1% of men
- Though not broken down by gender, disabled people are the least satisfied with life; only 36% reporting that they are compared with the Bristol average of 68%
- Though not broken down by gender, 15.5% of disabled people feel lonely as they don't see family of friends enough, compared with the Bristol average of just 5%

Disparities

Local inequalities data on the prevalence and impact of long-term conditions, disability and chronic pain in women is limited. However, national research shows that MSK prevalence is higher in areas of deprivation (DHSC, 2022a, p.110). We also know, for example, that the Gypsy, Roma and Traveller community are substantially more likely to have a long-term illness or health problem (BCC, 2022h).

Figures X and X, taken from the Versus Arthritis paper on chronic pain, show a clear relationship between deprivation, ethnicity and chronic pain (Versus Arthritis, 2022b, pp.61-62).

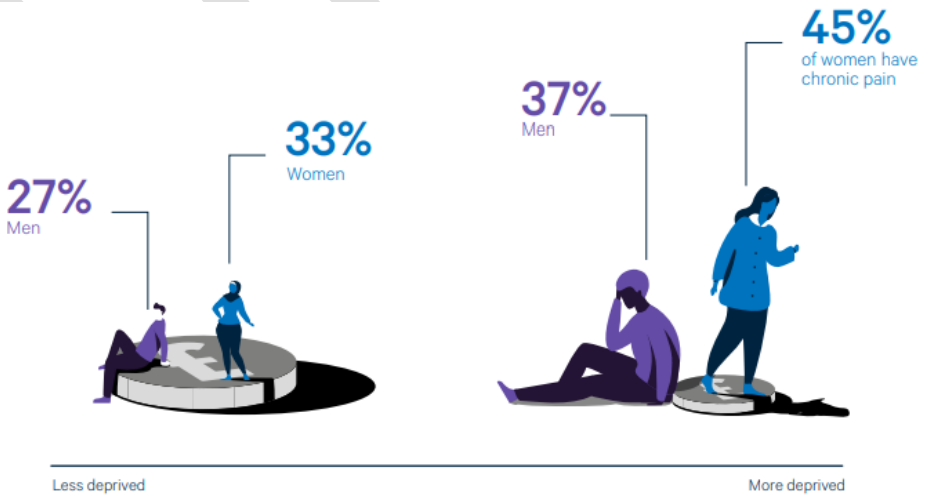

Figure 50: Chronic Pain by Deprivation in England (Source: Versus Arthritis, 2021b)

Figure 51: Chronic Pain by Ethnicity in England (Source: Versus Arthritis, 2021b)

3.3.4. Violence against women and girls

Crimes of violence against women and girls are varied, including rape and other sexual offences, domestic abuse, stalking, coercive control and so-called 'honour-based' abuse (including female genital mutilation and forced marriage), among many others (Home Office, 2021, p.8).

The health impacts of such are wide ranging and extensive, having long-term impacts on both the physical and mental health of women and girls (DHSC, 2022a, p.100).

Through recognising all of the various forms as part of the same problem, we are able to better appreciate the sheer size of the issue. Moreover, tackling violence against women and girls has been recognised as a priority for England (Home Office, 2021).

Domestic abuse

The recent Domestic Abuse Act (2021) introduced a number of tools and powers that will positively impact on victims and survivors, their children and perpetrators (*Domestic Abuse Act 2021)*. The Act has created, for the first time, a cross-government statutory definition of domestic abuse, to ensure that domestic abuse is properly understood, considered unacceptable and actively challenged across statutory agencies and in public attitudes.

Domestic abuse not only causes direct and immediate physical health issues, but also long-term chronic health problems (Women's Aid, 2022), in addition to the mental health implications, which are discussed later. We also know that domestic abuse often begins or escalates when women are pregnant (Women's Aid, 2019).

It is widely accepted as a gendered crime, with the majority of victims being female. In 2020/21, the victim was female in 73% of domestic abuse related crimes (BCC, 2022p). On average, 2 women a week are killed by a partner or ex-partner in England (Missing Link, 2022).

In 2020/21, the rate of domestic abuse related crimes and incidents was 30.3 per 1,000 in England, and 28.4 per 1,000 in Bristol. Trend data shows that whilst the rate is rising in England, it fell from 28.8 to 28.4 in Bristol (BCC, 2022p), though this is not to suggest that it is no longer a problem within the city and could simply demonstrate lower reporting of crimes.

In Bristol, females aged 16 and over are 2.9 times more likely than men to be a victim of domestic abuse. This varies by age, and women aged 30-39 are 3.9 times more likely to be a victim of domestic abuse than their male counterparts (BCC, 2022p).

Sexual violence

The Crime Survey for England and Wales (CSEW) provides a good reflection of the prevalence of crime, including where it is not reported to the police. In the year ending March 2020, the CSEW found that 618,000 women and 155,000 men experienced sexual assault (Home Office, 2021b, p.10).

Figure 52 shows that the rate of sexual offences in Bristol is consistently higher than England (BCC, 2022q). Though, this could indicate that sexual offences are better reported in Bristol.

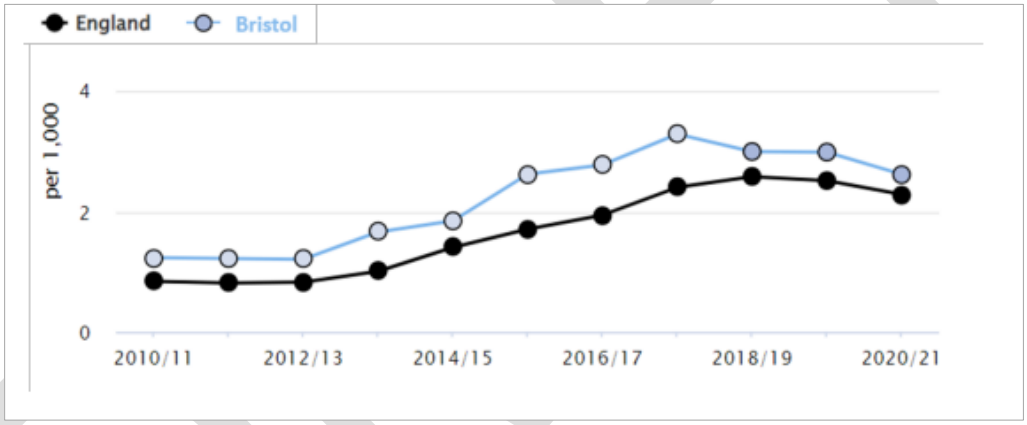

Figure 52: Sexual Offences in Bristol and England 2010/11-2020/21 (Source: BCC, 2022q)

Though this is useful indication, true prevalence is likely to be much higher than the numbers recorded. Latest estimates from the CSEW show that fewer than 1 in 6 (16%) female victims of rape reported it to the police (BCC, 2022q).

Female Genital Mutilation (FGM)

FGM refers to procedures that intentionally alter or injure the female genital organs for non-medical reasons. It has been illegal in the UK since 1985, and in 2003, the law strengthened to prevent girls travelling to undergo FGM abroad (BCC, 2022r).

In 2021, there were 95 newly recorded cases of FGM in Bristol (of 2,800 total across England). Moreover, Bristol has a strong reputation for FGM awareness, and we therefore expect local medical staff to identify and record FGM appropriately (BCC, 2022r). NB: data on FGM is collected via new cases recorded, which does not necessarily mean it has occurred recently and does not suggest the total prevalence within the city.

Mental health impacts of violence against women and girls

There are clear and strong links between VAWG and poor mental health. Research has shown that over half of women that have experience extensive physical and sexual violence meet the diagnostic criteria for at least one common mental health disorder (Agenda, 2016, p.14). Every day, almost 30 women attempt suicide as a result of experiencing domestic violence (Missing Link, 2022).

The relationship is complex; women experiencing domestic abuse are at greater risk of mental ill health, whilst having a mental health condition makes women more vulnerable to abuse (Devries *et al.,* 2013).

In Bristol, the most common request from victims and survivors of domestic abuse and sexual violence is for mental health support – with 62% requesting such (BCC, 2022d).

The Bristol City Listening Project also found that women were reluctant to access mental health support, though fear of having to relive their abuse-related trauma (2022, pp.26-67).

Disparities

Local data shows an association between poverty and domestic abuse. Figure 53 shows disparities in crimes relating to domestic abuse by ward in Bristol in 2020/21, where rates range from 6 per 1,000 in Clifton Down to 77 per 1,000 in Hartcliffe and Withywood – representing an almost 13 fold increase (BCC, 2022p).

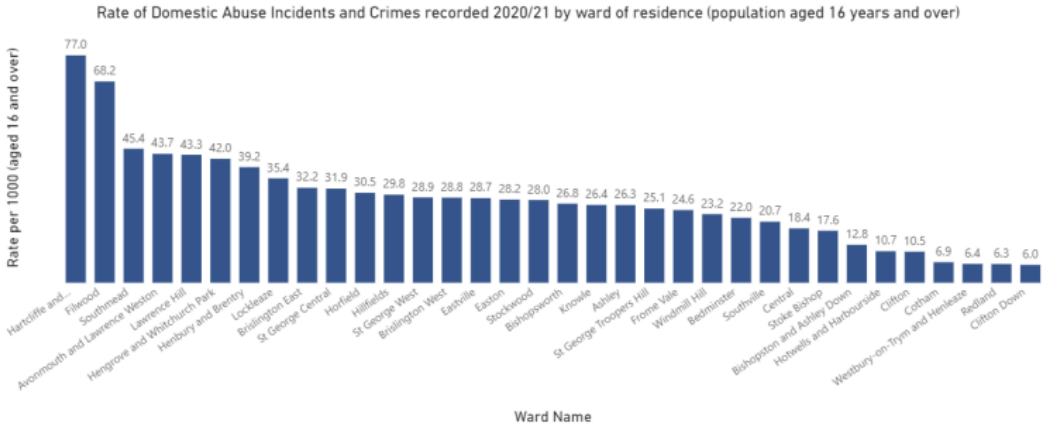

Figure 53: Domestic Abuse Rates by Ward in Bristol 2020/21 (Source: BCC, 2022p)

National research also informs us that disabled women are more than twice as likely to be victims of abuse, stalking or rape (DHSC, 2022a, p.100; Home Office, 2021, p.24). The abuse that disabled women experience is also likely to be more frequent, more prolonged and more severe (Breckenridge, 2018).

LGBTQ+ women are also substantially more likely to experience abuse, sexual violence, rape and stalking (DHSC, 2022a, p.100; Home Office, 2021, p.24).

Domestic abuse affects women from all ethnic groups, though the form of abuse may differ. Critically though, minority ethnic women are likely to face additional barriers in accessing help (BCC, 2022p, p.3).

Moreover, domestic abuse is often a reason causing homelessness, with 7.5% of homeless applications in Bristol in 2020/21 citing domestic abuse (BCC, 2022d). Being homeless then puts women at further risk of abuse, exacerbating inequalities.

We also know that refugees are at increased risk of violence against women and girls "prior to, during and following forced migration journeys", though these crimes often go unreported (OHID, 2021b).

3.3.5. Osteoporosis and bone health

"Osteoporosis is a major cause of ill-health and death and affects around three million people in the UK. Post-menopausal women are the most common sufferers, and it is estimated that women can lose up to 20% of their bone density during the five to seven years after the menopause."

(RCOG, 2019, p.106)

Osteoporosis is a health condition that weakens bones. It develops slowly, making bones fragile and more likely to break. Women are at a greater risk than men due to the lower levels of oestrogen following menopause. Its prevalence increases substantially with age; approximately 2% at age 50, to almost 50% by age 80 (BCC, 2022o).

It is therefore important that women are informed on how to prevent poor bone health before and during the menopause, as equipping them with the right knowledge can be an effective form of prevention. HRT can also be used to maintain oestrogen levels during the menopause and therefore reduce the risk of osteoporosis (Royal Osteoporosis Society, 2022a).

Figure 54 shows the prevalence of osteoporosis in Bristol compared with England since 2012/13. It shows that whilst prevalence rates were broadly similar a decade ago, Bristol's prevalence is rising at a much faster rate than England and is now significantly higher. Though this data is not specific to women, it should be considered in the context that osteoporosis disproportionately affects women.

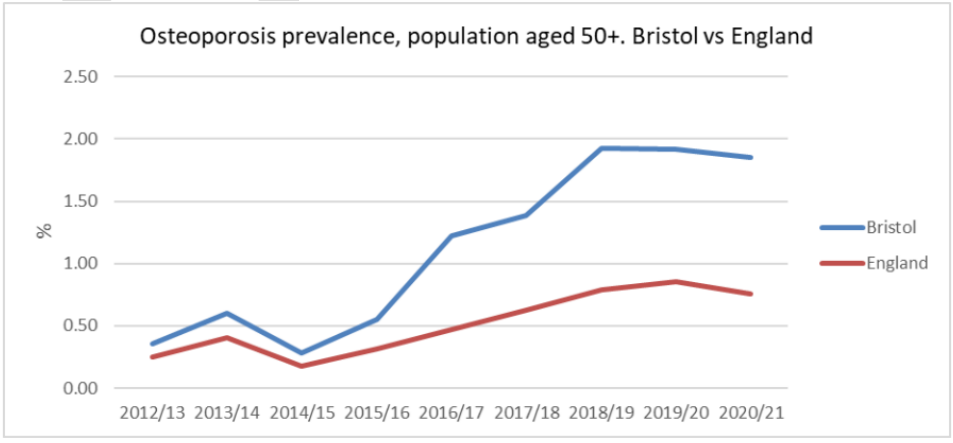

Figure 54: Osteoporosis Prevalence in Bristol and England 2012/13-2020/21 (Source: BCC, 2022o)

Hip fractures are a common consequence of osteoporosis, and in Bristol, 72% of hip fracture admissions in 2020/21 were women (BCC, 2022s).

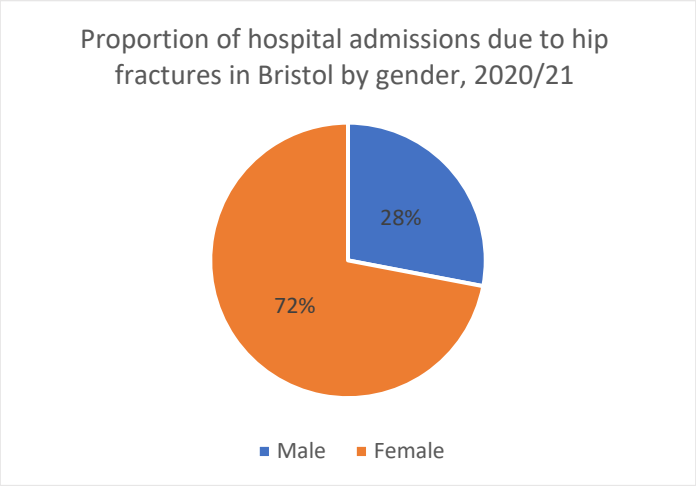

Figure 55: Proportion of Hip Fractures by Gender in Bristol 2020/21 (Source: BCC, 2022s)

Disparities

There is limited inequalities data for osteoporosis in Bristol. Though, the national Women's Health Strategy recognises a 'treatment gap' i.e., the gap between those who have osteoporosis and those who receive treatment for it (DHSC, 2022a, p.107). According to the Royal Osteoporosis Society, this is largely due to the inconsistent coverage of Fracture Liaison Services across England, with only half of Trusts in England providing the service (Royal Osteoporosis Society, 2022b).

3.3.6. Dementia and ageing well

Women live longer in poor health than men. In Bristol, women live an average of 21.2 years in poor health, compared to 18.7 years for men in Bristol, 19.2 years for women nationally (OHID, 2022a).

Ageing well is highly dependent upon maintaining good health throughout women's lives. The higher prevalence of risk factors in women in Bristol e.g., higher rates of smoking, lower rates of physical activity, higher rates of obesity, will therefore have implications for healthy ageing.

Almost two thirds of falls-related admissions in the over 65s in Bristol are among females. Rates have increased slightly in females since 2018/19 and remain significantly higher than the England rate – see Figure 56 (BCC, 2022s).

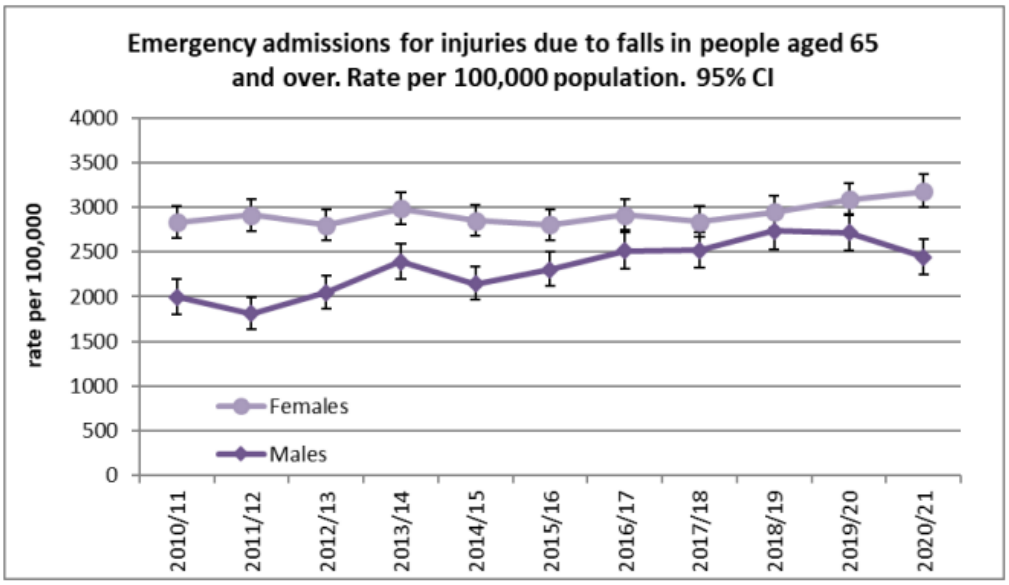

Figure 56: Admissions due to Falls by Gender in Bristol 2010/11-2020/21 (Source: BCC, 2022s)

Moreover, women accounted for 68% of excess winter deaths in 2019/20 (BCC, 2022t).

Dementia

Nationally, approximately 65% of people living with dementia are women. It was the leading cause of death for females in 2020 (DHSC, 2022a, p.109).

At surface level, it seems as though Bristol's rates of dementia are lower than the England average. Yet, as a proportion of patients 65 and over, 4.43% in Bristol are recorded as having dementia, which is higher than the England average of 3.97% (BCC, 2021d).

In Bristol, it is estimated that there were over 2,300 women 65+ with dementia in 2020, compared with 1,900 men (BCC, 2021d).

NICE guidelines state that a blood test should be a standard aspect of dementia screening, to exclude potentially reversible causes of the disease. According to 2018/19 Quality and Outcomes Framework (QOF) data, the percentage of patients with a new diagnosis of dementia with a blood test on record was 62%, lower than the England average of 70% (BCC, 2021d).

Disparities

Local data on disparities is not readily available. Though due to the relationship between healthy lifestyle factors and ageing well, disparities between wards in Bristol is to be expected.

4. What are we doing?

This section seeks to recognise current initiatives and core pieces of work that relate to women's health, so that any subsequent gaps can be identified. It is not an exhaustive list, though does demonstrate current areas of focus.

This is not to suggest that any of the associated issues have been resolved, rather that they have already been identified as issues and work is already underway.

Domestic abuse and sexual violence

In 2022, domestic abuse services in Bristol have been recommissioned in line with the requirements of the new Domestic Abuse Act (2021). A local needs assessment on domestic abuse was undertaken in order to inform the commissioning process. It included extensive engagement and consultation with key stakeholders including members of the public, service providers and their staff, and a high number of those with lived experience, using a trauma-informed approach. Key messages from this included the need to have a single point of access, more co-located services, more specialist services for minoritised communities, support for survivors to stay in their own homes, among many others. Next Link Plus secured the contract, with Next Link as the lead provider working with a number of other organisations. This service launched on the 1st of October 2022. Next Link Plus has a vision that all child and adult victims and survivors can get the help and support they need when they need it, making sure that services are accessible for all.

There is also a new Domestic Abuse and Sexual Violence Survivor and Victim Forum. It was established in 2021 in response to the new Domestic Abuse Act to ensure the voices of victims and survivors are heard. The purpose of the group is to influence strategic change using the lived experience of its members, and it has helped to inform commissioning, influence training packages and hosted a multi-agency event to raise awareness.

Moreover, Respite Rooms have been commissioned to offer emergency accommodation and support for women who need more specialised, trauma and gender informed support than is available in our alternative homeless pathway. Opened in October 2021, the 10-bed respite room facility offers immediate safe spaces to women who have experienced domestic abuse, violence, rape or sexual assault, sex work or exploitation and who are sleeping rough or at risk of doing so. Initially this was a 12 month pilot funded by DLUHC but was extended by a further 6 months. Bristol City Council has committed to continue this service for a further two years.

Additionally, IRIS ADViSE (Identification and Referral to Improve Safety, Assessing for Domestic Violence and Abuse in Sexual Health Environments) is a newly commissioned programme which supports sexual health clinicians to identify and respond to patients affected by domestic violence and abuse, and facilitates referral to specialist services. It aims to reach a wider group of people than the initial IRIS programme within primary care. Bristol is second site in the country to be piloting the programme, and the new service launched on 26 September.

Schools are also encouraged to sign up to the Bristol Ideal Award, which is a set of standards to improve their approach to important issues like domestic abuse, sexual violence, and healthy relationships. The award represents a commitment to safeguarding staff, students and preventing unhealthy behaviours in the next generation.

Therapeutic support for survivors of sexual violence was also recommissioned in 2022, following a health needs assessment. The assessment identified that commissioning needed to be more joined up, and that the pathway for survivors of sexual assault and abuse needed to be more integrated. As a result, Bristol City Council's recommissioning of therapeutic sexual violence services has taken place as part of a wider joint tendering and procurement process led by NHS England, in collaboration with the BNSSG Integrated Care Board and the Office of the Police and Crime Commissioner for Avon and Somerset. The new service will provide, or enable access to, a range of evidence-based, trauma-informed therapeutic interventions for adults and children who have experienced sexual violence and abuse. It will also include an innovative waiting list management approach that seeks to support people whilst they are on the waiting list.

Furthermore, Somerset and Avon Rape and Sexual Abuse Support (SARSAS) are currently working on a project to better understand how the menopause can retrigger trauma caused by sexual violence in some women. It will build on our understanding of the intersectionality between sexual violence, mental health and the menopause.

Sexual health

Bristol City Council Public Health is the lead commissioner for open access specialist sexual health services for BNSSG. This includes all types of contraception, testing for sexually transmitted infections including HIV, treatment of STIs and terminations of pregnancy. In addition, local authorities commission Long Acting Reversible Contraception (LARC) from GPs, emergency contraception for young women from pharmacies and chlamydia screening for young women from both GPs and pharmacies.

Health promotion is undertaken by Unity sexual health service. This includes campaigns to promote safe sex, as well as outreach to vulnerable people as well as working in some schools. Schools are now required to deliver relationships and sex education to pupils.

A comprehensive sexual health needs assessment is currently underway in BNSSG. This includes reviewing our current sexual health services, looking at local data around outcomes and activity, summarising the evidence around what works to improve sexual health and surveying the public, service users and professionals. This information is then used to inform us of key issues and make recommendations to improve sexual health and reduce inequalities. This needs assessment will be completed by the end of 2022 and will inform future commissioning of services to ensure women's sexual and reproductive needs are met.

There are currently a number of pilot projects taking place in Bristol. This includes a project to increase routine enquiry around sexual and domestic abuse within sexual health services, and to refer women to in house support where appropriate, and a project piloting the routine provision of post-partum contraception to women following delivery of their baby – as the national Women's Health Strategy highlights as best practice. We have also installed two vending machines in Bristol to enable another route to access STI and HIV tests and are working with people of African and Caribbean Heritage to improve access to HIV testing and sexual health services.

Work is also underway to improve access to LARC, including exploring other delivery models within the community such as women's health hubs. These are hubs incorporating

reproductive and sexual health, cervical smears, care for menopause and heavy periods and have been recommended in the national Women's Health Strategy to improve access for women. This will require system level collaborative working and needs to be informed by outcomes from other areas currently piloting such models in the UK.

Moreover, a national plan to end HIV in England was published in December 2021 (DHSC, 2021) and we are awaiting a new national sexual and reproductive health strategy. These will inform our local strategy.

Maternity

In 2022, Bristol secured national funding for a new Family Hubs and Start for Life programme to develop a network of Family Hubs and support best start in life priorities. The Family Hubs and Start for Life programme will be fundamental to improving the health and wellbeing of women. The programme includes dedicated investment for essential services in the crucial Start for Life period from conception to age two, including infant-parent mental health support, infant feeding support, parenting programmes and support with early language and the home learning environment. The programme will accelerate and expand efforts to develop an integrated service offer for children and families, joining up a wide range of services to ensure there a single access point for families to a range of universal and early help support. Healthy pregnancy and birth are recognised as important elements of the Start for Life programme and so maternity services are part of the core offer.

Several projects that will also contribute to good maternal health outcomes are currently underway, including:

- A major transformation programme in Public Health Nursing, to align the service with the new national Healthy Child Programme and ensure needs-led, evidence based, best practice delivery, based on the 'i-thrive' model (I-Thrive, 2022). An important element is the implementation of 'MESCH' (Maternal Early Childhood Sustained Home-Visiting), which offers a more intensive health visiting programme for vulnerable families to reduce health inequalities. A perinatal mental health and parent-infant relationships health visiting team has also been established to provide leadership, training and direct interventions.
- A continued commitment to commissioning the Family Nurse Partnership in Bristol - an evidence-based programme to support young parents (under 19) and their families to achieve good outcomes in the early years and beyond.
- A continued focus on work to reduce inequalities with regards to breastfeeding. While significant inequalities still exist, it is believed that the targeted peer-support service operating in the areas with the lowest rates has contributed to the improvement of rates in these areas. A key priority going forward is ensuring further reductions in inequalities in breastfeeding rates, while also ensuring good access to support for all. There have been continued efforts across the system in working towards Gold UNICEF Baby Friendly Accreditation. Bristol is also one of multiple sites across the UK taking part in the ABA Feed Study, which aims to provide high quality evidence regarding the effectiveness of peer support.
- An Integrated Care Board (ICB) led project to remap perinatal mental health care pathways.

Menopause

Healthwatch Bristol are running a project to evaluate the local NHS menopause provision. Over the next 6 months, this project will listen to and synthesise the voices of women who have interacted with the healthcare system in Bristol for menopause and peri-menopause support. It will include discussions of symptoms, availability of appointments, treatment options, follow up care, and the availability of information and education.

The project aims for a greater understanding of the health impact of menopause, to boost health outcomes for all women and have improved ways in which the health care system listens and responds to their needs. The outcomes will include bringing a greater awareness of health inequalities, and ensuring that women's ethnicity, sexuality, or disability does not impact on access or treatments for menopause symptoms.

Mental health

Thrive Bristol is a ten year programme that aims to improve mental health and wellbeing. It focuses on various parts of the city and how they can keep us mentally healthy, such as our communities, our places of education and work, and our homes.

Mental health and wellbeing training has been delivered to staff and volunteers from nearly 100 community organisations over the last year, including Mothers for Mothers – a postnatal mental health support service in Bristol. Several small grants schemes have also run, funding community wellbeing activities and targeting communities experiencing inequalities in mental health.

Supporting workforce and workplace mental health

Building on Thriving at Work in Bristol, the Thrive at Work West of England programme was developed to offer businesses and their staff, help to respond to mental health concerns in the workplace. The package of support includes resources, tools and training, including free elearning. Since its launch in Sept 2020, nearly 600 people have taken the mental health elearning and 68% of those were female.

The Night Time Economy (NTE) was significantly impacted during lockdown, particularly during the periods of lockdown when bars, nightclubs, music venues etc. had to close for prolonged periods. This resulted in a significant impact on the mental health and wellbeing of the workforce in the NTE.

Bristol City Council are currently working with partners and businesses in the NTE to develop a package of support to NTE businesses and workforce. The aim is for these resources to be available towards the end of 2022.

In addition to the work of Thrive Bristol, there have been multiple other grant programmes around mental health. Some of these have been specific to women's mental health, including grants given to Refugee Women of Bristol, Women Together for Change and One25, among others – all of which seek to help disadvantaged and marginalised women in the city.

The ICB has also led work on the Community Mental Health Framework, which engaged with several women's mental health partners, including Missing Link, Mothers for Mothers, Womankind and One25.

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The ICB has also led work on the Community Mental Health Framework, which engaged with several women's mental health partners, including Missing Link, Mothers for Mothers, Womankind and One25.

Healthy lifestyles

Bristol offers a free specialist smoking cessation service for specific high risk groups, including pregnant women and their co-resident family or significant others. The service provides a gold standard delivery model consisting of behavioural support, optimised and safe nicotine replacement therapy, incentive based rewards and optional e-cigarettes. It delivers targeted engagement to women at higher risk of smoking during pregnancy, in hope of reducing inequalities. This targeted approach has been commissioned for a second year. The service is also available to anyone with diagnosed long term condition and people referred following an NHS Health Check. Bristol also has a leadership role in the BNSSG-wide Treating Tobacco Dependence programme, which will upscale smoking cessation support available within NHS hospital services.

Bristol is taking a whole systems approach to healthy weight that recognises the need for joined-up working and long-term planning. This is made up of several pieces of work, and a few of note include:

- The Food Equality Strategy and Action Plan, which intend to address food insecurity and inequalities across the city, recognising the beneficial impacts that nutritious food has on our health

- The Sports and Physical Activity Strategy, which aims to halt the rise in levels of childhood and adult obesity by 2025
- The Bristol Eating Better Award, which encourages businesses, schools, caterers and early years settings to offer healthier food options and promote food sustainability
- The commissioning of a tier 2 weight management service (currently until the end of June 2023)

In terms of physical activity, the Bristol Girls Can campaign (funded by Sport England and delivered by Bristol City Council's Public Health team) aims to reduce the gender gap around physical activity by breaking down barriers around exercise and inspiring more women to get active in the city. The latest project of the campaign is to engage inactive mothers with young children, with a focus on reducing health inequalities across the city. In 2021, the 'small steps' campaign was launched, and is designed to inspire inactive mums to take small steps to becoming more active.

Period dignity

In recent years, the council has actioned work around period poverty. It has now been incorporated into the Bristol Healthy Schools scheme, and there are plans to further embed this aspect of young women's health.

Incontinence

Bristol Health Partners are running a project to explore unmet needs for women with incontinence in the Somali community. Due to cultural expectations, incontinence is often even more of a taboo in specific communities and this project has highlighted additional barriers to accessing services that are experienced by Somali women. Culturally sensitive levelling up equity in accessibility and Bladder and Bowel Service provision is underway with findings to be reported in early 2023, informed by the community and for the community.

5. Where are the gaps?

Through taking a comprehensive look at women's health needs in Bristol and identifying key areas of work that are currently underway, it is possible to identify gaps in need of further attention. These largely fall into the following three categories and are central to the recommendations of this paper.

- Areas which we have limited local data on and would therefore benefit from further local research in order to give a fuller understanding of the issues in Bristol. These are areas where national data and research show cause for concern, and a better understanding of the prevalence and nature of the issue in Bristol would set the foundations for any future work to improve women's health. It is also important that any research into these areas includes a disparities lens. Specific women's health topics that would benefit from this include:
  - Menstrual health and gynaecological conditions
  - Menopause
  - Pelvic floor health, prolapse and incontinence
  - Long-term conditions, disability and chronic pain

- Areas where we have some local data, and perhaps can see a concerning trend, but lack sufficient inequalities data that is crucial in tackling the issue and reducing health inequalities. These are areas where national data and research show differences in health outcomes, access and/or experience between women. For these areas, there is need for research into disparities locally, so that we can build the Bristol picture and create a tailored approach to improve women's health. Specific topics that would benefit from this include:
  - HPV vaccination and cervical screening
  - Pregnancy loss and fertility
  - Breast cancer
  - Mental health, including perinatal mental health
  - Osteoporosis and bone health
  - Dementia and ageing well

- Areas where local data shows increasing disparity and that are in need of further attention, including:
  - HPV vaccination uptake - in recent years, HPV vaccination uptake has dropped substantially in Bristol and is significantly lower than the average for England, as well as rates for other school-age immunisations.
  - Breast cancer - in Bristol, rates of breast cancer screening, prevalence and mortality are worse than the average for England.
  - Long-term conditions, disability and chronic pain – national research shows that women are disproportionately affected, though there is limited local data.
  - Osteoporosis and bone health – there has been a significant rise in prevalence in Bristol and women are disproportionately affected.
  - Dementia and ageing well – dementia screening is lower in Bristol than nationally, and dementia, falls and excess winter deaths disproportionately affect women.

6. Recommendations

This paper makes the following recommendations to improve women's health in Bristol.

Recommendation 1: Investigate the experience of menstrual health and gynaecological conditions for women in Bristol.

Our current understanding of menstrual health and gynaecological conditions in Bristol is limited, though we know nationally that it often takes years for women to be diagnosed and receive support and/or treatment for gynaecological conditions. Creating a JSNA data profile specifically for this health topic should be considered.

Recommendation 2: Ensure that increasing HPV vaccination uptake is a priority for Bristol.

HPV vaccination uptake is significantly lower than the England average. More work needs to be done to understand why uptake is low in Bristol, and sufficiently understand whether there are inequalities between different women and girls.

Recommendation 3: Explore ways of improving cervical cancer screening uptake, with a focus on inequalities.

Cervical screening coverage is slightly lower in Bristol than the England average. More research is needed to understand whether there are inequalities between different groups of women, and what can be done to reduce inequalities whilst improving screening coverage for all.

Recommendation 4: Consider how Women's Health Hubs could best work in Bristol.

Women's Health Hubs provide a means of improving access for women and this offering should be considered within Bristol. This will require system-level collaborative working and needs to be informed by outcomes from other areas currently piloting such models in the UK.

Recommendation 5: Conduct further research into pregnancy loss and fertility, with a focus on inequalities.

Research into the underlying causes of inequalities is required. Research specifically into fertility treatment options for LGBTQ+ people should also be considered.

Recommendation 6: Ensure that clear learning and actions are taken from the recent BNSSG Maternity Health Equity Audit.

The BNSSG Maternity Health Equity Audit provided useful data and it is important that actions result from it, especially in relation to the work uncovering health inequalities.

Recommendation 7: Continue work to reduce inequalities relating to breastfeeding.

A continued focus on reducing inequalities in relation to breastfeeding uptake is required, recognising that significant inequalities still exist within Bristol.

Recommendation 8: Take action on the findings of the upcoming Healthwatch menopause project.

The Healthwatch Bristol menopause project is due to be completed in Spring 2023 and will provide new local information on the topic. It is recommended that Bristol City Council is cited on the findings and consider subsequent action to improve women's health in this regard.

Recommendation 9: Undertake research into pelvic floor health, prolapse and incontinence in Bristol.

More research into pelvic floor health, prolapse and incontinence in Bristol is required to truly understand the prevalence and nature of the issue. Bristol Health Partners are currently researching Incontinence in the Bristol Somali community and it is recommended that Bristol City Council are cited on the findings. Work to reduce stigma on the issue should also be considered.

Recommendation 10: Support national work on increasing uptake of breast cancer screening.

Breast cancer is recommended as a key area of focus in relation to women's health in Bristol. Research is needed to better understand the issues and a plan of action to improve uptake is also required, with a focus on inequalities throughout. A health equity audit should be considered.

Recommendation 11: Continue work to improve women's wellbeing and lifestyle across Bristol.

A continued focus on reducing inequalities in relation to women's wellbeing and lifestyle is required, recognising that significant inequalities still exist within Bristol and the significant impact that it has across the span of women's health issues.

Recommendation 12: Conduct further research to better understand mental health across the female life course, from adolescence, the perinatal period, and the menopause.

There are specific stages within a woman's life where poor mental health may be more likely to occur. From eating disorders and self-harm in adolescent and young women, poor mental health associated with the perinatal period and poor mental health associated with the menopause. These are key areas where further investigation into women's mental health specifically is required. It is also recommended that Bristol City Council are cited on the findings of the upcoming SARSAS project looking into how the menopause can retrigger trauma for victims and survivors of sexual abuse.

Recommendation 13: Conduct research into how long-term conditions, disability and chronic pain affects women in Bristol.

Research into how long-term conditions, disability and chronic pain affect women, including a focus on inequalities, is a key recommendation of this paper.

Recommendation 14: Continue work to tackle violence against women and girls.

A continued focus on tackling violence against women and girls in Bristol is recommended, recognising the ongoing work around domestic abuse and sexual violence. More work around FGM and other issues relating to VAWG should also be considered.

Recommendation 15: Conduct further research into osteoporosis and bone health in Bristol.

Further research into osteoporosis in Bristol is needed to determine how it affects women differently to men, and whether there are inequalities between women locally. Osteoporosis and bone health should be considered when mapping services for Women's Health Hubs.

Recommendation 16: Ensure that system-level work on dementia and ageing well includes a women's health perspective.

ICB-led work into dementia and ageing well should include consideration of issues from a women's health perspective.

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