BETTER HEALTH FOR WOMEN

How to incorporate women's health needs into Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
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Summary

Women form half the community. They have specific and different health needs from men, which need to be identified and responded to if health and care services are to be effective and deliver for everyone. Some of these differences are about different needs for clinical services; some are about different needs in terms of access.

Women hold different assets, resources and play different roles within the community. They are more likely to live in poverty, but may have developed effective self-help strategies and resilience in the face of this, often at neighbourhood level. However, there are barriers to their participation in the development of health strategies – many women don’t have a voice in decision-making.

Unless this gendered analysis is understood, Joint Strategic Needs Assessments (JSNAs), and Joint Health and Wellbeing Strategies (JHWSs), will not successfully identify the needs of the whole community, including those in disadvantaged areas or those in vulnerable groups who experience inequalities.

This guidance offers signposts to essential sources of supporting evidence to inform JSNAs, which can then be fed into JHWSs. It includes a simple, five-step process to identify where there are either health gaps for women, where special action is needed to close the gap in health outcomes across the community; or where there are women-specific health issues. It draws together data on women’s health needs and provides an example ‘Women’s JSNA’ and case studies.

It can be used to meet the first two goals of the NHS Equality Delivery System (EDS) - the toolkit for the NHS to meet its obligations under the Equality Act, the Care Quality Commission and NHS Constitution. We hope it will support the cost-effective delivery of improved health and well-being outcomes, and be useful for those charged with developing these crucial documents as well as those who seek to influence them.
Foreword

The Women’s Health and Equality Consortium (WHEC) is a Strategic Partner of the Department of Health (DH), supporting its direct engagement with the voluntary and community sector (VCS). WHEC works together with the government, the women’s VCS and other partners to develop and inform health policy on appropriate and accessible services.

Health and wellbeing boards are responsible for assessing the current and future health and social care needs of their local communities through Joint Strategic Needs Assessments (JSNAs) and Joint Health and developing Joint Health and Wellbeing Strategies (JHWSs) to prioritise and meet the identified needs. Boards will need to ensure that staff supporting JSNAs and JHWSs have easy access to the evidence they need, informed by detailed local needs assessments at a district or ward level, looking at specific groups (such as those likely to have poor health outcomes), or wider determinants of health such as crime or housing. Therefore health and wellbeing boards need to consider:

- the needs of the whole community, including how needs vary for people of different ages, and how needs may be harder to meet for those in disadvantaged areas or vulnerable groups that experience inequalities, such as people who find it difficult to access services or are isolated;
- wider social, environmental and economic factors that determine health and wellbeing – such as access to green space, air quality, housing, community safety, employment;
- what health and social care information the local community needs, including how they access it and what support they may need to understand it.

They should also consider what local communities can offer in terms of assets, knowledge and resources to help meet the identified needs.

The aim of this document is to support the development of JSNAs and JHWSs in England which includes women’s needs. We outline a simple five step process to identify where there are either health and care gaps for women, where special action is needed to close the gap between women and men in health outcomes across the community; or where there are women-specific health needs. We also include gender disaggregated data and analysis on a range of women’s health needs.

Using this document will support boards to meet the operating principles for JSNAs and JHWSs set out by the NHS Confederation, and the first two goals of the NHS Equality Delivery System (EDS), the toolkit for NHS organisations to meet their obligations under the Equality Act 2010, the NHS Outcomes Framework and the NHS Constitution and, if they are providers, meet the Care Quality Commission’s “Essential Standards of Quality and Safety”. We hope this document will be useful both for those who develop JSNAs and JHWSs and for those who seek to influence that development.

2 Goal one: better health outcomes for all; Goal two: improved patient access and experience
3 The Equality Delivery System for the NHS: Fact Sheet

The Women’s Health and Equality Consortium is

**FORWARD UK** committed to eliminating gender-based violence against African girls and women, particularly female genital mutilation and child and forced marriage.

**Imkaan** developing the Black, Asian, Minority Ethnic and Refugee (BAMER) Violence against Women and Girls (VAWG) sector.

**Maternity Action** working to end inequality and promote the health and well-being of all pregnant women, new mothers and their families.

**Platform 51** working with the most disadvantaged women and girls in England and Wales.

**Positively UK** champions the rights of people living with HIV and related conditions and coordinates PozFem UK the national network of women living with HIV.

**Rape Crisis (England and Wales)** providing specialist services for women and girls who have been raped or experienced another form of sexual violence.

**Women’s Resource Centre (WRC)** supporting women’s organisations to be more effective and sustainable, providing training and resources.
Introduction

The vision for leadership and delivery of health and care services

Local authorities and clinical commissioning groups (CCGs) will be enabled to plan and commission services in an integrated way so that health and care services better meet everyone’s needs within the local community, including people in the most vulnerable circumstances and the groups with the worst health outcomes.

Health and wellbeing boards will be able to understand, and take action to help tackle inequalities in health and wellbeing; and supported by local partners to influence factors that affect health and wellbeing to improve outcomes through every stage in people’s lives.

The aim of this document is to support those responsible for undertaking JSNAs and developing JHWs in England to understand women’s needs.

The Department of Health’s draft guidance includes a clear steer on the role of JSNAs and JHWs in tackling inequality. A number of JSNAs have included “deep dives” on key priorities and some authorities have included women’s needs as one of their ‘specialist subjects’.

This document is designed to go one step further – to introduce a process of mainstreaming gender which ensures a consistent approach to gender analysis within JSNAs, which will then feed into JHWs. We also include an example woman's JSNA for those authorities that prefer to highlight women's needs separately. We hope this document will be useful for both approaches.

Why focus on women?

Inequality impacts on a number of vulnerable sections of our communities. Some of these vulnerabilities are recognised in law, the protected characteristics being age, race, ethnicity, sex, sexual orientation, gender identity, pregnancy/maternity, marriage/civil partnership, disability and religion/belief. Women are part of all these groups as well as being represented in their own right. In most cases, being female within a disadvantaged group creates a double disadvantage, increasing the likelihood of living in poverty, poor housing, having care responsibilities, and being vulnerable to gender based violence. See Annex A for more details about women’s inequality as it impacts on health and wellbeing.

This focus on women rests on an evidence, business and legal case:

It's evidence-based

JSNAs must be based on evidence, and there is a wealth of evidence (national and local) of health gaps for women, where special action is needed to close the gap between women and men in health outcomes across the community; or where there are women-specific health needs. Examples of this evidence will be found in Annex A and in the example Woman’s JSNA, both in this document. Women’s VCS organisations also hold a great deal of
information about women's health needs which address some of the deficiencies in official data and which taken together, demonstrates why a gender analysis is important.

**It's better policy**

Investment decisions based on women's specific health needs are a practical, cost-effective way of delivering a wider agenda of improving access to services and health outcomes. Health policies that take gender into consideration will increase the likelihood that services will meet their national public health targets; improve outcomes, and provide an effective health system that is fit for purpose. It is central to the NHS Constitution and enables everyone to receive quality care and eliminate inequality and discrimination.

Policies that ensure equal access to high quality services will tackle the inequalities women and girls face in relation to mental, physical and sexual health. There are efficiency savings which flow from effective early intervention: for example, high quality maternal health care for pregnant women and mothers will improve the life chances of mothers and future generations. Policies that are sensitive to women’s needs – such as commissioning women-only services – will be more effective in reaching the women in that target population.

**Better health outcomes through prevention**

Greater public investment must be directed towards prevention to tackle the root causes of poor mental and physical health. For example, violence against women and girls (VAWG), both intimate partner violence and sexual violence, are major public health problems and violations of women’s human rights. The law, and central government strategy, defines violence against women as requiring a gender based response, designed to ensure that public bodies treat women differently according to their needs, rather than treating everybody the same. Without early intervention, they present significant social and economic costs and seriously depress women’s ability to contribute to society and the economy: an indicative figure for the minimum and overlapping cost of VAWG in the United Kingdom is estimated to be £36.7bn annually. Even this does not take into account the cost of treating the long-term emotional and mental health problems experienced by survivors or the fact that as many as 90 per cent of these crimes go unreported and undetected each year.

The direct cost of VAWG to the NHS is around £1.2 billion a year; domestic abuse alone costs an additional £176 million a year in mental health services. Each rape costs in total around

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7 87 per cent of women thought it was important to see a female health professional and some would not use a service unless it was female-only - the consequence of which could be deteriorating health.

8 Women’s Resource Centre (2011) ''Women-only services: making the case: a guide for women's organisations’

9 WHO (2011) Violence Against Women: Intimate partner and sexual violence against women Factsheet 239


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£96,000. The return on investment in prevention is therefore significant: for example, low-cost community-based support services (refuges, rape crisis) can reduce the demand on local GP services, A&E and admissions to hospital. Around 50 per cent of women who use mental health services have experienced violence and abuse.

There must be more support early on and measures to close gaps in services.

It’s better community engagement

JSNAs need to be rooted in communities, and reflect their priorities. Women are under-represented in many decision-making arenas, especially among senior clinicians and in elected office. Real engagement means ensuring the diversity of women’s views are heard. The health and social care voluntary and community sector that works with women collects valuable intelligence on service users’ needs; developing long term relationships with this sector can support better community engagement. The research that women’s organisations undertake in areas of unmet need and current and future health and social care requirements can help health and wellbeing boards meet the requirement to consider what local communities can offer in terms of assets and resources to help meet local needs. Community assets include the local community and voluntary associations as well as the public, private and third sector organisations that are available to support a community.

There needs to be a more systematic approach to engaging communities... Moving beyond often routine brief consultations to effective participation in which individuals and communities define the problems and develop community solutions. Without such participation and a shift of power towards individuals and communities, it will be difficult to achieve the penetration of interventions needed to impact effectively on health inequalities.

The Marmot Review

It is open to local discretion to widen participation in health and wellbeing boards to district councils, the community and voluntary sector and to other agencies with a major contribution to make in promoting health and wellbeing. Wider influences on health and wellbeing such as housing, economic development, and spatial planning are well documented, but only the health and wellbeing board has the potential to bring them together around a common theme. A comprehensive and robust JSNA will identify the scope for these contributions, providing coherent single-needs assessment for all services and the opportunity to maximise investment across a locality. Finally, local democratic accountability and the participation of Healthwatch are key to making sure this all happens. They offer a real opportunity to develop a much stronger relationship with the people in local communities who, in turn, can shape the balance of services. A strong JSNA will strike the right balance between facts and figures about local health and wellbeing, and local views about what should be done. It will play its part in our goal of passing power to communities and individuals.

Paul Burstow MP, Former Minister of State (Care Services)

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11 The Government Response to the Stern Review: An independent review into how rape complaints are handled by public authorities in England and Wales, Cabinet Office, 2011
13 The Marmot Review, 2010
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It’s the law

Under the Health and Social Care Act 2012, the Secretary of State for Health has a duty to reduce inequality.

*In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.*

Clinical Commissioning Groups (CCGs) have duties to reduce health inequalities, and in taking on public health functions, local authorities have duties to improve the health of their communities.

All members of the health and wellbeing board responsible for drafting JSNAs and JHWSs are subject to the Public Sector Equality Duty (Equality Act 2010) and so must give equal consideration to the needs, experiences, outcomes and aspirations of people with protected characteristics under equalities law as well as equal access engagement. This includes women, who form more than half the population.

**Compliance with the general equality duty is a legal obligation, but it also makes good business sense. Overall, it can lead to services that are more appropriate to the user, and services that are more effective and cost effective. This can lead to increased satisfaction with public services.**

**Equality and Human Rights Commission**

As well as domestic law, the UK has commitments under international law: for example, the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

For more about legal obligations, see Annex C.

Where’s the evidence?

There is evidence of both health inequalities between women and men and broader inequalities that impact on health – such as poverty.

Women and girls across England face significant barriers to both good mental and physical health. Women face poorer health, not only as a result of a poor response to the physiological differences between them and men, but because of the economic disadvantage and discrimination they face, pregnancy and their caring roles, experiences of violence and abuse, and age. This has a detrimental impact on them as individuals. Women’s position as main care givers means their poor health will also have a detrimental impact on the lives of their families and their ability to function in wider society, in their community and in the labour market. Women and girls have greater health and social care needs than men across their lives.

On many measures, women and men experience differential health and wellbeing outcomes, access to services and service experience. These are often worse for women. A gender-neutral approach will not identify or respond effectively to these differences, so a gendered approach is required that takes account of inequalities and social reality of women and girls.

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14 [http://www.legislation.gov.uk/ukpga/2012/7/part/1/enacted](http://www.legislation.gov.uk/ukpga/2012/7/part/1/enacted)
15 The protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation, and, for some elements of the duty, marriage or civil partnership status.
16 CEDAW article 12/general recommendations 14, 15, 18, 24 [http://www.homeoffice.gov.uk/equalities/international-equality/united-nations/cedaw/](http://www.homeoffice.gov.uk/equalities/international-equality/united-nations/cedaw/)
17 As a result of longer life expectancy and longer durations of poor health – ONS (2010) ‘Health Statistics Quarterly’ 45 Spring 2010
The differences between women which impact on these inequalities, apart from those identified above, also include: ethnicity, religion/belief, age, disability and migration status and sexual orientation.

Whilst there are biological differences between men and women, it is the ways in which gender roles and norms are socially constructed around these differences that are mainly responsible for the inequalities we observe (e.g. notions of femininity which identify women as care-givers).

See Annex A for key facts and a detailed analysis of women’s health and inequality.
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How to do it: the five-step process

1. Gather gender disaggregated data

Some data may already be available for the analysis of need undertaken at the beginning of the commissioning cycle. If not, the new data gathered should be fed into the next cycle.

National level data in a range of relevant areas (for example disease/condition prevalence, health outcomes, lifestyle choices (e.g. smoking), take-up of services, service experience) are often already disaggregated by gender. However, it is more difficult to find sources of data that give information about specific groups of women (older lesbians, disabled Traveller women). It is also important to remember that:

- national level data are often based on standardised assumptions which do not necessarily apply to small groups within the community;
- women and girls are often invisible in official data;
- data on particular minority groups, where they exist, are often not disaggregated by gender. Beyond this, however, women may be invisible for other reasons. For example, only around 10 per cent of women report rape to the police. Rape figures will therefore be an unreliable estimate of the true incidence in an area. Eight in ten lesbian and bisexual women who have experienced domestic violence have never reported incidents to the police. Child sexual abuse is also under-reported. Women's homelessness tends to be under recorded because they are less likely to sleep rough for safety reasons, and more likely to be a part of the 'hidden-homeless' population – staying with others, often in exchange for sex. Women involved in prostitution are largely invisible and therefore data on violence from clients, sexually transmitted infections, and other health impacts are not appropriately categorised. Among women involved in prostitution, transgender women are still more invisible because of their small numbers. Rates of HIV prevalence are likely to be under-reported because of stigma; and some vulnerable populations, such as women in prison, are not routinely reported in official data – the last survey of HIV prevalence and incidence among women prisoners was in 1997. Although there is some evidence that treatment of HIV in prisons is compromised by transfers and other delays, more research is needed;
- local women’s organisations hold a great deal of data about service users and women’s needs more broadly, and should be included in the process of information gathering;
- there is a lot of good practice guidance you can use on how to gather new data and how to ask sensitive questions;
- Annex A contains many sources of gender disaggregated data, as does the example women’s JSNA.

2. Analyse data

Some analysis may already have been undertaken as part of the commissioning cycle – if not, the analysis should be used to inform the next cycle.

Consider:

- where are the gaps?

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19 The survey showed prevalence rates of 0.3 per cent adult male prisoners and 1.2 per cent adult female prisoners
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- are there local data? Are they valid? Sometimes it is difficult to find data for a very small group in the community. This should not be used as an excuse for inactivity or for turning down a business case where communities have clearly identified an unmet need. The next step (3) will help you in identifying this;

- what do the data tell us about priorities for women's health services?

- refer to Annex A to identify key areas for analysis.

3. Listen to women

This step will support the need to ensure that commissioned services meet users’ needs

- use surveys to identify women's health needs;

- use good engagement practice guides,\(^{22}\) to help you consider issues such as capacity building of organisations, representation, gate-keeping, feeding back what you have heard and how you are responding;

- hold open meetings, designed to avoid excluding particular groups of women. Public meetings are often designed in such a way as to only permit women who are not working to attend. In order to broaden the spectrum of attendees, meetings need to be organised at different times of day, at different points in the week. Special efforts are needed to target the women who are most marginalised (Black, Minority Ethnic and Refugee (BMER) women living with HIV; women with experience of prison, Gypsy, Traveller and Roma women; lesbians within the Muslim community; women involved in prostitution; women who have experienced Female Genital Mutilation (FGM), etc.\(^ {23}\) See Annex B for example case studies of services designed to reach Traveller women and women in communities that practice FGM as well as on separate engagement with young women;

- some groups, such as women from some faith or ethnic minority communities may find it easier to attend meetings that are women-only; while lesbians from these and other communities (including young women and girls) may find it impossible to speak out in open meetings at all, and may require separate, anonymised modes of engagement, such as focus groups held by representative organisations. Groups that speak for particular sections of the community may be led by men, excluding women’s voices, and special care needs to be taken to reach women in those communities. Access should be considered: women are less likely to have access to private transport than men, and therefore are disproportionately reliant on public transport. Venues should be convenient to public transport and meetings held at times when public transport is running (i.e. not late into the evening). Research shows that many women do not leave their homes in the evening for safety reasons, and this should be taken into account. Consideration should also be given to allowing women with caring responsibilities to attend (e.g., by providing a crèche) and avoiding holding meetings in school holidays. Offering to reimburse travelling expenses will avoid excluding women living in poverty;

- create effective, long-term engagement with organisations that support women and women's health, through dialogue, consultation, and funding. Such organisations are directly in contact with women who may find it hard is to get their voices heard in formal consultation events. Such organisations can therefore act as useful intermediaries to reaching such women, and consideration should be given to funding them to hold “listening” events. Recognising that service commissioning has created a competitive market among grassroots service providers, ensure equitable ways for provider groups to be represented on advisory and other boards (when places are for obvious reasons limited).


\(^ {23}\) See Annex B for example case studies of services designed to reach Traveller women and women in communities that practice FGM as well as on separate engagement with young women;
4. Design and implement

*Commissioning the right services from providers with the right expertise to meet users’ needs*

- develop JSNAs sensitive to women’s needs: you may choose to do this by following the example in this guidance and developing a women’s JSNA, or by mainstreaming your analysis of women’s needs into your full JSNA. The example women’s JSNAs can be used in either fashion. However you decide to structure it, you should use the evidence from user groups and official data to feed into the agreed priorities in JHWSs. This is about identifying priorities for specialist women’s services and for taking women’s needs into account in mainstream services, both those which are directly provided by health and social care services and those services which are commissioned. Women’s organisations may be best placed to provide commissioned services, particularly for vulnerable or excluded women who face barriers to accessing mainstream services.

5. Evaluate (listen again)

*Reviewing, auditing, and recommissioning services*

- listen to women and women’s organisations about their changing experiences, following the methodology in step 3;

- refresh JSNAs; feed revisions into JHWSs and future commissioning plans.
Annex A

Understanding Women and Girls’ Health

Women and girls face particular risks to their health:

- whilst women live longer than men, they spend more years in poor health and with a disability;\(^{24}\)
- one in three women die from cardiovascular disease (similar to men), yet they are less likely to think they are at risk, call for help or attend a cardio rehabilitation programme;\(^{25}\)
- women are more at risk of stroke than men and tend to be more seriously affected, needing long-term care;\(^{26}\)
- more men than women suffer from diabetes in England, but women are at relatively greater risk of dying from it than men. This may be because gender compounds other inequalities, such as poverty, and socio-economic differences, which are linked to differences in smoking rates, food choices and the prevalence of obesity. Women are less likely to receive routine surveillance checks for the long-term complications of diabetes. Pre-menopausal women with diabetes do not have the same protection against coronary heart disease as women who do not have diabetes. Women also tend to take on the main role of carer if another member of the family has diabetes;\(^{27}\)
- there are higher rates of self-harm\(^{28}\) and eating disorders\(^{29}\) amongst women;
- women are much more likely than men to suffer arthritis and rheumatism - the most common types of chronic diseases in the UK;\(^{30}\)
- in the last 20 years, the rates of smoking and lung cancer fell sharply for men, but increased and then stabilised for women. More young women (age 16-19) smoke and so are at risk of lung cancer, than young men;\(^{31}\)
- women living in the most deprived areas have cervical cancer rates more than three times as high as those in the least deprived areas;\(^{32}\)
- women living in deprived areas have a lower survival rate for breast cancer\(^{33}\) and inequalities in rates of breast cancer are increasing;\(^{34}\)
- for social and biological reasons, women are particularly vulnerable to HIV. In 2011 23,800 women were living with HIV in the UK. Approximately 25 per cent are unaware of their

\(^{24}\) ONS (2008) ‘Focus on Gender’
\(^{25}\) British Heart Foundation (2010) ‘Women and Heart Disease’
\(^{26}\) British Heart Foundation (2010) ‘Women and Heart Disease’
\(^{28}\) Self-harm is 2-3 times more common amongst women (Department of Health, Into the Mainstream, 2002)
\(^{29}\) 90% of people with eating disorders are women (Eating Disorders Association)
\(^{30}\) ONS (2008) ‘Focus on Gender’
\(^{31}\) ONS (2008) ‘Focus on Gender’
\(^{32}\) Cancer Research Cervical Cancer Factsheet http://info.cancerresearchuk.org/cancerstats/types/cervix/riskfactors/
\(^{33}\) Cancer Research UK http://info.cancerresearchuk.org/cancerstats/types/breast/survival/
\(^{34}\) Breast Cancer Care (2011) ‘Breast Cancer and inequalities: a review of the evidence’
diagnosis. BME women are disproportionately affected by HIV: 50 per 1000 African women are living with HIV compared to 25 per 1000 among African Men;\textsuperscript{35} 

- recorded rates of depression and anxiety are more than twice as high for women than for men;\textsuperscript{36} 

- women and girls in the UK are more likely to have poor sexual health than their European counterparts.\textsuperscript{37} 

Women and girls’ physical and mental health are negatively impacted both by biological factors and gender roles, including:

**Economic disadvantage**

Women are at greater risk of poverty than men and are more likely to suffer recurrent and longer spells of poverty (22 per cent of women have a persistent low income compared to 14 per cent of men\textsuperscript{38}), which negatively impacts their physical and mental health. Women are the main ‘shock absorbers’ of poverty in households\textsuperscript{39} and feel the pressures of managing on a low budget most. Single parent families, the vast majority of whom are women, are more likely to be below the poverty line,\textsuperscript{40} and women are more likely to be in minimum wage, low paid and insecure employment – two thirds of those in low paid work are women.\textsuperscript{41} Around twice as many women as men are low paid.\textsuperscript{42}

**Poverty and safety**

There is strong evidence that poverty and perceptions of safety are linked. Among those aged 60 or over, women are around four times as likely to feel very unsafe out at night as men: 22 per cent compared with 5 per cent. Among women aged 60 and over, those from lower-income households are one and a half times as likely to feel very unsafe out at night as those from higher-income households: 28 per cent compared with 18 per cent.\textsuperscript{43}

**Women’s caring roles**

Women’s reproductive roles can put their physical and mental health at risk including (but not restricted to) maternal mortality, anaemia, pre-eclampsia and depression in and after pregnancy.\textsuperscript{44} 

Pregnant women also face discrimination at work and their health, and that of their unborn child, is put at risk where there is inadequate health and safety or well-paid parental leave.\textsuperscript{45} 

Carers are more likely to be women than men – 58 per cent of carers are female and 42 per cent are male.\textsuperscript{46} Over 50 per cent of women will be carers before they are 60 and are more likely than men to give up paid work to care. The impact of caring can be detrimental to their physical and mental health, with carers twice as likely to have a mental health problem or be ‘permanently sick or disabled’.\textsuperscript{47} Carers who give up work or reduce their working hours to

\textsuperscript{35} HPA, HIV in the United Kingdom Report 2012 page 5 & 6 http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317137200016  
\textsuperscript{37} Platform 51 http://www.platform51.org/whatwedo/health  
\textsuperscript{38} The Fawcett Society http://www.fawcettsociety.org.uk/index.asp?PageID=22  
\textsuperscript{39} WBG (2005) ‘Women’s and children’s poverty: making the links’  
\textsuperscript{40} Millar, J and Gardiner, K (2004) ‘Low Pay, Household Resources and Poverty’  
\textsuperscript{41} Carers UK (2009) ‘Facts about Carers’
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care are at greater risk of poverty: a fifth are in the region of £10,000-£15,000 a year worse off, with a further fifth losing out on between £15,000-£20,000 of earned income. Working carers who are older are more likely to suffer a drop in income of at least £30,000 when they take on greater caring responsibilities, reflecting the fact that many carers aged 55-64 had skilled jobs. 48 Women who are ‘sandwich generation’ carers, most typically caring for a disabled child and elderly parents, are more likely to hold higher qualifications. Increasing numbers of employees are forced to give up work at the peak of their careers, with inevitable damage to businesses which then face expensive recruitment and retraining costs as well as a loss of expertise and knowledge. When carers fall out of work there are also considerable costs to the wider economy and the Government – with estimates showing a cost of £5.3 billion a year to the economy in lost earnings and tax revenue and additional benefit payments. 49

Gender-based violence

Sexual and domestic violence and abuse puts women and girls’ lives at risk and can have serious consequences on their health and wellbeing.

- sexual violence is not gender neutral: about 92 per cent of reported rapes are of women; 50
- domestic violence is not gender neutral: 89 per cent of those who suffer sustained violence are women. 51 Men are less likely to be repeat victims, are less seriously injured and are less likely to report being fearful; 52
- 44 per cent of all female homicide victims in 2007/08 were killed by a current or former partner. This compares with 6 per cent of male victims killed by current or former partners; 53
- gender-based violence is both a cause and a consequence of HIV, and women with HIV are less likely to seek support because of the stigma they face and the fear their HIV status will be revealed; 54
- child sexual abuse is not gender neutral: around twice as many girls as boys (21 per cent of girls and 11 per cent of boys) are sexually abused before they reach the age of 16; 55
- more than one in four women (4.8 million) aged between 16 and 59 has been affected by domestic abuse; 56
- 50 per cent of women who have experienced domestic violence are raped within their abusive relationship; 57
- 23 per cent of women have being sexually assaulted as an adult; 58
- uUp to 6,500 girls are at risk of female genital mutilation (FGM) in the UK every year. 59 The numbers of women with FGM living in London giving birth rose from 4,238 in 2000 to around 7,000 in each of the years 2007 to 2009. 60

48 Carers UK’s State of Caring 2011
49 Facts about Carers, 2009, ibid
56 British Crime Survey 2009/10
Better Health for Women

- Direct physical health consequences of sexual violence and child sexual abuse include physical injury, sexually transmitted infections and unwanted pregnancy. Long-term consequences include post-traumatic stress disorder, anxiety and panic attacks, depression, social phobia, substance abuse, obesity, eating disorders, self-harm and suicide;
- Violence in the home can normalise violence in future relationships for both boys and girls, whereby boys think it is normal to be violent and girls think that it is normal to accept it;
- Women and girls affected by forced marriage may experience self-harm, panic attacks, depression, psychosis and trauma and gaps in responses can exacerbate mental health needs. The Government's review found that "health services do not engage or work proactively to ensure staff are able to identify cases of forced marriage".

Women's health needs over the life course

Understanding the health inequalities women face demands an understanding of the ways in which different groups of women face specific barriers to good physical and mental health across their life course:

Young women and girls

- Up to 13 per cent of children experience sexual abuse, physical abuse or neglect, with higher figures for girls than boys;
- Teenage girls and young women are at particular risk of traumatic experiences such as sexual abuse, rape and domestic violence and research shows women aged 16-19 are at the highest risk of experiencing domestic violence and sexual assault, yet relevant services are rarely available;
- Girls self-harm almost four times more than boys; one in five is unhappy with how they look; one in every 20 women will experience some form of eating distress during her lifetime, with the majority of sufferers aged between 14 and 25;
- Young women are twice as likely as young men to suffer a depressive disorder;
- Girls appear to have lower levels of life satisfaction than boys, and to worry more than boys. Over half (51 per cent) of 14-15 year-old girls worry about their appearance and nearly six out of ten (57 per cent) girls in this age group worry about exams and tests;
- Girls' disengagement from school is often a hidden and invisible problem. Physical and emotional withdrawal problems among girls, including anxiety and depression, are more easily overlooked than 'acting out' among boys.

59 FORWARD http://www.forwarduk.org.uk/key-issues/fm
62 www.nspcc.org.uk/inform
63 Department of Health (2002) ‘Women’s Mental Health: Into the mainstream’
67 Notes from Young People and Gender – a Review of the Research. A report submitted to: the Women’s Unit, Cabinet Office and the Family Policy Unit, Home Office (2001)

- Teenage mothers are three times more likely to develop postnatal depression and other mental health problems than older mothers, and are more likely to delay seeking maternity care by up to five months or more.

- The rate at which young women are drinking heavily has increased dramatically in the last 10 years. The proportion of girls who had five or more drinks on one occasion, three times or more in the past 30 days rose from 20 per cent in 1995 to 29 per cent in 2003 (compared to 24 per cent to 26 per cent for boys). Half of 15 year old girls reported being drunk in the past week compared to 37 per cent of boys.

- Heavy drinking puts women at risk of accidents and makes them vulnerable to assault. 12 per cent of girls reported having unprotected sex after drinking alcohol.

- Young women who were born with HIV have high rates of unwanted pregnancies and terminations - reflective of how their sexual and reproductive health and rights are not met in current services.

Adult women

- Poor mental health is a serious threat to women’s wellbeing, with 63 per cent of women having experienced some form of low-level mental health problem in their lifetime.

- Women are more than twice as likely to become depressed as men and more likely to experience depression for longer periods of time.

- Despite overall increases in midwife numbers over the last 10 years, they have failed to keep pace with the rising birth rate.

- Women in disadvantaged areas do not receive the same quality in care, which negatively impacts their (and their child’s) health.

- One in ten women reported significant depressive symptoms during pregnancy and a further 15 per cent of mothers experience postnatal depression.

Older women

- Although women have a longer life expectancy than men, they spend more years of their lives suffering from physical ill health or longer-term disability leading to restrictions in mobility and inability to care for themselves.

- Women in later life often live with the cumulative impact of poverty, having had lower earnings throughout their lives, and are more dependent on state pensions than older men.

- Older women are particularly vulnerable to the factors leading to poor mental health including poverty, social isolation, and chronic illness. They are more likely to have to live in care, and deal with the loss of loved ones. Older women have higher rates of mental health problems.

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70 DCSF (2008) ‘Children and Young People in Mind – the final report of the National CAMHS review’
71 Platform 51 (2011) ‘Health and wellbeing briefing’
72 Platform 51 (2010) ‘Young women and alcohol’
73 Platform 51 (2010) ibid
74 Kenny et al, Pregnancy outcomes in adolescents in the UK and Ireland growing up with HIV. HIV Medicine, December 2011
75 Platform 51 (2011) ‘Women like me: Supporting wellbeing in girls and women’
77 Royal College of Midwives, State of Maternity Report, 2011
79 National Mental Health Development Unit (2010) ‘Equalities in Mental Health’
20. Better Health for Women

than men - women aged 50 to 54 have the highest prevalence rates for any neurotic disorder (25 per cent).\(^{81}\)

Factors that increase marginalisation and vulnerability

Tackling the health inequalities women face requires a focus on the disparities between men and women, boys and girls, but also amongst different groups of women, some of whom face significant disadvantage and marginalisation. For example:

- **Women in prison**: more than half the women in prison have experienced domestic violence and one in three, sexual violence.\(^{82}\) Women in prison have high levels of mental distress – over half have severe and enduring mental illness and 47 per cent a major depressive disorder. A staggering 37 per cent of women in prisons said they had attempted suicide in their life and worryingly almost a third has had a previous psychiatric admission before they came into prison. Women in prison report high levels of sickness and poor health - 83 per cent of women in prison stated that they had long-standing illness compared with 32 per cent of the general female population and three quarters were on medication on arrival at prison.\(^{83}\) Prior to imprisonment 85 per cent of women were smokers, 75 per cent had used illegal drugs and 40 per cent drank alcohol in excess of the recommended limits. 52 per cent of women surveyed said that they had used heroin, crack, or cocaine powder in the four weeks prior to custody (this may be an under report as women fear that admitting to substance misuse may lead to losing their children).\(^{84}\) Early intervention and support for these women through focused health interventions could save the estimated annual cost per woman in a local prison of £42,477.\(^{85}\)

- **Women in prostitution**: women involved in prostitution suffer a range of complex issues that can lead to high levels of problematic drug use (87 per cent of women in street-based prostitution use heroin).\(^{86}\) These women have high levels of poor mental health\(^{87}\) and have a significant history of sexual and domestic violence – 85 per cent reported sexual abuse in the family and domestic violence. Sex work is also associated with a higher incidence of physical, sexual and emotional assault. Women involved in prostitution may face barriers to accessing sexual health services due to fear of discrimination and the fact that prostitution is still criminalised. Poverty, drug addiction, domestic violence and homelessness can also be significant barriers because of associated travel costs and the nature of appointment systems. Fear of losing custody of children may also deter them from approaching health professionals.\(^{88}\)

- **Asylum seekers and refugee women**: face significant barriers to wellbeing. They can be vulnerable to high levels of depression and anxiety as a result of experiences of trauma, violence, lost social support, discrimination and racist abuse and harassment in the UK. Women face significant barriers to healthcare as a result of a lack of accessible information, language barriers, a lack of clarity of entitlement to services, low incomes and vulnerability


\(^{83}\) Prison Reform Trust (2012) ‘Bromley Briefing Prison Factfile’

\(^{84}\) Ibid, 2012


\(^{87}\) Department for Health (2002) Women’s mental health: into the mainstream, Strategic development of mental healthcare for women’

\(^{88}\) Matrix Project (for Sex Workers), Norfolk Community Health and Care NHS Trust, [http://www.norfolkcommunityhealthandcare.nhs.uk/our-services/adult-services/adult-h-m/matrix-project/](http://www.norfolkcommunityhealthandcare.nhs.uk/our-services/adult-services/adult-h-m/matrix-project/)
to domestic violence and abuse. Asylum seeker and refugee women make up 12 per cent of all maternal deaths and 0.03 per cent of the population. Migrant women: migrant groups are diverse and this goes beyond ethnicity. They include dispersed asylum seekers, refugees, seasonal agricultural workers, students, ‘Tier 1’ (highly skilled) migrant workers, dependants joining already settled family members, people with irregular migration status such as those who have overstayed their visa or who are working in breach of their visa conditions, women who have left violent partners and have no recourse to public funds, and people from inside and outside the EU. Local areas vary according to the size and distribution of these groups in their population.

BMER women: Black, Minority Ethnic and Refugee Women (BMER) face the double disadvantage of ethnicity and gender. For example, black women over 65 face higher risk of cervical cancer than white women. Additionally women with no recourse to public funds are at particular risk of poor maternal and infant health. Black African women face a rate of maternal deaths six times that of white women. Women from some South Asian communities face higher rates of cardiovascular disease and significantly higher rates of cervical and mouth cancer. BMER women are disproportionately affected by HIV: in 2011 an estimated 20,200 African-born women were living with HIV in the UK (two thirds of all women with HIV in the UK). This adds a further layer of marginalization, because of the high levels of stigma around HIV within African communities and society at large.

Gypsy and Irish Traveller women live twelve years less than women in the general population (compared to ten years less for Gypsy and Irish Traveller men).

Lesbians and bisexual women: lesbians and bisexual women report high levels of dissatisfaction with the health system and discrimination by healthcare professionals. They face barriers to accessing breast screening and have higher rates of breast cancer. They also face barriers to appropriate sexual health services and being open about their sexual orientation with GPs. Lesbians and bisexual women have higher incidents of alcohol use and report higher rates of depression and anxiety, as well as suicide and suicidal thoughts.

Disabled women: disabled women face significant barriers to good health and discrimination. They face barriers to accessing birth control and family planning and in having control over care and treatment. Disabled women face a high risk of violence and spend longer periods of time in institutions than disabled men as they are less likely to be cared for by a partner.

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89 Refugee Council (2005) ‘Refugee and Asylum Seeking Women: challenges, changes, choices’
91 Lewis, G (ed) (2007) ibid
93 British Heart Foundation (2010) ‘Women and Heart Disease’
100 Stonewall (2008) ibid
Women living with HIV: in spite of the advancement of Anti Retro Viral therapy, which has greatly improved life expectancy, women living with HIV in the UK still face a huge burden of stigma and discrimination, including accessing health care services,\textsuperscript{102} and are extremely vulnerable to gender-based violence.\textsuperscript{103} Because of complex factors, including small numbers of women in clinical trials, HIV-positive women have worse outcomes in relation to treatment and are more likely to discontinue their medications.\textsuperscript{104} HIV-positive women suffer from institutional discrimination which makes it hard for them to access services. The pregnancy rate among women accessing HIV clinical care increased in 2000-2009. HIV-positive women with, or planning, a pregnancy require a high level of care and this is likely to continue and increase as more women of older age have pregnancies.\textsuperscript{105}

**Barriers to health services**

Women face many barriers to accessing health and social care, which can delay treatment and make their health worse:

- women often have time constraints as a result of caring for others which may mean they do not receive the care they need;

- women who are suffering domestic violence and sexual abuse may face barriers to accessing health and social care services. There is a lack of funding for women-only spaces, without which some women will be put off accessing services;

- women within mainstream services experience a lack of security in their relationships with professionals. This is especially important for women with mental health needs and complex needs because they have often experienced abusive relationships and abuse of their trust. Therefore services that do not build ‘relational security’ between workers and women may leave women isolated and unwilling to trust the service provider. This was acknowledged as important in the Department of Health policy document ‘Into the Mainstream’;\textsuperscript{106}

- many women (in particular young, BMER and/or women who are experiencing poverty) report being judged or having received inappropriate responses from healthcare professionals. Experiences of discrimination mean women do not receive the service they need and their health is put at risk;\textsuperscript{107}

- BMER women are less likely to receive appropriate and useful information about services and experience less continuity of care as a result. Women who are less proficient in English face language barriers and receive inadequate translation services that limit their ability to access care;\textsuperscript{108}

- migrant women who are charged for health care are not only deterred from seeking help, but their needs are rendered invisible: women who are chargeable are less likely to appear in data collected from health services. Charging regimes often lead to increased costs overall;\textsuperscript{109}

\textsuperscript{102}Ibid
\textsuperscript{103}Petretti et al 2012 http://www.bhiva.org/documents/Conferences/2012Birmingham/Presentations/Posters/Age-Gender- and-Migration-related-Issues/P50.pdf
\textsuperscript{104}Barber TJ et al. Antiviral Therapy 2011 (in press)
\textsuperscript{105}Predictors of pregnancy and changes in pregnancy incidence among HIV-positive women accessing HIV clinical care at 13 large UK clinics, Huntington, et al, 2012, on behalf of the UK Collaborative HIV Cohort (UK CHIC) Study and the National Study of HIV in Pregnancy and Childhood (NSHPC)
\textsuperscript{107}Imkaan (2010) ‘Dispelling myths, Speaking Truths’
\textsuperscript{108}Bharj, K et al (2008) ‘Addressing ethnic inequalities in maternity service experiences and outcomes: Responding to women’s needs and preferences’
\textsuperscript{109}WHEC and Maternity Action (2012) Guidance For Commissioning Health Services For Vulnerable Migrant Women
• another barrier to accessing care is some health professionals’ lack of cultural competence and effective engagement in terms of responding to the health needs of BMER communities, which affect overall attitudes to women’s care. For example, a lack of competence can include making cultural assumptions or being over sensitive about culture which can lead to professionals not knowing how to intervene appropriately or not intervening at all. Women may also find it difficult to disclose health problems associated with FGM due to fears of embarrassment and being judged;\textsuperscript{110}

• women living with HIV face multiple stigma and discrimination and are much less likely to ‘come out’ about their condition. They have complex and growing health needs (as people with HIV are living longer and facing an old age aggrevated by HIV and HIV medications, socio economic factors etc.) They often belong to other disadvantaged groups like black and ethnic minority and refugee women, drug users, or women involved in prostitution. They will access health services frequently but may remain invisible as a group, as the fear of their HIV status being known locally to schools, neighbours, employers and landlords can be paralyzing. Unlike other types of disability, HIV has serious public health implications. It affects a small number of people but is very expensive to treat (partly because treatment is lifelong). Specific prevention plans are needed for those groups of women who are much more vulnerable to HIV infection.

\textsuperscript{110} FORWARD (2009) ‘FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London: Results from a PEER Study’
Case studies: Sources of Information

We thank Imkaan for the first three case studies.  

Example of targeted casework and refuge support

Solace, Irish Travellers Outreach & Resettlement Service meets the gap in service provision for Irish Traveller women and children who are experiencing violence, including ‘honour’-based violence and forced marriage. Women can access refuge provision, resettlement support, advocacy, and translation. Over the last year the worker had 138 active cases and this figure is increasing. Many of the women find out about the service through word of mouth and from other women who have been assisted before. Women trust and value the service’s approach, flexibility and understanding of the context in which they are facing violence. Solace provides the only dedicated service for the Irish travelling community.

Example of female genital mutilation (FGM) awareness-raising and early intervention

African Advocacy Foundation takes a ‘whole family approach’ to female genital mutilation (FGM) prevention. Women are supported to overcome the trauma, stigma and other barriers that prevent them accessing treatment for medical complications of FGM whilst also accessing support and advice on domestic violence. Early intervention through relationship-building is critical to their approach. Birthing/naming ceremonies, weddings, and community events provide avenues for engagement on FGM. Last year, they supported 600 women with FGM; 300 women through a peer-support group; 122 through the DV support programme and 66 women received counselling and advice.

Example of early identification and referral of domestic violence

IRIS is based at the nia project in Hackney. The Identification & Referral to Improve Safety project delivers a primary care domestic violence and abuse (DVA) educational and support programme for general practices to help them identify and refer patients who are experiencing, or who have experienced, DVA. An electronic prompt is used, which appears in the patient medical record, is linked to health symptoms of DVA, and acts as a reminder to enquire about DVA and to ask a safety question. IRIS also provides care pathways for all patients living with DVA and specialist advocacy for female survivors. IRIS is a partnership between third sector specialist agencies and primary care.

Example of targeted engagement with young women

Northumberland Young People’s Health Project organised focus groups involving young women and young men separately to produce qualitative data relating to their experiences, opinions, perceptions and needs as users of the Health Service.

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http://imkaan.org.uk/resources
Annex C

The Women's JSNA for Hertown

Background

Hertown is a town of 200,000 people on the edge of a large conurbation (Manningham), in north-west England.

How we developed this JSNA

Women make up 51 per cent of Hertown, but they are not a homogenous group, and they are underrepresented in decision-making forums (for example, only 16 per cent of our councillors are women, and none of them is in the Cabinet). We looked at the draft mandate\(^{112}\) to the NHS Commissioning Board and we note that it highlights the requirement under the Health and Social Care Act 2012 for the Board and CCGs to "promote the involvement of patients and carers in decisions about their treatment and care, and to act with a view to enabling patients to make choices about their healthcare".

So in developing this JSNA, we first talked to women's organisations that had experience of women's health issues in our community.

From them, we learnt that there were no real mechanisms to identify women's health needs and include them in strategic priorities, and there was a strong perception that statistics about women's health were not used to inform JSNAs.

We were told that especially within the more rural communities on the outskirts of the town it is difficult for women to access services due to lack of public and private transport, childcare problems, and travel costs. We held an on-line survey of organisations that try to help women, which showed that they felt their ability to influence the setting of strategic priorities and participate in the JSNA and JHWSs process was limited; they also gave us ideas about how this could be improved.

We looked at the basic health indicators for our area (for example, our health profile).\(^ {113}\) We looked at existing advice and guidance on women's health issues (for example, the Royal College of obstetricians and gynaecologists' report on women's health)\(^ {114}\) and on equalities (for example, The Equality and Human Rights Commission's guidance on health care and social care services).\(^ {115}\) We looked at the Health and Social Care Information Centre health indicators\(^ {116}\) (previously available on the Clinical and Health Outcomes Knowledge Base website (also known as NCHOD)).

\(^{112}\) The Health and Social Care Act 2012 requires the Board Our NHS care objectives: A draft mandate to the NHS Commissioning Board and CCGs to promote the involvement of patients and carers in decisions about their treatment and care and to act with a view to enabling patients to make choices about their healthcare.


\(^ {116}\) Compendium of Population Health Indicators ( GP Practice data, Local Basket of Inequalities Indicators (LBOI), NHS Outcomes Framework, Summary Hospital-level Mortality Indicator (SHMI) https://indicators.ic.nhs.uk/webview/
We drew extensively on data in the Marmot Review.\textsuperscript{117} We used a simple description of the Health equity audit\textsuperscript{118} process on the NICE website. The aim of the health equity audit is for partners to:

- systematically review inequities in the causes of ill health, and access to effective services and their outcomes, for a defined population;
- ensure that further action is agreed and incorporated into policy, plans and practice;
- review actions taken to assess whether inequities have been reduced.

**Health equity audit**

We used the NICE working definitions of health inequality and health inequity which describe differences in health experience and health outcomes between different population groups – according to socioeconomic status, geographical area, age, disability, gender or ethnic group. In contrast, health inequity describes differences in opportunity for different population groups which result in unequal life chances, access to health services, nutritious food, adequate housing and so on. These can lead to health inequalities.

Health equity audits focus on how fairly resources are distributed in relation to the health needs of different groups. (This may include resources such as services, facilities, and the determinants of health, like employment and education). The overall aim is not to distribute resources equally, but rather in relation to need. Changes in investment and services as a result of health equity audits will aim to reduce avoidable health inequalities and promote equal opportunity to the determinants of good health, access to health and other services.

**Including women's voices**

We set up a wide-ranging expert stakeholder group to address women’s particular health needs and access advice and frontline knowledge about specialist areas of health needs for women, and groups of women in the communities within Hertown who do not normally access health services.

This helped us to:

- build on national data and begin to identify the local picture and gaps in gender segregated data;
- identify new sources of data on women's health needs (e.g. through user statistics kept by frontline service providers in the women’s sector);
- consult with women in the community directly and indirectly, through community groups and specialised service providers.

The expert advisory group (now established as the Hertown Women’s Health Forum) included:

- New Hertown Estate Tenants’ Association
- New Hertown Estate Mother and Baby Group
- Manningham Black Sisters
- Hertown Women's Institute
- Platform 51
- Hertown Refugee Project
- Manningham Rape Crisis and Incest Centre


\textsuperscript{118} Health Equity Audit Made Simple: A briefing for Primary Care Trusts and Local Strategic Partnerships Working document January 2003, \url{http://www.nice.org.uk/niceMedia/documents/equityauditfinal.pdf}
Better Health for Women

- Mind (Hertown Group)
- Hertown Citizens Advice Bureau
- Hertown Crisis Service for Women (supporting girls and women in emotional distress)
- The Carers Centre for West Manningham and Hertown
- Health Watch

On the basis of the evidence and analysis in Annex A, we worked with the Women’s Health Forum to identify key priorities to be tackled over the next 10 years.

Summary priorities

As this is our first woman's JSNA we have identified just two key initial areas for action: mental health and violence against women and girls (VAWG). We have decided we need to prioritise improving and strengthening our gender analysis capability, so we have therefore also created a new priority of mainstreaming a gender analysis into our other priorities. In addition, we have decided to commission additional data collection to fill gaps in local gender disaggregated data, to better inform our next set of priorities.

Process of selecting priorities

These two priorities, mental health and VAWG, were drawn up in consultation with the Women’s Health Forum who have also helped us to organise a number of women’s focus group discussions and three open events for women. In order to ensure that we reached out to all sections of the community, we held specific focus groups in partnership with organisations dedicated to providing services for particular sections of the community, such as young BME women; Gypsy and Travelling women; lesbians within the Muslim community; women who were experiencing violence; women with mental health issues; and women involved in prostitution. We ensured that a number of special arrangements were in place to allow such women to attend easily. Where possible, we funded grassroots organisations that work within these minority and sometimes hidden communities, and are trusted by them, to host and organise the event. We ensured that any special dietary requirements were catered for; that access arrangements were suitable for disabled women; and that prayer rooms were available. We also endeavoured to avoid holding these events on the dates of religious festivals. We arranged for professional interpreters to be available during the focus groups to enable women whose first language was not English to participate. We provided funds for support workers to attend the focus groups to give support to women with a learning disability or other support needs. Because of confidentiality issues, these support workers stayed outside the room where the focus group discussion was taking place until it was absolutely necessary for his or her presence in the focus group itself. For women with caring responsibilities, we provided crèche facilities.

Next steps

This JSNA, and these priorities, will feed into the HWBS and will be developed in more detail for implementation.

Priority one

Mental Health. Put the expertise and experience of women service users at the heart of the planning and delivery of mental health services for women; identify women with mental health needs from all parts of the community, for example, migrant women/asylum seeking women; women involved in prostitution; women carers, including women with children; Gypsy and Traveller women; women with disabilities; lesbians; transgender women; older women; women offenders. women involved in substance misuse, and adult women survivors of childhood sexual abuse. Review existing service provision for its accessibility and effectiveness in meeting the diverse needs of these women, and consider the safety of women patients during treatment in clinical settings, from violence and abuse by other patients, visitors, intruders or staff members. Work in partnership with local women's organisations with expertise in mental
health to commission tailored women only services within the community as appropriate. Definition of services could include:

- talking therapies
- advocacy
- women’s support groups
- art and writing groups
- telephone counselling

These are specialist women’s services.

**Priority two**

**Violence against Women and Girls (VAWG)**[^119] — we aim to implement the recommendations of the Alberti Review.[^120]

Appoint a single designated point of contact at all relevant levels (strategic and operational) to advise on appropriate services, care pathways and referrals for all victims of violence and abuse, providing urgent advice in cases of immediate and significant risk; improve the early identification of victims; enhance the quality of and access to services, both those which are provided within the NHS and those which are commissioned from external community-based service providers.

Consider the breadth of forms of VAWG, including the specific needs of minority and vulnerable groups such as black and ethnic minority women, older women, and disabled women; commission prevention initiatives, including those which raise awareness of violence against women and children; include this issue in induction and continuing training and development (where possible carried out by appropriate voluntary sector VAWG organisations, in partnership with relevant health professionals); and work together with other agencies (including specialist VAWG services, and BME VAWG services) to ensure that appropriate services are available to meet the needs of all women and girl victims of violence and abuse, to include the commissioning of women-only service provision from grassroots organisations working in the VAWG services sector.[^121] Meet with women’s voluntary and community organisations to access information and relevant data linked to the needs of service users.

**Gender analysis of other JSNA priorities**

Gender training for frontline professionals and commissioners, within the context of the broader equalities framework; setting up a subgroup to work on the implementation of gender mainstreaming and this JSNA, and work with the health and wellbeing board to translate the outcomes of the assessment into the HWBS. Ensure that outcomes-based commissioning includes a gender analysis. Build our capacity to undertake gender sensitive costings to identify the return on investment in women’s health initiatives.

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[^119]: We used the resources available on the NHS primary care commissioning website page on commissioning services for women and girls who are victims of violence http://www.pcc.nhs.uk/violence, and Commissioning services For Women And Children Who Have Experienced Violence Or Abuse – A Guide For Health Commissioners Golding, Duggal, Dept of Health, 2011.


[^121]: In developing specific actions on this priority, we drew on the recommendations in the Report of the Task Force on the Health Aspects of Violence against Women and Children, 2010 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113727
Research: we will work with the Women's Health Forum, local Healthwatch and the Police and Crime Commissioner to identify key gaps in local information, determine a methodology to collect this missing information, and commission data collection accordingly. Our initial work indicates an absence of intersectional data on local women in disadvantaged groups (such as Traveller women, women involved in prostitution, homeless women, women involved in substance abuse, women living with HIV/AIDS).

Our Analysis of Women’s Needs

<table>
<thead>
<tr>
<th>Issues</th>
<th>Data Sources</th>
<th>Gender Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing the local population of women and girls</td>
<td>Population Estimates for UK (age and gender profile) 122, ethnicity and sex profile 123, School Census 124</td>
<td>There is an above-average number of women of childbearing age in the Hertown population. We have a higher than average number of mixed race, Black or Black British women.</td>
</tr>
<tr>
<td>Women living in poverty</td>
<td>The Impact of the Economic Downturn and Policy Changes on Health Inequalities in London 125</td>
<td>Poverty is associated with worse mental health outcomes (including sleep deprivation and depression among new mothers). This is particularly the case for women because they are more likely than men to handle family budgets, have caring responsibilities and are often the 'shock absorbers' of reduced family incomes, meaning that they 'go without' to protect their children from the worst effects of poverty.</td>
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</table>

Women's needs within mainstream JSNA priorities

<table>
<thead>
<tr>
<th>Issues</th>
<th>Data Sources</th>
<th>Gender Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>British Heart Foundation 126</td>
<td>One in three women die from cardiovascular disease (similar to men), yet they are less likely to think they are at risk, call for help or attend a cardio rehabilitation programme.</td>
</tr>
<tr>
<td>Smoking</td>
<td>ONS 127</td>
<td>In the last 20 years, the rates of smoking and lung cancer fell sharply for men, yet at the same time, rates increased and stabilised for women. More young women (age 16-19) smoke and so are at risk of lung cancer, compared to young men.</td>
</tr>
</tbody>
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124 http://www.education.gov.uk/rsgateway/sc-schoolpupil.shtml
126 Women and Heart Disease, British Heart Foundation, 2010
<table>
<thead>
<tr>
<th>Issues</th>
<th>Data Sources</th>
<th>Gender Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Department of Health [128]</td>
<td>Women are at relatively greater risk of dying than men. This may be because gender compounds other inequalities, such as poverty, and socio-economic differences, which are linked to differences in smoking rates, food choices and the prevalence of obesity. Women are less likely to receive routine surveillance checks for the long-term complications of diabetes.</td>
</tr>
<tr>
<td>Mental health</td>
<td>Women more at risk than men, by 4% [129]</td>
<td>Hard for rural women to access services: 25% of men but 40% of women have no car in household; no driving licence. [130]</td>
</tr>
<tr>
<td>Mental health for girls</td>
<td>Platform 51 [131]</td>
<td>Platform 51 report on the triggers for mental health problems in girls. In England and Wales 63% of the girls and women surveyed had been affected by mental health problems.</td>
</tr>
<tr>
<td>Mental health and ethnicity</td>
<td>Imkaan, Equality Now and City University [132]</td>
<td>Links between self-harm, anxiety, depression, post-natal depression, psychosis and trauma, and forced marriage, ‘honour-based’ violence and FGM.</td>
</tr>
<tr>
<td>Mental health and ethnicity</td>
<td>Department of Health research on Gypsies and Travellers [133]</td>
<td>Gypsy/Traveller women twice as likely as men to be anxious, even when education, smoking and carer status was taken into account.</td>
</tr>
<tr>
<td>Mental health and ethnicity</td>
<td>‘Recovery and Resilience’ Mental Health Foundation [134]</td>
<td>Case studies on successful recovery of mental health of women from BME communities.</td>
</tr>
<tr>
<td>Self-harm – by age</td>
<td>Hertown Crisis Service for Women, service user statistics</td>
<td>Young people: 10% of 15 to 16 year olds have self-harmed; girls are far more likely to self-harm.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In the UK at least one in every 15 young people has experience of self-injury. That is two young people in every classroom. [135]</td>
</tr>
</tbody>
</table>

[127] Focus on Gender, 2008, ONS
<table>
<thead>
<tr>
<th>Issues</th>
<th>Data Sources</th>
<th>Gender Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-harm – by sexual orientation</td>
<td>Stonewall survey, 2008, gives national and local incidence</td>
<td>One in five lesbian and bisexual women self-harmed in the last year, against 0.4 per cent of general population. For the North West the average is slightly higher – 22%. and for Hertford higher again at 27%.</td>
</tr>
<tr>
<td>Self-harm – by ethnicity</td>
<td>Newham Asian Women’s Project</td>
<td>A mix of environmental/personal factors impact the emotional health of young women between 11-25: domestic and sexual violence, racism, bullying, family/home life, education, work/employment, and refugee status. The issues do not vary between ethnic groups but accessing support is more difficult for young South Asian women.</td>
</tr>
<tr>
<td>Autism spectrum disorders</td>
<td></td>
<td>Boys with autism mostly diagnosed between 5-7. Girls diagnosed in adolescence or adulthood, if at all.</td>
</tr>
<tr>
<td>Carers health</td>
<td>Census data, Carers UK data</td>
<td>58 per cent of carers are women. One in four women aged 50-59 is providing some care compared with 18 per cent of men. Women have a 50:50 chance of providing care by the time they are 59; compared with men who have the same chance by the time they are 75 years old. Women are more likely to give up work in order to care.</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>BEAT</td>
<td>Around 1.4 million women are affected by an eating disorder in the UK.</td>
</tr>
</tbody>
</table>

### Women’s specialist health needs

<table>
<thead>
<tr>
<th>Issues</th>
<th>Data Sources</th>
<th>Gender Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td>ONS</td>
<td>Women living in deprived areas have a lower survival rate for breast cancer and inequalities in rates of breast cancer are increasing.</td>
</tr>
<tr>
<td>Maternity &amp; infant mortality</td>
<td>Department of Health commissioned research on Gypsies and Travellers</td>
<td>Excess prevalence of miscarriages, stillbirths, neonatal deaths and premature death of older offspring.</td>
</tr>
</tbody>
</table>

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http://www.stonewall.org.uk/what_we_do/research_and_policy/3101.asp

**137** Prescription for Change: Lesbian and bisexual women’s health check 2008: Supplementary Report, North West England  

**138** Painful Secrets – A qualitative study into the reasons why young women self-harm and Everybody Hurts – A training DVD on young people and self-harm  

**139** Research Autism, citing Prof C Gillberg’s research on under-diagnosis of autism in women and girls.  
http://www.researchautism.net/pages/about_research_autism/research_autism_press_office/research_autism_news_release_20100225

**140** Statistics from Carers UK, taken from the 2001 census

**141** Source: It could be you, Carers UK 2000,  

**142** Beating Eating Disorders,  
http://www.beat.co.uk/about-beat/media-centre/facts-and-figures/

**143** Focus on Gender, 2008, ONS
### Better Health for Women

#### Issues

<table>
<thead>
<tr>
<th>Maternity &amp; infant mortality</th>
<th>Data Sources</th>
<th>Gender Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>8th report on confidential enquiries into maternal deaths in the UK</td>
<td></td>
<td>Asylum seeker and refugee women make up 12 per cent of all maternal deaths and 0.03 per cent of the population.</td>
</tr>
</tbody>
</table>

| Abortion | WHEC briefing | Teenage pregnancy rates are at their lowest level since 1981. Half of conceptions to under 18s result in abortion. Abortion rates are highest for women aged 19-20 (3.3%). Rates are also high (3%) for women aged 20-24 who are at the peak of their fertility and increasingly less likely to be actively considering starting a family than previously. There is also a demand for abortion for women in their late twenties – the rate for women aged 25-29 is 23 per 100. Less than 1% are to women aged 15 or under. The vast majority of abortions (91%) are carried out in the first 13 weeks of pregnancy. In 2010, 77% were carried out in the first 10 weeks, compared to only 58% in 2000. However, there is still a need for women to access abortion at later gestations. In 2010, approximately 9 percent of abortions took place in the second trimester of pregnancy because continuing the pregnancy posed a risk to the physical or mental health of the woman or there was a risk to the health of the child if it were born. However, risk of complication increases, the later the gestation. |

| Sexual and reproductive health | Stonewall Lesbian Health Survey | Less than half of lesbian and bisexual women have ever been screened for sexually transmitted infections. Half of those who have been screened had an STI and a quarter of those with STIs have only had sex with women in the last five years. |

| FGM | National prevalence figures | FGM uniquely affects women. In Hertown, there is a small community where FGM has traditionally been practised. The women in this community are mainly of childbearing age and there is a high number of children under 15. |

| FGM | Service user statistics, Hertown Black Sisters; Hertown Refugee Project | Evidence that girls are being taken overseas in the summer holidays for FGM, with long-term impacts on their physical and mental health. |

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<table>
<thead>
<tr>
<th>Issues</th>
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<th>Gender Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual violence</td>
<td>National prevalence figures, Home Office website</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Commissioning guidance on SARCs/victims services 148</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manningham Rape Crisis Database</td>
<td>Demand for services for rape, sexual violence and legacies of child sexual abuse outstrip support services.</td>
</tr>
<tr>
<td></td>
<td>ROTA 149</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Children’s Commissioner 150</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hertown Crisis Service for Women, service user statistics</td>
<td>Girls subject to rape and sexual violence.</td>
</tr>
<tr>
<td></td>
<td>National prevalence figures, Home Office website</td>
<td></td>
</tr>
<tr>
<td>Domestic violence by ethnicity</td>
<td>Saheli Project, Manchester 151</td>
<td>90% of South Asian Women surveyed reported having endured domestic violence at some time in their life, while 31 (39%) were still in an abusive relationship. An overwhelming majority of the women interviewed perceived a direct causal link between their experiences of domestic violence and their mental health problem.</td>
</tr>
</tbody>
</table>

148 Commissioning services for women and children who have experienced violence or abuse – a guide for health commissioners, Golding and Duggal, Dept of Health, 2011.  
http://c466622.workcast.net/10067_Commissioning_services_for_women_and_children_who_experience_violence_or_abuse_%E2%80%93_a_guide_for_health_commissioners_20110211163144.pdf


150 http://www.childrenscommissioner.gov.uk/info/csegg1

151 Community Engagement Project (NIHME Mental Health programme), Domestic violence and mental health: experiences of South Asian women in Manchester: Report on the community-led research project focusing on the mental health needs of South Asian women who are survivors of domestic violence, 2009, Saheli Asian Women’s Project, Manchester,  
### Issues | Data Sources | Gender Analysis
---|---|---
Domestic violence by ethnicity | University of Warwick and Imkaan [152] | The report profiles the experiences of 183 women and 242 children from different regions of the UK experiencing different forms of VAWG and records BME women’s interactions with mainstream voluntary and statutory services. Key findings: violence has a significant impact on women’s emotional, mental and physical health. 75% report depression; 34% report nightmares/flashbacks; 20% report suicidal thoughts, 18% attempted suicide, 13% self-harm; 19% eating disorder. The majority (89%) stated that their mental health had improved whilst accessing BME specialist VAWG services.

‘Honour’-based violence | Metropolitan Police 2010, Greater London (exc. City of London) [153] | No published UK statistics. In London, 2009/10, there were a total of 477 allegations of ‘honour’-based violence. In 12% of these allegations, the victim was aged under 18.

Bed spaces in refuge | Hertown women’s/ PCC statistics on refuge bed spaces | Existing bed spaces in Hertown refuge do not meet demand.

Forced marriage | Forced marriage Practice Guidance for Health professionals [154] | Most cases involve young women and girls aged between 10 and 30. About 85 per cent of those helped by the National Forced Marriage Unit are women.

Refugee women | Hertown Refugee Project | The majority of the women in the small refugee population in Hertown come from rural villages with poor health provision. Most have chronic health problems and do not have English as a first language.

Migrant women | Guidance on commissioning health services for Vulnerable Migrant Women [155] | Problems of access, late presentation and poor management of serious conditions generate costs such as inappropriate and excessive use of A & E services, urgent admissions, care of low birth and preterm babies or caesarean sections in maternity services. For example the estimated average cost of an emergency caesarean section is £2,539 per birth, compared with an average cost of £1,324 per normal delivery without complications and comorbidities.

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153 Commissioning Services for Women and Children Who Have Experienced Violence or Abuse, op. cit.

154 Dealing with cases of forced marriage, Practice Guidance for Health Professionals, 2007, Foreign & Commonwealth Office, Department of Health, NHS

### Better Health for Women

<table>
<thead>
<tr>
<th>Issues</th>
<th>Data Sources</th>
<th>Gender Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled women</td>
<td>Women’s Aid(^\text{156})</td>
<td>Women with disabilities face particular barriers to accessing domestic violence services.</td>
</tr>
<tr>
<td>Women with learning disabilities</td>
<td>Respond(^\text{157}), Change People(^\text{158})</td>
<td>Women with learning disabilities face significant health inequalities including a lower life expectancy; higher risks of violence and abuse; barriers to accessing health services (including screening, sexual and reproductive health services; maternity services).</td>
</tr>
<tr>
<td>Traveller Women</td>
<td>Department of Health commissioned research, EHRC research report</td>
<td>Reported health problems in the Gypsy and Traveller population between 2-5 times more than in general population. Housing problems impact on health through difficulty in accessing services and ability to register with a GP.(^\text{159}) Gender roles are strongly delineated. Women’s access to health care may be affected by restrictions on their autonomy, so that gender awareness is an important part of cultural diversity training. Need for sensitive and culturally appropriate services relating to sexual and reproductive health and gender violence.</td>
</tr>
<tr>
<td>Lesbians</td>
<td>Stonewall report</td>
<td></td>
</tr>
</tbody>
</table>

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\(^{156}\) [http://www.womensaid.org.uk/domestic-violence-articles.asp?itemid=1722&itemTitle=Making+the+links%3A+disabled+women+and+domestic+violence\&section=00010001002200080001&sectionTitle=Articles%3A+disabled+women](http://www.womensaid.org.uk/domestic-violence-articles.asp?itemid=1722&itemTitle=Making+the+links%3A+disabled+women+and+domestic+violence\&section=00010001002200080001&sectionTitle=Articles%3A+disabled+women)  
\(^{157}\) [http://www.respond.org.uk/](http://www.respond.org.uk/)  
\(^{158}\) [http://www.changepeople.co.uk/](http://www.changepeople.co.uk/)  
\(^{159}\) The Health Status of Gypsies & Travellers in England, Ibid
Annex D

Useful Links

The Daisy Network
Provides support and information for women who have experienced a premature menopause.

www.daisynetwork.org.uk

End Violence against Women Coalition
The End Violence Against Women Coalition is a coalition of organisations and individuals working to end all forms of violence against women.

http://www.endviolenceagainstwomen.org.uk/resources

Equality and Human Rights Commission
The EHRC has a statutory remit to promote and monitor human rights; and to protect, enforce and promote equality across the nine "protected" grounds - age, disability, gender, race, religion and belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment.


Fawcett Society
Fawcett campaigns for equality between women and men.


Forward UK
Foundation for Women's Health Research and Development is an African Diaspora women-led charity safeguarding the sexual and reproductive health and rights of African girls and women, including female genital mutilation (FGM), and child marriage.

http://www.forwarduk.org.uk/

The Government Equalities Office
The Government Equalities Office (GEO) promotes equality of opportunity and equal treatment, putting equality at the heart of government.

http://www.homeoffice.gov.uk/equalities/equality-government/

Guidance on Commissioning Health Services for Vulnerable Migrant Women

The Hysterectomy Association
www.hysterectomy-association.org.uk
**37. Better Health for Women**

**Imkaan**
The national Black, Minority Ethnic and Refugee (BMER) charity addressing violence against women and girls.
http://imkaan.org.uk/resources

**Maternity Action**
Maternity Action works to end inequality and promote the health and well-being of all pregnant women, their partners and children from before conception through to the child’s early years.
http://www.maternityaction.org.uk/index.html

**Medicine Guide**
Medicines used to manage the menopause.
www.medicines.org.uk/guides

**Menopause Matters**
www.menopausematters.co.uk

**The National Osteoporosis Society (NOS)**
www.nos.org.uk

**Platform 51**
Platform 51 works with the most disadvantaged women and girls in England and Wales.
http://platform51.org/

**Positively UK**
Positively UK champions the rights of people living with HIV and related conditions and coordinates PozFem UK the national network of women living with HIV.
http://www.positivelyuk.org/index.php

**Rape Crisis (England and Wales)**
Rape Crisis (England and Wales) is the national umbrella organisation for Rape Crisis Centres across the country.
http://www.rapecrisis.org.uk

**Royal College of Obstetricians and Gynaecologists**
http://www.rcog.org.uk/womens-health/

**Wish - a voice for women’s mental health**
Wish is a national, user-led charity working with women with mental health needs in prison, hospital and the community. It provides independent advocacy, emotional support and practical guidance, and acts to increase women's participation in the services they receive, and campaigns to get their voice heard at a policy level.
www.womenatwish.org.uk

**Women's Health Concern**
Provides an independent service to advise women of all ages about their health, wellbeing and lifestyle concerns, to enable them to work in partnership with their own medical practitioners and health advisers.
http://www.womens-health-concern.org/index.html

Women’s National Commission
The WNC, now disbanded, was the Government’s independent advisory body on women. Its report ‘A bitter pill to swallow’ reports women’s views on health and inequality.


Women's Resource Centre
Supports women’s organisations to be more effective and sustainable.

http://www.wrc.org.uk/
Annex E

The legal context

The Health and Social Care Act, 2012

Extract from Factsheet C2\textsuperscript{160} on healthcare and inequalities and the Health and Social Care Act 2012.

The Act enshrines in legislation for the first time, explicit duties on the Secretary of State, NHS Commissioning Board and clinical commissioning groups (CCGs) to have regard for the need to reduce inequalities in the benefits which can be obtained from health services. The duty on the Secretary of State extends to functions in relation to both the NHS and public health. The duties on the Board and CCGs incorporate both access to, and benefits from, healthcare services.

The Act puts clinicians in charge of shaping services. A number of CCG’s key responsibilities are directly designed to help reduce health inequalities:

i. Promoting integration. The Board and CCGs will be responsible for promoting better integration of health services with health, social care and other health-related services – where this would improve service quality or reduce inequalities.

ii. Quality reward. The NHS Commissioning Board will be able to reward CCGs for providing high quality services, for improving outcomes and reducing inequalities.

iii. No decision about me, without me. The Board and CCGs will be required to involve the public in the planning of commissioning arrangements and proposals to change those arrangements.

Equality Act 2010

Section 149 of the Act sets out the Public Sector Equality Duty, which consists of a general equality duty that came into force on 5 April 2011. Specific duties came into law in England through secondary legislation on the 10th September 2011.

Those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and those who do not;
- foster good relations between people who share a protected characteristic and those who do not.

These are sometimes referred to as the three aims or arms of the general equality duty. The Act explains that having due regard for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics;
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people;

\textsuperscript{160} www.dh.gov.uk/healthandsocialcarebill
• encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The Act states that meeting different needs involves taking steps to take account of disabled people’s disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups. It states that compliance with the duty may involve treating some people more favourably than others.

The duty covers the following eight protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Public authorities also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status. This means that the first arm of the duty applies to this characteristic but that the other arms (advancing equality and fostering good relations) do not apply.

Purpose of the general equality duty

The broad purpose of the equality duty is to integrate consideration of equality and good relations into the day-to-day business of public authorities. If you do not consider how a function can affect different groups in different ways, it is unlikely to have the intended effect. This can contribute to greater inequality and poor outcomes.

The general equality duty therefore requires organisations to consider how they could positively contribute to the advancement of equality and good relations. It requires equality considerations to be reflected into the design of policies and the delivery of services, including internal policies, and for these issues to be kept under review.

The Equality and Human Rights Commission has published guidance on the Equality Act 2010 about the need to provide single sex services or to make particular provision for women or men. (What equality law means to your business, Equality Act 2010 Guidance for service providers, volume 2 of 3 March 2011).

Separate services for men and women and single sex services

You are allowed to provide separate services for men and women where providing a joint service (i.e. one where men and women are provided with exactly the same service) would not be as effective. You are also allowed to provide separate services for men and women in different ways or to a different level where:

• providing a joint service would not be as effective, and
• the extent to which the service is required by one sex makes it not reasonably practicable to provide the service except in different ways or to a different level.

In each case, you need to be able to objectively justify what you are doing.

You are allowed to provide single-sex services (services just for men or just for women) where this is objectively justified and:

• only men or only women require the service, or
• there is joint provision for both sexes but that is not enough on its own, or
• if the service were provided for men and women jointly, it would not be as effective and the extent to which each sex requires the service makes it not reasonably practicable to provide separate services for each sex, or
• the services are provided in a hospital or other place where users need special care, supervision or attention (or in parts of such an establishment), or

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- the services may be used by more than one person at the same time and a woman might reasonably object to the presence of a man (or vice versa), or
- the services may involve physical contact between a user and someone else and that other person may reasonably object if the user is of the opposite sex.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this Article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Human Rights Act 1998

The Act sets out the fundamental rights and freedoms that individuals in the UK have access to, some of which are directly related to health and well-being, and the right to receive, and refuse, medical treatment. They include:

- right to life
- freedom from torture and inhuman or degrading treatment
- right to liberty and security
- respect for your private and family life, home and correspondence
- freedom of thought, belief and religion
- freedom of expression
- right to marry and start a family
- protection from discrimination in respect of these rights and freedoms
- right to education
Women’s Health and Equality Consortium (WHEC)

The Women’s Health and Equality Consortium (WHEC) aims to tackle health inequalities and advance policies and practices to improve the health of all women and girls.

WHEC partners are FORWARD, Imkaan, Maternity Action, Positively UK, Platform 51, Rape Crisis (England and Wales) and Women’s Resource Centre.

www.whec.org.uk