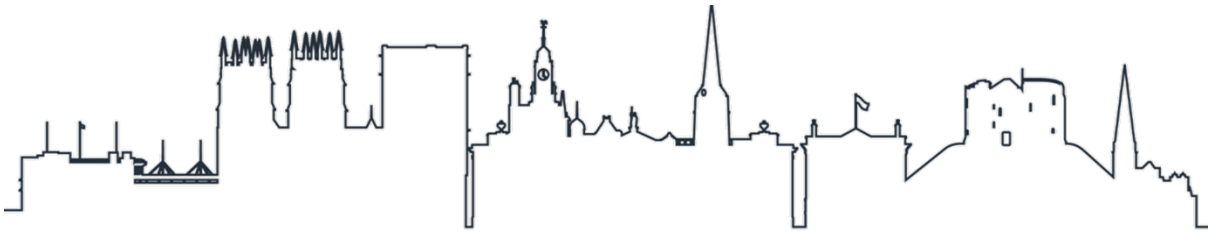
Women's Health in York

A Health Needs Assessment

June 2025

"Prioritising women's health is crucial for reducing inequalities and improving family and societal health outcomes."

Sue Mann, NHS National Clinical Director for Women's Health



Contents

1. Introduction

This report presents York's strategic approach to women's health and equality, shaped around six key priorities that aim to address systemic barriers, promote gender equality, and improve well-being for women in the city. Each chapter is deliberately short, and concise, designed to be easily digestible for readers while offering clear, actionable insights.

For those interested in learning more, relevant links to additional resources and detailed information are provided at the end of the report in the references and bibliography section. This report lays the groundwork for the future, and we look forward to continued collaboration across all sectors to bring about meaningful, lasting change.

Definitions used in this report

The UK Supreme Court recently ruled that the legal definition of "woman" under the Equality Act 2010 is based on biological sex assigned at birth. This document uses the statutory definition, in part because much health-related data aligns with that approach. However, a trans and non-binary data and insights group has been convened and, along with partners such as Healthwatch feeding in the views and experiences of residents, will publish further data in the future of the health needs of other gender identities as part of the JSNA process. In this document, the term "women" is used in both biological and social contexts:

- Biologically, when referring to issues like cervical screening or reproductive healthcare.
- Socially, when addressing factors such as gender-based violence or the gender pay gap and their impact on health.

Health Needs Assessments (HNAs)

A Health Needs Assessment (HNA) identifies unmet health and care needs within a population—in this case, women—and outlines the changes needed to address them. It is a systematic, data-driven approach used to:

- Describe population health issues
- Identify health inequalities and gaps in service access
- Set priorities for effective resource use
- Understanding women's specific needs is essential for planning responsive and inclusive local services.

Background

While women generally live longer than men, they often spend more years in poor health. Their health is disproportionately affected by factors such as financial hardship and caregiving responsibilities. Additionally, many healthcare systems and pharmaceutical treatments have historically been developed without fully accounting for women's specific needs.

This HNA pays particular attention to women from groups known to experience poorer outcomes or additional barriers to care, such as those affected by deprivation, minority ethnic status, or complex social needs.

Purpose

This assessment is not intended to replicate the Women's Health Strategy for England, but to build a clearer, York-specific picture to support local decision-making around commissioning and service design.

Given the breadth of the topic, we focused on areas where the Council and its partners can directly influence change—through commissioning, funding decisions, and collaborative action. Our aim was to use data, lived experience, and service feedback to highlight key issues and inequalities affecting women in York.

Methodology

A working group oversaw this project, and conducted over 20 in-depth interviews (in-person and virtual) with key stakeholders, including:

- Primary care
- Cancer Alliance
- Healthwatch York and Humber and North Yorkshire ICB
- Justice services
- Kyra Women's Project
- York Carers Centre
- Homestart York
- Midwifery, maternity, neonatal, and infant feeding teams
- IDAS (domestic abuse support)
- Healthy Child Service
- Sexual health providers
- Housing and resettlement services
- NHS screening teams
- Mental health services

We outlined the scope of the project to all key stakeholders, explaining that while it was inspired by the National Women's Health Strategy, our focus would be on the health of women in York, with an emphasis on the wider determinants of health.

Key principles

The national strategy takes a life-course approach to women's health, addressing areas such as workplace wellbeing, healthcare professional training, and medical issues including menstruation, menopause, and violence against women and girls.

Locally, the focus would be on areas we can influence—through strategy, commissioning, and programme funding—while also addressing broader determinants like deprivation, housing, insecurity, addiction, and involvement with the justice system.

We would use both quantitative data (to describe the "average" woman in York) and qualitative insights, including quotes, service feedback, and lived experience, to highlight health inequalities.

The primary focus would be on adult women, including older women, with a question raised about whether to also include children and teenage girls.

All stakeholders supported this approach.

We asked each stakeholder the following questions:

- What do you see as the key health issues facing women in York?
- How can you support this work? Do you have relevant data, stories, or capacity to help with writing or reviewing?
- Would you be willing to be part of a working group or participate in a follow-up interview?
- Who else should we speak to?
- Can we have your contact details?

Stakeholder feedback highlighted several priority areas for women's health in York, including careering responsibilities, maternal health, screening, period health, Violence against women and girls, isolation and mental health in older women, menopause, employment, and accessibility of primary care services.

These are the issues around which this report has subsequently been developed.

Next Steps

The findings of this report are being shared with stakeholders, who are invited to contribute any relevant resources—such as service data, case studies, evaluations, or personal stories—to support women's health improvement in York. This report will be discussed at the York Health and Wellbeing Board in July 2025, and we hope partners will take forward the key actions and take into account the 6 strategic themes at the document's conclusion.

2. What We Know

National Strategy

The Women's Health Strategy for England (2022) focuses on tackling health inequalities and improving the health and wellbeing of women and girls. As part of its implementation, Integrated Care Boards (ICBs) received funding to develop Women's Health Hubs—either virtual or physical clinics offering integrated women's health services.

- Key commitments in the strategy include:
- Coordinated care through Women's Health Hubs
- Expanded mental health support for women
- Improved sexual and reproductive health education in schools

Progress Since Publication - Notable achievements include:

- HRT Prepayment Certificates: Women can now pay £19.30 annually to access a wide range of hormone replacement therapies (HRT), including tablets, patches, and topical treatments.
- NHS Pharmacy Contraception Service: Women can consult with participating pharmacies for the initiation of oral contraceptives without needing a GP appointment.
- Expansion of Women's Health Hubs: Continued rollout of integrated health hubs for women.
- Domestic Abuse Support: A £2 million investment (January 2024) to provide financial assistance to survivors of domestic abuse. Police forces have also adopted new approaches to investigating sexual assault, with 2,000 officers trained in sexual offences by April 2024.

National and Regional Data

Women in the North of England face greater health and social inequalities compared to those in other parts of the country. According to the Woman of the North report:

- Women in the North are more likely to work longer hours for lower pay, experience poorer health, live in poverty, and have lower levels of educational attainment.
- They are also more likely to be unpaid carers, which adds further strain on their health and wellbeing.
- These inequalities have widened over the past decade, negatively impacting women's quality of life, employment, families, and communities.

The report also highlights a major gap in data:

"We cannot paint a complete picture of how the social determinants of health impact outcomes for marginalised northern women due to the lack of health data about the lived realities of marginalised northern women."

This underscores the urgent need for improved data collection and targeted interventions to address these disparities.

The Humber and North Yorkshire Health and Care Partnership published an interactive report offering an overview of women's health across the ICB area. While it highlights key inequalities and health risk factors, the report is not broken down by place or local authority, limiting its usefulness for understanding the specific needs of women in York.

Key Findings:

- Women live longer than men but spend more of those years in poor health.
- The gap in healthy life expectancy between the most and least deprived areas is widening.
- Cancer is the leading cause of death and early mortality, followed by circulatory diseases and dementia/Alzheimer's.
- About 25% of working-age women are economically inactive, compared to 21% of men.
- Women working full-time earn less, on average, than men.
- Nearly 13% of girls and women in the ICB area live in the most deprived 10% of neighbourhoods.
- Access to long-acting reversible contraception (LARC) has not returned to pre-pandemic levels.
- Abortion rates, including repeat abortions among under-25s, are rising but it is lower than regional and national averages.
- Hospital admissions for hip fractures in women aged 65+ are nearly double those of men.

The report highlights a lack of focus on women-specific health issues such as miscarriage and menopause. It also notes that women are underrepresented in clinical trials, leading to gaps in knowledge about conditions that uniquely affect women or affect them differently than men.

Marginalised groups

A growing body of research has highlighted the significant social and economic costs of 'severe and multiple disadvantage' (SMD) in the UK, attracting increasing policy attention.

For women, the routes into and out of SMD are often highly gendered. In homelessness, while street homelessness was less common, sofa-surfing and sleeping in hidden places were nearly universal. Substance use was frequently triggered by a partner and often served as a coping mechanism for past trauma. For many, prison was seen as a temporary escape from chronic domestic violence and harmful environments.

Women from minoritised ethnic backgrounds, those with long-term illness or disability, and neurodivergent women often face additional challenges, further increasing barriers

to support. Trauma linked to child removal was another key issue, with many women experiencing lasting emotional harm, though for some, fostering provided hope.

A gendered pattern also emerged in how women would go to extreme lengths to conceal or downplay their circumstances—staying in abusive relationships or exchanging sex for shelter or drugs—often to protect access to their children or to avoid exploitation by predatory men. This concealment was driven by fear of judgment or losing custody of their children, as well as a desire to protect themselves from further harm.

Key Local Programmes

In York, two key initiatives will support the reshaping of the local response to women's health care: the ICB-led Women Living Well Longer (WLWL) programme and a 2025 Healthwatch report on women's health, which has within it recommendations and future actions work with local GP's.

In 2023, the Department of Health and Social Care (DHSC) announced funding for Integrated Care Boards (ICBs) to develop Women's Health Hubs. These hubs were envisioned as 'one-stop' centres to deliver care closer to home, improve patient experience, tackle health inequalities, and ease pressure on secondary care.

In Humber and North Yorkshire, the WLWL programme implemented these hubs. The key principles included:

- Reducing health inequalities and improving access
- Placing women's voices at the centre
- Creating sustainable services
- Involving the whole health system

However, a single centralised Women's Health Hub was not feasible for the geography of the ICB due to accessibility concerns. Instead, the focus shifted to enhancing services in local GP surgeries. This approach allowed more women to receive the care they needed in their communities, without adding extra steps to their healthcare journey.

As a result, 24 Primary Care Networks (PCNs) became Women's Health Hubs, with funding used to train clinicians in menopause care, contraceptive provision, and pelvic health. A designated Women's Health Champion at each PCN led improvement projects and networking events. This initiative aimed to increase clinicians' skills and confidence in delivering women's health services locally. The programme will conclude in 2025, but the networks and relationships developed will continue.

Key focus areas for the Women's Health Hubs include:

- Menopause assessment and treatment
- Contraceptive counselling and provision
- Pelvic health, including pessary fitting and removal

In 2024, Healthwatch York invited women to share their health experiences to improve future services. This initiative was based on the belief that those who use the services are best placed to shape them.

The Healthwatch York report covered a wide range of topics, many of which overlap with this report, but others highlight the need for a more prominent focus on women's health within healthcare services. The full report, Women's Health: Stories of Women's Experiences in York and North Yorkshire, is expected to be published in 2025.

Women's health in York

A summary of the York Women's Health Needs Assessment 2025

A targeted stop-smoking initiative for pregnant women, delivered through the City of York Council Health Trainer Service, has contributed to a significant reduction in smoking rates among expectant mothers.

The self-reported **four-week quit rate** in York is currently **88.9%**, markedly higher than the regional (56.6%) and national (49.4%) averages.

Fewer women than men in York **claim out-of- work benefits** (1.7% vs. 2.1%), reflecting high overall employment.

19% of women in York are **obese at the start of pregnancy**. (21.3% nationally)

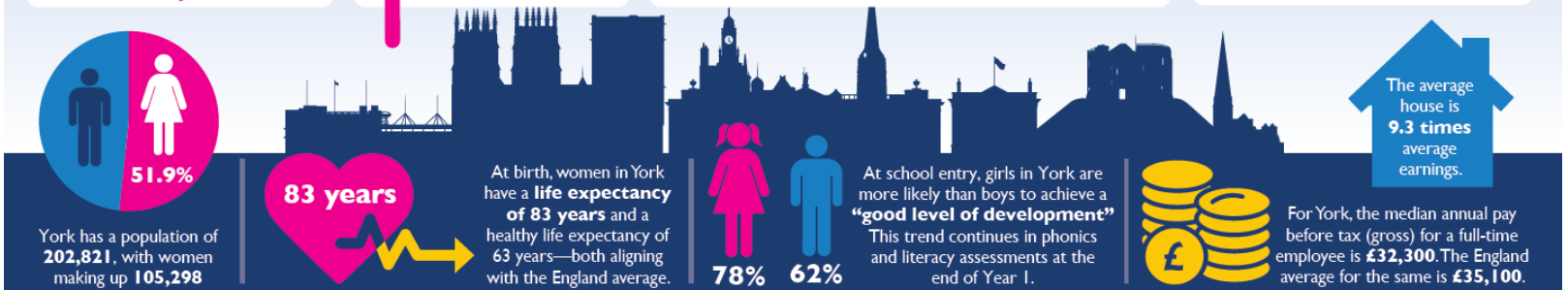
Breastfeeding rates see a notable decline by 6 to 8 weeks postpartum, with around **45%** of families in York **continuing to breastfeed** during this period. This rate is higher than the national average of 33% (OHID, 2025).

However, there is significant variation across different areas of the city. Westfield ward has the lowest breastfeeding continuation rate at 6-8 weeks, with only 29% of mothers still breastfeeding, in contrast to 61% in Micklegate ward.

However, **73%** of York **babies were breastfed at time of delivery** which is similar to the national average (71.7%).

75% of women aged 53 to 70 are **up-to-date with their breast screening** in 2022 and 2023. This is better than the England average of 67%. (VoY)

70% of women aged 25 to 49 years were **up-to-date with their cervical screening** in 2022 and 2023. This is better than the England average of 67% (VoY)



York has a population of **202,821**, with women making up **105,298**

At birth, women in York have a **life expectancy of 83 years** and a healthy life expectancy of 63 years—both aligning with the England average.

At school entry, girls in York are more likely than boys to achieve a **"good level of development"** This trend continues in phonics and literacy assessments at the end of Year 1.

The average house is **9.3 times** average earnings.

For York, the median annual pay before tax (gross) for a full-time employee is **£32,300**. The England average for the same is **£35,100**.

Women born in the most affluent areas can expect to **live 10 more years in good health** compared to those born in the most deprived areas.

By age 16, girls are slightly more likely than boys to be **not in employment, education, or training** (NEET) – 4.2% compared to 3.9%.

11% are smoking at the start of pregnancy (England ave 13%), dropping to 6% by delivery (8.0% nationally)

A 2023/24 health and wellbeing survey in York showed that **5% of young women reported experiencing period poverty** in the last year.

The trend for **teenage conception rates among under 18's has been falling** each year since 1998. the latest data for 2021 showing York's count as being 10.2 cases per 1,000 people.

Nationally, the figure is 13.1 per 1,000.

Breastfeeding rates are significantly lower among mothers living in York's more deprived wards, particularly Westfield, Hull Road, and Clifton.

4 year aggregated data in York indicates that fewer than **half of babies are breastfed at 6 to 8 weeks** (44.8%).

York's fertility rate is significantly below the national average. Fertility data from OHID Fingertips (2020/21) reported a general fertility rate of 39.74 live births per 1,000 women aged 15-44 in York – well below the national benchmark of 59.19.

63% of respondents to the York and North Yorkshire VAWG survey reported **experiencing a VAWG related Crime**.

Health improvement timeline for women

Over arching policies/changes which will impact on the health of women in York.

CITY OF YORK COUNCIL

2022

Women's Health Strategy for England – Published in 2022 the strategy aims to improve health outcomes and how the healthcare system listens to women.

The NHS 10 Year Plan targets women's health by improving service access, tackling inequalities, and investing in research and workforce. It focuses on better maternity care, gynaecological conditions, mental health support, and overall women's health.

2021-2023
Domestic Abuse Act 2021
Tackling Violence against Women and girls strategy 2021
Tackling Domestic Abuse Plan 2022

2023

Introduction of **HRT prepayment certificates**, saving an estimated £1.13 million annually.

£25million funding for **Women's Health Hubs.**

NHS Pharmacy contraception service, allowing women to get contraception directly from pharmacists without seeing a GP or visiting a sexual health clinic.

2024

Conservative government priorities: tackle period issues, fund women's health research, support abuse victims, and establish at least one women's health hub in every ICB by December 2024 to improve care access and quality.

Dr Sue Mann appointed as the first national clinical director for women's health.

The **Women of the North report** (Sept 2024) highlights that, women in Northern England face greater inequalities in life and health than elsewhere in the country.

Pharmacy First service begins.

Pharmacy contraception service expands to include confidential consultations to request repeat prescription of the contraceptive pill.

Domestic Abuse safe accommodation strategy 2021-26

North Yorkshire and CYC Domestic Abuse Strategy 2024–28:
Four priorities—prevention and early identification, inclusive support, collective action, and perpetrator accountability.

2025

Labour government committed to:
reducing gynaecology wating lists, tackling maternity care inequalities

Supporting women's health hubs

Key responsibilities:
Implement the Women's Health Strategy and support recruiting Women's Health Champions.
Embed the Hatfield Vision's goals, focusing on contraception access, reproductive rights, menopause, menstrual health, cervical screening, and maternal health for Black women and women of colour.

22 May 2025. Three Northern Metro mayors – from York and North Yorkshire, the North East, and West Yorkshire – backed a charter pledging to use their powers to improve fairness for women in education, work, welfare, and health.

Response from the Royal College of obstetricians and gynaecologists.

The plan must show how its three shifts— 'Hospital to community,' 'Sickness to prevention,' and 'Analogue to digital'—will improve women's healthcare and access throughout their lives. Key focus areas include:

- Prioritising women's health
- Women's health hubs
- Gynaecology waiting lists
- Maternity care
- Prevention supporting reproductive choice and tackling inequalities.

Addition of Emergency Hormonal Contraception – October 2025

Planned:
Independent prescribing qualification will be held by all pharmacists from registration after 2026, enabling them to prescribe medication for all patients.
Often, the reason for attending the GP is the cost of purchasing the 'over the counter' (OTC) medicines they need. Allowing patients to receive NHS funded OTC treatments for minor illnesses, for instance when they are eligible for free prescriptions, will help move millions of patients away from GPs and into pharmacy.

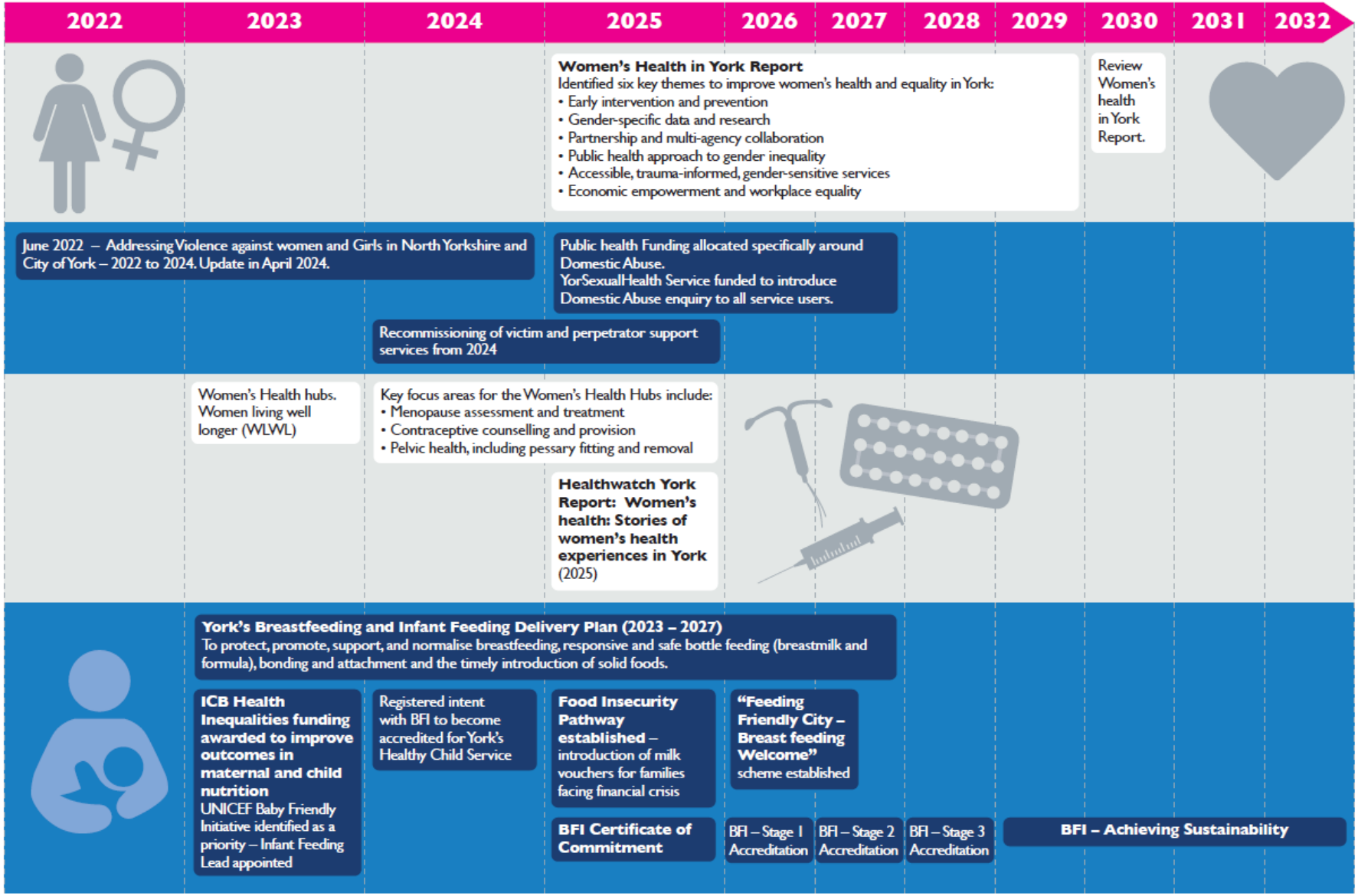
2026 2027 2028 2029

2030

The FSRH Hatfield Vision
By 2030, reproductive health inequalities will have significantly improved for all women and girls, enabling them to thrive and achieve their ambitions.

2031 2032

Local Interventions



3. Unpaid Care and Gender Disparities

In England, women disproportionately take on the responsibility of providing unpaid care, with those in their fifties making the most significant contributions. However, the full scope of who provides unpaid care remains underexplored, as many individuals who support family members or friends do not identify themselves as carers. This gap in understanding is highlighted in the Woman of the North Report (2024), which examines inequality in health and work.

Unpaid care can be provided to a range of dependents, including adult children, grandchildren, partners, parents, and friends, both within and outside of the household. While caregiving can be fulfilling, it is also mentally, emotionally, and physically demanding. The implications for carers are profound, affecting their access to education, employment, social activities, and, ultimately, their health and well-being. (Key Census Data on Unpaid Care (2021))

The 2021 Census data reveals that across all age groups up to 74 years, women are more likely to provide unpaid care than men. Additionally, more women in deprived areas provide care compared to those in the least deprived regions. (Office for National Statistics. (2023).

The Survey of Adult Carers in England (SACE), conducted biennially since 2012, sheds light on the experiences of informal, unpaid carers aged 18 or over. The most recent survey highlights significant disparities between female and male carers, with women reporting worse outcomes in various aspects of care provision. (Personal Social Services Survey of Adult Carers (NHS Digital).

Local Data on Care

In York, 936 carers known to Adult Social Care (ASC) and receiving services were eligible for the 2023-24 SACE survey. A total of 807 carers received questionnaires, and 311 responded, offering valuable insights into their experiences. These responses were compared with regional and national data, including results from York's Statistical Neighbour Local Authorities (SNLAs). Key Findings from the York Carers Survey (2023-24) included:

According to the Carers UK State of Caring 2022 report, 29% of carers reported feeling lonely “often or always.” In York, nearly 48% of carers expressed feelings of loneliness at least "some of the time," with younger carers and women more likely to report such feelings. This was notably higher than regional and national averages.

Carers' physical and mental health can suffer as a result of their caregiving responsibilities. In York, many carers reported poor health, including disturbed sleep, stress, and depression. Women carers, particularly those under 60, were more likely to report these negative health outcomes. Many carers neglect their own health Chapter 2needs, missing essential medical appointments due to their caregiving duties.

Juggling unpaid care with paid employment is a common struggle for many carers, especially women. Carers often face stress and fatigue, with many reporting difficulty in balancing work and caregiving. In York, a rise in carers facing financial hardship was particularly evident among younger carers and women. Nationally, financial hardship among carers has also increased since the 2021-22 survey.

Since 2021-22, there has been a marked decline in satisfaction with support services among women carers. Women were less likely than men to express satisfaction, with carers in the east of York particularly dissatisfied. In contrast, satisfaction levels have improved nationally.

Carers' ability to care for themselves has significantly declined since the last survey. The percentage of carers who reported being able to look after themselves fully dropped, particularly among younger carers and women. Social contact also decreased, with younger carers and women again reporting the lowest levels of social interaction.

Conclusions

- Women are more likely to provide unpaid care than men, with the largest proportion in deprived areas.
- Female carers experience worse outcomes than their male counterparts in areas such as health, social isolation, and financial hardship.
- Women carers, particularly in York, are less likely to prioritise their own health and well-being.
- There has been a marked deterioration in satisfaction with support services, especially among women carers.
- Social contact and the ability to care for themselves are declining, with younger carers and women facing particular challenges.

4. Women in employment

In the 2021 Census, there were 68,000 working-age women in York. Of these, 54,400 were classified as 'economically active,' meaning they were either employed or self-employed.

However, a pay gap persists in York. In 2024, the average weekly earnings for full-time male workers were £160 higher than those for women (£810 versus £649 gross, before tax). This continues into a gender pension gap, the latest pension contribution data from Aviva has found the gender pension gap is closing, but the rate of progress is slow and inconsistent across different age groups.

While local data for part-time female workers is unavailable, national figures show that the pay gap for part-time work is significantly smaller. In fact, part-time female workers tend to earn more per hour overall than their male counterparts (House of Commons Library, *Women and the UK Economy*).

Nationally, the gender pay gap widens significantly with age. There is virtually no pay gap for workers in their teens and twenties, but by retirement age, women earn about 10% less than men. This is often linked to career progression being slowed by time spent away from the workforce—due to childcare or caregiving responsibilities—or a preference for less demanding roles that offer more flexibility, shorter commutes, or family-friendly employment terms.

In York, women are slightly less likely than men to receive out-of-work benefits through Universal Credit. Around 2.1% of men receive these benefits compared to 1.7% of women. Both figures are lower than regional and national averages, reflecting the overall high rates of employment or study in the city.

A report from the University of York published in April 2025, offers a detailed snapshot of the current state of human rights across the city and highlights both areas of concern and positive progress. Based on its findings the report put forward a number of recommendations including a suggestion for the city's Human Rights and Equalities Board (HREB) to advocate for research into "the gender pay gap - which was found to have increased from 20.2% to 22.6% – and encourage the publication of data on other pay inequalities."

Conclusions

We can conclude that, in York:

- **There is high workforce participation, but ongoing pay inequality**
  80% of York's 68,000 working-age women are economically active, yet in 2024, full-time men earned £160 more per week than women.
- **Part-Time Work Masks Deeper Inequities**
  Though women working part-time earn more per hour nationally, gaps in local data hinder understanding of long-term career and pay equity.

- **Pay Gap Widens with Age**
  Earnings disparities grow over time due to caregiving breaks and shifts into lower-paid roles—highlighting systemic, not personal, barriers.
- **Low Benefit Uptake Doesn't Equal Equity**
  Fewer women claim out-of-work benefits, but this may reflect hidden underemployment and low-paid, insecure work, especially among carers.

5. Loneliness and Social Isolation

Social isolation and loneliness are prevalent issues across all age groups, but they have particularly significant consequences for older individuals, both physically and emotionally. In recent years, the UK government has recognized the growing concern around loneliness and launched its first loneliness strategy, appointing a Minister for Loneliness in 2018. This initiative follows the work of the Jo Cox Loneliness Commission, which raised awareness about the importance of tackling social isolation (Jo Cox Commission on Loneliness, 2017).

While both social isolation and loneliness are linked, they are distinct experiences. Social isolation is typically defined as the objective lack of meaningful, sustained communication, whereas loneliness refers to the subjective feeling of missing social interaction.

Several factors contribute to the feeling of loneliness, including:

- **Widowed older women** living alone with long-term health conditions.
- **Unmarried middle-aged individuals** with ongoing health issues.
- **Younger renters** who feel a lack of trust or belonging in their local community (ONS, 2018).

Health Impacts of Social Isolation and Loneliness

Social isolation and loneliness have been linked to various physical and mental health issues, including an increased risk of mortality. Multiple studies have shown that these experiences can lead to poor health outcomes, including heart disease, depression, and premature death. (The State of Women's Health in Leeds, White A., Erskine S, and Seims A, 2019)

A large study conducted in the UK on the effects of social isolation and loneliness on mortality revealed that while loneliness itself did not lead to excess mortality—except when associated with depressive symptoms—the higher death rates in socially isolated individuals were linked to lifestyle factors, socioeconomic status, and mental health problems.

Further research confirmed that individuals who are socially isolated or lonely are at a higher risk of mortality, especially when they also experience poor socioeconomic conditions, unhealthy behaviours (like smoking), and mental health issues. When social isolation is combined with food insecurity, the mental health risks escalate, with women being more adversely affected than men (The State of Women's Health in Leeds, White A., Erskine S, and Seims A, 2019).

Gender Differences in Social Isolation

Women, on average, live longer than men, and as a result, they are more likely to experience social isolation in later life. The combination of increased age and a higher incidence of multiple morbidities can make it more difficult for older women to maintain social connections or participate in social activities (Pettigrew et al., 2014). While women tend to report higher levels of loneliness than men, this may be partly

because women are generally more willing to acknowledge and report their feelings of isolation (ONS, 2018).

In addition, the growing number of divorces in people aged 60 and over (ONS, 2013b) may contribute to increased isolation for older women, as they navigate the challenges of maintaining or rebuilding social networks in the absence of a partner.

Conclusions

- **Increased Vulnerability of Older Women**
  Older women in York are more likely to live alone, facing higher risks of social isolation, worsened by health issues and widowhood.
- **Health Risks of Isolation**
  Social isolation, often linked to socioeconomic disadvantage, leads to poor physical and mental health, such as heart disease and depression, especially in older women.
- **Loneliness is Underreported**
  Older women may underreport loneliness or avoid seeking help, underscoring the need for proactive support from health and social services.
- **Need for Gender-Specific Approaches**
  Interventions should address the unique emotional and practical challenges older women face, moving beyond a one-size-fits-all approach.
- **Addressing Socioeconomic Factors**
  Loneliness in York is closely tied to income, housing, and access to services, with a focus on food insecurity, transport, and community infrastructure for older women.
- **Importance of Community-Based Support**
  Creating accessible social activities and supporting older women in staying connected, active, and mentally well should be a priority.

6. Menopause

Menopause is defined as the permanent cessation of menstruation for at least 12 consecutive months with no other obvious cause.

Menopause affects all individuals assigned female at birth, (referred to as "women" in this needs assessment). Common symptoms of menopause include hot flushes, night sweats, muscle aches/joint pain, low mood, vaginal dryness, changes to body shape and weigh gain and difficulty sleeping. In addition to these immediate symptoms, menopause is associated with several long-term health risks, particularly cardiovascular disease and osteoporosis.

Cardiovascular disease (CVD), which is the leading cause of death in women, is an especially significant concern during menopause, as the drop in oestrogen levels increases the risk of CVD. Osteoporosis can lead to fractures and higher rates of disability and urogenital atrophy, including vaginal dryness, urinary incontinence, and a higher susceptibility to urinary tract infections.

Common mental health symptoms include frequent mood swings, anxiety and low self-esteem and problems with memory or concentration – referred to as "brain fog".

Despite the severity of both the acute symptoms and the long-term health risks of menopause, access to appropriate care varies widely, with often limited access to healthcare professionals with expertise in menopause. NICE guidance QS143 published in 2017 and updated in 2024 describes high quality care. NICE recommends 5 Quality statements for women, trans men and non-binary people registered female at birth.

Cultural and societal factors can prevent individuals from seeking care, further complicating the management of menopause-related health concerns. This can lead to inadequate workplace support, early retirement and stigma. The lack of understanding and acceptance exacerbates the mental and emotional strain of menopause.

A report on "The effects of menopause transition on women's economic participations in the UK" published in 2017 reviewed English evidence base from 1990 to March 2016. (Transition refers to the time in women's lives when they are moving towards the menopause, when their periods stop permanently.) The report identified that the menopause is not well understood or provided for in workplace cultures, policy and training. The Equality Act (2010) protects women against workplace discrimination based on their sex or age and so the legal case for organisational attention to the menopause and the transition period is clear.

As life expectancy continues to rise globally, more individuals will spend a larger portion of their lives in the post-menopausal phase. This demographic shift, coupled with the far-reaching effects of menopause on health and well-being, underscores the need for improved management in the workplace and equitable access to care.

Stakeholder Feedback

Feedback from stakeholders interviewed as part of this Health Needs Assessment highlighted several concerns – common themes where:

- Access to health care, with long waiting times for women experiencing perimenopause or menopause to see a GP.

- All GP's and healthcare professionals should have the knowledge to support women presenting with perimenopause and menopause as it affects all women during their life course
- Menopause symptoms not always taken seriously or seen as "normal" and something to be endured.
- Women are often prescribed anti-depressant medication unnecessarily in the first instance. Many women described a lack of decent follow-up and care around menopause, and it is often a lottery in terms of who you get to see.
- Women who are carers where significantly affected, with complaints that they found raising issues around menopause, even with a health professional, challenging and feel disregarded. They are made to feel 'neurotic'. This had a huge impact on their ability to cope on top of caring responsibilities/holding down a job etc.
- There is a lack of information available for partners/men to understand the situation and what their partner is experiencing and the impact this can have.
- Questions were raised about workplaces, the lack of support women receive in the workplace, and how workplace menopause policies are implemented.

Conclusions

- **Inadequate Access to Menopause Care**
  Long GP wait times and inconsistent access to specialists leave many women feeling their menopause symptoms are dismissed, with some being inappropriately prescribed antidepressants instead of tailored treatments like HRT.
- **Need for Better Training for Healthcare Professionals**
  Many GPs and healthcare providers lack sufficient knowledge of menopause, highlighting the need for standardised training across the healthcare system.
- **Lack of Mental Health and Emotional Support**
  Women often feel dismissed or labelled "neurotic," this particularly affects those with caregiving responsibilities.
- **Insufficient Workplace Support**
  Menopause is poorly understood and unsupported in many workplaces, with women reporting difficulty discussing symptoms, resulting in challenges in job performance.
- **Persistent Social Stigma and Low Awareness**
  Cultural attitudes and limited public information create embarrassment and isolation for women seeking help, and there is insufficient support for partners and families to understand menopause.
- **Vulnerable Groups Face Greater Challenges**
  Women with caregiving responsibilities and those in low-income or precarious jobs experience compounded barriers to healthcare, workplace support, and overall well-being.

7. Period Poverty.

What is Period Poverty?

Period poverty, also known as menstrual poverty or menstrual inequality, occurs when people who menstruate lack access to safe, hygienic period products, proper sanitation, or menstrual hygiene education. While the term is relatively new, it highlights a longstanding issue that disproportionately affects low-income individuals, communities, and countries.

Period poverty is a global health issue that is often overlooked. Research by Jaafar et al. (2023) and Rossouw et al. (2021) defines it as insufficient access to menstrual products, education, and clean, private sanitation facilities.

Why is Period Poverty a Public Health Issue?

Period poverty is driven by income inequality and the inability to meet basic household needs. Factors like conflict, climate events, and global health crises exacerbate the issue, as shortages of essentials like pads and tampons worsen the problem. Without affordable products, individuals are forced to improvise with unsafe alternatives, putting them at risk for infections, irritation, and toxic shock syndrome. According to a 2023 ActionAid report, 41% of respondents used period products for longer than recommended, and 8% reused disposable pads. Additionally, 37% used tissues, cotton wool, or other materials like socks, while 9% resorted to paper or newspaper.

Menstrual stigma — including myths and shame surrounding menstruation — can fuel gender bias in healthcare systems and society. A significant number of respondents (28%) reported that they could rely on period products at school or work, but 17% stayed at home during their period, impacting their mental health and social opportunities. The same ActionAid report found that 21% of women and menstruators in the UK are struggling to afford period products, up from 12% the previous year.

The COVID-19 pandemic exacerbated period poverty, as many individuals prioritised essentials like food and utilities over menstrual products, leading to the reuse of products or improvisation. The cost of period products has increased by 57% since 2022, putting an additional strain on already stretched household budgets.

Period Poverty in the UK

Period poverty has gained increasing attention in the UK over the past decade, especially considering the cost-of-living crisis. A growing number of people, particularly young people, are unable to afford menstrual products. Recent data shows that 10% of girls in the UK have been unable to buy products, 15% have struggled to access them, and 19% have turned to less suitable alternatives due to high costs (Jaafar, H et al., 2023).

In response, the UK government introduced the **Period Product Scheme for Schools and Colleges** in 2020, providing free menstrual products to students. However, a 2022 assessment by Girl Guiding found that further improvements are needed to ensure the scheme's effectiveness and prevent waste.

Efforts in York to Address Period Poverty

York has seen several initiatives aimed at tackling period poverty. In 2019, the Soroptimist Society began offering free period products, and in 2022, University of York students launched a program to ensure all students had access to menstrual products. York Minster also hosted a workshop to sew reusable pads for distribution. The **Period Angels** initiative, which connects volunteers with local organizations like food banks and GP practices, aims to eradicate period poverty by 2025.

A 2023/24 health and wellbeing survey in York showed that 5% of young women reported experiencing period poverty in the last year. The survey, based on responses from over 1,900 girls across six schools and a sixth form college, illustrates that period poverty remains a significant issue.

Conclusions

Despite ongoing efforts, period poverty is far from eradicated. A nationwide response is needed, with consistent access to menstrual products in schools, hospitals, GP practices, and other community spaces. Broader public recognition of the issue is crucial.

8. Cancer Screening

Cancer screening programmes are a vital component of the NHS's broader preventative health strategy and play a key role in public health. These programmes are designed to detect cancer at an early stage—before symptoms appear—allowing for timely intervention, improved treatment outcomes, and reduced mortality.

Screening not only enhances early detection but also provides an opportunity to educate the public, promote healthier behaviours, and empower individuals—particularly women—to take charge of their health. Educational components embedded within screening initiatives help raise awareness of risk factors, symptoms, and the importance of regular check-ups. Importantly, these programmes also help address health inequalities by offering free screening to all eligible individuals, regardless of socio-economic status.

However, challenges remain in ensuring equitable access. Barriers such as cultural stigma, lack of awareness, or logistical issues (e.g. transport, location) can limit participation—particularly for women in rural, marginalised, including those from different religious backgrounds or underserved communities. It is critical that cancer screening services remain accessible, inclusive, and responsive to diverse needs.

Improving cancer screening among Muslim women.

A Scottish project to encourage Muslim women to take up cancer screening invitations began in 2020 in Glasgow and aims to reach Muslim women with information to enable them to make informed choices. This expanded to the North of England in 2023 and will run to December 2025. It is hoped that the results and lessons learned from this project can help reduce barriers and increase uptake in other groups.

Screening programmes also support wider public health goals by enabling more efficient allocation of resources, particularly to those at greater risk or with higher need. Most programmes incorporate educational elements to raise awareness of cancer risks, early symptoms, and the importance of routine check-ups. This not only promotes healthier behaviours but also empowers women to make informed decisions about their health and helps reduce stigma associated with cancer and other health conditions.

Regular screening for breast, cervical, and bowel cancer plays a vital role in early diagnosis:

- **Breast screening** (via mammograms) women are invited every 3 years via their GP practice, and it is crucial for identifying tumours early.
- **Cervical screening** helps detect pre-cancerous cell changes. It is not a test for cancer but for Human Papilloma Virus (HPV). It is a preventative test, not a diagnostic one.
- **Bowel Cancer** via a home testing kit (FIT kit) delivered though the post, which allows for the early detection of potential cancer indicators.

Breast Screening

Breast cancer is the most common cancer in the UK, with around 1 in 8 women diagnosed in their lifetime. In England, the NHS Breast Screening Programme helps save approximately 1,400 lives annually through early detection.

Women registered as female with a GP are invited for screening every three years between ages 50 and 71, though some may not receive their first invite until age 52 or 53 due to the programme's rolling schedule.

York's screening coverage exceeds both national and regional averages, with consistent improvements since the COVID-19 pandemic.

The North Yorkshire and York Breast Screening Programme, led by York and Scarborough NHS Trust, collaborates with GP practices to identify eligible women, including those with disabilities. Invitations can be adapted for accessibility, and appointments rescheduled if needed. Non-attenders receive personalised follow-up support. Out-of-hours clinics are also offered to accommodate those with work or caring responsibilities.

Informed by a regional Health Equity Audit, targeted actions by the National Breast Screening System (NBSS) aim to improve access for underserved groups such as people experiencing homelessness, refugees, Gypsy, Roma and Traveller communities, LGBTQ+ individuals, military personnel, and those with severe mental illness or learning disabilities. While the current system cannot yet identify these groups, development are underway to enable ethnicity data collection in the future.

Bowel Cancer Screening

The Harrogate, Leeds, and York Bowel Cancer Screening Programme covers the York population. Currently, bowel screening is offered every two years to individuals aged 54 to 74, but this will soon be extended to include those aged 50 to 74.

Bowel cancer is the fourth most common cancer in the UK, and the risk increases with age. According to Fingertips data (Department of Health and Social Care), 77.7% of eligible residents in York participate in bowel screening, a rate significantly higher than the national average of 71.0%. Rates across England range from 57.4% to 78.3%.

Although data is not currently broken down by gender or other demographic groups—except for people with learning disabilities—the screening Hub that distributes the kits will identify individuals who may require additional support and arrange personalised assistance throughout the screening process.

Cervical Screening

Cervical screening is offered in England to women and people with a cervix aged 25 to 64. Those registered with a GP as female are automatically invited. The test checks for human papillomavirus (HPV), a virus that can lead to cervical cancer if untreated. It is a preventative, not diagnostic, test.

Screening is mainly delivered by GP practices. In York, Yorsexual Health offers additional support, especially in areas of low uptake and among marginalised groups. Outreach with LGBTQ+ and trans communities has improved participation. Further access is available through Women's Health Hubs and extended-hours clinics.

NHS England data shows York's screening uptake is above the national average: 70.5% for ages 25–49 (vs. 67.16% nationally) and 77.19% for ages 50–64 (vs. 74.69%).

Currently, only service providers hold data on uptake among marginalised groups, as national reporting is limited to practice-level figures and sample counts, without detailed demographic breakdowns.

To address this, a large York Primary Care Network, working with City of York Council, the Integrated Care Board, and the Cancer Alliance, has secured funding for a nurse-led project to build a real-time dashboard. This tool will identify disparities in screening uptake and support targeted community-led interventions.

National cancer awareness campaigns throughout the year promote screening for bowel, breast, and cervical cancer. These are locally supported by healthcare providers and the Cancer Alliance, which also runs a Cancer Champions programme to empower community members to talk about cancer, reduce stigma, and encourage early detection.

Screening is a key prevention strategy, helping detect conditions early, reducing the need for advanced treatment, easing NHS pressure, and improving outcomes across communities.

Conclusion

- **Cancer Screening and Its Importance**
  Cancer screening is a vital part of the NHS's prevention strategy, helping to detect cancer early, improve treatment outcomes, and save lives. It also encourages healthier habits and empowers women to take charge of their health.
- **York's Success in Screening Uptake**
  York is performing well, with screening participation rates higher than the national average. Local services are actively working to engage more people, particularly those facing additional barriers, through mobile units and out-of-hours clinics.
- **Challenges in Ensuring Fair Access**
  Despite success, there is still work to be done to ensure screening is accessible and equitable for all, particularly for marginalised groups.
- **Future Focus for Improved Health Outcomes**
  Continued emphasis on early diagnosis, education, and inclusivity will help improve health outcomes and reduce pressure on NHS services.

9. Maternal Health

Introduction

Maternal health is a critical aspect of women's overall health and well-being, significantly influencing both immediate and long-term outcomes for mothers and their children. This chapter explores the maternal health needs in York, focusing on physical health, mental well-being, and access to healthcare services.

Understanding the specific needs of mothers in York is essential for shaping responsive and inclusive services, enabling mothers to thrive and contribute to a healthier community.

Key Challenges Facing Mothers in York

- 24.1% of mothers are obese during early pregnancy.
- 16.5% of mothers smoke during pregnancy—higher than the national average.
- York's fertility rate is significantly below the national average.
- An increasing proportion of births are among women from ethnic minority backgrounds.
- The stillbirth rate in York is comparable to the national average but higher than many statistical neighbours.
- Breastfeeding rates are significantly lower among mothers living in York's more deprived wards, particularly Westfield, Hull Road, and Clifton. These disparities highlight the need for targeted support and culturally appropriate interventions to improve breastfeeding outcomes in underserved communities.
- Local experiences suggest a higher level of need in relation to Perinatal Mental Health than reflected by the data on service contact rates.

Preconception Health

Obesity in Early Pregnancy

A woman's weight before and during pregnancy strongly influences health outcomes. Obesity—defined as a BMI of 30kg/m^2 or more at the first antenatal appointment (usually within 14 weeks)—raises the risk of complications for both mother and baby.

Risk Factors:
Maternal obesity is shaped by complex, interconnected factors, including pre-pregnancy weight, socioeconomic disadvantage, limited access to healthy food and exercise, low health literacy, cultural influences, and mental health issues. Inadequate access to personalised preconception and antenatal care also limits early interventions.

Impact:
Obesity increases the risk of gestational diabetes, hypertension, pre-eclampsia, thrombosis, caesarean delivery, and anaesthesia complications. It also raises the

likelihood of miscarriage, premature birth, stillbirth, and macrosomia. Early identification and tailored support are essential to improve outcomes.

Prevalence in York:
In 2023/24, 24.1% of pregnant women in York were obese at their initial antenatal appointment, close to the national average of 26.2%. This highlights the need for targeted, evidence-based interventions.

Smoking During Pregnancy

Impact:
Smoking during pregnancy is linked to miscarriage, premature birth, low birth weight, stillbirth, and infant respiratory and congenital issues. It also increases maternal risks, including prevalence in York:**
11% of pregnant women in York smoke, lower than the national average of 13.6% (2023/24). However, data accuracy remains a concern, and improved methods are expected.

CYC Stop-Smoking Support:
City of York Council's Health Trainer Service offers personalised stop-smoking support for pregnant women. With a self-reported four-week quit rate of 88.9%—well above regional and national averages—this service has proven effective in improving maternal and infant health. Its success underscores the value of targeted, locally delivered interventions.

Fertility

As of 2023, the average age of first-time mothers in England and Wales is 30.9 years, up from 25.8 in 1993. While more women are having children later in life, overall fertility rates are declining. The total fertility rate in England and Wales reached a record low of 1.44 children per woman in 2023—a trend mirrored in York.

Fertility Rate in York
In 2020/21, York's general fertility rate was 39.74 live births per 1,000 women aged 15–44, significantly below the national average of 59.19. In 2022, the city recorded just 1,573 live births—the lowest since at least 2013—placing York among the lowest fertility rates compared to similar local authorities.

Implications of Delayed Childbearing
Having children later in life increases the risk of miscarriage, gestational diabetes, preeclampsia, stillbirth, and labour complications. It also heightens the likelihood of chromosomal abnormalities and fertility challenges, often requiring assisted reproductive technologies, which can be costly and emotionally demanding.

Drivers of Declining Fertility in York
Fertility decline in York is driven by factors such as rising living and housing costs, financial pressures of parenthood, and shifting societal norms. Higher rates of female participation in education and the workforce, evolving gender roles, and changing family structures also influence reproductive choices. These trends call for responsive local reproductive health policies.

Stillbirth and Infant Mortality

Stillbirth
Stillbirth—defined as the death of a foetus after 24 weeks of pregnancy—remains a major public health concern in the UK, which has one of the highest rates among high-income countries. The stillbirth rate, measured per 1,000 live and stillbirths, is a key indicator of perinatal health.

Risk Factors
Risk factors include maternal age (under 20 or over 35), smoking during pregnancy, obesity, pre-existing conditions (e.g. diabetes, hypertension), infections, multiple pregnancies, prior stillbirths, and inadequate prenatal care. Socioeconomic disadvantage further increases the risk.

Inequalities by Ethnicity and Deprivation
Stillbirth rates are higher in deprived areas than those less deprived , (4.69 vs. 2.37 per 1,000 births) and among Black and Asian women (7.52 and 5.15 per 1,000) compared to White women (3.30). Black African and Caribbean women in the most deprived areas face the highest rates (8.10 and 7.96 per 1,000). (MBRACE-UK)

York's Stillbirth Rate
York's stillbirth rate for 2021–2023 is 4.1 per 1,000 births, slightly above the national average of 4.0 and the third highest among its statistical neighbours. As this data new, it is too early to draw definitive trends. These figures should be interpreted with caution, as sample sizes and data collection methods are still being refined.

Maternal Deaths

Maternal mortality remains a major concern in the UK, with rates now at their highest in 20 years, highlighting persistent health inequalities. The latest MBRRACE-UK annual report on maternal deaths and morbidity has revealed that maternal mortality rates have reached their highest level in 20 years.

Inequalities by Ethnicity and Deprivation
The report found notable disparities in maternal mortality rates based on ethnicity and socioeconomic status. Black women are three times, and Asian women twice as likely, to die during or shortly after pregnancy compared to White women. Women in the most deprived areas face maternal death rates over twice those in the least deprived areas.

Causes of Maternal Death
Leading direct causes include obstetric haemorrhage, sepsis, and thromboembolism, with the latter most common recently (MBRRACE-UK, 2021). Indirect causes involve pre-existing conditions such as cardiac disease, diabetes, obesity, and mental health issues, notably suicide in the first postpartum year. Age is another important risk factor, with women over 35 at a higher risk of complications, including stillbirth and maternal death (NHS Digital, 2022).

Maternal Death Rate in York
As of April 2025, York's specific maternal mortality data is unavailable. Nonetheless, national trends highlight the critical need for targeted interventions to address these

disparities. Ensuring equitable access to high-quality maternal care, providing targeted support for at-risk populations, and continuing efforts to reduce preventable deaths through improved monitoring, early intervention, and personalised healthcare strategies are essential. Additionally improving mental health services, postnatal care, and education to reduce preventable maternal deaths locally.

Teenage Pregnancy

Teenage pregnancy can significantly affect a young woman's physical, emotional, and social wellbeing. While rates have declined nationally, the highest remain in the North East and Yorkshire.

Young women from disadvantaged backgrounds—particularly those in deprived areas or not in education, employment, or training (NEET)—are at greater risk. Key contributing factors include limited access to education, lower socioeconomic status, and inconsistent contraception use.

Teenage mothers face higher risks of preterm birth, low birth weight, pregnancy-related complications, and postnatal mental health issues. They are also more likely to encounter stigma, economic hardship, and disrupted education and career prospects, affecting both mother and child long term.

These challenges highlight the need for accessible sexual health education, youth-friendly services, and sustained support. Currently, there is a gap in under-18 conception data, with no confirmed release date for updated figures from the Office for National Statistics.

Teenage Pregnancy rate in York

Available data indicates a general decline in teenage pregnancies in York. In 2021/22, 1.6% of pregnancies at the time of booking were to teenage mothers, down from 2.2% in 2018/19. However, in some areas of the city, this trend has reversed. Wards such as Acomb, Guildhall, Holgate, Micklegate, Osbaldwick, Derwent, and Westfield have seen an increase in teenage pregnancies (CYC Business Intelligence Public Health Maternity and Pregnancy Indicators 2022/23).

Breastfeeding

Breastfeeding provides significant health benefits for mothers. In the short term, it aids postpartum recovery, reduces bleeding, and supports weight loss. Long-term, it lowers the risk of breast and ovarian cancers, cardiovascular disease, type 2 diabetes, and high blood pressure. It also supports maternal mental health and bonding with the baby, potentially reducing postpartum depression (WHO, NHS, 2020).

National and international guidelines recommend exclusive breastfeeding for the first six months (NICE).

Breastfeeding Initiation

In York, 74% of mothers initiate breastfeeding—slightly above the national average of

72%. However, data accuracy remains a concern due to data collection methods. Clear inequalities exist when considering socioeconomic factors. Initiation rates are lower in more deprived areas, particularly Westfield, Hull Road, and Clifton, with Westfield recording the lowest at just over 50%.

Breastfeeding duration at 6–8 Weeks
By 6–8 weeks, breastfeeding drops to 45% in York—higher than the national average of 33% (OHID, 2025). Rates vary widely, Westfield ward has the lowest breastfeeding continuation rate at 6-8 weeks, with only 29% of mothers still breastfeeding, in contrast to 61% in Micklegate ward.

Perinatal Mental Health

The perinatal period is a vulnerable time for women's mental health, with new or worsening conditions common. Postpartum psychosis is unique and severe, while depression and anxiety remain prevalent. Since 63% of mental health disorders begin before age 25 and the average first-time mother is 31, many enter pregnancy with pre-existing conditions, making early identification and ongoing support essential for maternal and infant wellbeing.

Impact on Mothers
Poor perinatal mental health can profoundly affect a mother's well-being and her ability to care for her baby. It can lead to inadequate nutrition, challenges with initiating or maintaining breastfeeding, and disruptions in the critical bonding process between mother and child.

Impact on the baby
Children of mothers with mental health issues face higher risks of developmental delays, poor health, and even infant mortality. These children are more likely to experience mental health struggles themselves during childhood, underscoring the intergenerational impact of insufficient support and intervention.

Women at Higher Risk of Developing Perinatal Mental Health Conditions. Women from lower socioeconomic backgrounds face greater risk due to financial stress, housing instability, and limited access to services, often compounded by barriers to care and support. These women may also face additional barriers to accessing care and support, including financial constraints or a lack of social support networks. Addressing these challenges is critical to improving perinatal mental health outcomes and ensuring better care for both mothers and their children.

Ethnic Inequalities
Ethnic minority women are less likely to register with GPs, seek help, or have mental health concerns recorded, leading to underdiagnosis and lower satisfaction with healthcare. With information regarding their mental health during the perinatal period being less likely to be recorded, and evidence that ethnic minority women are less often asked about their mental health by healthcare providers, they are less likely to receive a diagnosis for common mental health disorders during the perinatal period, exacerbating gaps in care and support.

This underreporting hinders effective support and national data collection and contributes to a lack of national health profile data on perinatal mental health among ethnic minority women, further complicating efforts to address these disparities.

Service Access and Regional Disparities
Access to perinatal mental health services is uneven, with long waits and limited availability. A notable disparity exists between regions in England, with the North-South divide in perinatal mental health access being a significant concern. Research and NHS data indicate that women in the North of England are more likely to experience delayed diagnoses, limited access to specialist perinatal mental health services, and higher rates of maternal mental illness compared to their counterparts in the South.

Cultural, spiritual and religious beliefs and practices can impact on health behaviours and practices, health outcomes, use of and access to healthcare, and decision-making regarding medical treatment. Other factors can also limit the success of healthcare provision, such as language barriers, insecure immigration status and housing, discrimination, lack of trust between patients and healthcare professionals, and time and financial cost of attending appointments.

Areas with the highest prevalence of perinatal mental health conditions often coincide with the lowest access to adequate services, further compounding the challenges faced by women in need of support.

Perinatal Mental Health in York
Approximately 24.1% of women in York experience perinatal mental health conditions, slightly below England's 25.8%. Specialist service contact rates are also lower than national and regional averages (52.7 vs. 77.8 and 63.6 per 1,000 women aged 15-54). Post-pandemic data is pending, but local reports, by Health and care professionals, indicate unmet need, with many women not accessing necessary support despite the lower recorded service use.

Suicide

Suicide is the leading cause of maternal death in the UK between six weeks and one year postpartum, accounting for about 39% of deaths in this time period.

The 2023 MBRRACE-UK report shows that mental health issues, including suicide and substance misuse, caused over a third of maternal deaths then. Many affected women had pre-existing mental health conditions and faced multiple challenges, such as domestic abuse and substance misuse.

These findings highlight the urgent need for improved mental health support and early intervention during the perinatal period to prevent such deaths.

Conclusions

- **Prevalence of Perinatal Mental Health Conditions**

  Estimating the prevalence of mental health conditions in pregnant and

postpartum women helps identify gaps in care and informs targeted interventions.

- **Impact of Demographic and Risk Factors**
  Understanding factors such as age, ethnicity, and socioeconomic status, along with risks like previous mental health issues and domestic abuse, is key to developing effective prevention strategies.
- **Role of Community Support for Prevention and Early Intervention**
  Leveraging local resources like support groups and outreach services strengthens community networks and prevents mental health issues from escalating.
- **Availability of Preventive Interventions**
  Ensuring accessible mental health and parenting programs during pregnancy and early parenthood is essential for improving outcomes and reaching those in need.
- **Mental Health Assessment in Maternity and Health Visiting Services**
  Integrating physical and mental health assessments in maternity and health visiting services enables early identification and timely intervention for mental health issues.
- **Perinatal Mental Health Support in Primary Care**
  Primary care professionals must be equipped to screen for mental health issues and refer women to appropriate services for effective support.
- **Trends in Specialist Perinatal Mental Health Services**
  Monitoring specialist perinatal mental health services helps assess if they meet population needs, identify service gaps, and inform better planning and resource allocation.

10. Accessibility of primary care services.

Published (March 2025) in the LSE Public Policy Review on-line, Jeffrey, G, paper "Barriers to women in accessing Healthcare in the UK" examined the persistent health gap in the UK and highlighted the disparities in health care access and outcomes between men and women.

The gender health gap.

While women report higher morbidity rates across a range of conditions compared to men, healthcare research have historically been structured around male-centric models, leading to diagnostic delays, inadequate treatment, and unmet healthcare needs. For example, endometriosis, which affects around 10% of women of reproductive age, often takes about seven years to diagnose. Conditions like Polycystic ovary syndrome (PCOS) which is also thought to affect about 1 in 10 women in the UK, and menopause-related health issues receive little attention in research and healthcare.

The study explores the socioeconomic, systemic, and behavioural roots of these disparities, and consequences, which include reduced productivity and labour market inefficiencies. Key factors contributing to the gender health gap – such as caregiving responsibilities, financial constraints, workplace policies, and structural biases in medical research – are analysed.

The gender health gap in the UK is caused by a mix of social, behavioural, and systemic issues that negatively affect women's health. Women often put their families' health before their own, especially in low-income households, leading to delays in seeking care. Female unpaid carers report more health issues than male carers. Stigma around periods, infertility, and menopause can also stop women from seeking help. Instead, many self-treat or rely on the internet or friends for health advice. A 2021 survey showed that many women lack reliable information on basic health topics like menstruation, menopause, and gynaecological conditions. "Women's Health - Let's Talk about it" Survey updated April 2022.

Investment in women's health.

There is little investment in women's health. In 2020, only 5% of global health research funding went to women's health (WEF May 2025), with most of it focused on fertility. FemTech[1] companies also receive very little funding. This lack of research leads to poor diagnosis and treatment—such as heart disease in women being mistaken for stress. Women from ethnic minority backgrounds face even greater barriers due to discrimination and cultural differences.

Low-income women face more health issues but are less likely to get medical help due to cost and lack of flexible work. Many delay treatment for chronic conditions like postpartum depression due to caregiving duties and financial stress. Menopause

[1] Femtech (or female technology) is a term used to define software and services that use technology tailored towards women's health. Femtech mainly focuses on menstruation care through period-tracking apps. Other aspects include fertility and reproductive system health care, pregnancy and nursing care, and sexual health.

symptoms alone participation, showing how health and job support are closely connected.

The Healthwatch report "Women's Health: Stories of women's health experiences in York and North Yorkshire" May 2025, highlights the difficulty of accessing services in York many women sharing their experiences of being passed from one health professional to another, of medical teams "presuming people knew who to go to", making appointments and seeing a GP seems unnecessarily difficult – some practices not making appointments for those to attend in person and others having queue at 8am with others waiting for the surgery to open, having to repeat their story to health professionals over and over again was a common complaint.

Medical Misogyny.

The "Healthwatch" report also highlighted "Medical misogyny". Medical Misogyny is described as "clinicians who have an "ingrained Belief" that women, particularly those from ethnic minority groups, are exaggerating their symptoms, meaning that conditions are left undiagnosed". (BMJ December 2024)

A parliamentary enquiry ("Medical Misogyny" is leaving women in unnecessary pain and undiagnosed for years" December 2024) found that doctors are too often dismissive of women's symptoms when they present for treatment for reproductive health conditions. Key Findings from the enquiry included:

- **Pain is often dismissed & normalised:** Women with conditions like endometriosis and heavy menstrual bleeding often have their symptoms dismissed or normalised by healthcare professionals.
- **Women often experience delayed diagnosis & treatment:** Delays in diagnosis and care can take years, disrupting women's lives, impacting education, careers, relationships, and fertility, often leading them to seek private care.
- **Stigma & Medical Misogyny:** Social stigma, gender bias, and a lack of education contribute to poor awareness, research gaps, and under-prioritisation of gynaecological care.
- **NHS Shortcomings where also identified:**
    - Inadequate training for primary care practitioners, particularly for young women and girls.
    - Poor understanding of treatment options.
    - Long waiting lists due to under-resourcing.
      Need for urgent training and better patient communication.

Violence against minorities ethnic women in the healthcare workforce.

The most recent NHS staff survey (March 2024) showed that frontline NHS staff are facing record levels of discrimination from the public. Minoritised ethnic women using health care services and providing them face a heightened risk of being targeted. For the first time, the survey asked NHS staff if they had experienced sexual harassment while at work, with the results revealing 58,000, or 1 in 9, of the roughly 670,000-strong workforce had experienced sexual harassment from patients, patients' relatives, or other members of the public in 2023.

These unacceptable findings have troubling implications for a workforce that employs high numbers of minoritised ethnic women. With nurses most likely to be both minoritised ethnic and women, it is troubling to see that 60% of nurses surveyed reported experiencing sexual harassment. Two-thirds of women surgeons reported being sexually harassed, and a third had been sexually assaulted, by male colleagues in the past five years.

Conclusion

- **Underdiagnosis and Delays in Care**
  The gender health gap is likely more significant than it seems, with many women facing underdiagnosis and delays in receiving care.
- **Barriers to Service Access**
  Despite efforts to improve access, women struggle to utilise healthcare services due to time constraints, financial limitations, and caregiving responsibilities.
- **Addressing Structural Inequalities**
  Closing the gender health gap requires tackling not only access issues but also deeper structural inequalities and economic barriers.
- **Need for Accurate Health Information**
  A lack of accurate and accessible health information for women must be addressed to ensure better healthcare outcomes and informed decision-making.
- **Intersecting racialised and sexualised violence.**
  It is well documented that significant inequality exists for women when accessing health services, the intersectionality of ethic inequity further exacerbates this.

11. Violence against women and girls (VAWG)

Introduction

Violence Against Women and Girls (VAWG) encompasses a range of crimes that disproportionately affect women and girls, though people of all genders may be impacted. These crimes include:

- Domestic abuse
- Rape and sexual offences
- Stalking and harassment
- 'Honour'-based abuse (e.g. FGM (Female Genital Mutilation), forced marriage, 'honour' killings)
- Digital abuse (e.g. revenge porn, upskirting)

Offenders may be partners, ex-partners, family, acquaintances, or strangers. Victims span all ages, backgrounds, sexualities, and races. VAWG is inherently intersectional[2] and factors including ethnicity, immigration status, economic inequality, LGBTQ+ status, and disability can increase risk.

Data Limitations

Police-recorded crime data is used to monitor VAWG incidents in York and North Yorkshire. However, survey data shows fewer than half of victims report these crimes, mirroring national trends. Specialist support services offer insight into victim demographics, but health-related data is often inconsistent, difficult to share, and dependent on individual workers' ability to identify and record needs.

VAWG also impacts families, friends, and communities. National research shows that 35% of stalking victims reported harm to others close to them.

Prevalence

Domestic Abuse

- 1,886 domestic abuse crimes recorded (2024)
- SafeLives estimates: 2,000 visible and 4,500 hidden victims in York
- 82% of domestic abuse crimes were "violence against the person," mainly common assault and actual bodily harm
- 7% of victims were repeat cases
- 1,966 high-risk cases reviewed by MARAC (Multi Agency Risk Assessment Conference)
- 0 domestic homicides reported in York in the same period

[2] Intersectionality is an analytical framework for understanding how groups' and individuals' social and political identities result in unique combinations of discrimination and privilege. A simpler term that captures the essence of 'intersectionality' is 'convergence. ' It refers to the way different aspects of a person's identity or background come together and interact.

Rape and Sexual Offences

In 2024/25, North Yorkshire Police recorded 90 cases of rape and sexual assault. In the same period, 202 individuals in York received support from Independent Sexual Violence Adviser (ISVA).

Stalking and Harassment

Nationally, 3.8% of adults aged 16–59 experienced stalking in the past year. In 2023/24, North Yorkshire Police recorded 66 cases of stalking involving fear of violence, following the launch of a specialist stalking team and screening tool.

'Honour'-Based Abuse

According to national data, between April 2024 and March 2025, 8,545 women and girls attended healthcare settings where FGM was identified, with a total of 15,905 attendances. An estimated 12 to 15 honour killings occur annually in the UK. In 2022, the Forced Marriage Unit (FMU) supported 302 cases of potential forced marriage.

Structural Gendered Racism

The UN's "16 days of activism against Gender-Based Violence" campaign take place every year and spotlights and advocates for the prevention and elimination of all forms of male violence against women and girls (VAWG).

To tackle VAWG we need to acknowledge the interlocking nature of gender and ethnicity – called structural gendered racism – as a root cause of health problems among black women and other women of colour. Structure gendered racism recognises that for minoritised ethnic women racism and sexism coalesce and intwine, leading to heightened risks, worse outcomes and is a root cause of health inequity among minoritised ethnic women.

The fact that minority ethnic women are disproportionately affected by gender based violence has been recognised at a national level by NHS England. Femicide is the most extreme manifestation of violence against women, in which a woman is killed by a man every three days on average in the UK, with government statistics showing that minority ethnic women being over represented in domestic homicide.

Digital Abuse

Nationally, 1 in 10 women have experienced online violence. This increases to:

- 25% among women aged 16–24
- 35% among LGBTQ+ women.
- Of those affected, 13% reported the abuse later escalated to offline violence.

Health impacts of VAWG

VAWG crimes can cause significant and long-lasting impacts to both physical and mental health, and even to loss of life including death by homicide and suicide.[i]

Physical Health

- In 2024/25, 12% of domestic abuse victims assessed by the IDAS hub had identified physical health needs, though professionals estimated this figure to be as high as 62% (SafeLives).
- 14% of 799 sexual assault survivors supported by ISVA (Independent Sexual Violence Advisor) services across York and North Yorkshire disclosed physical health needs.
- FGM-related impacts include severe pain, bleeding, infections, and potentially fatal complications.
- VAWG is associated with chronic conditions such as chronic pain, arthritis, asthma, and digestive issues.
- Nationally, 68% of those at risk of Honour-Based Violence (HBV) face serious harm or homicide.
- One woman is killed every five days in England and Wales by a current or former partner (SafeLives).

Sexual and Reproductive Health

- Sexual assault can result in STIs, including HIV, unintended pregnancies, and other reproductive complications.
- Women with FGM are more likely to experience serious childbirth complications, including the need for caesarean sections, severe bleeding, and increased infant mortality.
- Domestic abuse often intensifies during pregnancy, increasing risks to both mother and unborn child.

Mental Health

- 40% of domestic abuse survivors assessed by IDAS had mental health needs; professionals estimate this could be as high as 92%.
- 58% of individuals accessing ISVA support service disclosed a mental health need.
- Common barriers to mental health support include long waiting lists, unclear criteria, lack of communication and signposting back to domestic abuse services for support.
- National data shows VAWG survivors are twice as likely to experience depression.
    - 7% have attempted suicide
    - 17% have attempted suicide or self-harm (SafeLives)
    - High prevalence of PTSD (Post traumatic stress disorder) and generalised anxiety disorders

- 63.4% of sexual assault survivors reported emotional or psychological effects as their primary non-physical effect of rape or assault.
- 93.7% of women nationally have experienced street harassment, often leading to anxiety and avoidance behaviours.
- 21% of respondents to the York and North Yorkshire VAWG survey said their area felt somewhat or very unsafe for women and girls, affecting perceptions of safety even among non-victims.

Behavioural Health

- Among domestic abuse victims assessed by IDAS (2024/25):
  - 6% had alcohol support needs
  - 3% had drug support needs
- Professionals estimated 66% of victims may require substance misuse support.
- Similar figures were reported among ISVA clients.
- National research suggests substance use may be a coping mechanism for trauma linked to abuse.

Other Health Implications

National research shows healthcare practitioners are often the first point of contact for survivors. 80% of women in relationships with domestic abuse had visited their GP before accessing support, 57% of victims at risk of HBV had visited their GP in the last 12 months and 19% had visited A&E as a direct result of the abuse[i].

National data suggests 54% of stalking victims disclosed practical impacts on their lives and activities, including investing in extra security, limiting social activities and changing a workplace or home.[ii]

Over a fifth of sexual assault victims said that they took time off work because of the assault, and 6% reported losing their job or giving up work[iii]. Furthermore, women who have experienced sexual abuse are less likely to attend routine cervical screening appointments[iv].

According to Refuge 40% of homeless women state domestic abuse as a contributory factor to their homelessness.

Efforts to address VAWG in York and North Yorkshire.

In line with the national *"Tackling VAWG Strategy"*, a joint VAWG Strategy for York and North Yorkshire was launched in June 2022 by the Police, Fire and Crime Commissioner's Office (now under the York and North Yorkshire Combined Authority YNYCA) launched a new joint Strategy to Address Violence Against Women and Girls and accompanying delivery plan. In York this work is overseen by the Safer York Partnership. The strategy has six key objectives;

1. Listening to women and girls
2. Prevention and early intervention
3. Building trust in policing
4. Strengthening multi-agency collaboration
5. Enhancing victim support
6. Facilitating perpetrator behaviour change.

A progress report on delivery against the VAWG strategy completed June 2023 found that 12% more referrals were being made to victim services and those who access services 154% reported positive outcomes. This strategy is supported by the North Yorkshire and City of York Domestic Abuse Strategy 2024–2028, launched in spring 2024.

Conclusions

- **Data Gaps in Assessing Unmet Health Needs**
  Data gaps make it difficult to fully understand the unmet health needs of women and girls affected by Violence Against Women and Girls (VAWG).
- **Physical and Mental Health Impacts of VAWG**
  VAWG results in significant short- and long-term physical and mental health consequences for survivors.
- **Addressing Immediate and Long-Term Care Needs**
  Health systems must address both immediate care and long-term recovery for those affected by VAWG.
- **Need for Further Research and Improved Data Collection**
  More research and better data collection are essential to understand and address the health impacts of VAWG.

12. Challenges and limitations of this HNA

Purpose and Intended Outcomes

The aim of a Health Needs Assessment is to identify unmet health and care needs within a given population—in this case, women—and recommend the changes necessary to address them. It is a systematic, data-driven approach used to:

- Describe population health issues
- Identify health inequalities and gaps in service access
- Set priorities for effective resource use

The purpose of this Health Needs Assessment (HNA) is to build system-wide awareness of unmet health needs among women in York, with a particular focus on those experiencing social marginalisation. Our aim is to embed learning from this process into the working practices of our own commissioned services and influence wider commissioning and service design across the local health and care system.

Despite the data challenges, we can confidently conclude that there is an unmet need for more detailed, gender-specific data collection to better address the health and care issues that affect women in York.

We intend to monitor for evidence of impact following publication and encourage all system partners to reflect on how they can respond to the findings.

Learning from conducting the HNA

3.1 Approach to Data Collection

We opted not to interview women directly for their views, as this work was being undertaken concurrently by Healthwatch. As such, we recommend that this report be read in conjunction with Healthwatch's findings to ensure a more comprehensive understanding.

3.2 Evolving Insights

As we progressed with the report, it became apparent that the initial topics we had identified—such as caring responsibilities, maternal health, and employment—while important, were insufficient to provide a complete picture of the needs of women in York. It is acknowledged that the scope of this HNA does not fully capture the diversity and complexity of the challenges faced by women in York.

3.3 Challenges with Data Availability

Data was hard to gather related to the identified themes, especially at the local level, despite stakeholders often being open to providing it. This may stem from capacity constraints across the system, which has made gender-disaggregated data difficult to gather.

3.4 Limitations and the Imperfect Nature of the Assessment

This Health Needs Assessment should be viewed as a starting point, not a final answer. The process of gathering information from a range of sources to build a clearer picture naturally involves challenges and limitations. The work presented here is exploratory, and the lack of easy access to high-quality, comprehensive data is a key reason why the assessment was necessary in the first place. It's important to remember that this work reflects an ongoing effort to understand and address the needs of women in York.

3.5 Complexity of Women's Health and Data Gaps

Women's health is a vast and complex field, with each of the topics covered in this report representing a significant area of inquiry. A lack of comprehensive data and system capacity has limited the research we were able to conduct.

One key lesson from this assessment is the fragmented and incoherent approach to women's health services in York. The value of a comprehensive national Women's Health Strategy is clear, and while it is too early to measure improvements, national and local stakeholders have already begun responding to the need for change in response to the national strategy.

Conclusion.

It is crucial to emphasise that no needs assessment can speak to, and for all, 51% of the population. However, this report provides insights into how we can better support women across various areas of life, from healthcare and education to caregiving roles and service access. We must continue addressing issues such as misogyny, period health, menopause, and maternal care.

The Humber and North Yorkshire ICB report on women living in the wider geographical region offers some more nuanced insights, but its usefulness in addressing the unique needs of women in York is limited due to the vast and diverse area it covers.

An additional challenge is the lack of consensus on how to define "woman." The complexity of this debate has been underscored by the recent Supreme Court ruling (April 2025), which determined that the legal definition of a woman is based on biological sex, and clarified how the law defines the words 'man', 'woman' and 'sex' in the Equality Act 2010.This ruling could have significant implications for the health and care needs of women, particularly transgender women. The impact of this legal decision is still being explored, and organisations should respond appropriately.

Awaiting timeline infographic with key initiatives which will impact on the HNA.

13. Recommendations: 6 Strategic Themes for York

The data and evidence in this report suggest that York's approach to women's health and equality should be shaped around six key priorities.

Adopting these priorities would focus efforts on addressing the barriers women face, promoting gender equality, and improving well-being. By collaborating across all sectors – public, private, and voluntary – York could take a city-wide approach to create lasting impact, fostering a more inclusive and supportive environment for all women in the city.

Strategic Theme #1: Early Intervention and Prevention

Why it matters: Tackling the root causes of poor health and gender-based violence reduces harm before it escalates. Good practice suggests that this includes:

- Prioritising early identification of issues across health, education, and community services.
- Implementing school-based education on menstrual health, consent, and healthy relationships (PHSE).
- Training frontline professionals to recognise early warning signs of abuse, health neglect, or social isolation.
- Expanding public campaigns to shift social norms and promote healthy, safe behaviours from a young age.

Strategic Theme #2: Gender-Specific Data, Research, and Monitoring

Why it matters: Lack of detailed, disaggregated data hides disparities and limits targeted action. Good practice suggests that this includes:

- Improving gender-disaggregated data on health, employment, and care burdens, taking into consideration the intersection of other protected characteristics including race and disability.
- Standardising recording of VAWG-related health needs across sectors.
- Commissioning local research to better understand hidden or unmet needs (e.g.' mental health, economic abuse).
- Embedding equity-focused data analysis in service planning and funding decisions.

Strategic Theme #3: Partnership and Multi-Agency Collaboration

Why this matters: Strong multi-agency collaboration ensures a coordinated, efficient, response to the complex, needs of women and girls, improving safety, support, and long-term outcomes. Good practice suggests that this includes:

- Strengthening cross-sector working between health, policing, education, local authorities, housing, and the voluntary sector.

- Embedding healthcare workers in domestic and sexual violence services.
- Use frameworks like MARAC more broadly to coordinate care and risk management.
- Co-producing solutions with lived experience voices through advisory panels and community engagement.

Strategic Theme #4: A Public Health Approach to Gender Inequality

Why this matters: A public health approach to gender inequality addresses the causes of women's health issues, builds resilience, and creates fair solutions for everyone. Good practice suggests that this includes:

- Addressing women's health issues as systemic public health challenges, not niche concerns.
- Tackling the root causes of inequality—poverty, trauma, discrimination, and social norms—through upstream investment.
- Promoting community-based supports (e.g. befriending, peer recovery, women's hubs) that reduce isolation and promote resilience.
- Focusing on intersectionality, recognising how age, ethnicity, religion, disability, sexuality, and income intersect with gender.

Strategic Theme #5: Accessible, Trauma-Informed and Gender-Sensitive Services

Why this matters: Women face multiple and overlapping challenges that require joined-up, sensitive responses. Good practice suggests that this includes:

- Improving access to reproductive, mental, and primary care, particularly for menopause, period health, and cancer screening.
- Ensuring trauma-informed practices in all medical procedures (e.g. IUD fittings).
- Reducing waiting times and barriers to mental health and substance misuse support with tailored services for women.
- Embedding support for survivors of VAWG into housing, health, and employment

Strategic Theme #6: Economic Empowerment and Workplace Equality

Why this matters: Economic empowerment and workplace equality remove barriers, giving women the opportunity to succeed, grow, and be financially independent. Good practice suggests that this includes:

- Addressing structural barriers to women's employment: flexible work, caregiving penalties, unequal pay, and lack of progression.
- Supporting women to re-enter, remain in, and progress through work, particularly carers and return.

14. Bibliography, references and further reading.

General

Women's Health Strategy for England 2022

Easy read version of the Women's Health Strategy for England.

NHS 10 Year Plan. Launched in October 2024 to hear people's views, experiences and ideas to help shape the new 10 year health plan. Due to be published in 2025.

Woman of the North Report, inequality, health and work.

Women's Health Profile: Humber and North Yorkshire Integrated Care Board, October 2023

Our City Health Narrative V4 A summary of the York Joint Strategic Needs Assessment (JSNA) in 2025

For information about York's demographics and wider determinants of health: York Health and wellbeing JSNA

Census Data for York: number of households.

Public health Outcomes Framework (fingertips) PHOF

The PHOF was introduced in 2012 to allow the whole public health system to be refocused around achieving positive health outcomes for the population and reducing inequalities in health, rather than focused on process targets.

Office for Health Improvement & Disparities. Public health profiles. [27 May 2025] https://fingertips.phe.org.uk © Crown copyright [2025].

Hard Edges: The reality for women affected by severe and multiple disadvantage Heriot Watt University published January 2024

New report provides snapshot of human rights in the City of York University of York 2025

Supreme Court ruling on the meaning of 'man', 'woman' and 'sex' – what it means for health and care Healthwatch North Yorkshire. Published April 2025.

Local Resources from Benenden Health

Please note that Benenden Health is a private healthcare provider, and we are not recommending this private provider above any other.

Benenden Health have also been working on *"Understanding the Gender Health Gap"*. Their National Survey results from 2024 are available here. *"Supporting women in the workplace – a guide for businesses"* is downloadable here.

Benenden Health partnered with The Fawcett Society to publish *The Gender Health Gap: Our Stories,* six real life stories of women's experiences in the health system and the impact on work and life.

Unpaid care and gender disparities.

Woman of the North Report Inequality health and Work, 2024
Ref: Bambra C, Davies H, Munford L, Taylor-Robinson D, Pickett K et al. (2024) Woman of the North. Health Equity North: Northern Health Science Alliance

Unpaid care by age, sex and deprivation, England and Wales: Census 2021

Survey of Adult Carers in York, Business Intelligence Hub 2024

Wellbeing and relationships Carers UK 2022

Caring as a social determinant of health Public health England, 2021

The state of caring 2022. Carers UK 2022

Women in employment.

Labour Market Profile - Nomis - Official Census and Labour Market Statistics York data

Women and the UK economy. Research briefing. Published February 2025. House of commons Library.

Mid-life women face growing pension gap Published 26 June 2025 AVIVA.

Loneliness and isolation in older women.

The State of Women's Health in Leeds White A., Erskine S., and Seims A (2019)

Jo Cox Commission on Loneliness and social isolation, 2017.

The state of aging 2022. Centre for ageing better. Summary The State of ageing 2023/24

Public Health Outcomes Framework – Fingertips

Loneliness Strategy 2018 (Published by Theresa May's conservative government).

State of healthy Ageing in Yorkshire and the Humber 2023. A resource to support Health Needs Assessments. February 2023.

Aging Well – York JSNA. York Health and Wellbeing.

Social Isolation and Loneliness in Older Adults—A Mental Health/Public Health Challenge. JAMA Psychiatry 2020.

Menopause

Menopause: a global health and wellbeing issue that needs urgent attention. Delanerolle, Gayathri, Pathiraja, Vindya et al.
The Lancet Global Health, Volume 13, Issue 2, e196 – e198

Nice Guidance QS 143 Quality statements | Menopause | Quality standards | NICE
Menopause NHS website Menopause - NHS

Menopause transition: effects on women's economic participation. Published 20 July 2017

Challenging the culture on menopause for working doctors report

Your guide to Menopause - BHA for Equality

Primary-care-HRT-guidelines-v15.pdf

Period Poverty.

Period product scheme for schools and colleges - GOV.UK Updated May 2025

Period Poverty in UK Higher Education: Addressing Stigma and Empowering Students - HEPI Higher Education policy Institute. January 2024

Home | PeriodPoverty.uk

Period Poverty - What is it and what can be done? - Initial UK - Blog

Who Will Tackle the UK's Crippling Period Poverty Crisis? Shout Out UK (SOUK October 2024)

york-youth-council-make-your-mark-report-2019

Period poverty: a public health crisis. Peer reviewed by **Dr Krishna Vakharia, MRCGP** Authored by **Amberley Davis** Originally published 10 Mar 2023

Period Poverty: A neglected Public Health Issue. Jaafar et al 2023. KJFM

UK Youth Parliament 2018. Briefing paper. Period poverty has been debated many times – May 2024, December 2021, March 2020 April 2019.

.Secondary and Sixth Form School Health and Wellbeing City Report. 2023/24 York

Understanding Period Poverty: Socio-Economic Inequalities in Menstrual Hygiene Management in Eight Low- and Middle-Income Countries. Rossouw, et al 2021. Int J Environ Res Public Health. 2021 Mar 4;18(5):2571. doi: 10.3390/ijerph18052571

Cost of living: UK period poverty has risen from 12% to 21% in a year. May 2023. Pyecroft, H. Action Aid

Cancer Screening

Women's Health Strategy for England – Chapter 15: Cancers. Updated August 2022.

Breast Screening Programme. England 2023-24. NHS England NHS Digital.

Public Health Outcomes Framework. Fingertips. Cancer Screening coverage York 2023/24.

Cervical Screening Programme for England 2023-24. NHS England. NHS Digital

Bowel Cancer Screening Programme for England 2023-24. NHS England. NHS Digital

Bowel Cancer screening - NHS UK

Breast Screening - NHS UK

Cervical Screening - NHS UK

Life-saving scheme to improve cancer screening among Muslim women. Cancer Research UK July 2023

Maternal Health

Births in England and Wales - Office for National Statistics
How is the fertility rate changing in England and Wales? - Office for National Statistics
Births in England and Wales - Office for National Statistics
Global, regional, and national estimates and trends in stillbirths from 2000 to 2019: a systematic assessment - The Lancet
MBRRACE-UK Maternal MAIN Report 2024 V2.0 ONLINE.pdf
Child and Maternal Health | Fingertips | Department of Health and Social Care
A national cohort study and confidential enquiry to investigate ethnic disparities in maternal mortality - PubMed
NHS Digital. (2022). *NHS maternity statistics 2021–2022* https://digital.nhs.uk
https://www.npeu.ox.ac.uk/mbrrace-uk Saving Lives improving mothers' care.
Woman-of-the-North-report.pdf
Conceptions in young people – RCPCH – State of Child Health
Suicide still a leading cause of maternal death | Maternal Mental Health Alliance
Culture, spirituality and religion: migrant health guide Gov.UK Updated September 2021

York JSNA – Health across the life course – starting and growing well.

York JSNA - Health across the life course – living and growing well

Accessibility of Primary care services.

Barriers to women accessing healthcare in the UK. Jeffery, G. LSE Policy Review. Published March 2025.

Women's Health – Let's Talk about it, survey. Updated in April 2022

North Yorkshire and York Healthwatch report: Women's Health: Stories of women's health experiences in York and North Yorkshire" Due to be published in 2025

Women's Health is a $1 trillion opportunity that demands greater investment. World Economic Forum (WEF) May 2025.

"Medical misogyny" leaves many women in pain, MPs' inquiry finds. *BMJ* 2024; 387 doi: https://doi.org/10.1136/bmj.q2780 (Published 11 December 2024) Cite this as: *BMJ* 2024; 387:q2780

Violence against Women and girls.

Tackling violence against women and girls strategy, Home Office, GOV.UK accessed 21/05/2025

Measuring gender equality in the UK: data on violence against women and girls report, King's Global Institute for Women's Leadership, 2024

The Impact of Stalking and Its Predictors: Characterizing the Needs of Stalking Victims. Storey et al, 2023 Journal of Interpersonal Violence

Safer York North Yorkshire and City of York Domestic Abuse Strategy 2024-2028

VAWG survey analysis 2025, York & North Yorkshire Combined Authority. Unpublished

SafeLives Safe Accommodation Strategy 2021-2024. North Yorkshire and City of York. Please note 'invisible' in this context means those not known to services such as the police or victim support services.

North Yorkshire Police Domestic Abuse Operational Problem Profile 2023-2024. Unpublished.

Home Office Community Safety Partnership Open Data Tables 2024-2025.

Crime in England and Wales: year ending December 2024, ONS

Female Genital Mutilation Enhanced Dataset (FGMED) accessed from NHS digital 20/05/2025

Forced Marriage Unit. Home Office and Foreign, Commonwealth & Development Office

Open University Observatory on Online Violence Against Women, Open Research Online

The lasting impact of violence against women and girls. ONS 2021

World Health Organization (2012). Understanding and addressing violence against women: Health consequences. Retrieved from: https://iris.who.int/bitstream/handle/10665/77431/WHO_RHR_12.43_eng.pd

www.haloproject.org.uk/img/FGM

The association between violence against women and chronic pain: a systematic review and meta-analysis, Uvelli et al *BMC Women's Health* volume 24, Article number: 321 (2024)

SafeLives, your choice spotlight on HBV and forced marriage https://safelives.org.uk/wp-content/uploads/Your-choice-Spotlight-on-HBV-and-forced-marriage.pdf

FGM the facts, Home Office, 2011

SafeLives Safe Accommodation Needs Assessment and Wider Review, North Yorkshire and City of York, 2023 (Unpublished)

Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. Trevillion, K., Oram, S., Feder, G., & Howard, L.M. (Pub Med 2012)

Women's Aid, Domestic Abuse Report 2022. https://www.womensaid.org.uk/wp-content/uploads/2022/03/The-Domestic-Abuse-Report-2022-The-Annual-Audit.pdf

Alcohol and violence briefing statement, Faculty of Public Health
IRISi, accessed from https://irisi.org/ May 2025) and SafeLives Spotlight on HBV and forced marriage.

Barriers to cervical screening in women who have experienced sexual abuse: an exploratory study. Cadman L et al, 2014, BMJ

Male violence against Minoritised ethnic women exacerbating ethnic health inequity and endangering staff. NHS Health and Race Observatory. **Published:** 10.12.2024

Acknowledgements

This document was produced by the Public Health Team at City of York Council.

We would like to thank all the stakeholders and colleagues who generously gave their time to be interviewed and shared valuable insights and data to inform this report. This report would not have been possible without the collaboration and commitment of everyone involved.

Note: This document contains a small amount of content generated by Artificial Intelligence (AI). AI-generated content has been reviewed by the author for accuracy and edited/revised where necessary. The author takes responsibility for this content.