Rosa, the UK Fund for Women and Girls, was set up to support initiatives that benefit women and girls in the UK. While many women and girls do enjoy freedom of choice and the opportunity for success in their lives, that's simply not true of all. This paper is one of four, which each look at where we are on a key issue: economic justice, safety, leadership & participation and health & wellbeing. Each paper describes the issues that need tackling, where we want to be, and how we'll know we're there.

Without a strong, vibrant women's sector, and the money to underpin action, we can't hope to bring about women's equality. Rosa's aims are to achieve social justice and equality for all women in the UK.

Health and Wellbeing

Where are we now?

There are differences between men and women in the incidence and prevalence of most health conditions. Sometimes there are clear biological reasons for these differences – but often there are not. Gender is the most significant factor interacting with economic status to compound health inequalities. Women and girls have greater health and social care needs than men across their lives and face significant barriers to both good mental and physical health. Women and girls' lives are shaped by physiological factors and social experiences that negatively impact on their physical and mental health, including poverty and economic disadvantage, women's reproductive and caring roles, experiencing violence and abuse, and age. Whilst women live longer than men, they spend more years in poor health and with a disability. This has a detrimental impact on them as individuals; but women's position in society as main care givers means their poor health will also have a detrimental impact on the lives of their families and their ability to function in wider society, in their community and in the labour market. – ***Women's Equality In The UK: A Health Check***[1]

Women's health across the world, including the UK, is impacted not just by their biological sex, such as illness and disease related to reproductive functions, but also their socially-constructed gender roles. Women's greater exposure to poverty; their greater responsibility for child and elder care and their greater reliance on men for household income; the endemic nature of men's violence against women, and the threat of it, with one in three women globally being affected, and the embodiment of family and community honour being imposed on women and used to police and control their actions: these lived experiences shape women's health needs, ability to live healthy lives, and access to services. Moreover, there is evidence that policies on gender equality have a measurable impact on women's health, for example suggesting that Nordic social democratic welfare regimes and dual-earner family models best promote women's health; that enforcement of reproductive policies is

associated with better mental health outcomes, and that longer paid maternity leave is linked to better mental health and longer duration of breastfeeding.[2]

Although medical models and research use men as their standard, biological differences between women and men - reproductive, genetic, hormonal and metabolic – mean that there are specifically female patterns in disease. Women are around 2.7 times more likely than men to develop an auto-immune disease such as diabetes.[3] Coronary artery disease (CAD) is a leading cause of death of women and men worldwide. CAD's impact on women traditionally has been underappreciated due to higher rates at younger ages in men. Women have unique risk factors for CAD, including those related to pregnancy and autoimmune disease.[4]

This distinction between the medical and the social has been extensively explored in relation to disability. The social model acknowledges that the impact of disability is more strongly driven by social factors such as the design of the built environment and transport than by medical conditions themselves. Disabled women are disempowered both by their disability and their gender, and by their race and sexual orientation or gender identity. They are liable to abuse by their carers, and more liable than able-bodied women experience domestic violence and childhood sexual abuse.

Gender inequality in income and autonomy make women vulnerable to poverty, and thence to an unhealthy lifestyle, particularly while their earning power is reduced during child rearing. The 'double burden' means that many women combine paid work with domestic duties, pregnancy, and childrearing. In the UK, 70% of all housework is done by women, and even if they work over 30 hours per week, nearly two-thirds of all housework is done by women.[5]

Mental Health

Socially determined gender norms and roles reduce women's control over important household and day to day decisions, as well as over their own lives. Women are 40% more likely to suffer from depression than men,[6] although there is no evidence that women are constitutionally more susceptible to such problems. The higher rates of anxiety and depression found among women in so many parts of the world have been linked to the gender socialisation that puts low value on women and their potential.

Learning disabilities in women carry increased risk for a range of other health problems, including osteoporosis, early menopause, obesity, and diabetes.[7]

Sexual and Reproductive Health

- Women are more likely than men to suffer health problems connected with their reproductive systems, especially during their active reproductive years. [8] Women's lives and health are circumscribed by their sexual and reproductive rights, and access to contraception, abortion and fertility treatment are therefore central. Globally, poor maternity services mean that women often suffer from long-term fistula and incontinence.

- In the UK, the current standard of maternity services is poor. Stillbirth rates are higher than in many other high-income countries, and there is also wide variation in the care provided to women across the country. Maternity care cost the NHS around £2.6 billion in 2012-13, while 35% of all clinical negligence claims received last year in the NHS, by value, were for

obstetrics. The total cost of maternity clinical negligence cover in 2012-13 was £482 million - 20% of the total budget.[9]

Although abortion is legal, interpretations of the law, levels of funding, and professional practice all influence health outcomes. Women with fewer resources, especially black and minority ethnic women, women with uncertain migration status, and disabled women, can find it harder to access support. Women in Northern Ireland are even more restricted as Northern Ireland is not covered by the 1967 Abortion Act, which applies in the rest of the UK, and have to travel to England for abortions, a route that is not available to poor women.

Violence and women's health

Violence is a leading cause of women's ill health.[10] Domestic violence often starts or escalates during pregnancy and is associated with increased miscarriage, low birth weight, premature birth, foetal injury and foetal death. Each adult rape is estimated to cost over £96,000; the long-term effects can include depression, anxiety, post traumatic stress disorder, substance misuse, self-harm and suicide.[11]

Following rape, nearly 1 in 3 women will develop PTSD compared with 1 in 20 non-victims. The severity and the duration of exposure to violence are closely linked to the severity of mental health outcomes. Rates of depression are 3 to 4 times higher in women exposed to childhood sexual abuse or physical partner violence in adult life. Levels of detection of violent victimization are poor and primary health care providers require better training to intervene successfully to arrest the compounding of mental health problems.[12]

The Refugee Council[13] has reported that more than 70% of women seeking asylum in the UK had experienced violence either in their country of origin or since arriving here; 57% had experienced gender based violence in their country of origin, and 44% had been raped. Half had mental health needs and over 20% had acute mental health problems. Shamefully, research by Women for Refugee Women has found that 16% of women made destitute after their asylum claim was turned down have experienced sexual violence here in the UK.[14]

Rape Crisis Centres and other specialist support services for women struggle to remain open, and often close through lack of funds.[15] In recent years, the statutory commissioners of such services often refuse to fund services for women only, on the grounds that this discriminates against men, despite the fact that women who have been attacked, often repeatedly throughout their lives, prefer the safety of women-only spaces.

Young women and girls

- 29% of young women and 28% of young men aged 16-21 report sexual intercourse under the age of 16.
- The impact of porn on young people's expectations about sex has been considerable, raising concerns about understandings of consent.[16] NSPCC research shows almost a third of school pupils believe online pornography dictates how young people have to behave in a relationship, while other research indicates that exposure to porn is associated with riskier sexual behaviour.[17]

- Worldwide, women with at least some formal education are more likely to seek medical care during pregnancy, ensure their children are immunized, be better informed about their children's nutritional requirements, and adopt improved sanitation practices. As a result, their infants and children have higher survival rates and tend to be healthier and better nourished. An extra year of secondary schooling for girls can increase their future wages by 10 to 20%.[18]
- Eating disorders are associated with poor self-esteem and body image. Anorexia nervosa commonly starts between the ages of 15 and 25; 90 % are women. It carries the highest risk of death of any psychiatric disorder.[19]

Older women

Women in the UK suffer from greater poverty in old age, exacerbating the problems of living a healthy life.

- Current life expectancy in the UK is 78.7 years for men and 82.6 for women.[20] Women therefore spend longer in old age, with the associated illnesses. 59% those who live alone in England and Wales are aged 85 and over. Of these, 76% are women.[21] These social and biological factors interact to make a significant impact on the health burden of older women. Women are particularly affected by dementia and Alzheimer's, which are associated with ageing.[22]
- In terms of disability, the situation has worsened for women but somewhat improved for men. At age 65, men are more likely than women in the UK to live over half of their remaining lives free from disability (53.2% and 58.5% for women and men, respectively).[23]
- In 2013, 45% of men aged 75 and over reported a limiting long-standing illness or disability, in comparison with 49% of women.[24]
- 1 in 3 women over 65 experience incontinence, as compared to 1 in 7 men.[25] This causes psychological distress and is a leading cause of moving into residential care, as family can no longer cope.
- The drop in oestrogen levels at menopause leaves older women more at risk of osteoporosis and heart disease and stroke. Hormone replacement therapy can increase the chances of breast cancer and heart problems.[26]

Minority women

Sex inequality is exacerbated by other forms of inequality: for example, Travelling women are less able to access health care, leading to higher rates of maternal deaths,[27] while black women in Britain develop breast cancer up to 21 years earlier than white women. They are seen at a median age of 46—four years before routine NHS screening for the disease starts—compared with 67 for white women.

FGM involves partial or total removal of the female external genitalia, and the stitching of the vagina (infibulation), leaving only a small opening for urine and menses. It is linked with childbirth complications and perinatal mortality. Around 66,000 women are living with the effects of female genital mutilation (FGM) and around 16,000 girls under 15 are at risk of FGM; clinics that can offer treatment are overwhelmed by demand.[28]

Refugee women are more likely than men to report poor health and depression. Screening and health promotion programmes have a low uptake: e.g., less than 25% of women refugees from the Horn of Africa report having a smear test.

The discrimination experienced by lesbians extends to how they are treated by some health care providers, who may hold homophobic views. They may not disclose their sexual orientation to their GP, because they anticipate discrimination, but then fail to receive appropriate health care, including mental health care. Research suggests that LGB people have very specific health concerns which the health sector does not always meet.[29] They report high rates of discrimination by health care workers. Many experience direct or indirect homophobia from professionals and at work, or have been physically or verbally abused by strangers on the street or on public transport.[30]

Lesbians and bisexual women are subject to a range of health problems apparently related to psychological issues: they report higher rates of substance abuse, including smoking, drinking, and drugs; and higher rates of self harm, including suicide attempts.[31] They are less likely than other women to have had cervical cancer screening. Lesbians with learning difficulties experience high levels of bullying and harassment as a direct result of their sexuality; much comes from close family. In some communities lesbians suffer the threat of forced marriage or being ostracised.

Where we want to be

Women's health needs require specific research, resources and support. Many of women's health problems would be resolved by tackling the indicators of women's inequality beyond health – reflecting the recommendations of the Marmot Report on health inequalities across the board. We need to see an improvement in women's social and economic position in order to see a parallel improvement in health outcomes: public policy needs to address women's poverty, their greater vulnerability to violence, and their lack of voice as well as their greater vulnerability to discrimination, especially that of minority women, either because of their ethnicity, sexuality, disability, and age. Women's sexual and reproductive rights need to be reinforced and sustained so that all women can access contraception sexual health and abortion rights. Joint Strategic Needs Assessments and Health and Wellbeing Boards need to work within a basic equalities framework, and an understanding of gendered issues, including violence against women and girls.[32] Better data on women's health needs is also required. [33]

Specific services such as trained advocates would help minority women such as refugees, travelling women and lesbians to discuss health and access health screening. Women need sexual health care, family planning, and maternity care that is sensitive to their cultures and GUM services should be tailored and extended. Women should be offered choice as to the sex of the health worker they see and of interpreter. Health workers need to be aware that some women will have undergone FGM and that this can affect sexual health and childbirth; and that many women experience sexual and domestic violence. The routine enquiry about domestic violence that has now been adopted by the NHS for pregnant women should be extended to include all forms of violence to all women, including for example sexual abuse, FGM, and forced marriage. Better caring, medical, and support services for older women especially those who live alone should be a priority. Women should be empowered to improve their own health and well-being through self-help groups and community

based initiatives. Women-only specialist support services should be funded and encouraged (for example, Rape Crisis Centres).

How we'll know when we're there

- Health inequalities driven by gender inequality will start to disappear. The causative factors that contribute to women's poor health like poverty and shorter leisure hours will no longer feature
- Women's mortality and morbidity rates will be falling steadily, and life limiting conditions of old age will have reduced
- Women's high rates of mental ill health, including depression and anxiety, will have reduced, and the even-higher rates for minority women will disappear
- FGM and other harmful practices, such as forced marriage, will have been eradicated
- Health care, and specialist, women-only spaces in support services for women who have suffered from violence and abuse will be readily and locally accessible; women will report violence more quickly, and the incidence of violence will have fallen.
- High quality SRE will be delivered within the mandatory National Curriculum
- High rates of eating disorders and self harm in girls and young women are reduced
- Women will report greater feelings of wellness and wellbeing; and fewer pressures on them to conform to stereotypes that can damage their health.

---

[1] 'Women's equality in the UK – A health check', Shadow report from the UK CEDAW Working Group assessing the United Kingdom Government's progress in implementing the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 2013, http://www.fawcettsociety.org.uk/wp-content/uploads/2013/05/Women's-Equality-in-the-UK-A-health-check.pdf

[2] Influence of Macrosocial Policies on Women's Health and Gender Inequalities in Health, Borrell et al, Special Issue on the Epidemiologic Approaches to Women's Health, Epidemiological Reviews, Volume 36 Issue 1 2014 2013, http://epirev.oxfordjournals.org/content/36/1/31.full.pdf+html

[3] NHS Scotland and the Gender Equality Duty: Improving Gender Equality Practice in NHS Scotland, 2008, http://www.equalityhumanrights.com/sites/default/files/documents/EqualityAct/PSED/research_doc_fair_for_all.pdf

[4] Coronary Artery Disease in Women, A 2013 Update, Sharma, Gulati, Global Heart, 2013,Volume 8, Issue 2, Pages 105–112, http://www.globalheart-journal.com/article/S2211-8160(13)00038-0/fulltext

[5] European Social Survey (ESS), ESRC, 2013, http://www.esrc.ac.uk/news-and-events/press-releases/27163/A_womans_work_is_never_done.aspx

[6] Women's Voices on Health - Addressing Barriers to Accessing Primary Care, Women's Health and Equality Consortium, 2014, http://www.instituteofhealthequity.org/projects/womens-voices-on-health-addressing-barriers-to-accessing-primary-care

[7] Health Inequalities & People with Learning Disabilities in the UK, Emerson and Baines, 2010, https://www.improvinghealthandlives.org.uk/uploads/doc/vid_7479_IHaL2010-3HealthInequality2010.pdf

[8] Gender, Health, and Cultures: Networking for a Better Future for Women within an enlarged Europe, Lasch, Freitag, Sonntag, 2006, Kassel University Press

[9] All figures from the Terms of Reference for the Maternity Review, 2015, NHS England, http://www.england.nhs.uk/wp-content/uploads/2015/03/maternity-rev-tor.pdf

[10] Domestic Violence: A National Report, Home Office, March 2005 page 2

[11] The Government Response to the Stern Review: An independent review into how rape complaints are handled by public authorities in England and Wales, Cabinet Office, 2011, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97907/government-stern-review.pdf

[12] Gender Disparities In Mental Health, World Health Organization, http://www.who.int/mental_health/prevention/genderwomen/en/ [accessed 11 June 2015]
[13] The experiences of refugee women in the UK, Refugee Council, 2012, http://www.refugeecouncil.org.uk/assets/0001/5837/Briefing_-_experiences_of_refugee_women_in_the_UK.pdf
[14] Refused: the experiences of women receive it refused asylum in the UK, 2012, Dorling et al, Women for Refugee Women, http://www.refugeewomen.co.uk/wp-content/uploads/2015/04/refused.pdf
[15] In 2007, 42 groups were associated with the Rape Crisis Network in England and Wales, 18 less than existed in 1996: Map of Gaps: The Postcode Lottery of Violence Against Women Support Services, Maddy Coy, Liz Kelly and Jo Foord, 2007).
[16] Sex without consent, I suppose that is rape: How young people in England understand sexual consent, Office of the Children's Commissioner, 2013
[17] Basically... porn is everywhere": A Rapid Evidence Assessment on the Effect that Access and Exposure to Pornography has on Children and Young People, Office of the Children's Commissioner, 2013
[18] http://www.worldbank.org/mdgs/education.html [accessed 10 June 2015]
[19] Funding boost for Anorexia research, Department of Health, 2007, http://www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=277098&NewsAreaID=2&NavigatedFromDepartment=True
[20] ONS, http://www.ons.gov.uk/ons/rel/lifetables/national-life-tables/2010---2012/sty-facts-about-le.html
[21] Living Alone in England and Wales, Part of 2011 Census Analysis, Do the Demographic and Socio-Economic Characteristics of those Living Alone in England and Wales Differ from the General Population? Office of National Statistics, 2014, http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/do-the-demographic-and-socio-economic-characteristics-of-those-living-alone-in-england-and-wales-differ-from-the-general-population-/sty-living-alone-in-the-uk.html
[22] Data and Information on Women's Health in the European Union, Directorate General For Health And Consumers, 2009, http://ec.europa.eu/health/population_groups/docs/women_report_en.pdf
[23] Health Expectancies at Birth and at Age 65 in the United Kingdom, 2009–11, ONS
[24] ONS, Self-Reported Prevalence of Long-Standing Illness or Disability, By Age and Gender 2005-2013, Source: Opinions and Lifestyle Survey, General Lifestyle Survey and General Household Survey; Office for National Statistics.
[25] Later Life in the United Kingdom, June 2015 edition, Help the Aged, http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true [accessed 11 June 2015]
[26] http://www.helptheaged.org.uk/en-gb/AdviceSupport/HealthAdvice/HealthyAgeing/Menopause/TheBasics/as_menbasic_130106_3.htm?&MSHiC=65001&L=10&W=WOMENS%20women%20&Pre=%3CFONT%20STYLE%3D%22color%3A%20%23000000%3B%20background-color%3A%20%23FFFF00%22%3E&Post=%3C/FONT%3E
[27] Inequalities experienced by Gypsy and Traveller communities: A review, 2009, EHRC, http://www.equalityhumanrights.com/sites/default/files/documents/research/12inequalities_experienced_by_gypsy_and_traveller_communities_a_review.pdf
[28] A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales, Dorkenoo, FORWARD, 2007, http://www.forwarduk.org.uk/download/96
[29] Lesbian, gay and bisexual people: Discrimination and impact on general health care needs, Stonewall, http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/10763.asp [accessed 2 July2015]
[30] Challenging homophobia and heterosexism, Joyce Howarth, David Abbott & Karen Gyde, Norah Fry Research Centre, 2005
[31] Prescription for Change: Lesbian and bisexual women's health check 2008, Stonewall, 2008, http://www.stonewall.org.uk/documents/prescription_for_change_1.pdf
[32] Recommendation, art. 12, 'Women's equality in the UK – A health check', 2013, op cit
[33] The Gender and Access to Health Services Study, Final Report, Department of Health, 2008, http://www.sfh-tr.nhs.uk/attachments/article/41/The%20gender%20and%20access%20to%20health%20services%20study.pdf