HEALTH EQUITY NORTH

Woman of the North

Inequality, health and work

nhsa
Northern Health Science Alliance
A Health Partnership for Northern England

Woman of the North: inequality, health and work

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Editorial team
Bambra, Clare – Newcastle University
Davies, Hannah – Northern Health Science Alliance
Pickett, Kate – University of York
Mott, Lily - University of Manchester
Scott, Kathryn – University of Liverpool

Design Sean Collins – NHSA

Health Equity North Directors
Bambra, Clare - Newcastle University
Davies, Hannah - Northern Health Science Alliance
Munford, Luke - University of Manchester
Pickett, Kate - University of York
Taylor-Robinson, David - University of Liverpool

Health Equity North Member Representatives
Addison, Michelle - Durham University
Akhter, Nasima - Teesside University
Brown, Heather - Lancaster University
Fairbrother, Hannah - University of Sheffield
Froggett, Lynn - University of Central Lancashire
Norman, Paul - University of Leeds

Authors
Abel, Kathryn M. - University of Manchester
Addison, Michelle - Durham University
Zied Abozied, Dr Eman - Newcastle University
Akhter, Nasima - Teesside University
Akhter, Zainab - Newcastle University
Alderson, Hayley - Newcastle University
Anderson, Sara - University of York
Bambra, Clare - Newcastle University
Bennett, Natalie - University of Sheffield
Boyack, Lisa - Justice Services
Brown, Heather - Lancaster University
Browning, Anna - University of York
Changing Realities Participants
Cheetham, Mandy - Northumbria University
Cooper, Christina - Northumbria University
Cooper, Rachel - Newcastle University
Davies, Hannah - Northern Health Science Alliance
Esan, Oluwaseun B - University of Liverpool
Fairbrother, Hannah - University of Sheffield
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Munford, Luke - University of Manchester
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Pickett, Kate - University of York
Pleace, Nicholas - University of York
Powell, Lauren - University of Sheffield
Rankin, Judith - Newcastle University
Taylor-Robinson, David – University of Liverpool
Scott, Steph - Newcastle University
Simpson, Julija - Newcastle University
Smart, Deborah - Newcastle University
Snell, Carolyn - University of York
Spiers, Gemma - Newcastle University
Stockdale, Kelly - Northumbria University
UC CREATIVES
Westmarland, Nicole - Durham University
Wickham, Sophie - University of Liverpool
Wilding, Anna - University of Manchester

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Foreword

Tracy Brabin, Metro Mayor of West Yorkshire

Kim McGuinness, Metro Mayor of the North East

The women of the North are our sisters, mothers, daughters, grandmothers, aunts, and friends. They raised us, we raise them, we care for them - and they increasingly care for us. They have defined our lives.

They also face huge challenges - their health has been neglected, they are more likely to work longer, face greater ill health, be subject to domestic violence and give more unpaid care than men and women in other parts of the country.

Woman of the North is a report on inequality. On the increasing inequality that has been faced by women in our region over the past decade and a half. The effects of austerity, the cost-of-living crisis, economic stagnation, the pandemic and unequal funding formulas have all hit women living in the North, on average, harder than those in the rest of the country.

We expected those differences to be visible, but just how stark they are is made crystal clear in this report.

Ill health in the North means not only do women suffer more with their own physical and mental health, but also take on much more unpaid caring work. One in five women aged 55-59 in the North of England provide care to a family member because of illness, disability, mental illness or substance use.

Many women in the North experience poverty from cradle to the grave, in some deprived areas life expectancy is decreasing, and as the primary carers of children their poverty underlies the blight of child poverty that we see across the region.
There are things that we can do practically as mayors around skills. Educational attainment differs for women of the North with a significant number having no qualifications, much higher than the national average and the South East in particular.

We will also work to drive the economies of our regions and that of the North collectively. But we cannot do this in isolation. Central government must act with their powers as well as ours to improve outcomes through the departments of education, health and social care and work and pensions.

As the North's two female mayors we are determined to create the infrastructure of opportunity needed to change these statistics.

But this report is not only negative. The strength and resilience of women in the region is apparent.

Their hard work through paid and unpaid labour underpins the economy of the North. Through adversity, and sometimes unbearable conditions they still manage to live, hold families and communities together and even thrive.

Imagine how much more women in the North could achieve without the constraints, so clearly illustrated here.

This report must act as a wake up call to all of us in positions of power, that to unleash the potential of women in the North is to unleash the potential of the UK.

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Executive summary

60 SECOND SUMMARY

Women in the North of England face unequal challenges and inequalities in their lives and health compared to those in the rest of the country.

They are more likely to work more hours for less pay and to be in worse health. On top of this, they are more likely to be an unpaid carer, live in poverty and to have fewer qualifications.

The inequity between women living in the North of England and those in the rest of the country has grown over the past decade harming women's quality of life, work, their families and communities.

Girls born in the North East, North West and Yorkshire and the Humber in 2018-2020 can only expect to live in good health to **59.7, 62.4 and 62.1 years**, respectively. This is up to four years less than the national average and up to six years less than girls born in the South East.

Increases to retirement age would have greater adverse impacts on women in northern regions of England.

Lower levels of HRT prescribing in the North suggest some women may not be receiving adequate treatment for menopause symptoms, a concern as these affect employment, wellbeing and health.

Women in the North are paid less for their work.

They lose out on

£132m

every week, around

£6.86bn

a year compared to what they'd get if they were paid the national average.

Women in the North of England work more hours for less pay than women in the rest of the country.

Outside of London, the North consistently has a higher proportion of women who are Universal Credit claimants than the South.

A person living in the North East on Universal Credit is over 30 per cent more likely to be sanctioned than someone living in the South West.

Long-term sickness and disability in working age women is higher in the North of England. The additional economic costs of this are

£400m

a year.

All of the 12 Local Authorities (LAs) in the North East have rates of absolute child poverty above the English average.

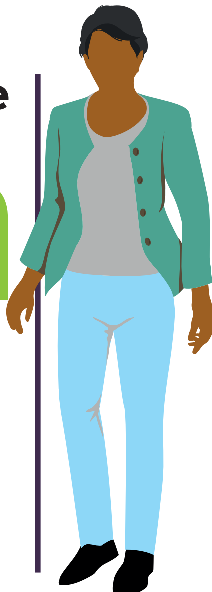
All of the 30 LAs in the South West have rates of absolute child poverty below the English average.

Women living in the North provide more unpaid care than average (10.3%) and those in London (8.4%). 12% of women in the North East, 11.2% of women in the North West, and 10.7% of women in Yorkshire and the Humber provide unpaid care.

Women in the North contribute

£10bn

of unpaid care to the UK economy each year. This is £2bn a year more than if they provided the national average of unpaid care.



One in five women aged 55-59 in the North of England provide care to a family member because of illness, disability, mental illness or substance use.

The North showed the biggest increases in abortion rates between 2012 and 2021.

There has been a demonstrable relationship between austerity, the implementation of the two-child limit, and increased rate of abortions.

Cuts to public health budgets have disproportionately affected the Midlands and North of England, with the **North enduring per-person cuts 15% higher than the average for England**, and the worst affected area in the country being the North East, with a cut of £23.24 per person.

Outside London, the three northern regions had the highest rates of new diagnoses of STIs and Gonorrhoea among people accessing sexual health services in 2022. The exception is Chlamydia in under 25s.

If services are tailored to meet the needs of those women at greatest risk within the region they serve, Women's Health Hubs could play an important role in tackling inequalities within and between regions

The repeat abortion rate among pregnant young people has been increasing nationally, but was highest in the North West in 2021, with all three northern regions in the top five across England.

For severe mental illness, such as bipolar disorder and schizophrenia the North West and North East have higher prevalence rates compared to the South and Yorkshire and Humber; eating disorders are the only low prevalence mental illness occurring in a higher proportion of women in the South.

Spending on sexual health advice, prevention, and promotion has declined dramatically since 2013-14 in almost all English regions. Regions in the North have seen a 26-28% decrease, however the North West, North East and Yorkshire and the Humber remain three of the top five highest spending regions, potentially reflecting higher STI burden in these regions.

The proportion of women with a diagnosis of mental illness who were receiving a treatment for their mental illness was lower in the North West and North East than in the South and Yorkshire and the Humber, likely indicating a treatment gap between regions.

Women in the North of England have the highest rates of domestic violence abuse in the country. The highest rates are in the North East at 19 per 1,000 population followed by 17 in Yorkshire and the Humber then 15 in the North West. The average for the rest of England is 11.

The North has disproportionate numbers of asylum seekers and resettled refugees highlighting the need for nuanced approaches to equitable resource allocation and support systems to ensure integration and welfare for vulnerable populations including asylum seekers.

Of the recorded deaths per 100,000 from alcohol-specific causes in 2021, women in the North East (13.9), North West (13.8) and Yorkshire and Humber (11.7) had the highest rates of deaths in women in England.

Nationally, less than half of women (47%) will have settled accommodation on release from prison, and one in ten will be homeless or sleep rough. Although data are not collected regionally, it is likely that these figures are much higher in the North of England.

Detailed findings

Employment and education

- Employment rates for women in the North are lower than the national average (72.2%); they are 69.8% in the North East, 71.2% in the North West, and 70.8% in Yorkshire and the Humber.
- Rates of economic inactivity among women in the North are higher than the national average (24.2%) at 26.9% in the North East, 25.5% in the North West, and 25.6% in Yorkshire and the Humber.
- Long-term sickness and disability is a major contributing factor to economic inactivity, affecting 5.8% of women in the North East, 5.4% of women in the North West, and 4.8% of women in Yorkshire and the Humber. These figures are higher than the national average (4.2%) and considerably higher than the South East (3.3%).

The estimated economic costs of this higher prevalence of long-term sickness is around £0.4bn per annum.

- Median weekly wages for women in the North are below the national average for those in both full-time and part-time employment. The average weekly wage for a full-time working woman in the North East is £569, much lower than the national average (£625) and considerably lower than for women in London (£757). The gap in pay between the North and London has grown over time.

o Multiplying the gap in median wages for each northern region, compared to the national average, by the number of women who are employed shows that women in the North lose out on around £132 million every week.

- The number of hours worked do not explain this gap. In fact, women working part-time in the North work more hours for less weekly pay.
- The wage gap can be explained by the type of jobs available. Only 6.1% of employed women living in the North East are Managers, Directors, or Senior Officials. This is lower than national average (8.5%) and considerably lower than in London (10.9%).
- Educational attainment differs for Women of the North. 22.3% of women living in the North East, 20.6% of women living in the North West, and 22.0% of women living in Yorkshire and the Humber have no qualifications. This is much higher than the national average (19.1%) and way higher than in the South East (16.3%).

Women and poverty

- Living in poverty has a sustained negative impact on physical and mental health and wellbeing, particularly for those women with children and/or health conditions or limited support.
- Universal Credit (UC), the standard allowance, is not enough to cover costs of basic essentials. Threat of sanctions for not meeting conditions imposed for receiving the allowance causes stress, anxiety and the exacerbation of health issues.
- The North East of England has the highest rate of UC Health claims (35%) relative to the overall numbers of claimants and the highest number of health claims relative to women on UC in comparison to all other regions. The North West and South East also have high rates of health claims relative to number of women on UC
- The North has higher percentages of families on UC (ranging from 18.27% to 19.67%) compared to regions in the South (14.68% to 17.17%).
- The average number of families on UC across the North is 3.41% higher than the three regions in the South, this rises to 4.18% when London is excluded.
- Outside of London, the North consistently has a higher proportion of women who are UC claimants than the South.
- The North East has the highest sanction rate (9.2%) in the UK, indicating that a person living in the North East is over 30 per cent more likely to be sanctioned than someone living in the South West.
- All of the 12 Local Authorities (LAs) in the North East have rates of absolute child poverty above the English average. All of the 30 LAs in the South West have rates of absolute child poverty below the English average.
- The North East has the second highest rate of poverty (25.4%), behind only the West Midlands (26.9%), and both the North West (22.7%) and Yorkshire and the Humber (23.3%) have higher rates of poverty than the national average.
- The cost-of-living crisis continues to have impact with parents and carers struggling to make ends meet.

Women and caring

- Women living in the North are more likely to provide unpaid care than the national average (10.3%) and those in London (8.4%). 12.0% of women in the North East, 11.2% of women in the North West, and 10.7% of women in Yorkshire and the Humber provide unpaid care
  - Unpaid carers are estimated to provide £57bn of care per year. We estimate that the women in the North contribute around £10bn is this, which is £2bn a year more than if they provided the national average.
- Women in the North, and particularly the North East, were also more likely to provide the highest levels of care (50 or more hours of unpaid care a week) as well as the second highest category (20-49 hours of unpaid care a week).
- The North East and North West have higher than national average rates of caring in young people age 5-24.
- The biggest contribution to unpaid care comes from those in their fifties: 1 in 5 women aged 55-59 in the North of England provide care to a family member because of illness, disability, mental illness or substance use.

Women's health and life expectancy

- The Women's Health Strategy for England (2022) outlines a range of ambitions that could deliver health improvements for all girls and women within the next decade. To achieve these improvements, regional disparities in the many different facets of women's health must be better understood and addressed.
- Although life expectancy at birth has increased across all regions in England for much of the last century, in the last decade the life expectancy at birth of girls born in deprived neighbourhoods, primarily in the North of England and Scotland, has begun to stall and in some cases decrease further exacerbating regional inequalities.
- Girls born in the North East, North West and Yorkshire and the Humber in 2018-2020 can only expect to live in good health to average ages of 59.7, 62.4 and 62.1 years, respectively, which is up to four years less than the national average and up to six years less than healthy life expectancy for girls born in the South East. This suggests that potential increases to retirement age would have greater adverse impact on women in northern regions of England.
- The 2021 Census showed that a smaller proportion of women in the three northern regions reported that their health was good or very good than in other regions. When compared with women living in other regions, those in northern regions were more likely to report that they had long-term illnesses and conditions that limited their day-to-day activities.
- There are myriad reasons for regional inequalities in women's health, not least the regional differences in levels of poverty and additional key social drivers of health outlined in other chapters of this report.
- Menopause is often cited as a potential driver of changes in women's health from mid-life onwards and so regional differences in the experience of this could also impact on regional inequalities in overall health and well-being.
- There are regional differences in levels of hormone replacement therapy (HRT) prescribing; lower levels of HRT prescribing in the North suggest that some women in this region may not be receiving adequate treatment for menopause symptoms which is a concern given these have been shown to affect employment, wellbeing and health.

Pregnancy and reproductive health

- The North showed the biggest increases in abortion rates between 2012 and 2021. There has been a demonstrable relationship between austerity and the implementation of the two-child limit and increased rate of abortions.
- Still births are highest in the most deprived communities, and in Black and Asian women compared to white women. Stillbirths are highest in Black African and Caribbean women living in the areas of greatest deprivation.
- The North West has the highest level of preterm delivery in England followed by the Midlands, North East and Yorkshire then London.
- Women living in deprivation, disproportionately in the North, are at increased risk of death and depression. Babies are at a higher risk of stillbirth, neonatal death, pre-term delivery and low birth weight.
- The North East has the highest proportions of pregnant women with preconception diabetes. A history of gestational hypertension in previous pregnancies is highest in the North East, followed by the North West and Yorkshire and the Humber. Preconception hypertension is highest in the South West, followed by the North West and North East.
- Fewer women in the North and Midlands are taking folic acid supplements in the preconception period.
- Maternal obesity is highest in the North East at 27.1% followed by Yorkshire and Humber at 25.6%.
- The North East and Yorkshire have the highest rates of smoking 17.7% at the booking appointment followed by the South West 17.4% and then North West 14.7%.

- The highest rates of teenage pregnancies are in the North East and Yorkshire with 4.9% of all pregnancies being in women under 20. This is followed by 3.9% for the Midlands and 3.6% in the North West compared to the England average of 3.2%.
- Over a 25% of pregnant women in the northern regions of England are living in the most deprived 10% of areas with 40% living in the top 20% most deprived areas. Less than 5% of pregnant women in the South East live in the most deprived 10% of areas.
- The highest levels of access to antenatal care in the first 10 weeks of pregnancy are in the North East and Yorkshire suggesting health services are considering socio-economic risk factors.
- The North has the lowest level of exclusive breastmilk feeding, 30% for the North East and Yorkshire and 33% for the North West; and in partial breastmilk feeding 15% for the North East and Yorkshire and 17% for the North West.

Sexual health

- Cuts to public health budgets have disproportionately affected the Midlands and North of England, with the North enduring per-person cuts 15% higher than the average for England, and the worst affected area in the country being the North East, with a cut of £23.24 per person.
- Outside London, the three northern regions had the highest rates of new diagnoses of STIs and Gonorrhoea among people accessing sexual health services in 2022. The exception is Chlamydia in under 25s.
- Spending on sexual health advice, prevention, and promotion has declined dramatically since 2013-14 in almost all England regions. Regions in the North have seen a 26-28% decrease, however the North West, North East and Yorkshire and the Humber remain three of the top five highest spending regions, potentially reflecting higher STI burden in these regions.
- The Yorkshire and the Humber, the North East and North West have some of the highest overall contraception prescribing rates (460.0, 396.6 and 400.9 per 1,000 women years respectively compared with 384.4 per 1,000 person-years for the South).

o These numbers potentially hide inequality in access to different forms of contraception across the North: Yorkshire and the Humber has the second highest usage of long-acting reversible contraception, whilst rates in the North East and North West are among the lowest in England.

- Primary care prescribing rates for emergency hormonal contraception were lower in the North West (3.85 per 1000 women-years), North East (4.53) and Yorkshire and the Humber (4.53) than the South (4.91), potentially reflecting better access to contraception overall in Northern regions.
- The repeat abortion rate among pregnant young people has been increasing nationally, but was highest in the North West in 2021, with all three northern regions in the top five across England.
- People in the three northern regions experienced the highest rates of recorded sexual offences in 2021/22, with the North East and North West having the first and second highest rates and Yorkshire and the Humber the fourth.

Mental health

- In a cohort of 1,092,166 women aged 16 to 65 from 2008 and 2018, the prevalence of mental illness was higher in the North West, North East, and Yorkshire and the Humber than in the South of England.
- For severe mental illness, such as bipolar disorder and schizophrenia the North West and North East have higher prevalence rates compared to the South and Yorkshire and Humber; eating disorders are the only low prevalence mental illness occurring in a higher proportion of women in the South.
- The proportion of women with a diagnosis of mental illness who were receiving a treatment for their mental illness was lower in the North West and North East than in the South and Yorkshire and the Humber, likely indicating a treatment gap between regions.
- In contrast, the referral rates into NHS Talking Therapies (formerly known as Improving Access to Psychological Therapies, IAPT) services were higher for the North West and North East and Yorkshire commissioning regions than for the South West, South East and London.

Domestic violence

- Domestic Violence and Abuse (DVA) is a gendered crime that disproportionately affects women living within the North of England.
- Women in the North of England have the highest rates of domestic violence abuse in the country. The highest rates are in the North East at 19 per 1,000 population followed by 17 in Yorkshire and the Humber then 15 in the North West. The average for the rest of England is 11.
- Many children in the North are exposed to domestic violence - incidents of DVA are higher for individuals living in single parent households with one or more children compared to those living in a no-children household.
- Services should offer needs-led and trauma-informed care that focuses on the recovery needs of both the adult and child victim/survivors of DVA
- Mothers are often held responsible for protecting their children, despite the perpetrator's/father's responsibility for the abuse. Protective responses made by mothers in an attempt to minimise the impact of DVA on their children are often overlooked.

Marginalised women

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.

There is a need for more research to understand the scale and scope of the health problems marginalised women of the North are facing.

- It is likely unequal funding for health services and resources for socioeconomic in the northern regions may lead to the health needs of women from minoritised ethnic groups in the region being amplified.
- During 2020-2021, minoritised ethnic women in the North had poorer physical health compared to the status of women living in South regions.
- Minoritised ethnic women had significantly lower physical health status than White British women with Pakistani women having the largest difference.
- Regional differences in physical health of ethnic minority women are largely explained by regional differences in socioeconomic status.
- Women from the North with experience of the justice system are likely to also be involved with other systems and support services, they frequently juggle 'a maze' of different services, including criminal justice services, drug and alcohol recovery services, social care, mental health, homelessness, domestic and sexual abuse, and healthcare systems.

o In 2019, all of the police areas with the 10 highest rates of female imprisonment were in the North of England, the Midlands or in Wales. In 2022, 9 of the 10 police areas with the highest rates of female imprisonment were in the North of England.

- Women's homelessness is an 'invisible problem' since women are much more likely than men to exhaust all social avenues before resorting to rough sleeping, often alternating between sofa surfing and nights on the streets.
- The North East of England has the highest rate of children being taken into care in the country (113 per 10,000) followed by the North West (96 per 10,000). This compares to the national average of 70 children per 10,000.
- The proportions of trans women from the North East and North West of England who described themselves as disabled with 'day-to-day activities limited a lot' was 16.1%, and 'with activities limited a little' was 19.1%. These proportions compare to 10% and 9.5% with 'day-to-day activities limited a lot' and 12.2% and 11.3% with 'activities limited a little' in age-standardised data for women in the North East and North West respectively.
- Several areas of northern England have the lowest school attendance in the country. Over half of the cases related to school attendance prosecuted nationally are prosecuted in North East England. This risks bringing civil matters into a criminal justice space and is potentially linked to other 'crimes of survival' such as non-payment of council tax and electricity.
- Fears around child removal for justice-involved women may be particularly exacerbated in the North of England which has higher proportions of child poverty and children living in lone parent families, which tend to be headed by women.
- Nationally, less than half of women (47%) will have settled accommodation on release from prison, and one in 10 will be homeless or sleep rough. Although data are not collected regionally, it is likely that these figures are much higher in the North of England.
- There is an acute shortage of approved premises for women on licence in the North of England. There are also fewer women's centres in the North of England, and no specialist residential centres offering trauma-informed and therapeutic-based alternatives to prison for women.
- Women from the North of England, like elsewhere, commonly report that they begin and continue to use substances to cope with gender-based trauma[5] and to escape from other adverse life experiences[6].
- Of the recorded deaths per 100,000 from alcohol-specific causes in 2021, women in the North East (13.9), North West (13.8) and Yorkshire and Humber (11.7) had the highest rates of deaths in women in England[7].
- There is an even more pronounced North-South divide in drug-related deaths in women. There were more reported drug-related deaths per million women in the North-West of England in 2022 than there were for men in London, and the South East[8].
- Alcohol and illicit drug use are associated with multiple physical health conditions in women. Some of these are gender-specific including increased risk of breast cancer from alcohol use, ovulation and menstrual difficulties, sexually transmitted infections, and risks to the child in pregnancy[5].

Woman of the North key recommendations

These key recommendations are supported by detailed recommendations given at the end of each chapter.

Regional government

- Combined Authorities play an increasingly important role in closing the gap between the most and least deprived areas of the country. Trailblazer deals offer new powers to address issues specific to the region.
- Combined Authorities should ensure that support delivered to 11–18-year-olds through Careers Hubs are targeted at areas of greatest deprivation. Young women should be supported to develop the skills needed to access good quality work opportunities in their area.
- Women in the North have higher rates of no or low level qualifications compared to the national average, with even more stark differences compared to London. There is a clear case for regional governments in the North of England to negotiate for higher levels of the Adult Education Budget than their counterparts in the South of England. Where Combined Authorities are receiving consolidated funding with new Devolution Agreements, funding for adult education must be protected.
- Combined Authorities with powers to deliver free training courses for residents should include specific targets for uptake amongst women. Targets should additionally focus on women who experience more barriers into the labour market, such as those from an minoritised ethnic background, those with caring responsibilities, those in contact with the criminal justice system and neurodivergent women. Delivery of this training must be flexible around their working practices and caring needs.
- Local Authorities should use existing advice services to support benefits uptake for women and help claimants navigate the benefit system.
- Extend financial support beyond the current social security system to groups most in need, especially carers, those dependent on essential powered medical equipment, and low income households not receiving means-tested benefits.
- Local Authorities and Combined Authorities across the North should champion Living Wage Places and adopt the Socioeconomic Duty.

Central government

- The Prime Minister needs to deliver a national health inequalities strategy, convening government departments across Whitehall to put health at the heart of all policies across all government departments to address the wider determinants of health. The strategy should be paired with targets to track progress in reducing health inequalities.
- There is clear evidence that the Universal Credit system is harming women and their families. The government must make a long-term commitment to update benefits in-line with inflation to ensure that families can meet the pace of rising living costs and cover the essential costs needed to live. Additionally, policies that punish families, such as the two-child limit, sanctions and the benefit cap must be abolished.
- The Treasury should improve targeted support for pregnant women including reversing restrictions to the Sure Start Maternity Grant and re-introducing the Health in Pregnancy Grant. The government should also explore rolling out the Baby Box model across the country, based on successful delivery of the scheme in Scotland and the North East.
- The government must deliver a sustainable childcare model that enables more women to access education and work opportunities. This model should link in with family hubs and next generation Sure Start centres.
- Women make up a large number of the part-time workforce, abolish zero hours contracts to ensure jobs provide stability and security.

Health system

- As the government rolls out the Women's Health Strategy for England, Integrated Care Systems need to consider the varying health needs of different women, particularly those from underserved groups. NHS England should provide additional financial support and investment for Women's Health Hubs that are established across the North.
- Health services need to be supported to collect routine data on ethnicity and other key demographic data as standard. Improving data in health records will in turn deliver better information for service development and improve our understanding of different health needs.
- Health services should explore ways in which their work can be adapted to address health inequalities across different population groups. This might include cultural sensitivity training for staff, adopting a trauma-informed approach to care, and promoting person-centred approaches, including for transgender people and sex workers.

Chapter 1
Introduction

Authors: Kate Pickett and Hannah Davies

"We cannot all succeed when half of us are held back."
Malala Yousafzai, Nobel Peace Prize laureate

Women in the North of England face a double challenge – their wellbeing, throughout their lives, is shaped by both gender and geography. Compared to women living in other parts of the country, women in the North experience inequalities in the wider determinants of health and, consequentially, inequalities in their health. These inequalities have grown in the past decade, diminishing women's life chances and quality of life on an unacceptable scale.

Woman of the North. What a powerful image that conjures up. And what a mighty number and range of women that describes. This report cannot cover them all or all of the issues they face, instead it takes a look at a number of the social determinants of health for women, and how they play out in the overall health of women in the region.

The picture is a stark one; unsurprising to most of us who have contributed to this report but nevertheless shocking. This has been a damaging decade for women in the North of England – they have experienced the brunt of the poly-crisis: austerity, Covid, and the rising cost of living. Women, and their families and communities, have been relentlessly harmed by cuts to services, rising prices, their experience of lockdowns, and diminished livelihoods.

Much of the regional inequalities that we see affecting women in the North are a direct consequence of poverty – both relative and absolute – a context of increasing levels of deprivation and destitution that is completely unacceptable in the 6th largest economy in the world. Many of the disturbing statistics in this report can also be laid at the door of cuts to welfare and public health funding, which have hit the most deprived communities and the North the hardest. Cuts to public health budgets have disproportionately affected the Midlands and North of England, with the North enduring per-person cuts 15% higher than the average for England, and the worst affected area in the country being the North East, with a cut of £23.24 per person.

Women in the North are less likely than their sisters in the rest of the country to be in work; they are more likely to claim Universal Credit and are also more likely to receive sanctions – over 30% more likely in the North East compared to the South West. But it's not just about damaging changes to social security and services. Our report also shows that women in the North who are working are losing out on £132 million, every single week, compared to what they would be paid if they had the same wages as women in the rest of the country.

We are failing women in the North across the whole span of their lives, from preconception through to sexual health, from reproductive and maternal health through to menopause, and in terms of both physical and mental health. Women in the North live shorter lives compared to the average in the South and their lives are spent in worse health. In the North East, women have 4.2 fewer years of good health compared to the English average. This means that women cannot look forward with confidence to a happy and healthy retirement. In fact, as healthy life expectancy has risen for women in the wealthier areas of the country, for those in the most deprived areas healthy life expectancy has declined. Nowhere is the impact of regional inequalities in socioeconomic factors seen more clearly in the North of England than in the impact on the children of the women of the North, as we first showed in our 2021 report, Child of the North. Our updated analyses in this report show that all 12 local authority areas in the North East have higher absolute child poverty levels than average – in contrast to the South West where all 30 local authorities have lower than average child poverty areas.

As well as their children suffering the impact of regional inequality, the North-South divide in health means that all members of the family are more likely to have poor health in the North, and so northern women are more likely to be carers than their counterparts in the rest of the country. Unpaid carers in the North are also much more likely to suffer from worse health themselves.

The list of damning statistics goes on…the North has the highest proportions of pregnant women with preconception diabetes, infant mortality is higher, abortions are more common (and there is evidence in our report that this is tied to increased poverty in the region as well as the two-child limit on Universal Credit), mental health is worse. And these statistics accumulate and entangle in women's lives - if your child dies, you are more likely to suffer from poor mental health, which means that you are also more likely to be unable to work, which will then put you into further poverty or destitution. We see some of the most extreme outcomes in our report among women from the most marginalised groups with multiple unmet needs. In the North of England, women are more likely to suffer from domestic violence, and we know that domestic violence is linked to poverty. They are more likely to end up in the criminal justice system and less likely to have somewhere to go when they leave prison. And unsurprisingly women in the North of England are more likely to die from "deaths of despair", alcohol, drugs and suicide, than those in the rest of the country

This report shows that if you are a woman of the North you may be blessed to live in one of the most beautiful regions of this country, in a strong and supportive community, inheriting a tradition of cultural strength and progressive development, but that your wellbeing is also being compromised – and this is especially true for women in poverty, women in minoritised ethnicities, and women with other minoritised identities.

The good news is that this isn't inevitable - the situation for women's health in the North can be changed for the better through proven policy implementations. Our report goes beyond description of the problem to recommend a wide range of solutions. Our message is clear and our recommendations are evidence based. We stand with the Woman of the North, and we ask that you invest in and empower her.

Chapter 2
Employment and education

Authors: Luke Munford, Courtney McNamara, and Clare Bambra

Summary

- Employment rates for women in the North are lower than the national average (72.2%); they are 69.8% in the North East, 71.2% in the North West, and 70.8% in Yorkshire and the Humber
- Rates of economic inactivity among women in the North are higher than the national average (24.2%) at 26.9% in the North East, 25.5% in the North West, and 25.6 in Yorkshire and the Humber
- Long-term sickness and disability is a major contributing factor to economic inactivity, affecting 5.8% of women in the North East, 5.4% of women in the North West, and 4.8% of women in Yorkshire and the Humber. These figures are higher than the national average (4.2%) and considerably higher than the South East (3.3%)
    - The estimated economic costs of this higher prevalence of long-term sickness is around £0.4bn per annum
- Median weekly wages for women in the North are below the national average for those in both full-time and part-time employment. The average weekly wage for a full-time working woman in the North East is £569, much lower than the national average (£625) and considerably lower than for women in London (£757). The gap in pay between the North and London has grown over time
    - Multiplying the gap in median wages for each northern region, compared to the national average, by the number of women who are employed, shows that women in the North lose out on around £132 million every week, £6.86bn a year
- The number of hours worked do not explain this gap. In fact, women working part-time in the North work more hours for less weekly pay
- The wage gap can be explained by the type of jobs available. Only 6.1% of employed women living in the North East are Managers, Directors, or Senior Officials. This is lower than national average (8.5%) and considerably lower than in London (10.9%)
- Educational attainment differs for Women of the North. 22.3% of women living in the North East, 20.6% of women living in the North West, and 22.0% of women living in Yorkshire and the Humber have no qualifications. This is much higher than the national average (19.1%) and way higher than in the South East (16.3%)

Context

Women living in the North of England experience strong regional inequalities in their wages, the type of work available and in their levels of education. It is important to consider these outcomes, as jobs – and in particular 'good jobs' – are an important social determinant of health. Women who have good quality jobs typically have higher levels of health and well-being. Jobs are also important in that they provide income, in the form of wages, that can be spent on health-promoting goods and services. Likewise, education is an important factor to consider as it is strongly linked to economic prosperity and health. Higher levels of education are associated with a range of positive outcomes, including better jobs, economic prosperity and higher levels of health and well-being. There is a growing body of evidence that women's education and employment are also positively associated with the health and economic prospects of their children through, for example, the intergeneration transition of health and education.

Economic outcomes for Women of the North

When comparing measures of economic outcomes, such as employment rate, median wage and job type, women living in the North of England fare worse than the English national average. The differences we report may, at first glance, appear small, but when these percentage differences are aggregated to the regional level, they reflect significant variances in lived experiences. For women in the North, a few percentage points below the national average translates to around 200,000 more women facing economic vulnerability and poorer health.

For simplicity and clarity, this chapter presents regional averages. This approach masks some important differences that exist within regions; for example, not all women living in the North have lower wages and not all women living in London have above average wages. However, focussing on the regional level allows us to communicate the high-level differences in economic outcomes.

Employment rates for women

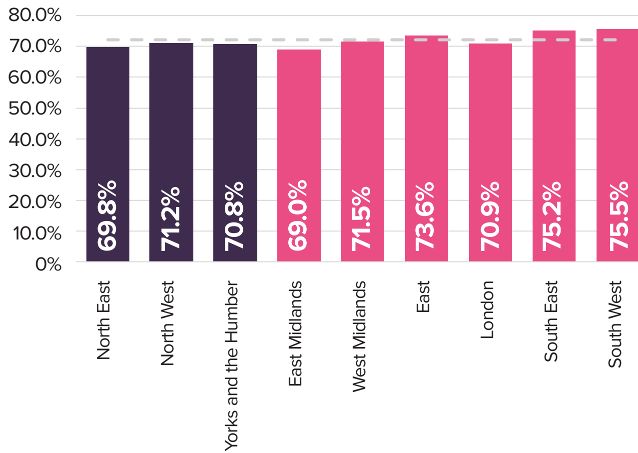
From October 2022 to September 2023[9] the three regions of the North had the lowest rates of employment, except for the East Midlands (See Figure 2.1). Compared to the national average of 72.2% and the South West which had the highest average employment rate at 75.5%:

- The employment rate for women in the North East was 69.8%, 2.4 percentage points below the national average and 5.7 percentage points below the South West
- The employment rate for women in the North West was 71.2%, 1.0 percentage points below the national average and 4.3 percentage points below the South West
- The employment rate for women in Yorkshire and the Humber was 70.8%, 1.4 percentage points below the national average and 4.7 percentage points below the South West

Rates of economic inactivity for women

The Office for National Statistics (ONS) define economic inactivity as "People not in employment who have not been seeking work within the last 4 weeks and/or are unable to start work within the next 2 weeks"[10]. In recent years, the economically inactive have represented a growing proportion of working aged individuals. In the 12-month period from

Figure 2.1. Employment rates for women between October 2022 and September 2023, by region of England



Notes: The grey dashed line represents the English average (=72.2%). Bars coloured in purple represent employment rates less than the English average but more than 10% less. Data are taken from the nomis service provided by the Office for National Statistics [5].

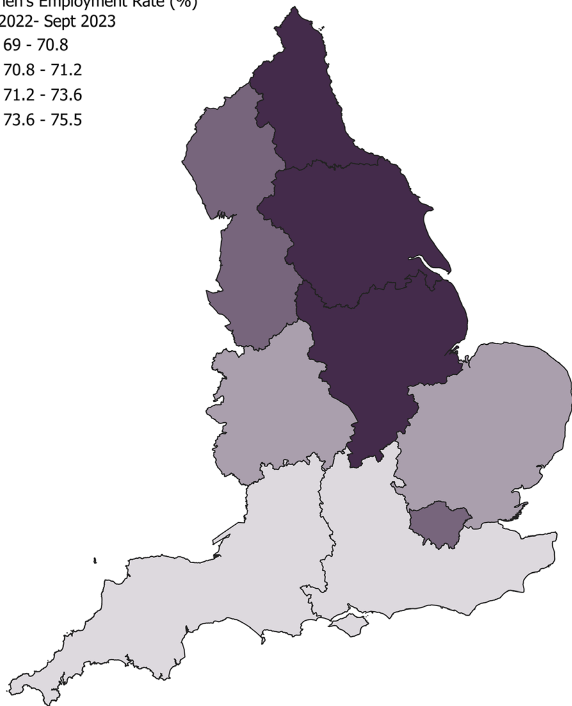
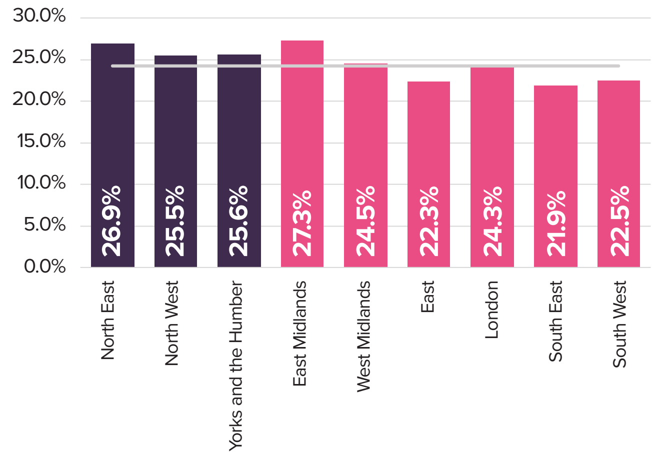
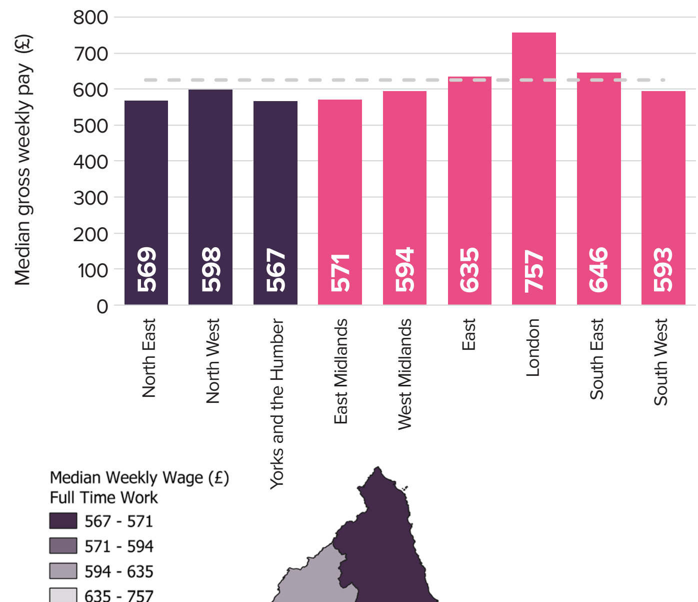


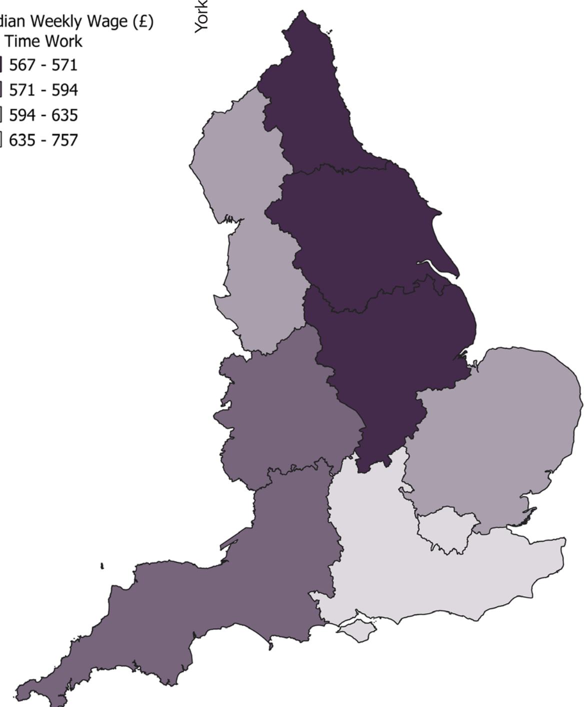
Figure 2.2. Rates of economic inactivity for women between October 2022 and September 2023, by region of England



Notes: The grey line is the English average (=24.2%). Bars coloured in purple represent rates that are more than 10% above the English average. Data are taken from the nomis service provided by the Office for National Statistics [5].

Figure 2.3. Median gross weekly pay in 2023 for women, by region of England for full-time workers





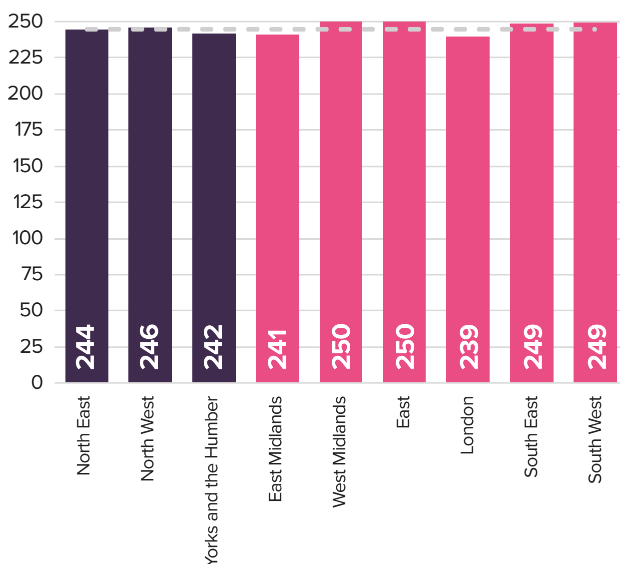
October 2022 to September 2023, except for the East Midlands (27.3%), the three regions of the North have the highest rates of economic inactivity for women (See Figure 2.2).

- The rate of economic inactivity for women in the North East was 26.9%, 2.7 percentage points above the national average (24.2%) and 5.0 percentage points above the South East (21.9%, the region with the lowest rate of economic inactivity for women)
- The rate of economic inactivity for women in the North West was 25.5%, 1.3 percentage points above the national average (24.2%) and 3.6 percentage points above the South East (21.9%)
- The rate of economic inactivity for women in Yorkshire and the Humber was 25.6%, 1.4 percentage points above the national average (24.2%) and 3.7 percentage points above the South East (21.9%)

Median weekly wages in 2023

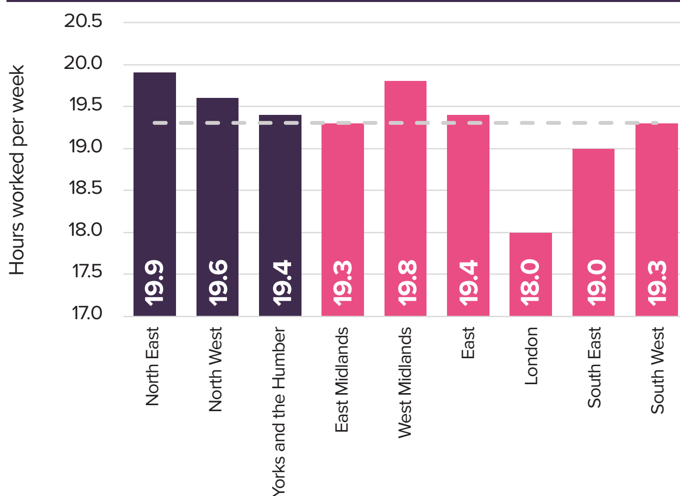
Given that women are more likely than men to work part-time 11, figures

Figure 2.4. Median gross weekly pay in 2023 for women, by region of England for part-time workers



Notes: For both figures 1.3. and 1.4, the black line is the English average (£625 for full time and £245 for part-time). Bars coloured in purple represent wages less than 10% above the English average. Data are taken from the nomis service provided by the Office for National Statistics [5]

Figure 2.6. Median number of hours worked per week in 2023 for part-time workers



Notes: The black dashed line is the English average (=37.4 hours for full time and =19.3 for part-time). Bars coloured in purple represent hours worked more than the English average but not more than 10% above. Data are taken from the nomis service provided by the Office for National Statistics [5].

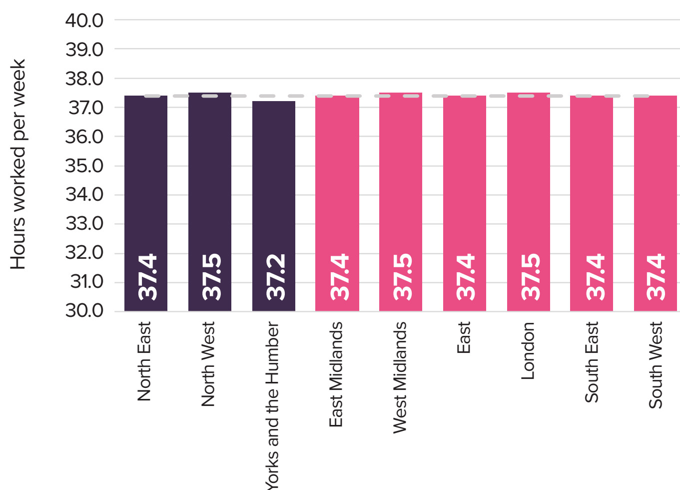
for the median gross weekly wages for have been analysed for both full-time (Figure 2.3) and part-time (Figure 2.4) women workers.
Full-time women workers who live in Yorkshire and the Humber and the North East have the lowest weekly wages (£567 and £569, respectively), considerably lower than the English average (£625). The region with the highest full-time weekly wage among women is London (£757). In fact, women in full-time work living in:

- The North East (£569) earn wages that are £56 per-week less than the English average and £188 less than in London
- The North West (£598) earn wages that are £27 per-week less than the English average and £159 less than in London
- Yorkshire and the Humber (£567) earn wages that are £58 per-week less than the English average and £190 less than in London

There is very little regional variability in part-time gross median weekly pay among women (Figure 2.4).

If we multiply the gap in median wages for each northern region by

Figure 2.5. Median number of hours worked per week in 2023 for full-time workers



Notes: The grey dashed line is the English average (=37.4 hours for full time and =19.3 for part-time). Bars coloured in purple represent hours worked more than the English average but not more than 10% above. Data are taken from the nomis service provided by the Office for National Statistics [5].

Figure 2.7. The percentage of women who worked in each of the nine broad job classifications, based on standard occupational classification (SOC) codes, in 2023 by North vs. Rest of England

Note: Code labels: 1. Managers, directors and senior officials; 2. Professional occupations; 3. Associate professional and technical occupations; 4. Administrative and secretarial occupations; 5. Skilled trades occupations; 6. Caring, leisure and other service occupations; 7. Sales and customer service occupations; 8. Process plant and machine operatives; 9. Elementary occupations. Data are taken from the nomis service proved by the Office for National Statistics [5].

the estimated working age population among women, we can get an estimated value of how much money women in the North are paid less than the English average. For the North East, this is around £29 million a week, in the North West it is around £40 million a week, and in Yorkshire and the Humber it is around £63 million a week. Therefore, because of the difference in their wages to the national average, women in the North lose out on around £132 million a week.

Median hours worked in 2019

The regional differences in earnings for women in full-time employment cannot be explained by women living in the North of England working fewer hours than those elsewhere. In fact, women living in the North worked slightly more hours, on average, than women living in the rest of England (Figure 2.5). Whilst these differences are small, it is clear then working hours do not explain the gap in weekly pay for women working full-time.
Whilst the previous section demonstrated very little regional variability in gross median weekly pay among women working part-time (see Figure 2.4), the differences in hours worked were more pronounced for women who worked part-time than for women who worked full-time (See Figure

2.6) What this means is that on average, women in the North working part-time are spending more time at work for roughly similar pay of women in other regions.

Occupational classifications

Given that the number of hours worked cannot explain the gap in weekly pay, it is important to consider whether it is the type of job that women in the North of England are more likely to have that is driving these differences in wages.

There is evidence to suggest that occupation type is an important factor driving the regional pay gap (Figure 2.7). On average, women living in the North of England are more likely to work in manual type professions, whereas women living in the rest of England are more likely to work in managerial and professional occupations.

Table 2.1 presents occupational classification data for each of the nine regions. When examining the percentage of women employed in the category of Managers, Directors and Senior Officials, i.e. the category with the highest salaries on average, the data shows:

- 6.1% of employed women living in the North East are Managers, Directors, or Senior Officials. This is 2.4 percentage points lower than national average (8.5%) and 4.8 percentage points lower than in London (10.9%; the region with the highest percentage)
- 8.2% of employed women living in the North West are Managers, Directors, or Senior Officials. This is 0.3 percentage points lower than national average (8.5%) and 2.7 percentage points lower than in London (10.9%)
- 7.8% of employed women living in the Yorkshire and the Humber are Managers, Directors, or Senior Officials. This is 0.7 percentage points lower than national average (8.5%) and 3.1 percentage points lower than in London (10.9%)

In contrast, when examining the percentage of women employed in the category of elementary occupations which on average have the lowest salaries (e.g. occupations like cleaners and sales assistants), the data shows:

- 10.9% of employed women living in the North East have Elementary Occupations. This is 1.7 percentage points higher than national average (9.2%) and 4.5 percentage points higher than in London (6.4%; the region with the lowest percentage)
- 9.5% of employed women living in the North West have Elementary Occupations. This is 1.3 percentage points higher than national average (9.2%) and 3.1 percentage points higher than in London (6.4%)
- 10.6% of employed women living in Yorkshire and the Humber have

Table 2.1. The percentage of women who worked in each of the nine broad job classifications, based on standard occupational classification (SOC) codes, in 2023 by Region. Data are taken from the nomis service provided by the Office for National Statistics [5].

	1 : Managers, Directors And Senior Official	2 : Professional Occupations	3 : Associate Professional Occu-pations	4 : Administrative And Secretarial Occupations	5 : Skilled Trades Occupations	6 : Caring, Leisure And Other Service Occupations	7 : Sales And Customer Service Occupations	8 : Process, Plant And Machine Operatives	9 : Elementary Occupations
England	8.5	27.6	15.6	14.9	2.0	13.0	7.5	1.5	9.2
North East	**6.1**	**22.2**	**13.9**	**15.1**	**2.1**	**15.9**	**11.8**	**1.8**	**10.9**
North West	**8.2**	**26.5**	**15.5**	**15.4**	**1.8**	**13.3**	**8.3**	**1.4**	**9.5**
Yorkshire and The Humber	**7.8**	**25.8**	**14.5**	**14.0**	**2.8**	**13.3**	**8.9**	**2.3**	**10.6**
East Midlands	6.8	24.8	13.9	15.0	1.6	15.7	7.8	2.5	11.9
West Midlands	7.3	26.7	13.9	15.6	2.0	14.2	8.2	1.5	10.6
East	8.5	25.6	16.2	18.0	1.9	12.6	7.0	1.5	8.5
London	10.9	33.9	17.1	13.0	1.5	10.3	6.0	0.7	6.4
South East	9.3	28.5	17.1	14.5	2.1	12.2	6.4	1.1	8.6
South West	7.8	26.5	15.2	15.2	2.7	13.6	7.5	1.4	10.0

Table 2.2. Annual gross pay of women over time, by region of England. Data are taken from the nomis service provided by the Office for National Statistics [5]

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
England	15,729	16,250	16,431	16,271	16,750	17,090	17,226	17,437	18,000	18,270	18,716	19,616	20,618	21,227	22,733	24,674
North East	**14,230**	**14,983**	**15,126**	**15,390**	**15,679**	**15,716**	**15,745**	**16,087**	**16,776**	**17,137**	**17,551**	**18,202**	**19,189**	**19,457**	**20,740**	**22,683**
North West	**15,396**	**15,626**	**15,864**	**15,874**	**16,179**	**16,678**	**16,772**	**17,182**	**17,372**	**17,817**	**18,130**	**19,005**	**20,035**	**20,426**	**21,777**	**24,000**
Yorkshire and The Humber	**14,208**	**14,934**	**15,049**	**14,839**	**15,162**	**15,377**	**15,494**	**15,714**	**16,100**	**16,544**	**16,986**	**17,845**	**18,803**	**19,343**	**20,953**	**22,886**
East Midlands	14,373	15,241	14,965	14,917	15,509	15,814	15,843	15,746	16,417	16,503	16,911	18,061	19,033	19,846	20,977	22,515
West Midlands	14,523	15,061	15,081	14,952	15,140	15,856	15,585	15,860	16,484	17,212	17,469	18,424	19,530	20,177	21,495	23,533
East	15,550	16,273	16,343	16,407	16,544	17,218	17,175	17,284	17,789	18,000	18,614	19,690	20,463	21,019	22,787	24,948
London	22,732	23,852	23,620	22,961	24,000	23,728	23,961	24,017	24,778	25,161	26,026	26,510	27,500	27,818	29,847	31,868
South East	16,275	16,789	17,001	16,919	17,694	17,657	18,291	18,623	19,168	19,204	19,943	20,743	21,520	22,468	24,159	25,709
South West	14,643	15,000	15,191	14,870	15,223	15,345	15,736	16,000	16,524	16,726	16,926	17,917	18,600	19,512	21,353	23,269

Elementary Occupations. This is 1.4 percentage points higher than national average (9.2%) and 4.2 percentage points higher than in London (6.4%)

Wages over time

We investigated what has happened to wages over time by looking at median annual salaries for women. Figure 2.2 shows trends in annual gross pay for women in the North, women in the rest of England, and women in the rest of England when we exclude London. We add this last group as wages in London are often significantly higher than in other regions. We observe that women in the North, on average, have had consistently lower salaries, and that the gaps have grown over time. The underlying regional data is presented in Table 2.2. Here we can see that in the period from 2008 to 2023, pay increased the most in the South East (by £9,434 from £16,275 to £25,709) and the least in the East Midlands (by £8,142, from £14,373 to £22,515). In contrast:

- In the North East pay increased by £8,453 (from £14,230 to £22,683), the second smallest increase in pay (behind the East Midlands)
- In the North West pay increased by £8,604 (from £15,396 to £24,000), the third smallest increase in pay
- In Yorkshire and the Humber pay increased by £8,678 (from £14,208 to £22,886), the fifth smallest increase in pay

Economic inactivity due to long-term sickness and disability

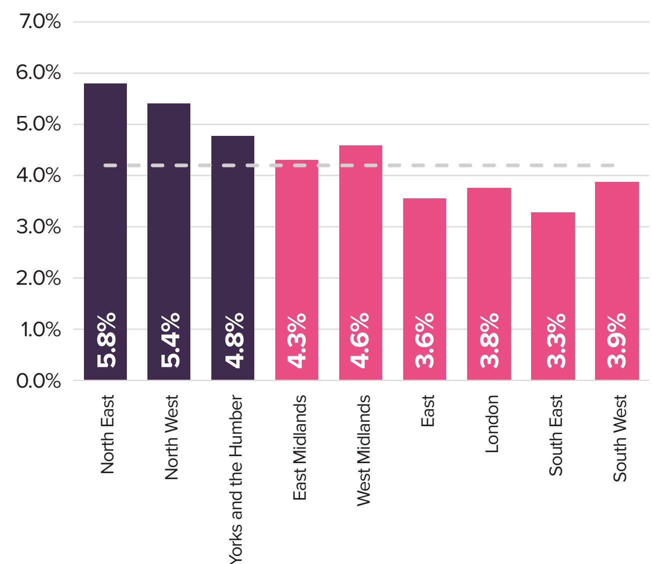
As highlighted earlier via Figure 2.2, rates of economic inactivity for women were much higher in the northern regions than other regions of England. Using data from the 2021 Census, we investigated whether long-term health conditions and disability could be driving this inactivity. For women aged 16-64, Figure 2.9 shows all three northern regions have higher rates of economic inactivity due to long-term sickness or disability when compared to the English average of 4.2%:

- 5.8% of women in the North East are economically inactive due to long-term sickness or disability, 1.6 percentage points higher than the national average
- 5.4% of women in the North West are economically inactive due to long-terms sickness or disability, 1.2 percentage points higher than the national average
- 4.8% of women in Yorkshire and the Humber are economically inactive due to long-terms sickness or disability, 0.6 percentage points higher than the national average

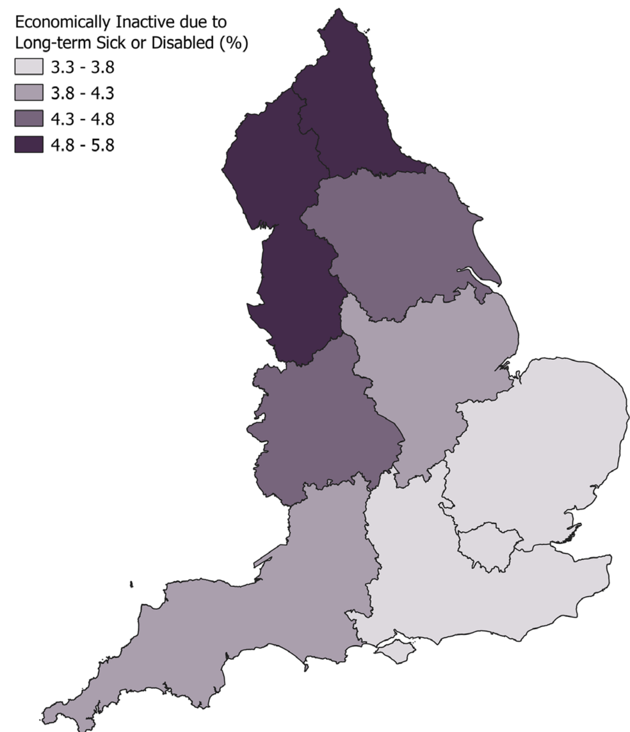
The South East had the lowest rate of economic inactivity due to long-terms sickness or disability (3.3%).

The estimated economic costs of this higher prevalence of long-term sickness keeping women in the North out of the labour market is around £0.4bn per annum, based on estimates from a 2023 report[12].

Figure 2.9. The percentage of all usual female residents aged 16-64 years who are economically inactive due to being long-term sick or disabled across the nine English regions, Census 2021



Notes: The black dashed line is the English average (=4.2%). Bars coloured in purple represent rates that are more than 10% above the English average. Data are taken from the Nomis service provided by the Office for National Statistics using indicator RM208 [5]



Educational outcomes for Women of the North

As well as employment and employment-related outcomes, it is important to examine regional variations in women's education. The 2021 Census collected information on the highest level of qualification that an individual has, and this data is available by sex and region[13]. Women could self-report one of the following eight options:

- No qualifications
- Level 1 and entry level qualifications: 1 to 4 GCSEs grade A* to C, Any GCSEs at other grades, O levels or CSEs (any grades), 1 AS level, NVQ level 1, Foundation GNVQ, Basic or Essential Skills
- Level 2 qualifications: 5 or more GCSEs (A* to C or 9 to 4), O levels (passes), CSEs (grade 1), School Certification, 1 A level, 2 to 3 AS levels, VCEs, Intermediate or Higher Diploma, Welsh Baccalaureate Intermediate Diploma, NVQ level 2, Intermediate GNVQ, City and Guilds Craft, BTEC First or General Diploma, RSA Diploma
- Apprenticeship
- Level 3 qualifications: 2 or more A levels or VCEs, 4 or more AS levels, Higher School Certificate, Progression or Advanced Diploma, Welsh Baccalaureate Advance Diploma, NVQ level 3; Advanced GNVQ, City and Guilds Advanced Craft, ONC, OND, BTEC National, RSA Advanced Diploma
- Level 4 qualifications or above: degree (BA, BSc), higher degree (MA, PhD, PGCE), NVQ level 4 to 5, HNC, HND, RSA Higher Diploma, BTEC Higher level, professional qualifications (for example, teaching, nursing, accountancy)
- Other: vocational or work-related qualifications, other qualifications achieved in England or Wales, qualifications achieved outside England

or Wales (equivalent not stated or unknown)
- Does not apply

Table 2.3 shows the percentages of women reporting to be in each category for the nine regions of England.

Figure 2.10 shows there are stark regional inequalities in the percentage of women who have no formal qualifications. Across England as a whole, 19.1% of women report having no qualifications with the South East having the lowest rate (16.3%). Across the women of the North:

- 22.3% of women living in the North East have no qualifications (the highest rate in England), 3.2 percentage points higher than the national average and 6.0 percentage points higher than the South East
- 20.6% of women living in the North West have no qualifications, 1.5 percentage points higher than the national average and 4.3 percentage points higher than the South East
- 22.0% of women living in Yorkshire and the Humber have no qualifications, 2.9 percentage points higher than the national average and 5.7 percentage points higher than the South East

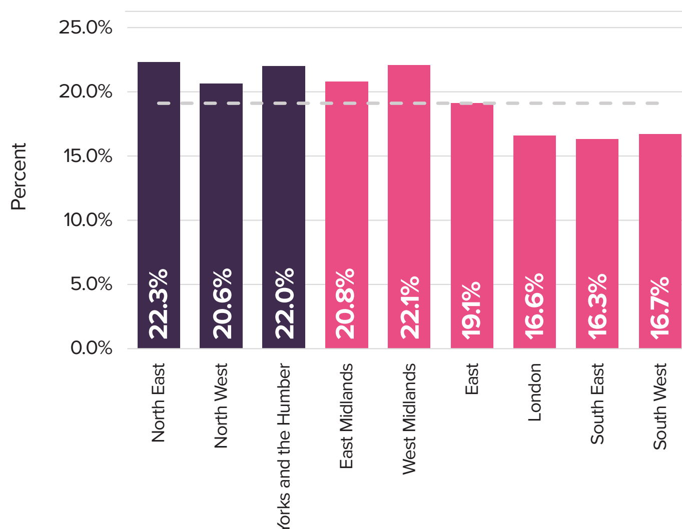
There also exist regional inequalities in the percentage of women who have the highest levels of qualifications (Level 4) (Figure 2.11). Across England as a whole, 34.7% of women report having Level 4 qualifications, whereas London has by far the highest rate (47.4%). Across the women of the North:

- 29.3% of women living in the North East have the highest levels of qualifications (the lowest rate in England), 5.4 percentage points lower than the national average and 18.1 percentage points lower than London
- 32.1% of women living in the North West have the highest levels of qualifications, 2.6 percentage points lower than the national average and 15.3 percentage points lower than London
- 30.5% of women living in Yorkshire and the Humber have the highest levels of qualifications, 4.2 percentage points lower than the national average and 16.9 percentage points lower than London

We have demonstrated that there are large inequalities in the levels of education women have across the regions of England. However, it is well documented that people move to university and are less likely to return to northern locations than they are southern locations. The Institute for Fiscal Studies (IFS) produced a report[14] that stated:

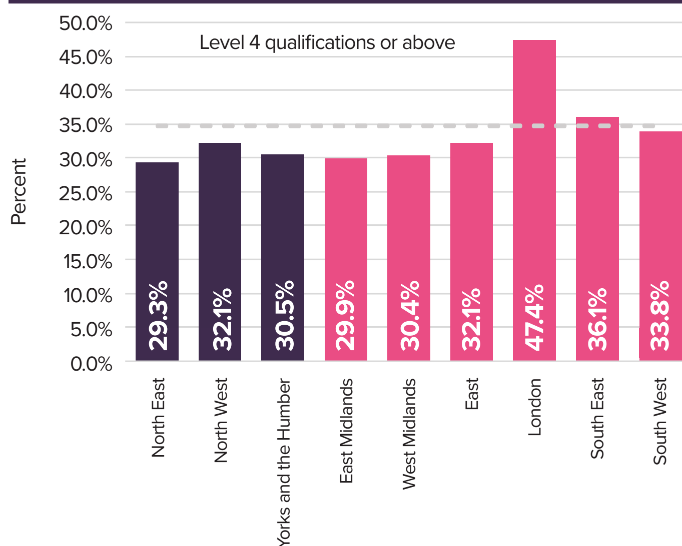
"patterns of graduate mobility exacerbate geographical inequalities in skills. Cities like London, Bristol and Brighton, which already produce large numbers of graduates, further gain graduates through migration. Conversely, there is brain drain from the North and coastal areas, which already produce low numbers of graduates."

Figure 2.10. Percentage of women who self-report that they do not have any qualifications, by region of England [9]



Notes: The grey dashed line is the English average (=19.1%). Bars coloured in purple represent rates that are more than 10% above the English average. Data taken from the ONS[9].

Figure 2.11. Percentage of women who self-report having the highest level of qualification (Level 4), by region of England



Notes: The black dashed line is the English average (=34.7%). Bars coloured in purple represent rates that are more than 10% below the English average. Data taken from the ONS 9.

Table 2.3. Percentage of women who self-report their highest level of qualification, by region of England [9]

	No qualifications	Level 1 and entry level qualifications	Level 2 qualifications	Apprenticeship	Level 3 qualifications	Level 4 qualifications or above	Other qualifications
England	19.1	10.0	14.2	2.7	16.3	34.7	2.9
North East	**22.3**	**10.1**	**15.0**	**2.8**	**17.7**	**29.3**	**2.8**
North West	**20.6**	**10.0**	**14.6**	**2.8**	**17.1**	**32.1**	**2.7**
Yorkshire and The Humber	**22.0**	**10.5**	**14.7**	**2.9**	**16.6**	**30.5**	**2.9**
East Midlands	20.8	10.7	14.9	3.0	17.7	29.9	3.0
West Midlands	22.1	10.4	14.7	2.7	16.7	30.4	3.0
East	19.1	11.2	15.5	2.9	16.1	32.1	3.0
London	16.6	7.7	10.1	2.1	12.9	47.4	3.2
South East	16.3	10.2	14.9	2.8	16.8	36.1	3.0
South West	16.7	10.2	15.6	3.0	17.8	33.8	2.9

Conclusion

Women of the North fare worse than their counterparts living in other parts of the country, particularly London and the South East. Women in the North have worse economic outcomes in terms of rates of employment and economic inactivity. In particular, women in the North have much higher rate of economic inactivity due to long-term sickness and disability.

Not only are they less likely to have a job, but women in the North are also paid less and work more hours. This juxtaposition can be explained by the fact that the jobs available to women in the North typically pay less. The gap in wages between women of the North and London has been growing over time, not shrinking. Women in the North have lower levels of education. However, this could be explained by the fact that many university-educated women from the North end up moving to, in particular, London and the South East to try and get better jobs.

These are worrying statistics in terms of their impacts on women of the North, particularly for their lived experience and quality of life. They are also important factors that may explain why women of the North have worse health outcomes (Chapters 5 – 8). It is also worth stressing that these factors can impact upon children, hence quickening the spiral.

If not tackled urgently, these factors will continue to grow and lead to exacerbated regional inequalities. Intergenerational transmission means these gaps will continue to widen and the problem will continue to grow.

Recommendations

- Extra educational support targeted at the areas of greatest deprivation and need to support women's education.
- Support should be given to help those from more disadvantaged areas to access qualification and skills opportunities.
- Local government and central government should link to offer flexible further education and training for women together with large employers such as the NHS.
- Childcare and skills should be linked through family hubs and next generation Sure Start centres, recognising it is harder for women with children to access opportunities for education.
- Employers and employer organisations should be supported to upskill their female employees allowing flexibility around working practices and caring needs.
- Carers rights should be implemented into working practices and enforced.

Chapter 3
Lived experiences of poverty

Chapter authors: Hannah Fairbrother, Heather Brown, Mandy Cheetham, Uisce Jordan, Marcia Gibson, Steph Morris, Luke Munford, Ruth Patrick, Julija Simpson, Sophie Wickham, with UC CREATIVES and Changing Realities Participants

Summary

- The cost-of-living crisis continues to bite, with parents and carers struggling to make ends meet
- Parents and carers are playing a perpetual juggling act, navigating mounting bills and rising living costs, while trying to prioritise their children
- Living in poverty has a sustained negative impact on physical and mental health and wellbeing, particularly for those women with children and/or health conditions or limited support
- Parents and carers worry that they cannot fully shield their children from poverty, yet children and young people are aware when parents and carers are struggling financially and may try to ease pressures on their family
- Outside of London, the North consistently has a higher proportion of women who are Universal Credit claimants than the South
- For those on Universal Credit, the standard allowance is not enough to cover costs of basic essentials
- The threat of sanctions for not meeting conditions imposed for receiving the allowance causes stress, anxiety and the exacerbation of health issues
- Children and young people stress the importance of minimum standards of income and tailored support for Universal Credit claimants

Context

Over recent years there have been increasing efforts to understand the extent, nature and consequences of poverty for households. The media have reported on everyday realities of living on a low-income, with interest growing in tandem with the cost-of-living crisis in the UK. There is a level of public outrage about the growing reliance on emergency food provision through food banks, which has become a normal part of our wider social infrastructure. Yet there are many unanswered questions around how poverty affects different groups in society. In this chapter, we highlight regional differences in poverty before focusing on the lived experience of poverty for mothers, carers and their children in the North.

We reveal the realities of women struggling to provide the essentials for their family whilst neglecting themselves, trying to shield their children from the consequences of their hardship, and desperately juggling mounting bills in the face of rising living costs. In addition to these challenges, many women are claiming Universal Credit (UC), which we show often creates further stress and anxiety through the way in which it is designed and implemented, particularly in relation to conditionality.

Our source materials are primarily drawn from four important projects:

- Changing Realities study – a participatory online project working with over 100 parents and carers living on a low income across the UK which is asking the question, "What is life really like on a low income in the UK?" (see Box 3.1)
- The NIHR-funded 'Evaluation of the mental health impacts of Universal Credit (UC)' project 16 – looking at the experience of living and claiming the key state benefit for working age people, including those

3.1 Changing Realities

Changing Realities is a participatory research programme working in partnership with over 100 parents and carers living on a low income to document everyday life and collaboratively develop recommendations for change.

Changing Realities participants live across the UK, spanning full-time workers, part-time workers, active job seekers, and individuals not working due to health and/or disability. As part of the research programme, participants regularly write diary entries and answer video-elicited questions; these entries can be found in the Changing Realities Archive, a live online evidence base of life on a low income.

All participants self-identify as living on a low income and have a dependent child living at home. In this report we draw on diary entries and video responses from women in the North of England, seeking to understand their unique perspectives and experiences of everyday life in poverty. Further reports are available via the project website[19-22].

3.2 Evaluation of the mental health impacts of Universal Credit (UC)

The ongoing large-scale evaluation of the mental health impacts of Universal Credit by Craig et al. is looking at the ways in which Universal Credit is delivered and how policy changes are affecting people claiming Universal Credit and their households. The study seeks to explore the ways in which Universal Credit impacts people's lives, including their health, wellbeing, debt, heating or eating decisions, housing, employment, family life, social relationships, and use of health and other support services. The work includes a qualitative longitudinal study revealing the experiences of Universal Credit claimants[16].

The team conducted in-depth interviews with 70 people living in Tyne and Wear and Glasgow in 2022, and follow-up interviews with ~50% of participants in 2023/2024. The NIHR study team are working with DWP to facilitate shared learning highlighted by the research. A recent event, jointly organised with DWP, brought together parents, policy makers, academics and voluntary and community organisations to share their experiences and views about UC as it affects children, young people and families.

living with health conditions and disabilities. (see Box 3.2)

- UC CREATIVES 17 – a participatory arts project, co-produced and co-delivered with nine individuals with lived experience of receiving UC about the impacts of UC (see Box 3.3)
- An NIHR Applied Research Collaboration North East and North Cumbria (ARC NENC) study 18 – exploring young people's views on Universal Credit in North East England (see Box 3.4)

Regional differences in poverty in England

According to the recently published report by the Joseph Rowntree Foundation[23], more than 14.4 million people in the UK were living in poverty in 2021-22. This is equivalent to around 22% of the total population, with some variation by country: 22% in England, 22% in Wales, 21% in Scotland, and 16% in Northern Ireland. Estimates of poverty in different regions of England also vary substantially (Figure 3.1). The North East (25.4%) has the second highest rate of poverty, behind only the West Midlands (26.9%), and both the North West (22.7%) and Yorkshire and the Humber (23.3%) have higher rates of poverty than the national average.

These regional differences are mirrored by the proportion of women receiving Universal Credit - the key UK state benefit for working-age people since 2013. As of December 2023, Universal Credit is claimed by 6.3 million people. Outside of London there are clear differences in the number of women on Universal Credit in the North compared to the South, with the North having a consistently higher percentage of women who are Universal Credit claimants than the South over time (Figure 3.1). The inequality between the number of women receiving Universal Credit in the North versus the South appeared to increase during the COVID-19 pandemic and has subsequently remained higher in the North than in the South (Figure 3.2).

The levels of poverty for women in the North is reflected in the number of Universal Credit Health claims, the element of Universal Credit that reduces a claimant's work requirements and/or provides additional finance for living with a disability [24-26]. In June 2023, 29% of Universal Credit claimants nationally were on one of two elements of Universal Credit Health. Figure 3.3 highlights that while the North East has consistently higher proportions of women on Universal Credit, the North East of England has the highest rate of Universal Credit Health claims (35%) relative to the overall numbers of claimants. The North East also has the highest number of health claims relative to women on Universal Credit in comparison to all other regions, the North West and South East also have high rates of health claims relative to number of women on Universal Credit.

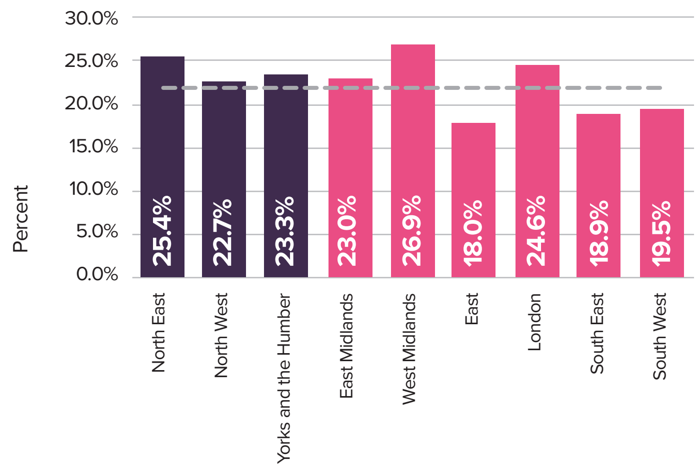
The latest available data suggests that by the end of 2023 there were approximately 2.1 million families on Universal Credit in England[26]. The proportion of families claiming Universal Credit has increased over time (Figure 3.4). The most recent data show that the three northern regions have higher percentages of families on Universal Credit (ranging from 18.27% to 19.67%) compared to regions in the South (14.68% to 17.17%). The average number of families on Universal Credit across the North is 3.41% higher than the three regions in the South, this rises to 4.18% when London is excluded.

Changing Realities participants describe the continued pressures they face in trying to make ends meet. They express their anger and disappointment at claims that the cost-of-living crisis is over:

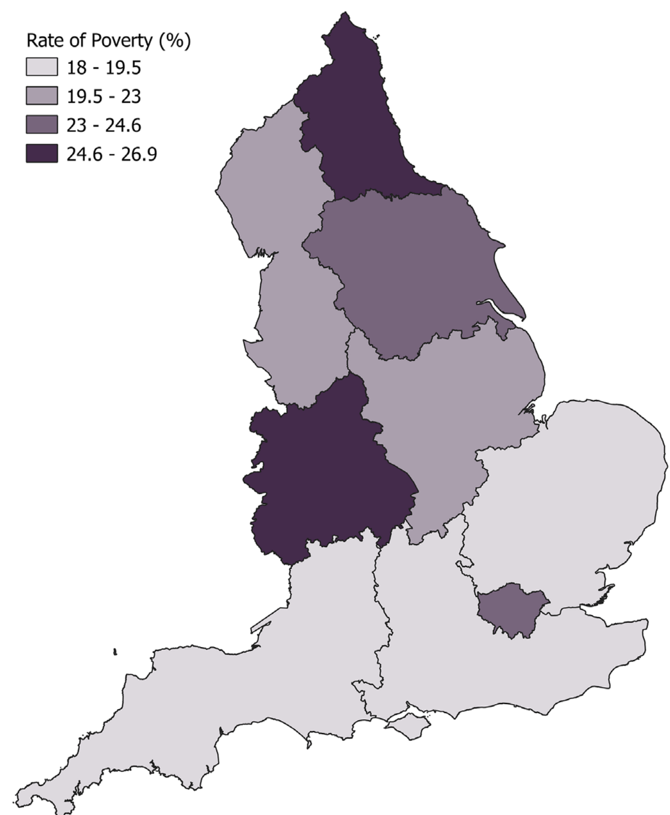
The cost of living crisis is absolutely NOT over. Did all the rising prices go back to what they were? No! Did we all get pay rises? No! Things are still creeping up. And the culmination of everything being more expensive is putting more pressure than ever before on my household finances. (Changing Realities Participant Sadie Q, Yorkshire)

Nothing's come down. Food shopping hasn't come down. Nothing. We're just having to survive any way we can. It's definitely not getting any better, if not worse. (Changing Realities Participant Roxy, Yorkshire)

Figure 3.1. Rates of poverty by region of England



Notes: The black dashed line represents the English average poverty rate (22.0%). Bars coloured in purple represent poverty rates more than 10% above the English average.

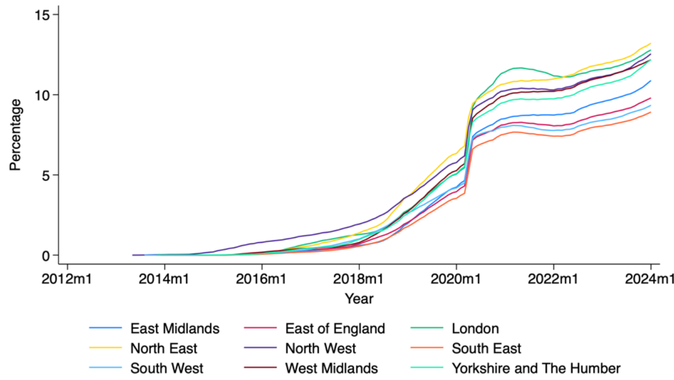


Evelyn, a lone parent living in the North West, poignantly articulates her anger at the way in which the cost-of-living crisis has been portrayed as something that has simply emerged and for which no one should shoulder the responsibility. Evelyn, like many of the participants, describes a constant sense of fear of not being able to make ends meet and the toll this takes on her:

I'm so fed up of seeing the portrayal of this cost-of-living crisis. It's not a cost-of-living crisis, it's a cost of greed crisis. It's by far not over. I've never had such expensive shopping, such expensive services, and just generally the amount that is coming in won't be enough to cover what's going out. And I'm frightened and I'm really sick of being frightened… I'm really sad and angry that it's being portrayed that it is over, because it absolutely isn't. (Changing Realities Participant Evelyn D, North West England)

Diary entries of Changing Realities participants show how those who were struggling to meet basic needs and manage their limited resources

Figure 3.2. **Percentage of women on Universal Credit across the regions of England between 2013 and 2024**



Notes: Data are from the DWP via Stat Xplore [20, 21].

3.3 UC CREATIVES

UC CREATIVES (www.uccreatives.co.uk) is one of the key public involvement outputs within the evaluation of the mental health impacts of Universal Credit 16. UC CREATIVES is a participatory arts project co-produced and co-delivered with people with lived experience of Universal Credit.

A group of nine individuals came together to create mixed media art and creative writing about the impacts of Universal Credit, and collectively design an exhibition of this artwork. As a collective voice, the UC CREATIVES group are using their exhibition to influence attitudes and awareness about the impacts of Universal Credit on mental health and wellbeing.

The exhibition illuminates a range of themes such as: fear, anxiety, worth, financial hardship and dehumanisation. It calls for more compassion and hope for change in the UK's social security system. The full virtual exhibition can be seen online at https://www.uccreatives.co.uk/virtual-exhibition-tour. Pieces from the exhibition have also been shared with staff in the Department for Work and Pensions (DWP).

before the cost-of-living crisis find it unrealistic to be expected to make further sacrifices. Donnie and Annie explain:

People are talking about the energy prices like they're normal now. Well it's not normal to have to pay £300 a month to heat your house, to keep your toddler warm! I'm receiving letters after letter about not paying enough, but I'm paying what I can afford… (Changing Realities Participant Donnie C, Yorkshire)

…I'm glad it's getting warmer so at least the heating won't be on as much. And as of food, constantly rising. I'm looking at all options. I shop at the cheapest supermarket and even doing food plans to lower the cost as much as possible. (Changing Realities Participant Annie W, Yorkshire)

UC CREATIVES also highlight how financial insecurity has been worsened by the cost of living crisis. In Box 3.5 Anna (pseudonym) illustrates the relentless toll of financial insecurity through the piece, "H'yer we gan again!" and the effects of 'Being Poor' in Figure 3.5.

Prioritizing children's basic needs risks women's health and wellbeing

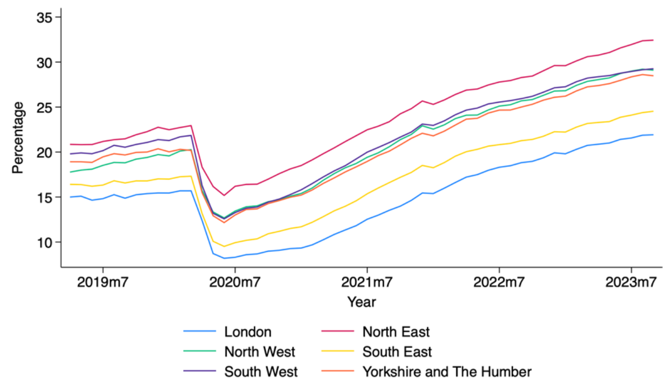
The strain on family finances is also strongly articulated by Changing Realities participants, who commonly describe juggling priorities every

3.4 "Money is health" – young people share their views on Universal Credit

Young people's views on UC are drawn from recent work by NIHR ARC NENC researchers from Newcastle, Northumbria and Cumbria Universities[18]. In what is believed to be the first UK study to specifically focus on children and young people's views of UC, researchers recruited 41 young people aged 12-16 years from diverse backgrounds across North East England.

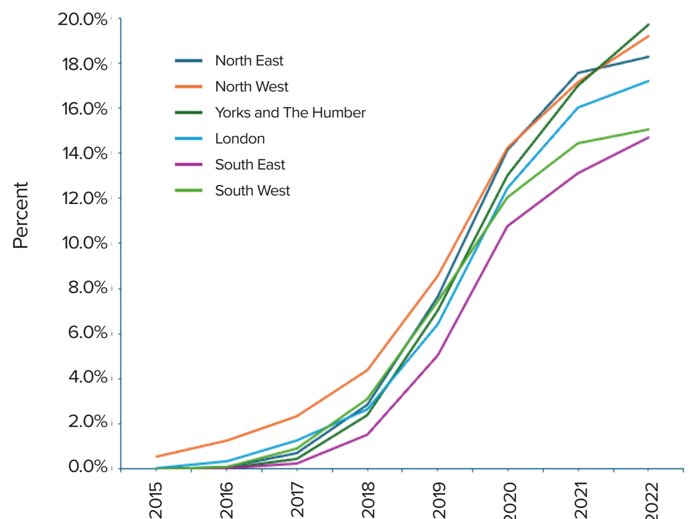
They used a range of creative interviews, focus groups and workshops – co-designed with young advisers to promote participant engagement – to understand whether, and how, young people were aware of UC and its effects, if any, on children, families and households. The study was funded by the Newcastle University QR Policy Support Fund and carried out with collaborative partners Investing in Children, Children North East, and The North East Child Poverty Commission.

Figure 3.3. **The proportion of women that have a UC health case as a proportion of total number of women on UC in each region in England between 2019 and 2023**



Notes: The DWP statistics defines health cases as "the number of people on UC health comprises those with a restricted ability to work supported by acceptable medical evidence (pre-WCA) or with a Limited Capacity for Work (LCW) or Limited Capacity for Work-Related Activity (LCWRA) outcome" [20, 21].

Figure 3.4. **Yearly average of families on Universal Credit by region in England as a proportion of number of households with children in each region**



Notes: This figure shows the number of families with children (single and coupled families with children) on Universal Credit each year over time by region, as a percentage of the total number of households with children in each region [22].

day, and their efforts to put their children first. Millie G writes:

3 days until payday. 3 more packed lunches to magic from nothing. 3 more teas to make with little in the cupboard and using a lot of imagination. (Millie G, Yorkshire)

Millie's reflection captures the ingenuity required by parents to stretch limited resources, as well as emphasising the cyclical nature of financial strain and the constant pressure to make ends meet. Similarly, Beverly, like many other participants, describes the challenging decisions parents on low incomes face daily, where basic necessities such as food become a trade-off between personal well-being and meeting their children's needs:

...I've resorted to eating snacks for lunch or dinner on days where I can get away without my son noticing, rather than both of us eating... (Beverly W, North West England)

Parents often share in their diaries how thoughts of the cost of living crisis consume much of their time, negatively impacting on their family relationships and subsequently their mental and physical health.

My children are happy and that's what counts. I just wish my thoughts weren't clouded with worries all the time. I always feel like I'm not giving them my full attention, like I'm not really in the moment. Instead I'm worrying about how I will juggle money, how I will pay for whatever is coming up next etc. (Thea F, North West England)

Many parents also share how they are trying to shield their children from the impact of poverty at the expense of their own health and wellbeing. Gabriel, for example, describes how she wouldn't even think about putting the heating on at home when the children are out:

Figure 3.5 Being Poor by Anna (pseudonym) UC Creatives

3.5 H'yer we gan again!

By UC CREATIVES participant Anna (pseudonym)

"Uh oh! H'yer we gan again! I'm in the middle of a beautiful warm shower, and all of a sudden...I scream! I scream because the shower water has gone cold and I suspect that the gas has run out, yet again.

I scream, not out of terror, but out of fear, fear because I wonder where I'm gonna get the next penny from to deal with this emergency.

The emergency is that, not only do I need to finish showering, but, it is also a freezing cold day, my house is dark, gloomy and freezing cold, and I have two children to also shower and keep warm, but yet, upon inspection of my gas meter (after getting out of the shower, with now freezing cold droplets of water dripping off my body and onto the floor) it sharp becomes apparent to me that we have definitely run out of gas.
I then wrap a towel around me in a desperate attempt to keep warm.

Owww, howay man! How can this be? I say to myself, when I only topped up the gas meter with credit just two days before? And how long is this going to go on for? I'm on Universal Credit, which means I have a limited amount of income as it is.

Besides, when I used to credit my gas meter with the same amount of money a year ago, it used to go so much further, but now it feels as if I'm having to top up the meter with credit every single day! especially since the prices have gone up.

This can't go on. Things need to change.

Now faced with the challenge of having to find money to credit my gas meter yet again, I take a deep breath... put my hands on my hips... roll back my eyes, and sigh... 'H'yer we gan again!"

Listen here: https://www.uccreatives.co.uk/our-gallery?wix-vod-video-id=0da17d92456240d887080197260314b0&wix-vod-comp-id=comp-ln66rcgf

I'm absolutely freezing. I have two jumpers and a dressing gown and a blanket. The thermostat says 12 degrees. I am too scared to put the heating on even though people with multiple sclerosis should ideally be at 18/19 degrees all the time. I have to save the money... given from the government for when it gets really cold. No chance I would use heating without kids at home.
(Gabriel K, North West England)

Similarly, many single parents from the Universal Credit evaluation, including Becky, describe the stress of trying to protect their children from poverty and how this protection means daily hunger and poor nutrition for themselves:

And it's not just me...it's the stress of I've got a little boy to think of that depends on me. I don't want him losing, not having, you know, going to kids' birthday parties, soft play, going swimming. And all this, like you say, costs money....But even just having enough to live on it sticks in your throat. It got to the point I didn't eat, because I thought anything in this house- I don't know when I'm going to get back on me feet- so anything that's in this freezer or in these cupboards I'd rather keep for him.
(Becky, lone parent, part-time paid work, 1 child)

However, parents also realise that they cannot totally protect their children from the impact of poverty, which makes them feel even worse. Changing Realities participants share a constant sense of anxiety and worry, related to the uncertainty of whether they will be able to make ends meet each week:

What's in our bank account is all the money we have to our names. So is it any wonder we tend to feel so stressed about the balance between increasing costs and inadequate benefit levels. I really am not looking forward to more mould, condensation, rationing the heating and the overall expense of paying for 'Christmas' in all its glory (Beverley W, North West England)

The added pressure of winter bills, more food, dark nights is very depressing indeed.
(Sadie Q, Yorkshire) '

Surviving but not really living: the negative impact of poverty on women's health and wellbeing

Women's narratives reinforce the mental and physical toll of existing on a low income and emphasise how preventative health policy needs to tackle the inadequacy of social security provision and the prevalence of insecure, low-paid employment.

Lili K from Changing Realities describes both the relational and material impact of poverty on everyday life, and the sense of shame she feels about the strategies she is forced to employ to save money:
'Scrimping like this does have a negative effect on us all. We are more

isolated, spend less time with our friends and family. We feel scruffy and self-conscious when our clothes are not as fresh and clean as we would like them to feel. I spend more time in bed just keeping warm when our house should be warm enough for us to move about comfortably. I wake up in the night worrying about money and how much it costs to use every single appliance. My standard of self care and wellbeing has declined but I am trying to ensure our daughter's does not we are surviving but not really living, let alone thriving. (Changing Realities Participant Lili K, North West England)

Similarly, Gracie, a lone parent of 3 children in receipt of Universal Credit, wrote in her diary:

...I say surviving as it's most certainly not living and long term I hope to be in a better position financially. But for now my youngest son is almost 2 and I have no childcare to access work right now. Anyways I digress, the worries of everyday life sometimes consume me. Will I be able to afford food this week? What am I going to do for his upcoming 2nd birthday? What do I do when my older two are growing so fast they constantly need bigger clothes and shoes...
(Changing Realities Participant Gracie E, North West England)

The Universal Credit evaluation qualitative study also found that many women claiming Universal Credit, particularly those with children and/or health conditions or limited support, experienced significant impacts on their mental health, including a sense of worthlessness, constant worry and anxiety about their financial insecurity, and social isolation due to being unable to afford transport or social activities. Echoing the work of others, many women and parents described impacts on their nutrition since being on Universal Credit, attending foodbanks and how this put them at risk of poorer health[22].

I remember eating smart price Weetabix with water because it was cheaper than milk....It [unexpectedly low UC payment] made me very wobbly, very teary. ... and it definitely exacerbated my depression....I actually contacted my doctor to say, look, my mental health is plummeting. My depression is severely affected by this. And it's largely to do with the financial situation.

(UC Evaluation study participant Jayne, single, 2 adult children, out of paid work, physical and mental health conditions, North East)

The feeling of 'coping' not living is also the subject of work by Anna (pseudonym) as part of UC CREATIVES (Figure 3.6)

Figure 3.6 Coping by Anna (pseudonym), UC CREATIVES

Box 3.6 Monologue

By UC CREATIVES participant Janet (pseudonym)

"Ping! Ooh a text! Not like love island obviously. Who is it? Oh god my stomach sinks. Universal Credit. What do they want? Why do they always provoke this sinking feeling? That dread. You always have to answer quickly too. It's almost like a demand. You have a message. You must go to your journal and sign in now. This is important. Ok, ok, ok I'm doing it. Ok UC log in. What's my username again? It's my email? I can never remember it. Nope that's not it.

Have I typed it correctly? Try again. Ok, relax. Think about it. Right ok, breathe, that's it. What's the password. Is that it? Nope. Send new password. Ok. Now wait. Oh god, how long does this take? No email reminder yet. Ok, breathe. But what if they are going to take money away? What if I've done something wrong? My heart is going. Beads of sweat are breaking out all over my body. Deep breaths. Ping! Ooh an email. Email reminder, password. Oh yeah, that's it! Ok, back to the page. Right, page has timed out ...... Ooh phone ringing. It's shrill. They tone suddenly vibrating shocked me. Cancel call. Arrrgh! I didn't even see who was calling.

Oh god it could have been important. Who was it? Check quickly. No, don't recognise the number. Will they ring back? Can't think about that now. Ok, log back in, correct details, I'm in. All fidgety. It's loading. We will call you if we need to get in touch with you. What?!?!! That can't be right? Hang on. Wait, I have to click on journal. Ok, click on journal. You are claiming ESA. You may be affected if you do not inform us. Yes? Wait, is that it? All that stress and worry for that. Ffs!! Am I supposed to respond to that?! I message asking about this. In a state of disbelief now I go to calm myself with a cup of tea. God I hate this benefit. Ping! Guess who that's from? Let's log in again! Message! Reply: it's just an automatic response we send out. Oh that's all right then! Thanks for giving me a mini heart attack! Aaaand breathe."

Listen here: https://www.uccreatives.co.uk/our-gallery?wix-vod-video-id=2b39c9a47e764f1cb1cad3e26cc9a685&wix-vod-comp-id=comp-ln66rcgf

Impacts of Universal Credit

It well known that living in poverty, experiencing material deprivation, poor housing, and debt is linked to increased risk of stress, and poor mental and physical health outcomes, both in the short and long term [27]. Yet multiple studies and reports show that the standard rate of Universal Credit is not enough to cover basic essentials, and The Joseph Rowntree Foundation and The Trussell Trust have called for an Essentials Guarantee [28].

In the Universal Credit evaluation's qualitative study many women reported not having enough income to live on and stay well. Those with children who had transitioned from other benefits (e.g. Employment and Support Allowance or Tax Credits) often lost substantial amounts of income of up to ~£300 per month. Many women also reported deductions on their Universal Creditaccounts to repay advance payments, budgeting loans required for furnishing homes, and surviving the minimum 5-week wait for first payment.

The eight women in the sample who received additional benefits for disabilities, including through Universal Credit Health and/or other benefits, sometimes managed better financially, and yet often these additional finances helped to cover essentials, such as energy bills or transport costs, rather than providing finance for living with their disabilities.

"Broken by it all": the impacts of the design and delivery of Universal Credit on women

In addition to inadequate levels of benefits, research evidence shows that particular design features of Universal Credit impact families experiencing poverty. These include the 'digital by default' claims process, monthly payments in arrears, and enhanced conditionality requirements. The minimum five week wait for an initial Universal Credit payment can leave families without enough money to pay bills or provide food for their children[29]. Advance payments of Universal Credit (provided as loans and repaid through deductions) exacerbate hardship and debt amongst Universal Credit claimants,[30] affecting social relationships and provoking stigma and shame[31].

Several studies now show that Universal Credit creates substantial mental distress through the way in which the benefit is designed and implemented. The negative impacts are often pronounced for

people with existing mental health conditions and those who are lone parents[32-35], as women experience additional harms from Universal Credit due to conflicts between Universal Credit work-requirements and the devaluation of unpaid childcare [36, 37].

The Universal Credit evaluation qualitative study found that women's mental health and wellbeing was often affected by communication with the Department for Work and Pensions (DWP), which is via an online platform, and with staff delivering Universal Credit via phone and in-person. For example, the sense of stress induced by a notification from Universal Credit is captured by UC CREATIVES participant Janet (Box 3.6).

Women's experiences with DWP staff in the call centre and at the Job Centre Plus were inconsistent, with many experiencing both negative and positive experiences at different points in time. Several women described communication as stressful due to frequent changes of Work Coaches or being "passed from pillar to post", with contradictory responses from staff in attempts to resolve queries. Others experienced little empathy, compassion or understanding of the realities of living with health issues.

Those women who had children and lived with health conditions or disabilities had additional challenges, including: the stress of unhelpful work-focused interviews; the work capability assessment process; receiving what they described as anxiety-provoking automated messages; and living with the uncertainty of benefit reassessments. Negative and stressful communication with staff could have deleterious impacts on health for those with existing mental health conditions, and when caring for children, the impacts could be even greater.

I'd be upset and then I was in a panic, and I'm not going to get paid, what am I going to do here?...it got to the point where actually I stood and actually cried in the Jobcentre in the doorway ... I was just broken by it all .... never felt so alone in my entire life ...you just felt like an inconvenience... it probably set me back a couple of years [with Post Traumatic Stress Disorder (PTSD) recovery] to be perfectly honest, everything that I'd been working hard for.... The stress... it's on the bairns, it's on the children because if I'm struggling physically and mentally to be perfectly honest, a whole lot more lands on [son aged 12].
(Evaluation Study Participant Sandra, lone parent, part-time self-employment, 2 children, physical and mental health conditions, North East)

Changing Realities participant Dotty describes how she makes every effort to avoid going to the Jobcentre and only goes if it is absolutely necessary, echoing the sense of shame that is exacerbated by difficult encounters with Job Centre Plus:

... because, as soon as you get to the door of a Jobcentre, you're immediately met by security guards, which is really intimidating.
(Changing Realities Participant Dotty G, North East England)

"Pure stress": the impacts of conditionality for lone parents on Universal Credit

Conditionality refers to the requirements for lone parents to work, apply for jobs, or take part in work-related activities in order to receive Universal Credit and was introduced in 2008. Since then, work requirements backed by the threat of benefit reductions (sanctions) have frequently increased.

The previous, more supportive benefit system had included increased Working Tax Credits and voluntary employment support via the New Deal for Lone Parents. Contemporary studies showed that this earlier system led to increased employment, higher incomes, and improved health for lone parent families.[38-41] In contrast, four recent population studies have provided strong evidence that while conditionality has led to increased employment, most jobs are low-paid and part-time, and equal numbers of lone parents have moved to health-related benefits. There has been little improvement in incomes or poverty rates, and all four studies show

Figure 3.7 Sanctioned by Patrick (pseudonym), UC CREATIVES 17

negative impacts on a range of child and parental mental and physical health measures[32, 42-44].

Conflict between roles such as working and parenting, and lack of control over key decisions such as whether to enter employment or use formal childcare, have been shown to impact health negatively in many studies[45]. The issue of conditionality, and its impacts on the health of lone parents in particular, was explored as part of the UC evaluation qualitative study the mental health impacts of UC[16].

Experiences reported by the lone parents who participated in the UC evaluation (n=18) illuminate the ways in which conditionality can negatively affect health. Conditions imposed in order to receive UC, underpinned by the threat of sanctions, resulted in lone parents: attending Job Centre Plus appointments with sick children; sending sick children to school; working during the summer holidays despite lacking suitable childcare; or apply for jobs (such as night shift work) that are incompatible with childcare responsibilities. These experiences caused stress, anxiety, and exhaustion, which exacerbated existing health conditions.

I've got this appointment with, it's Reed tomorrow, so I'm going to have to send him in [to school] whether he's struggling or not... 'cause my money might get stopped if I don't go, so it's kind of like, feeling bad sending the bairn if he's struggling, but then I have to otherwise I'm not going to be able to feed him for the next month...When he's crying, 'cause like he's in pain, and I'm like you have to go [to school], and you have to go there's nothing I can do. He's like, but you're my mam. I know that, but I can't do nothing. But obviously he's too young to understand.
(Tanya, lone parent, 4 children, mental health conditions, child with health conditions)

because the doctor even wrote me a letter to say that I didn't have to go in, because they knew my situation, because I'm on my own with the two kids. And he can be a handful, taking him anywhere, so going into town is just a no-no for me. And I explained that, and they were giving it, no you have to come in, so that was a pure stress.
(Sinead, lone parent, mental health conditions, child with special needs)
I said, I've got an appointment this week, I said, unfortunately, I says, I won't be able to make it because my little girl's got COVID ... I'm the only one available to look after her, we live together... she messaged us back the day after, and she went, Marianne, you know, you could be sanctioned for failure to turn up to your appointment.
(Marianne, lone parent, 1 child)

But I then had to pay to put my boy into [holiday club], which is not registered, so I can't claim my money back ... But yeah, I was, I was totally worse off. Eight till six, I was absolutely shattered. By the weekend I couldn't even do anything with my own kids. I was like, just let me sleep.

(Abigail, lone parent, 2 children, caring for disabled relative)

Work with UC Creatives captures the sense of entrapment that participant Patrick (pseudonym) felt due to the sanctioning process (Figure 3.7 and Figure 3.8).

Work Coaches have a degree of discretion regarding the conditions imposed, which is designed to allow them to tailor requirements to claimants' circumstances. In our study, respondents reported that Work Coaches often did not adapt conditions to lone parents' childcare or health needs. Imposed work requirements were often in excess of those stipulated by the policy, which states that the requirements should be determined by the age of the lone parent's youngest child or the number of hours they already work.

Figure 3.8 Am I a state of mind, or a mind of the state? by Patrick (pseudonym), UC CREATIVES 17

Lone parents are disadvantaged in the labour market because they have sole responsibility for childcare. They often struggle to find childcare, or jobs with shifts when suitable childcare is available. Given that lone parents and their children fare worse than average on health and many other outcomes, and lower levels of conditionality have been shown to cause direct harms[32, 42-44], the potential for negative health effects of recently implemented increases in conditionality is concerning.

Long term illness in single mothers – statistics snapshot

Based on data from the Understanding Society Survey (USS) covering the period 2009-2023[46], the rates of long-term illness are higher amongst single mothers than their partnered counterparts in England (25% vs 22%). However, there seems to be relatively little variation between regions (See Figure 3.9). Interestingly, lone mothers in the southern regions have slightly higher rates of long-term limiting illness (around 30%) than those in the northern regions (around 25%).
Similarly, the rates of psychological distress (as measured by GHQ-12 caseness score>3) are also higher amongst lone mothers than amongst partnered mothers in England (29% vs 20%). There is again little variation between regions, with East Midlands having the lowest rates of psychological distress amongst lone mothers (approximately 26% vs 29% on average amongst the rest) (See Figure 3.10).

Views on UC from children and young people

Despite concerns, including those outlined in this report, that UC is exacerbating inequalities, children and young peoples' voices remain largely absent from policymaking generally [47] and discussions about UC policy specifically [48]. In a recent qualitative study funded by Newcastle University, a team of researchers and staff from voluntary organisations used creative methods to understand the views of UC among 41 children and young people, aged 12-16 years, from the North East[18].

As the quotes below show, participants held contested views about conditionality, sanctions, lower UC rates for under 25s and the two-child limit; alongside recognition of the stigma and shame associated with being on benefits:

I feel like it's just like, uh, you don't work, you're lazy, you're jobless, uneducated, so you're on benefits [Online-Focus Group]

Figure 3.9. Proportion of lone mothers reporting long-term limiting illness across English regions

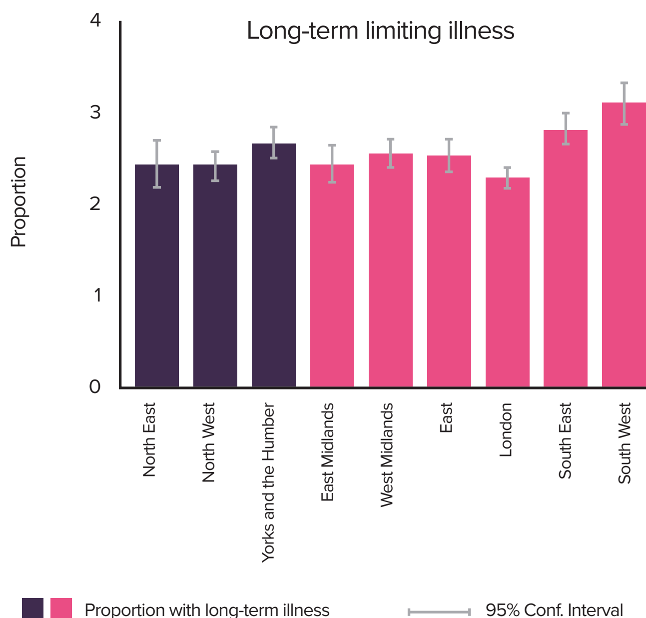
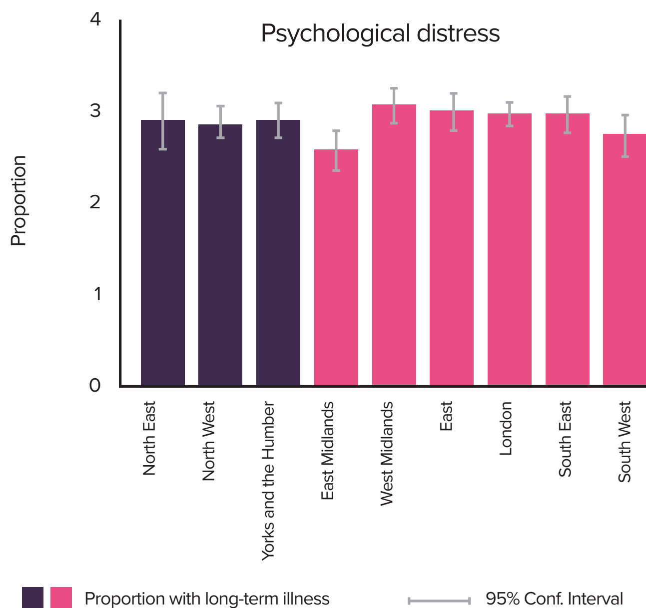


Figure 3.10. Proportion of lone mothers reporting psychological distress across English regions



Children and young people were aware when parents and carers were struggling financially and may try to ease pressures on their family. Participants could see the demands on parents, particularly mothers, who were often seen as time-pressured, juggling childcare and work, with recognition of the detrimental effects on their mental health.

You can see when your parents are struggling. If they're worrying about something, then you're going to worry about it…we're getting to this age now where we understand what's going on. [Face-to-face-Participant-Interview].

Children and young people stressed the importance of minimum standards of income and recommended tailored employment support for UC claimants, taking account of their personal, health and family circumstances. It was emphasised that employers had moral and legal responsibilities to make reasonable adjustments.

Some people might have kids or like they could be carers to like mams,

dads, nanas, grandas, so they should be able to put in for the hours they want to work around their family life [Face-to-face-Participant-Interview].

Some felt the Government could do more to help people out and “make it easier to get jobs”:

They’re [government] not doing enough to help you. They can do so much more to help people who are struggling financially and stuff like that…but they’re choosing not to [Face-to-face-Focus Group 2]

Most participants believed sanctions (temporary suspension of benefit payments) were unfair and counterproductive: describing them as “pathetic” and “horrible”:

I just don’t agree with it [sanctions], say that’s the only money they’re physically getting, say they’ve got kids, they’re not able to provide for their kids, they’re not able to put food on the table, they’re not able to provide a roof, water, gas, electric, bills. They won’t be able to provide any of that, or even for school, like school uniform [Face-to-face-Focus Group 2]

The majority of participants saw the two-child limit introduced in April 2017 as unfair because they thought families needed additional financial support if there were more children in the household.
A person with five kids means more uniforms, more clothes, more shoes, so a person with two kids gets the same amount as what that person is getting, yes they still need to provide uniform and clothes but she’s still only got two kids and they’ve got five, like she needs more help. [Face-to-face-Participant-Interview]

Participants understood the relationship between family finances and health:

“Money is health in a way. You need money to have health.” [Face-to-face-Participant-Interview]

Participants described links between UC, poverty, poor health, social and educational outcomes, recognising the complex, cumulative and interrelated effects of stigma, unemployment, precarious income, debt, poor housing, stress and financial insecurity.

Participants in this study recognised that not all children and young people benefitted from minimum standards of income to ensure access to basic necessities. They also saw that efforts are required to ensure the labour market is more supportive of those with caring responsibilities.

Raising awareness of the impacts of poverty and effecting change with research

The experiences described by our study participants reinforce the mental and physical toll of existing on a low income and emphasise how preventative health policy needs to tackle the inadequacy of social security provision and the prevalence of insecure, low-paid employment. One of the members of UC CREATIVES, Anna (pseudonym), who has been involved as a public contributor in the UC evaluation, shares her experience of this event in Box 3.7.

Conclusion

The women whose voices are heard here provide compelling evidence of how poverty restricts options, opportunities, and access to things that society takes for granted [23]. Their narratives are supported by data showing how women and children are at risk of harms and adversity due to low-incomes and policies and practices within UC. We see that, excluding London, the North has a higher proportion of women who are UC claimants than the South, and that for many women UC has a negative impact on their mental and emotional health. In particular, the threat of sanctions for not meeting conditions imposed for receiving UC

Box 3.7. Being a single mother on Universal Credit: efforts to bring about change for the better

By Anna (pseudonym) from Tyne and Wear

I am a single mother of two children on Universal Credit. My eldest child is now 20 years old, and my youngest is 8. I have been involved in the NIHR funded study evaluating the health effects of Universal Credit since 2022. And in 2023, I got involved in their arts project called UC CREATIVES, where a group of us with experience of UC produced a mixed media art and creative writing exhibition. I recently attended a workshop with staff from the Department of Work and Pensions and the voluntary sector which aimed to raise awareness of the impact of Universal Credit on children, young people and families across the UK. In this blog I reflect on being involved in the recent event with DWP about being a single mother on UC.

My initial reason for attending the workshop was to share a poem I had written as a representative of UC CREATIVES, and present key issues from the UC CREATIVES group about things myself and other parents in the group wished to change about UC. At the event, research was shared about the often negative impact that the current Universal Credit system has on the lives of families who are on the receiving end of it.

As the workshop progressed, I was completely amazed at how deeply the content of the workshop resonated with me, especially when I started to think about my own domestic situation with my two children. Similar to some of the research being shared, I too had had to visit foodbanks, struggled to find a job that would fit around my young child and health conditions, and had been subject to inappropriate conditionality (having to do work search activity whilst on sick notes from my GP). After initial nerves at the workshop, I felt relaxed enough to ask questions and raise additional issues throughout the sessions.

One of the first issues I raised, was to do with how I came about being on UC in the first place. I had to move from a ‘legacy benefit’ called income support to UC when my child turned 5 years old (required by law). This was something that I really didn’t want to do because I knew that I would lose out financially - and I did. I also waited for 2 years to be put in the limited capability for work group of UC, during which time I handed in sick notes but still had to go in for interviews at the job centre and search for work.

At the end of the workshop, I raised a recent challenge I’d experienced with UC. Since my recently turned 20-year-old was no longer in full-time state funded education, my UC payments were to be suddenly reduced by £300 per month! I also have to pay bedroom tax on her bedroom as she is living in student accommodation near her University, and yet she will also be using her bedroom out of term time when she comes home. These huge financial losses for me seem unjustified in the context of the cost-of-living crisis where my bills have risen dramatically, and when I will also need to continue to support my daughter with some financial means whilst she is a student.

The workshop was a great learning experience for all that attended and was also a chance for us all to learn from each other, and to try to bring about some form of change for the better, in whichever way that we could, no matter how small. The most important thing to me was that, at least these discussions were being had, which, in my opinion, always has a ‘ripple effect’ until eventually a bigger and better change takes place.

causes stress, anxiety and the exacerbation of health issues.

The work presented here also demonstrates that mothers living on a low income in the North of England continue to experience the everyday realities of the high cost of living. These women contest assertions that the cost-of-living crisis is over. Instead, their accounts show the constant struggle to juggle competing priorities, and their commitment to ensuring that the needs of their children are met over and above their own.

Despite such efforts, children and young people are highly aware of the pressure an inadequate income imposes on parents and stressed the importance of minimum standards of income. Improving the financial security of families with children is a highly cost-effective investment for the future as well as a moral imperative.

This chapter clearly shows the urgency of providing additional, effectively targeted support. It directly challenges the approach of addressing poverty in silos of food insecurity, fuel insecurity, and housing insecurity etc. It instead highlights the need to ensure that, as an absolute minimum, incomes enable people to afford everyday essentials. There is an urgent need for a holistic approach to tackling poverty, involving those directly affected by poverty and receiving social security, to build a support system which is fit for purpose.

Recommendations

The following recommendations for change are the product of collaboration between people with lived experience of poverty, and those with policy, campaigning, and academic expertise.

- The Government should make a long-term commitment to uprating benefits in line with inflation meeting the urgent need for incomes to – at the least – keep pace with rising costs in the lives of families with children. Benefits should, at the least, permit individuals to cover essential items; food, clothing housing, and utilities, and also allow for some social participation (see the JRF Essentials Guarantee [28])
- Stop the worrying turn toward the use of temporary, one-off, and flat-rate payments to address ongoing problems of poverty and hardship. These often intensify insecurity and leave families with children at a disadvantage. The Government should instead invest in people and in the social security system through regular payments that are proportionate to need
- Abolish policies that directly punish families with children. Sanctions, the two-child limit and the benefit cap have a disproportionate impact on women and children and damage the ability of low-income households to provide for their families - they must be abolished
- Rethink social security as a force for good and a vital component of a socially just society. To prevent the short- and long-term health and social impacts of the cost of living crisis, we need preventative rather than reactive change as part of a long-term view. Rethinking social security as an investment in the future, rather than as a temporary safety net that leaves families exposed to a permanent state of crisis, will be an important first step
- An integrated, national health inequalities strategy is needed with an explicit focus on addressing the social determinants of health to reduce poverty; create better jobs; improve early child development and education; create healthy and sustainable places in which to live and work; and improve efforts at prevention, as outlined by Munford et al [49].
- Further research is needed to understand the cumulative effects of welfare reform from the perspectives of children and young people under 18 and to integrate the views of children and young people and those with lived experience of UC in policy making.

Chapter 4
Caring

Authors: , Kat Jackson, Deborah Smart, Luke Munford, Gemma Spiers and Barbara Hanratty

Summary

- Women living in the North are more likely to provide unpaid care than the national average (10.3%) and those in London (8.4%). 12.0% of women in the North East, 11.2% of women in the North West, and 10.7% of women in Yorkshire and the Humber provide unpaid care
- o Unpaid carers are estimated to provide £57bn of care per year. We estimate that the women in the North contribute around £10bn is this, which is £2bn a year more than if they provided the national average
- Women in the North, and particularly the North East, were also more likely to provide the highest levels of care (50 or more hours of unpaid care a week) as well as the second highest category (20-49 hours of unpaid care a week)
- The North East and North West have higher than national average rates of caring in young people age 5-24
- The biggest contribution to unpaid care comes from those in their fifties: 1 in 5 women aged 55-59 in the North of England provide care to a family member because of illness, disability, mental illness or substance use

Context

In England, most unpaid care is provided by women, with the biggest contribution from those in their fifties. The impact of unpaid caring on health and wellbeing is particularly relevant to women in the North East, as the region with the highest levels of unpaid carers (10.1% of the adult population in the 2021 Census). Compared to the rest of the country, the North East and North West also have highest proportions of unpaid carers providing intensive support. Over three per cent of the adult population in these northern regions are working unpaid for over 50 hours a week and a high proportion of these carers are poor.

Our understanding of who provides unpaid care is incomplete, as many people who support family or friends do not identify themselves as a carer. There is also a paucity of granular data, particularly for young carers, making it difficult to provide comparisons by gender and region of England. However, we can make inferences based on education, employment and health outcomes of girls and women living in the North of England and what this may mean for those who provide unpaid care.

In this Chapter we discuss the prevalence and economic impact of unpaid care by women in the North, followed by an analysis of the impacts of caring at different times throughout the life course.

Prevalence of female carers across the North

Across the life course, people provide unpaid care for dependent and adult children, grandchildren, partners, parents, other family members and friends, both inside and outside the household. Providing unpaid care can be rewarding, but it can also be physically, mentally and emotionally demanding and have significant implications for unpaid carers' access to education, employment, social activities and their health and wellbeing. The most recent census data from 2021 indicates that across all age groups up to age 74 years, women are more likely to provide unpaid care than men, and more women living in deprived areas provide unpaid care than those in the least deprived areas[50].

There is currently, and has for at least 25 years been, a stark North-South regional divide in the proportions of women providing unpaid care[51]. In 2021 across all age groups women living in the North were more likely to provide unpaid care than the national average (10.3%), 12.0% of women in the North East, 11.2% of women in the North West, and 10.7% of women in Yorkshire and the Humber provide some unpaid care across the nine English regions, Census 2021 (Figure 4.1).

Moreover, women of all age groups in the North East and North West, are more likely than other regions to provide the highest levels of care (50 or more hours of unpaid care a week) as well as the second highest category (20-49 hours of unpaid care a week)[50] (Table 4.1). This is perhaps unsurprising as the North of England includes the most deprived areas of the country and has high rates of economic inactivity due to poor health and disability[53]. The Office for National Statistics estimate the annual value of unpaid social care to be £57bn per annum[54].

Applying this valuation to our regional prevalence of the provision of unpaid care, we estimate that women in the North provide around £10bn of care per year. The higher prevalence of unpaid care by women in the North is valued at around £2bn per year.

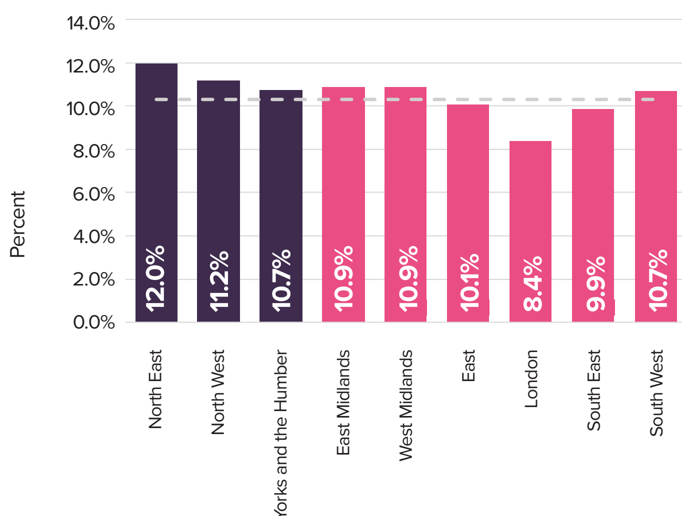
Female carers in the North of England

Young carers (aged 5-18 years) and young adult carers (aged 18-25 years) provide unpaid care to a family member or friend with an illness, disability, mental health condition or an addiction[55]. Nationally girls and young women aged 5-24 are more likely to be carers than boys and young men.

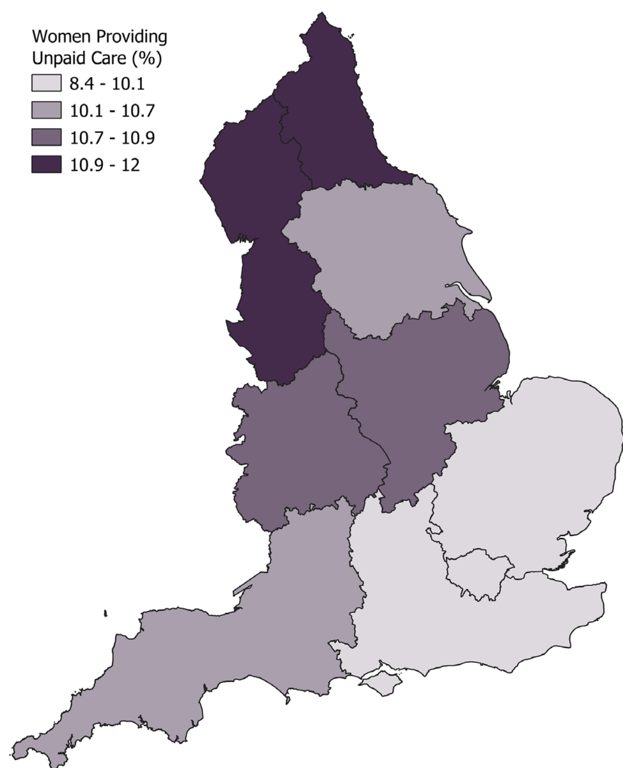
The 2021 Census reported there were 63,895 female young carers (1.5% of females aged 5-17 years) and 117,320 female carers (5.0% of females aged 18-24 years) in England[50], compared to 55,050 (1.2% of males aged 5-17 years) and 98,045 (4.3% of males aged 18-24 years). Across all three northern regions there is a higher proportion of young adult carers (18-24 year olds) than other areas of England. The North East and North West also have higher rates of females caring under the age of 18, as demonstrated in Table 4.2.

However, there are methodological issues related to these data being provided by the adult head of household, and an assumption that families recognise and are comfortable with their child being regarded as a carer. Frequently cited are the results from a school-based survey that estimate almost 800,000 young carers aged 11-16 years in England[56]. Young carers, of whom a greater number are female, are more likely to live in a household where no adults are in paid employment[57].

Figure 4.1. Percentage of women who reported that they provide some unpaid care across the nine English regions, Census 2021[48]



Notes: the black dashed line is the English average (=10.3%). Bars coloured in purple represent rates that are more than 10% above the English average.



Caring & education

Whilst women as a group nationally are more likely to go to university than men, students from areas with higher rates of economic deprivation, such as those in the North of England, are less likely to complete their studies, or achieve one of the highest grades[58].

Whilst we do not specifically know how female young adult carers in the North access higher education, as a group, young adult carers are nearly 40% less likely to attend university[59] and this becomes more stark the more hours of care they provide. Young adult carers providing care for more than 35 hours per week are 86% less likely to have a degree[59]. 35 hours may to many be associated with hours of full-time paid employment, but for young carers providing around 4 hours care per week they are 47% less likely to have a university level qualification[59].

Table 4.1. Percentage of women who report the level of unpaid care they provide per-week across the nine English regions, Census 2021[46]

	Provides no unpaid care	Provides 19 or less hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
England	89.7%	5.0%	2.2%	3.2%
North East	**88.0%**	**5.2%**	**2.8%**	**4.0%**
North West	**88.8%**	**5.1%**	**2.5%**	**3.6%**
Yorkshire and The Humber	**89.3%**	**5.0%**	**2.3%**	**3.4%**
East Midlands	89.1%	5.3%	2.2%	3.4%
West Midlands	89.1%	5.1%	2.4%	3.4%
East	89.9%	5.1%	1.9%	3.0%
London	91.6%	3.9%	2.0%	2.5%
South East	90.1%	5.1%	1.8%	2.9%
South West	89.3%	5.5%	2.0%	3.2%

Table 4.2. Percentage of female population who provide care by region and age group[46]

Region of England	Age 5-17 years	Age 18-24 years
North East	1.7%	5.8%
North West	1.6%	5.6%
Yorkshire & the Humber	1.4%	5.4%

Box 4.1 Experiences of a young carer

Nicole* is a young adult living in West Yorkshire and began caring for her mother at the age of 10. Nicole supports her mother by managing her money, taking her to the shops and managing her behaviour.

Growing up, Nicole often felt stressed about her caring responsibilities, especially during times when she couldn't be with her mother. Nicole found that her peers lacked understanding of her caring responsibilities which made forming and maintaining friendships challenging. As a young adult carer, Nicole has limited time to herself which means she is unable to engage in the hobbies she enjoys such as swimming or running. Nicole has experienced challenges relating to employment and due to her current caring responsibilities, is only able to work part-time.

Wakefield & District Carers is a non-profit organisation providing support to carers in the local area via a range of services including support groups; advice and training; social outings; and support for carers whilst a loved one is in hospital or a care home. Nicole has accessed their services and attended day trips, cooking sessions and game nights via the Wakefield young adult carers service, allowing for a few hours of respite.

Moving forwards, Nicole would like to see more funding, both locally and nationally, to provide support for unpaid carers services. It is also important for those running these services to have specialist knowledge and receive adequate training on the challenges facing unpaid carers to ensure the most appropriate support can be offered.

*Name changed to protect confidentiality

Young women in the North may be more likely than their male peers to pursue a university education, but the increased likelihood of them being a carer coupled with the higher chance of living in a deprived area may well add to the competing demands and pressures of both studying and caring [60].

Young caring and health

We know very little about the physical health implications of caring on young carers, with more studies reporting the mental health impact on young people. However, this is scant and further research is needed to explore the associations between caring and poor mental health[61], particularly with sub-groups such as young women living in the North. In the small body of research reporting the impact of caring on young carers health that exists, young carers were found to report increased occurrences of depression and anxiety[62], self-harm and increased reporting of wanting to end their life [63].

These figures are concerning, and it is difficult to imagine an improved situation for young carers in the North based on what we know about the experiences of girls in North of England in relation to their emotional well-being and mental health. There is a known gender gap in poor mental health outcomes, and girls experience higher levels of emotional problems [64] and psychological distress [65], with girls at increased risk of emotional problems compared to boys (Fink et al 2015). Box 4.1 highlights the personal impacts of being a young carer.

Working age female carers in the North of England

Women are more likely to provide care in middle age than in any other age group, with 19.9% of women aged 55-59 years providing unpaid care. In all three of the northern regions, women in this age bracket are more likely to be proving unpaid care than the English average (North West – 20.9%, Yorkshire and the Humber – 20.3%, North East – 21.6%). The highest rates are seen in the North East with over one in five women aged 55-59 years providing unpaid care.

During this period of intense care giving many women will combine unpaid care with paid work [66]. However, there is strong evidence that care giving has implications for women's opportunities to be engaged in paid work which in turn has significant implications for their finances and their own wellbeing. Women are more likely than men to work part time or to give up paid work to care than men [66]. While we don't know exactly how many women in the North of England give up work to care, people providing greater levels of care are most likely to have given up work, or to have reduced their working hours to care. We can therefore infer that unpaid care is affecting the finances and wellbeing of women in the North of England more than in the South of England. Relatedly, another recent report from Carers UK highlights that people providing 50 or more hours of unpaid care a week were most likely to say they had experienced a significant drop in income and struggle to afford the cost of food which again is more likely to be affecting women in the North of England [67].

Older carers

Many women in the North are providing unpaid care in later life, whilst coping with their own health problems. Healthy life expectancy for women is below the national average in two thirds of local authorities in the North West and Yorkshire and the Humber, and every local authority in the North East. (The Health Foundation 2022)[297]. A woman born in Stockton-on-Tees, for example, has a healthy life expectancy of 56.8 years. Women are also working for longer. They have experienced a larger rise in the state pension age (6 years) compared to men (1 year), which increases the number of women in the workforce with poor health, and may limit their capacity to provide unpaid care. They are more likely to have a disability or multiple health conditions, and experience chronic pain and loneliness (Davies et al 2023)[298].

Across the North, almost one in four people are living in poverty (23% in the North West and Yorkshire and the Humber, 25% in the North East) (Joseph Rowntree Foundation, 2024)[299]. The poverty gap in the past 10 years between carers and those who are not carers has widened (Joseph Rowntree Foundation, 2024)[299], alongside a 2% difference in the number of people in England providing care in the least and most deprived areas of the country (8% v 10%) (Carers UK, 2023)[300].

Providing unpaid care may have a range of adverse consequences for older women, and many of these are made worse by the unique economic and social circumstances in the North. Our understanding of how best to mitigate some of the most damaging impacts of caregiving, is limited, especially for the most disadvantaged carers (Spiers 2024).

Little is known about those carers who remain hidden from research who are caring for those living with more stigmatised issues such as substance misuse, mental health conditions or neurodiversity such as autism.

Recommendations

- Government to strengthen its commitment to carers across all age groups and should be evident through a range of services that support carers to maintain and improve their health and well-being.
- To improve our understanding of the needs of sub-groups of carers, by age, region, and poverty related outcome measures.
- To support carers to pursue their own education and employment ambitions alongside their caring role in a way that they want to.
- To make support that mitigates the negative impact of caring to all carers to ensure they do not become the 'cared for' of the future
- Improve understanding and evidence about how to mitigate the negative impacts of caring on the health and wellbeing on women living in the North, particularly related to those whose health and wellbeing are impacted by multiple disadvantage
- To support the wellbeing and financial security of older carers, especially the most disadvantaged.

Chapter 5
Women's health

Authors: Rachel Cooper, Sophie Wickham, Anna Wilding, Luke Munford, Sophie Patterson and Jane McDermott

Summary

- The Women's Health Strategy for England (2022) outlines a range of ambitions that could deliver health improvements for all girls and women within the next decade. To achieve these improvements, regional disparities in the many different facets of women's health must be better understood and addressed
- Girls born in northern regions of England in 2020-2022 have lower average life expectancy than girls born in other regions of England; those born in the North East, North West and Yorkshire and the Humber have average life expectancy at birth that is 1.6, 1.5 and 0.9 years lower that the national average, respectively
- Although life expectancy at birth has increased across all regions in England for much of the last century, in the last decade the life expectancy at birth of girls born in deprived neighbourhoods, primarily in the North of England and Scotland, has begun to stall and in some cases decrease further exacerbating regional inequalities
- Girls born in the North East, North West and Yorkshire and the Humber in 2018-2020 can only expect to live in good health to average ages of 59.7, 62.4 and 62.1 years, respectively, which is up to 4 years less than the national average and up to 6 years ess than healthy life expectancy for girls born in the South East. This suggests that potential increases to retirement age would have greater adverse impact on women in northern regions of England
- The 2021 Census showed that a smaller proportion of women in the three northern regions reported that their health was good or very good than in other regions. When compared with women living in other regions, those in northern regions were more likely to report that they had long-term illnesses and conditions that limited their day-to-day activities
- There are myriad reasons for regional inequalities in women's health, not least the regional differences in levels of poverty and additional key social drivers of health outlined in other chapters of this report
- Menopause is often cited as a potential driver of changes in women's health from mid-life onwards and so regional differences in the experience of this could also impact on regional inequalities in overall health and wellbeing
- There are regional differences in levels of hormone replacement therapy (HRT) prescribing; lower levels of HRT prescribing in the North suggest that some women in this region may not be receiving adequate treatment for menopause symptoms which is a concern given these have been shown to affect employment, wellbeing and health

Context

In 2022, the UK Government's Department for Health and Social Care published its first Women's Health Strategy for England[68] This 10-year strategy aims to improve the health of women across the country by delivering on a broad range of commitments. Almost 100,000 individuals, and over 400 organisations and experts in health and care responded to the call for evidence towards developing this strategy. This was an unprecedented response, highlighting the strength of feeling across the nation.

The needs of women are not adequately met by our current health and care system and substantial change is urgently required.

To achieve the Strategy's bold ambition of boosting health outcomes for all women and girls, a life course approach has been adopted. This recognises that the health and care needs of girls and women change across life and a 'one-size fits all' approach to addressing these needs will not be sufficient. Reproductive and sexual health are important drivers of women's interactions with care services in earlier adulthood see – Chapter 6 and 7 for more detail on these issues.

Other conditions and transitions specific to women, including menopause, are experienced in mid to later life and can greatly impact health and wellbeing. In addition, there are many health conditions which though not specific to women impact men and women differently, in many cases disproportionately affecting women, where alternative approaches to prevention and management may be required.
When identifying strategies to address the many and varied health and care needs of girls and women across life, regional disparities in the different facets of women's health, including general health and menopause, must be considered and better understood. This chapter uses publicly available data to explore regional differences in indicators of women's health. It paints a bleak picture of the additional challenges faced by women in the North and shines a spotlight on the need for action to reduce regional disparities in the health of women.

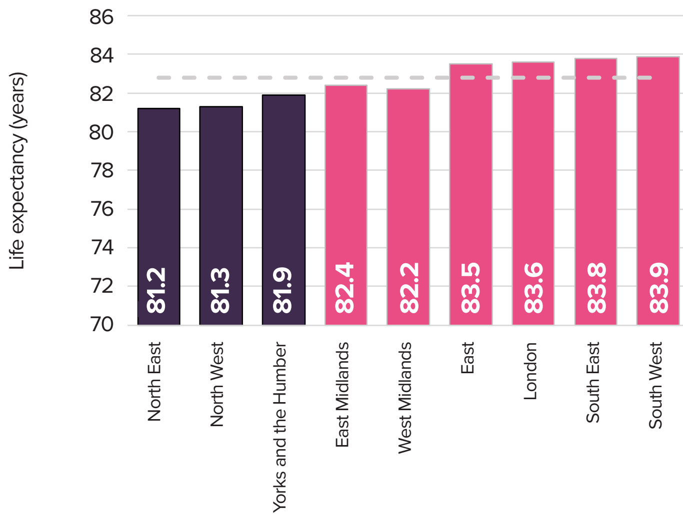
It is imperative that these disparities are further interrogated and addressed if the Women's Health Strategy for England is to be successful in achieving its laudable ambition of improving the health of all girls and women.

Life expectancy

For as long as records have existed, women have had higher average life expectancy than men. This may be one reason why the health of women is only now receiving the attention it so rightly deserves. However, a focus on average life expectancy overlooks the considerable variability in this widely used indicator of overall population health over time and between regions among women.

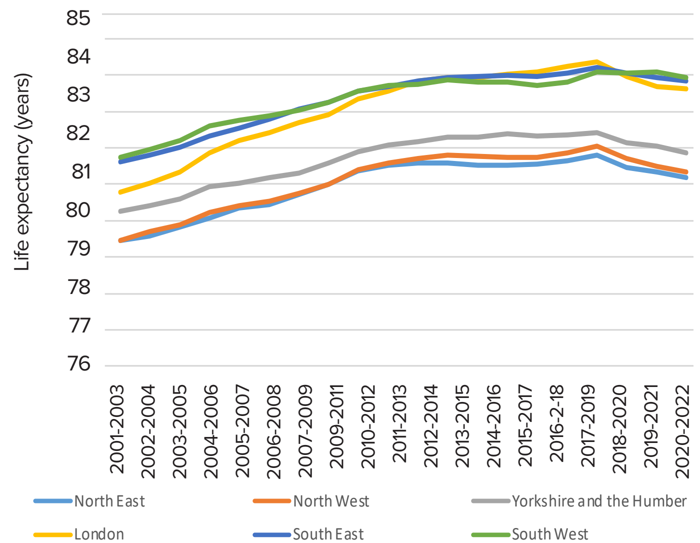
Drawing on the latest available data, the average life expectancy for a new-born baby girl in England in 2020-2022 was 82.8 years[69]. This

Figure 5.1. Life expectancy at birth for females in 2020-2022 across the nine English regions

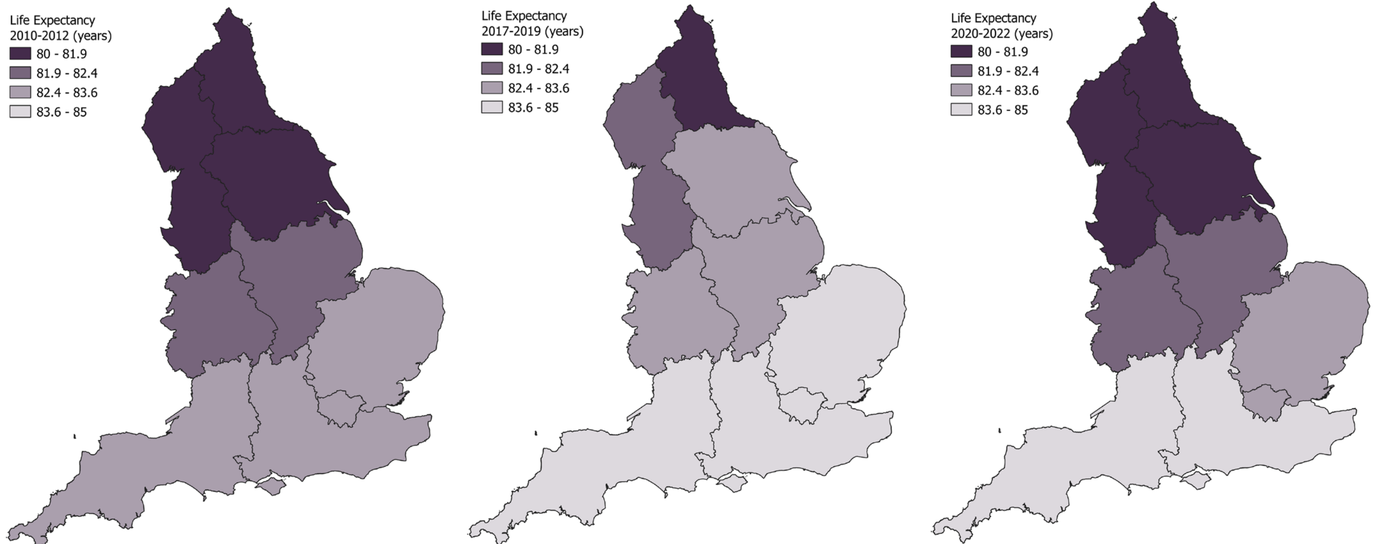


Note: the dashed black line is the English average (=82.8 years). Data from the Office for National Statistics [65].

Figure 5.2. Life expectancy at birth for females from 2001-2003 to 2020-2022 for six selected English regions



Notes: Data from the Office for National Statistics [65].



national figure masks regional inequality across nine regions of England (Figure 5.1). Compared with England's average, all regions in the North have lower life expectancy at birth.

Girls born in the North East, North West and Yorkshire and the Humber have 1.6 years, 1.5 years and 0.9 years respectively lower life expectancy compared with the England average. These differences are 1.1 year greater if figures for northern regions are compared with the South West, where baby girls had the highest average life expectancy.

Has life expectancy increased over time, and for who?

Over much of the last century, women's life expectancy at birth has increased across all regions of England. Much of this increase has been attributed to advances in healthcare (including the introduction of the National Health Service), improvements in socioeconomic conditions, and public health efforts.

Unfortunately, in the last decade the life expectancy of women living in deprived neighbourhoods, primarily in the North of England and Scotland has begun to stall. As areas in the South have experienced a plateau or increase in life expectancy over the same time period, regional inequalities in women's life expectancy have increased. Figure 5.2 shows trends in the life expectancy of women at birth between 2001-2003 and 2020-2022 for England and different regions [69].

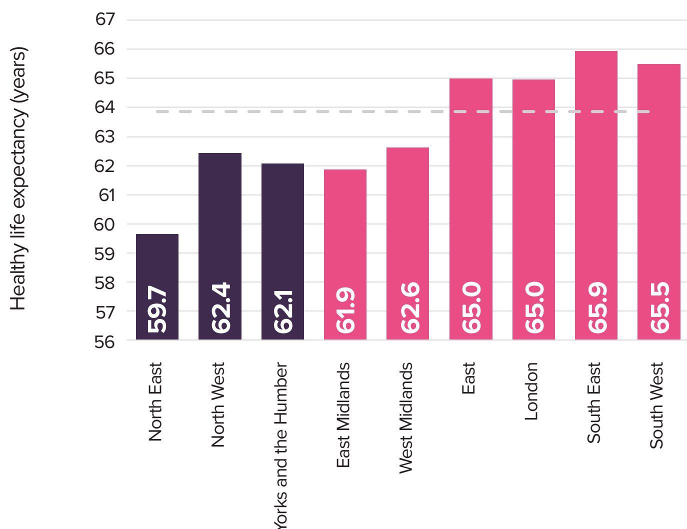
Overall, there were small gains in life expectancy in all regions when considering differences between 2001-03 and 2020-22. However, the increases of 1.7 years in the North East, 1.9 years in the North West and 1.6 years in Yorkshire and the Humber are smaller than the corresponding increases in southern regions, where London saw an increase of 2.8 years and the South East and South West both saw increases of 2.2 years.

These increases mask the fact that between 2009-2011 and 2020-2022 life expectancy fell among women in both the North East and North West (0.2 and 0.1 years respectively) whilst remaining the same in Yorkshire and the Humber and increasing modestly in southern regions.

Healthy life expectancy

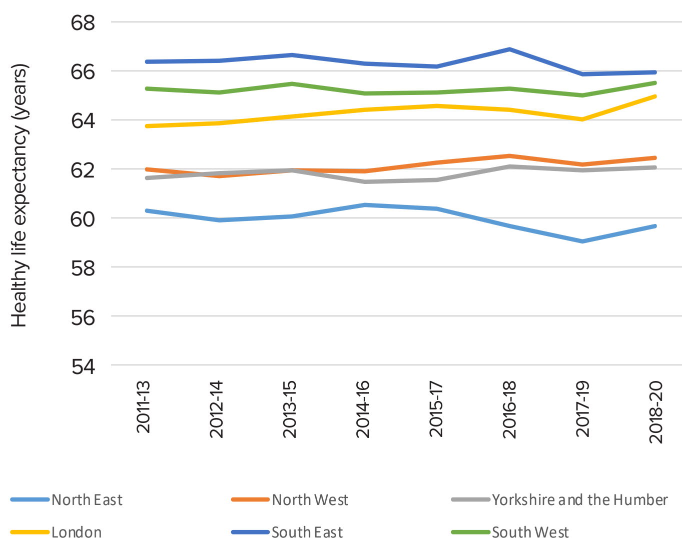
Although women have longer average life expectancy than men, paradoxically women are at greater risk of experiencing many health conditions and functional impairments typically associated with premature mortality. As a result, women are more likely than men to live a greater proportion of their lives with poor health and disability – regional variations in this can be assessed using indicators such as healthy life expectancy and disability free life expectancy. Healthy life expectancy (HLE) is defined as "a measure of the average number of years a person

Figure 5.3. Healthy life expectancy (HLE) at birth for females in 2018-2020 across the nine English regions

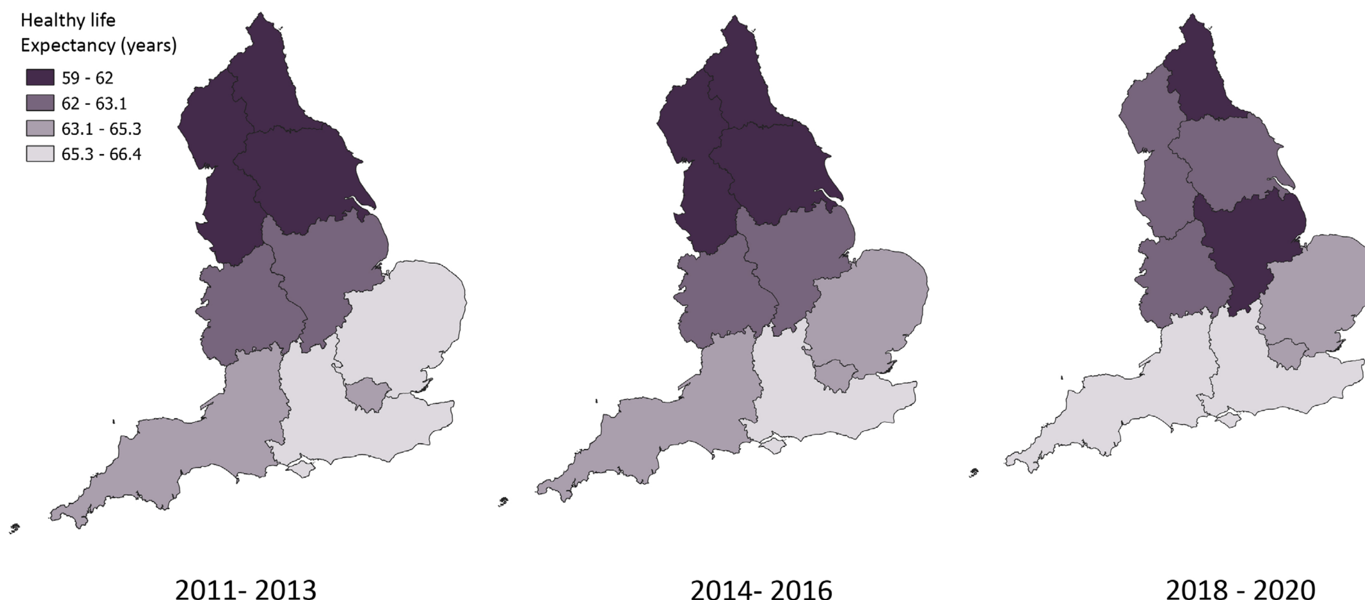


Notes: The dashed black line is the English average (=63.87 years). Data from the Office for National Statistics [67]

Figure 5.4. Healthy life expectancy (HLE) at birth for females from 2011-2013 to 2018-2020 for six selected English regions



Notes: Data from the Office for National Statistics [67]



would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health" [70].

Drawing on the latest available data, we find that the average HLE for a new-born baby girl in England in 2018-2020 was 63.9 years [71]. Compared with England's average, all northern regions have lower HLE (Figure 5.3). Women born in the North East, North West and Yorkshire and the Humber can expect to live 4.2, 1.4 and 1.8 fewer years in good health, respectively, than the England average and these differences increase by 2.1 years if the three northern regions are compared with estimates from the South East region where baby girls had the highest HLE.

Is there a growing regional divide in healthy life expectancy?

Consistent with findings for life expectancy, evidence suggests that regional inequalities in HLE have increased in recent years (Figure 5.4). For example, between 2011-13 and 2018-20, HLE fell by 0.6 years in the North East with marginal increases in the North West (0.5 years) and Yorkshire and Humber (0.5 years) while HLE increased by 1.2 years in London.

In the context of planned changes to pension age, which are being considered as the population continues to age, the implications of these regional differences in HLE are striking. Women in northern regions will, on average, no longer be living in good health by the time they are aged 60 to 62 years. Any policy that further increases the UK's pension age above 66 years will disproportionately impact women in the North as they will have to work for even more years in poor health compared with women in the South.

Self-rated health and long-term limiting illnesses

Further evidence of regional inequalities in women's general health is provided by data from the 2021 Census [72]. As part of this national survey, people were asked "How is your health in general?" to which they could respond "very good", "good", "fair", "bad", or "very bad". This measure of self-rated health is related to hospital admissions and mortality, and is a simple but useful indicator of a person's overall health.

In all of the analysis that follows, we used age-standardised percentages which take into account different age structures and population sizes so that different areas can be compared with each other. Figure 5.5 shows

the age-standardised percentages of women who reported that their health was "very good" or "good" across nine English regions. Overall, 81.3% of women in England reported that their health was either "very good" or "good". However, this differed markedly by region; from 78.1% in the North East up to 83.7% in the South East. Notably a lower percentage of women in all three northern regions reported "very good" or "good" health than in all other regions.

The 2021 Census also asked people "Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?". If people answered yes to this question they were then asked "Do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?" to which they could respond "Yes, a lot", "Yes, a little", or "Not at all". Using the responses to these questions it is possible to ascertain whether people would be classified as disabled under the Disability Act. Figure 5.6 reports the age-standardised percentage of women who self-report limitations of day-to-day activities as a result of long-term health conditions or illnesses.

Across England as a whole, 81.3% of women were classified as not disabled based on their responses to these Census questions. However, this differed by region with lower percentages of women classified as not disabled in the North East (77.8%) and North West (79.2%).

Conversely, the three northern regions had the highest percentages of women reporting long-term illnesses and conditions that limit their day-to-day activities a lot (Figure 5.6). The English average percentage of women reporting long-term illness or limiting condition is 7.8%, this figure rises to 10.0% in the North East, 9.5% in the North West and 8.6% in Yorkshire and the Humber. This has important implications for participation in work, the delivery of care (both paid and unpaid) and ability to live independently.

Explanations for regional inequalities in women's health

There are likely to be myriad reasons for the regional inequalities in women's health outlined in this chapter, not least the regional differences in levels of poverty and additional key social drivers of health outlined in other chapters of this report.

Women's health hubs

A potential contributing factor is access to relevant health and social care services. A national expansion of Women's Health Hubs was supported by the Women's Health Strategy and, the Department of Health and Social Care (DHSC) subsequently committed to investing £25 million to support Integrated Care Systems (ICS) to implement this model of care [73]. If services are tailored to meet the needs of those women at greatest risk within the region they serve, Women's Health Hubs could play an important role in tackling inequalities within and between regions. However, it is notable that DHSC have allocated an identical amount of funding to each Integrated Care Board (ICB) across the country to support the establishment of at least one Women's Health Hub in every ICS.

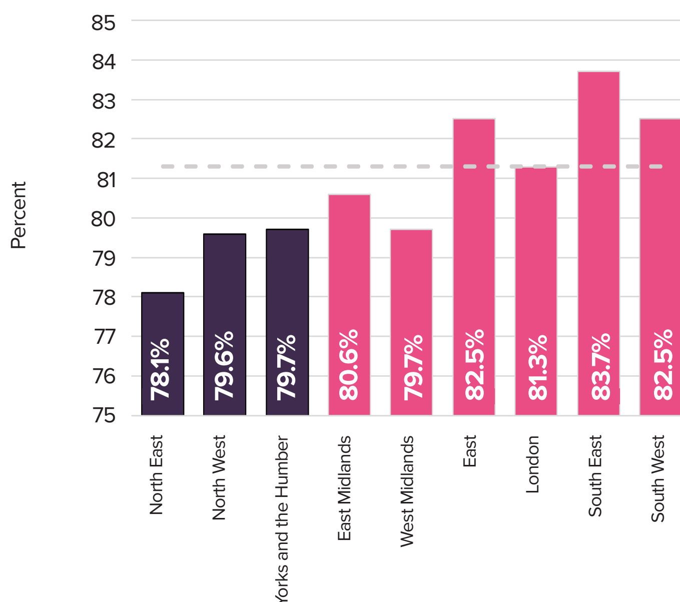
This is despite the larger sizes of the populations covered by each ICS in the North than in other regions and the greater levels of need among women in the North, which the data presented in this chapter exemplifies.

Menopause and access to HRT

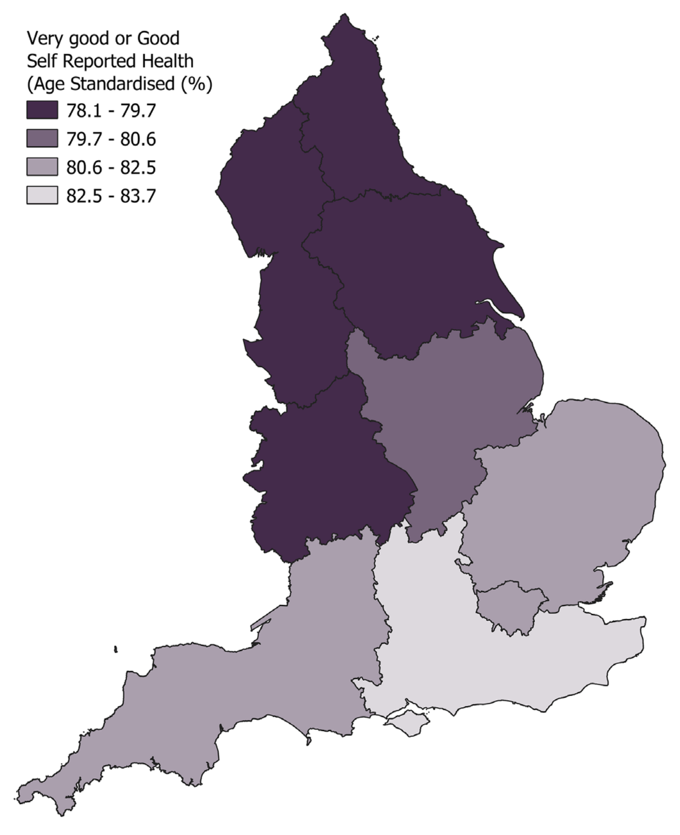
Menopause is a driver of changes in women's health from mid-life onwards. It is possible that regional differences in the experience of this important reproductive transition could impact on overall health and wellbeing. The menopausal transition typically occurs in women aged 45 to 55 years, with three-quarters experiencing physical and/or mental symptoms [74].

Symptoms can last seven years, or longer, during the period leading up to menopause (perimenopause) and in some women persist after

Figure 5.5. The age-standardised percentage of women who report that their health is very good or good across nine English regions, Census 2021



Note: The black dashed line is the English average (= 81.3%). Data from the Office for National Statistics[68].



menopause (postmenopausal)[75]. For some women, the symptoms are not severe; however, a survey of women in the UK found that 67% of respondents reported that their menopausal symptoms had negatively affected them at work[76], with 53% reporting absenteeism due to symptoms. Menopausal symptoms can also impact overall wellbeing, and mental and physical health[77].

Symptoms of menopause can be managed through lifestyle adjustments but also through hormone replacement therapy (HRT). HRT has been found to alleviate the frequency and intensity of both mental and physical symptoms by as much as 90%[78]. However, not all women experiencing symptoms access treatment and various factors influence this including a lack of education around menopause, cultural differences

and being unable to advocate for themselves at the doctors[79]. Updated NICE guidelines and awareness campaigns have led to an increase in prescriptions for HRT across England. Exploring variation across England reveals clear regional inequalities in HRT prescriptions, which mirrors known inequalities in health, education, and employment between the North and the rest of England (Figure 5.7 and Figure 5.8).

Compared with the South West, South East and East of England, the North of England (NHS Regions: North West, North East, and Yorkshire) have lower prescribing levels of HRT (Figure 5.7). Integrated Care Boards (ICB) in the Midlands and London have similar or lower prescribing levels than northern regions, whilst ICBs in the East, South East and South West of England have the highest levels of prescribing of HRT per patient (Figure 5.8).

Although northern regions of England are not performing considerably worse compared with England overall, there are clear differences in levels of prescribing when compared with the South. Understanding barriers to HRT access for women in the North is imperative to finding drivers of this regional variance across England. A prescription cost-saving policy was introduced in April 2023 80: women are now being charged a maximum fee of £19.30 for all eligible HRT prescriptions within a 12 month period.

This could narrow regional variations in the future but Figure 5.8 implies this has not yet occurred. This suggests inherent differences beyond financial factors may be limiting access to HRT for women. This has implications for women in the North and suggests they may not be receiving adequate treatment for menopause symptoms, symptoms that have been shown to affect employment, wellbeing and health, further widening inequalities.

Conclusions

This chapter shines a spotlight on regional inequalities in women's health across England. Women in the North East, North West and Yorkshire and the Humber have lower life expectancy and healthy life expectancy than their counterparts in other regions of England. This has far-reaching implications and taken together with evidence that a greater proportion of women in northern regions have long-term health conditions that limit their day-to-day activities, paints a bleak picture of the additional challenges faced by women in the North across life.

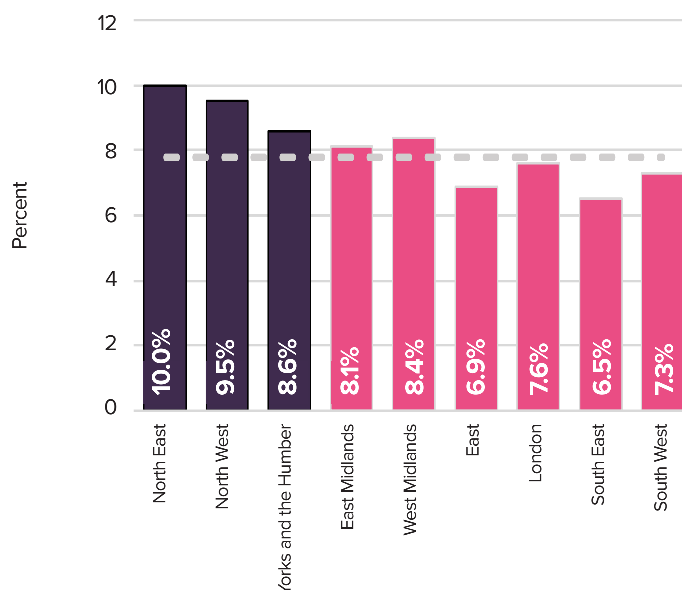
Currently too few publicly available data sources are disaggregated by age, sex and region as required to interrogate these regional inequalities further. Despite this, the data that are available provide a compelling case for urgent action to tackle regional inequalities in women's health across the life course.

The national expansion of Women's Health Hubs supported by the Women's Health Strategy for England presents a real opportunity to take the required action but only if the greater levels of need of women in northern regions are recognised and services are tailored to meet the varied needs of the populations they aim to support.

Recommendations

- We need better data captured at local levels, enabling monitoring and interrogation of regional variations in important health outcomes in women, including long-term health conditions and multiple long-term conditions. This recommendation aligns with the MESSAGE project[83] and NIHR Research Inclusion Strategy 2022-2027[84].
- Publication of more routine data disaggregated by sex, age, ethnicity and region is needed to dissect out the drivers of inequality; research funding should not be awarded for research that does not disaggregate by sex unless this can be clearly justified.
- To meet the needs of all women, we must think beyond those health outcomes directly associated with reproduction. Regional inequalities in women's general health need to be carefully considered when delivering the recommendations of the Women's Health Strategy otherwise we risk exacerbating these.
- As Women's Health Hubs are rolled out locally, careful attention must be paid to variations in the ICB population sizes and health needs of women of different ages and underserved groups across regions. Additional financial support and investment will be needed to support the successful roll out across the North.
- Regional disparities in healthy life expectancy need to be considered when developing policies on pension age as uniform changes will have a greater adverse impact on women in the North.

Figure 5.6. The age-standardised percentage of women who report a long-term illness or condition that limits their day-to-day activities a lot across the nine English regions, Census 2021



Note: The dashed black line is the English average (= 7.8%). Data from the Office for National Statistics[68].

Table 5.1. The age-standardised percentage of women who report having a disability across the nine English regions, Census 2021[68]

	Day-to-day activities limited a lot (%)	Day-to-day activities limited a little (%)	Not disabled under the Equality Act (%)
North East	10.0	12.2	77.8
North West	9.5	11.3	79.2
Yorks and Humber	8.6	11.4	80.0
East Midlands	8.1	11.5	80.5
West Midlands	8.4	11.1	80.5
East of England	6.9	10.8	82.3
London	7.6	9.1	83.4
South East	6.5	10.6	82.9
South West	7.3	11.6	81.0
ENGLAND	7.8	10.8	81.3

North East and North Cumbria Integrated Care System – A system-level approach to women's health

North East and North Cumbria (NENC) Integrated Care System (ICS) covers the largest geographical footprint of all ICSs nationwide, and serves a population of 3.14 million.

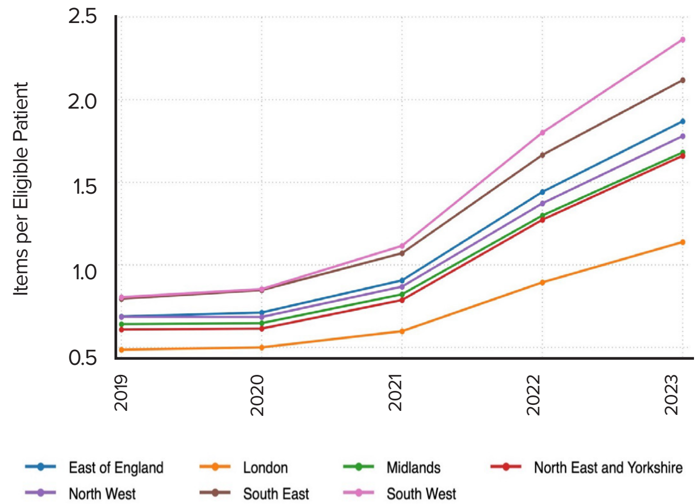
Women and girls make up just over half of the population of NENC, with a life expectancy 1.5 years less than the national average. However, additional layers of social inequity exist within the ICS, with a gap of almost 8 years between women living in the 20% most and least deprived neighbourhoods.

The publication of the Women's Health Strategy was an invitation for NENC ICS to mobilise a collective system-level approach to improve women's health for their population. In collaboration with cross-sector partners, the ICS is developing a women's health strategy implementation plan.

Whilst workstreams and cross cutting themes are broadly aligned with those listed in the Women's Health Strategy, they are tailored to reflect local priorities, inequalities and population health needs, building on existing good practice and community assets in the region. The implementation plan is being informed by a comprehensive intelligence-led needs assessment, drawing on qualitative data from the VCSE sector, stakeholder engagement, service mapping, and a purpose-built system-level dashboard, bringing together routine data on women's health and wider determinants. The implementation plan will launch in July 2024, during the second NENC Women's Health Conference.

Under the NENC women's health strategy implementation plan, the ICS will open three women's health hubs, located in Gateshead, Sunderland and North Cumbria. Each hub will vary in terms of service offer and mode of delivery to reflect local context, infrastructure, health needs and inequalities. For example, the North Cumbria model will incorporate a strong virtual offer to improve access options across this rural context. NENC ICS has plans to partner with local universities and the regional ARC to evaluate the impact of women's health hubs in the local system, as well as the women's health strategy implementation plan more broadly.[177]

Figure 5.7. Items of HRT prescribed per eligible patient in each of the regions of England



Eligible Patient - Female and aged 45 to 59 years old

Note: Data are from NHS England and Openprescribing[77, 78]

Figure 5.8. Average Number of Items of Hormone Replacement Treatment Prescribed per Eligible Patient by ICB regions in 2023

Items per Eligible Patient

- 2.25+
- 2 to 2.25
- 1.75 to 2
- 1.5 to 1.75
- less than 1.5

Eligible Patient - Female and Aged 45 to 59 years old

Note: Data are from NHS England and Openprescribing[81, 82]

Chapter 6
Pregnancy and Reproductive Health

Authors: Paris Lee, Zainab Akhter, Nicola Heslehurst, Oluwaseun B Esan, Kate Pickett, Judith Rankin, David Taylor-Robinson

Summary

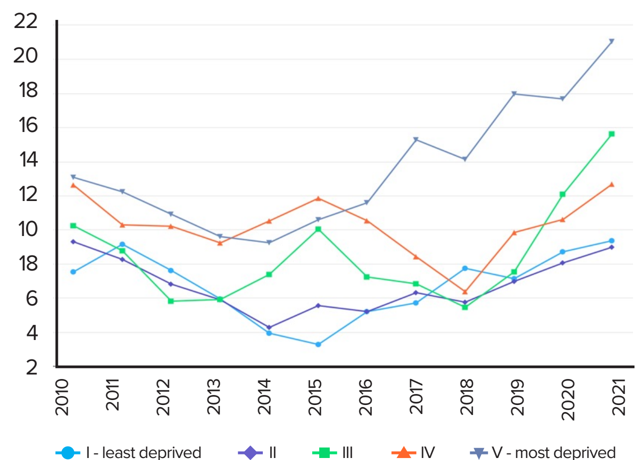
- The peri-pregnancy period significantly affects women and children's long-term health, wellbeing, and life expectancy. Addressing factors behind poor pregnancy outcomes is key to breaking cycles of health inequality.
- In the UK, significant inequalities in pregnancy health outcomes exist, particularly among women from deprived areas and those from Black, Asian, and Mixed ethnicity backgrounds, facing increased risks like maternal death, depression, and low birth weight, compounded by structural and accessibility barriers.
- Poverty and social disadvantage impact pregnancy health through complex issues like food and housing insecurity, financial stress, and limited healthcare engagement.
- Despite progress in England's Maternity Transformation Programme, socioeconomic inequalities in maternity care are widening, especially with the COVID-19 pandemic's impact, underscoring the urgent need for comprehensive strategies that address both social conditions and healthcare inequalities.
- Women in the northern regions have higher prevalence of pre-existing diabetes, previous gestational hypertension, obesity, smoking, and lower folic acid supplementation. Northern regions also had higher proportions of women living in areas of highest deprivation, pregnancy in women aged under 20 years, and complex social factors, reflecting inequalities relating to wider determinants of pregnancy health and well-being.
- The limited publicly available regional data relating to broader maternal health, such as gestational diabetes, preeclampsia, and maternal mortality, highlights a priority for better data to fully understand regional differences in pregnancy and reproductive health.
- To prevent the intergenerational transfer of social disadvantage, strategies must focus on reducing maternal health inequalities through integrated public health, social care, welfare, and education interventions, along with strengthened maternity and early years services, with investments that match the level of need.

Context

The period around pregnancy, including before conception and after birth, has lifelong impact. It is of critical importance for future health, wellbeing, and life expectancy for women and their children. Understanding and addressing the underlying causes of poor health in pregnancy, poor pregnancy outcomes, and their relation to lifelong health, is essential to breaking the cycle of inequality.

There are significant inequalities in pregnancy health in the UK. Women living in deprivation are at increased risk of maternal death and depression, and their babies have higher risk of stillbirth, neonatal death, preterm delivery, and low birth weight[85, 86]. A recent systematic review showed persistent inequalities in pregnancy outcomes (stillbirth, neonatal mortality, perinatal mortality, preterm birth, and low birth weight) for women from lower levels of occupation/social classes compared to women from the highest levels[87].

Figure 6.1. Maternal mortality rates 2009-22 among women from different levels of socio-economic deprivation in England



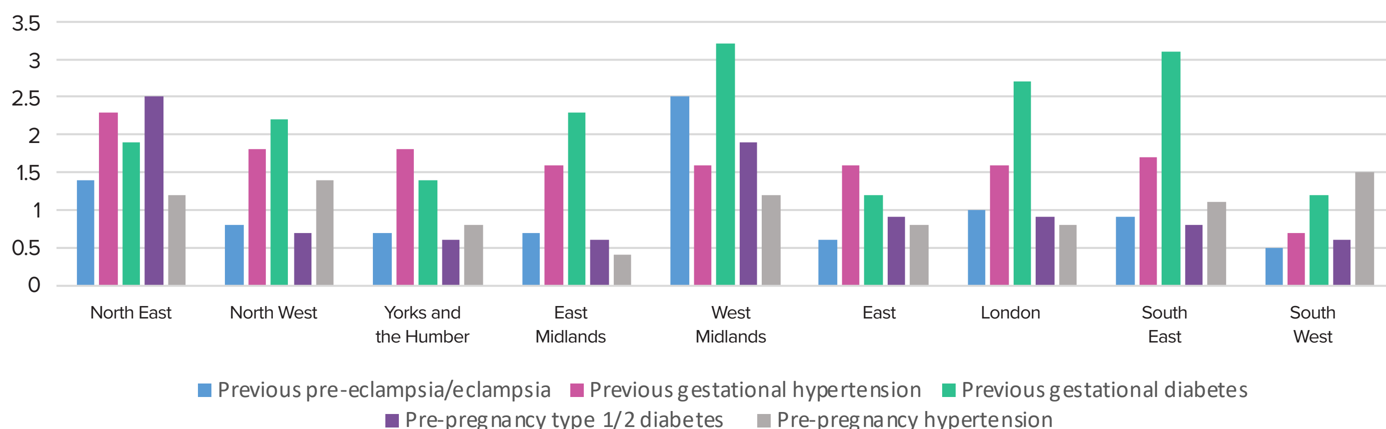
Notes: Data Source is MBRRACE-UK maternal mortality statistics 2020-2022[84].

The recent MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) annual report of the Confidential Enquiry into Maternal Deaths and Morbidity found that maternal mortality rates were the highest in 20 years with significant inequalities[88]. In 2020-22, 293 women in the UK died during or within six weeks following pregnancy. The primary cause of death was blood clots - thrombosis and thromboembolism. COVID-19 was the second leading cause, followed by cardiac disease and mental health (including suicide). Maternal mortality was 2.3 times higher for those women living in the most deprived areas compared with the least deprived (Figure 6.1), over three times higher among Black women, and two times higher among Asian women compared with White women[88]. Furthermore, these inequalities are getting larger. While data are not available for North-South comparison, these findings are particularly concerning for regional inequalities given the higher levels of women living in disadvantaged social conditions in the North.

Explanations for inequalities

Poverty and social disadvantage can contribute to unfavourable pregnancy health through interconnected factors like food insecurity and inadequate nutrition, uncertain housing conditions, financial strain, chronic stress, and broader societal influences on health. These links might be influenced by mental health and health-related behaviours. For example, mothers facing economic challenges are more likely to smoke during pregnancy. Key risk factors for adverse pregnancy outcomes are

Figure 6.2. **Percentage of pregnant women with a previous or existing health condition in England**



Notes: Data from preconception report card for England 2018 to 2019 [94].

highly socially patterned. These include maternal mental health, physical health (including BMI), behaviours (including smoking), healthcare access and working and environmental conditions. Despite the known risk factors, a large unexplained effect of socioeconomic status on pregnancy health is evident in many studies. This suggests the need to focus on levelling up social conditions and on addressing the risk factors associated with social disadvantage [89].

Exposure to poverty and social disadvantage are associated with lower levels of engagement with antenatal care. Those women on low incomes who do engage with services are more likely to report poor-quality interactions with maternity care services, including poor communication and feeling disrespected and unheard [90, 91]. Protected characteristics and identities that intersect with socioeconomic disadvantage, such as ethnicity, sexuality, disability, age, and gender identities, can further complicate access to, and quality of, maternity care [90].

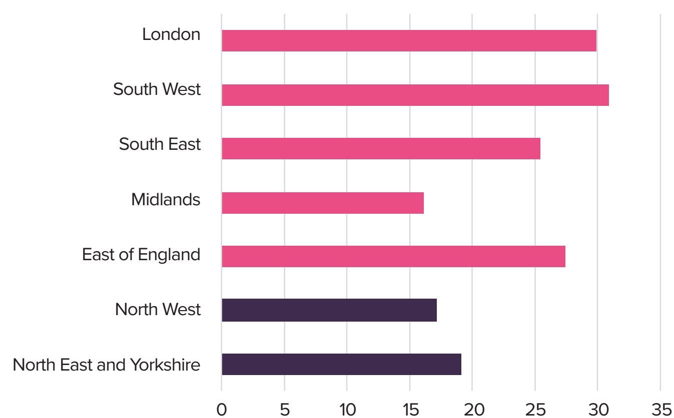
The Maternity Transformation Programme (MTP) set out a vision for England's maternity services to become "safer, more personalised, kinder, professional and more family friendly" [92]. A progress review published in 2020 identified a range of successes from the MTP, including improved perinatal mental health support, an increase in the number of women on continuity of care pathways, and a reduction in the number of stillbirths [93]. However, the 2020 review noted that much remains to be done to address inequalities for women and babies living with socioeconomic disadvantage.

Since the publication of the progress review, there has been a further increase in inequalities in maternal mortality rate (Figure 1). As outlined in our Child of the North report [94], large and widening inequalities in pregnancy outcomes were evident prior to the pandemic. This included an unprecedented rise in the infant mortality rate which disproportionately affected the poorest and most ethnically diverse areas of the country, leaving the more affluent areas unaffected. These inequalities were exacerbated by the COVID-19 pandemic. For example, women described a worsening of their mental health during the pandemic [95]. Key factors associated with depression or anxiety during the pandemic were loneliness, and financial, food and housing insecurities [96]. Due to changes in service provision during the pandemic, some women were not able to access specialist mental health services.

What do the latest data tell us about the North-South divide in pregnancy and reproductive health?

There are critical gaps in the data available on pregnancy and reproductive health outcomes. We are unable examine maternal mortality by region, and there is a general lack of compiled data sources reporting UK regional rates in maternal pregnancy health such as gestational diabetes and pre-eclampsia. However, there is strong evidence on

Figure 6.3. **Percentage of pregnant women that started taking a folic acid supplement preconception in England**



Notes: Data taken from Maternity Services Data Set 2022-23 [93].

Figure 6.4. **Prevalence of maternal obesity (BMI≥30kg/m2) in England**

Notes: Data from preconception report card for England 2018 to 2019, Office for Health Improvement and Disparities [94].

the associations between preconception and early pregnancy health indicators and pregnancy outcomes. We are also aware of many of the wider determinants of health on pregnancy outcomes. We have therefore explored the regional patterns in these data. We also report pregnancy outcome data that are available, which tend to focus on the child's health. In this section, we provide an overview of these data, taken from the

National Maternity Services Dataset (MSDS) and Preconception Report Card for England [97, 98].

Preconception and early pregnancy health indicators

Pregnancy history and pre-existing noncommunicable diseases (NCDs) preconception health indicators, including pregnancy history and pre-existing noncommunicable diseases, can have a significant impact on subsequent risk of adverse pregnancy outcomes. Data from the MSDS for 2022-23 indicate that the North East has the highest proportions of pregnant women with preconception diabetes (Figure 6.2). A history of gestational hypertension in previous pregnancies is highest in the North East, followed by the North West and Yorkshire and the Humber. Preconception hypertension is highest in the South West, followed by the North West and North East regions (Figure 6.2).

Taking folic acid supplements before conception, and ideally from three months before pregnancy to the 12th week of pregnancy, reduces the risk of neural tube defects developing in the baby. At the time of the first antenatal appointment, often called the 'booking' appointment, almost 90% of pregnant women in England report that they are taking a folic acid supplement across all regions [97]. However, there are inequalities in the timing of folic acid intake. Compared to other regions of England, fewer women in the North and the Midlands are taking folic acid supplements in the preconception period in preparation for pregnancy (Figure 6.3).

Obesity

Preconception or early pregnancy maternal obesity (BMI≥30kg/m^2) significantly increases the risk of multiple adverse pregnancy health outcomes, including gestational diabetes, pre-eclampsia, and maternal mortality. It also raises the life course risk for obesity and type 2 diabetes for women and their children. Maternal BMI also plays a crucial role in maternal mortality; 78% of maternal deaths from thromboembolism, the leading direct cause of death, were in women with an overweight or obesity BMI[88]. Data from the Office for Health Improvement and Disparities showed that maternal obesity prevalence at booking was highest in the North East, followed by Yorkshire and the Humber [98] (Figure 6.4).

Smoking

Smoking during pregnancy is a risk factor for numerous poor pregnancy outcomes, including low birth weight, preterm delivery, and infant mortality [97]. Smoking is also a cause of poor maternal health in the short and long term. While many women quit smoking when learning of their pregnancy, many babies are exposed to maternal smoking before women know they are pregnant; and many women cycle through quit and relapse throughout pregnancy and relapse to persistent smoking in the postnatal period. The North East and Yorkshire have the highest rate of smoking at the booking appointment (Figure 6.5).

Wider determinants

Deprivation

On average, levels of family social disadvantage and poverty are higher in the North, and there is a greater density of areas with very high levels of social disadvantage. We know it is the accumulation of multiple risk factors caused by, and that cluster with, deprivation that make this such a toxic exposure for maternal and child health [99]. Over a quarter of pregnant women in the northern regions of England are living in the most deprived tenth of areas, with around 40% living in the two most deprived tenth of areas – higher than any other region (Figure 6.6). By comparison less than 5% of pregnant women in the South East are in the most deprived tenth of areas.

Pregnancies in women under 20 years of age

Many conceptions in women under 20 years are unplanned. Some young women find motherhood at a young age a positive life-change. For most, it presents significant challenges. Unplanned pregnancy at a young age often results in adverse outcomes for mother and child, including health issues, emotional distress, and a higher likelihood of enduring poverty. While there has been considerable progress in reducing conception in young women, as per the English Teenage Pregnancy Strategy [100], the latest data show that pregnancy rates in women under 20 years of age are higher in the northern regions. The highest proportion of teenage pregnancies are found in the North East and Yorkshire, with 4.9% of all pregnancies being in women under 20 years of age (Figure 6.7).

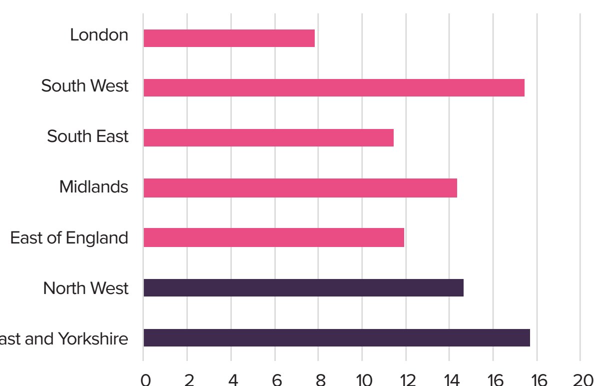
Complex social factors

Complex social factors in relation to pregnancy include being aged under 20; experiencing domestic abuse; being a recent migrant, asylum seeker or refugee; having difficulty reading or speaking English; or misusing substances including alcohol. These risk factors are all associated with a range of adverse pregnancy outcomes including higher rates of maternal death. These risk factors are more common in northern regions and in London than southern regions (Figure 6.8). However, studies show that neither increased social risk factors nor barriers to engagement with maternity services appear to fully explain differences in maternal mortality [101].

Minoritised Ethnic Groups

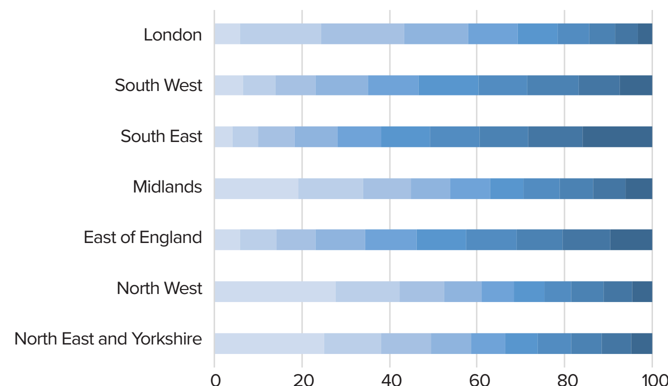
Several decades of evidence consistently report high levels of adverse

Figure 6.5. Percentage of pregnant women smoking at the time of their booking appointment in England



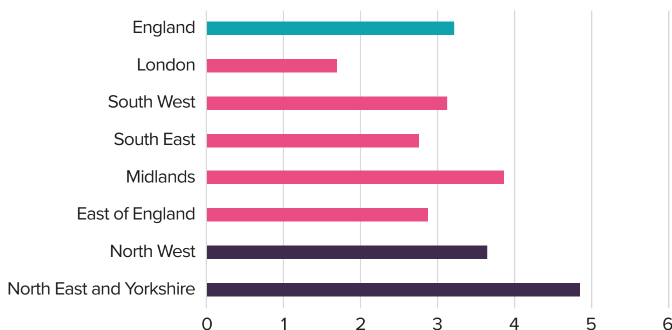
Notes: Data from preconception report card for England 2018 to 2019, MSDS[94].

Figure 6.6. Levels of deprivation in pregnant women in England



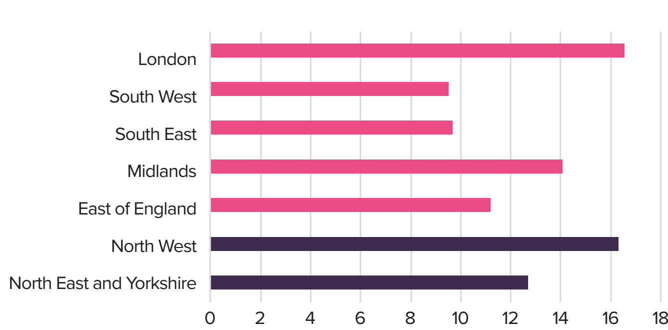
Notes: Data are from the Maternity Services Data Set 2022-23 [93].

Figure 6.7. Percentage of pregnancies in women under 20 years of age in England



Notes: Data are from the Maternity Services Data Set 2022-23 [93].

Figure 6.8. Percentage of pregnant women with complex social factors in England



Notes: Data are from Maternity Services Data Set 2022-23, missing data 2.7% [93].

pregnancy outcomes and higher rates of death in women from Black, Asian and Mixed ethnicity backgrounds [102]. Factors contributing to worse outcomes include cultural insensitivity, microaggression, and barriers to help-seeking and access to care [103]. There is a current policy target for local maternity systems to provide continuity of midwifery care (CoMC) for 75% of pregnant women from Black, Asian and other minoritised ethnic backgrounds, as well as women living in deprived areas [92]. The policy originally included a target date of 2024, however, there have been significant challenges in implementing change to meet this target, such as achieving adequate staffing levels. These challenges have led to a removal of a target date for delivering CoMC at this level. There remains an expectation for priority delivery of CoMC for minoritised ethnic groups and those living in deprived areas [104]. There are no publicly available data to assess regional progress towards this target. However, a recent publication by the Nuffield Trust demonstrated persistent ethnic and socio-economic inequalities in the receipt of CoMC. Their data show a decline in the rate of CoMC for Black, Asian and other ethnic minority women from 28% in August 2021 to 23% in September 2022 when the target date was scrapped [104].

Health service access

Timely access to antenatal care, within the first 10 weeks of pregnancy[105] helps to prevent and treat pregnancy-related and other problems, reducing health inequalities for mothers and their babies[91]. The booking appointment for pregnant women is crucial as it is when the care plan is established. This includes: identifying those needing extra care due to medical or social reasons; discussing antenatal screening options; and health checks including blood pressure, BMI, smoking, past medical history, and mental health. Current access rates before the 10th week of pregnancy are low across England, with some variations across regions. The highest levels of access to antenatal care in the first ten weeks of pregnancy are in the North East and Yorkshire (Figure 6.9). This may suggest that the health services are to some extent considering socio-demographic risk factors in the timing of care initiation, many of which are more common in the North [106]. These include; unemployment, deprivation, pregnancy in women under 20 years and maternal obesity [106, 107].

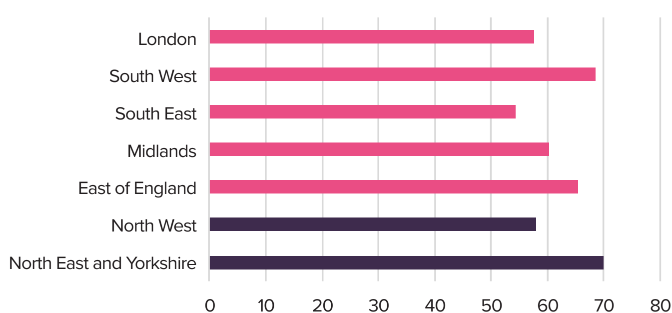
Pregnancy outcomes

Abortion

The North West had the highest abortion (termination of pregnancy) rate of all England regions in 2021, at 22.2 per 1,000 resident women aged 15-44 years. The West Midlands and London also have abortion rates over 20 per 1,000 women, whereas rates in Yorkshire and the Humber and the North East are typical of the rest of England [108].

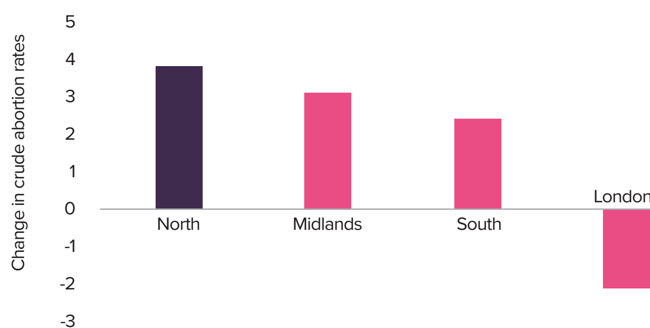
Looking over time, the northern regions have the biggest increase in abortion rates between 2012 and 2021 (Figure 6.10). The North saw an increase of 3.8 abortions per 1,000 women, followed closely by the

Figure 6.9. Percentage of pregnant women attending their first midwife appointment by their 10th week of pregnancy



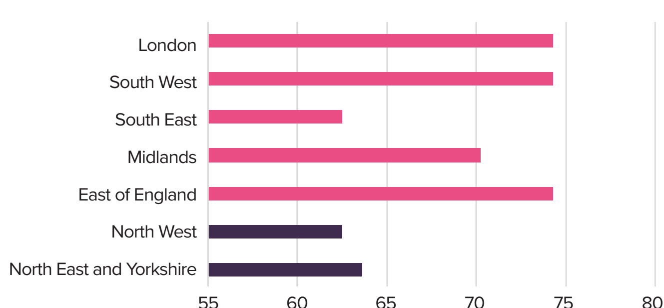
Notes: Date are from the Maternity Services Data Set 2022-23 [93].

Figure 6.10. Change in crude abortion rates per 1,000 women between 2012 and 2021 in England



Notes: Date are from the Office for Health Improvement and Disparities [104].

Figure 6.11. Percentage of babies receiving breast milk as their first feed in England



Notes: Data are from the Maternity Services Data Set 2022-23 93, baby's first feed includes maternal or donor breast milk, missing data: 6.4%.

Midlands with a rise of 3.1 abortions per 1,000 women. The South saw a moderate increase of 2.4 abortions per 1,000 women. In contrast, London notably experienced a decrease of -2.1 abortions per 1,000 women during the same timeframe.

The Kings Fund Report identified an increase in the deprivation gradient and abortion rates between 2015 and 2019, coinciding with austerity measures and local authorities having to make difficult choices in public spending which included 88% that reduced their expenditure on sexual health services. Women's contact with sexual health services over this period was reduced overall, but to a higher extent in women aged under 20 years and those residing in the most deprived locations. This period also marked a change in policy relating to the implementation of the "two child limit"; financial worries at the individual level was cited as being the main reason women in the North East accessed abortion services.

Breastfeeding

Breastfeeding initiation and continuation rates are low in the UK relative to comparable European countries. The multiple life course benefits of breastfeeding to both women and their children are well-established. The MSDS data for 2022-23[97], showed that, along with the South East, the northern region had the lowest percentage of babies receiving breastmilk as their first feed in England, with more than one third of babies not receiving breast milk (Figure 6.11). While follow up data for feeding method at 6-8 weeks is limited by missing data (only 25% of babies have feeding method recorded), the northern regions have the lowest level of exclusive breastmilk feeding (30% for North East and Yorkshire and 33% for North West) or partial breastmilk feeding in England (15% for North East and Yorkshire and 17% for North West).

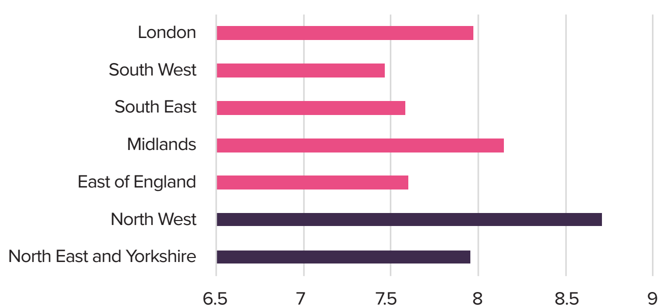
Stillbirth

There are many potential mechanisms for risk of stillbirth, and these include underlying inequalities in maternal health such as diabetes,

Figure 6.12. Stillbirth rate per 1,000 live and stillbirths

Notes: Data are from the ONS Births in England and Wales 2022 [105].

Figure 6.13. Percentage of babies born preterm (<37 weeks) in England



Notes: Data are from the Maternity Services Data Set 2022-23 [93].

hypertension, and poor mental health. The rate of stillbirth per 1,000 births is highest in Yorkshire and the Humber, and higher rates are found in the northern, Midlands and London regions of England (Figure 6.12). While it is not possible to explore the inequalities in stillbirth by region, MBRRACE-UK shows that stillbirths were higher in the most deprived areas compared with least deprived (4.69 vs 2.37 per 1,000 births respectively) and among Black and Asian women compared with White women (7.52, 5.15, and 3.30 per 1,000 respectively)[88]. They further reported intersectional inequalities, where stillbirths were highest in Black African and Caribbean women residing in areas of highest deprivation (8.10 and 7.96 respectively).

Pre-term delivery (<37 weeks)

While preterm delivery is important for life course health and well-being of children, it is also a potential indicator of underling maternal infection, stress, and inflammation in women, and impacts on women's mental health. The North West has the highest prevalence of preterm delivery in England, followed by the Midlands, North East and Yorkshire, and London (Figure 6.13). The same regional patterns are observed for extremely preterm delivery (<28 weeks).

Conclusions

The data in this chapter demonstrate the stark inequalities faced by pregnant women in the North. Regarding preconception and early pregnancy health indicators, there were patterns for women in the Northern regions to have higher prevalence of pre-existing diabetes, previous gestational hypertension, obesity, smoking, and lower folic acid supplementation. northern regions also had higher proportions of women living in areas of highest deprivation, pregnancy in women aged under 20 years, and complex social factors reflecting inequalities relating to wider determinants of pregnancy health and well-being. Pregnancy outcomes where regional data were available showed higher levels of abortion, stillbirth, and preterm delivery, and lower levels of breastfeeding in the North compared with the South. The limited publicly available regional data relating to broader maternal health, such as gestational diabetes, pre-eclampsia, and maternal mortality, highlights a priority for better data to fully understand regional differences in pregnancy and reproductive health. Research which has sought to explain both the socioeconomic and ethnic discrepancies in pregnancy outcomes pointed to differences in rates of maternal smoking, maternal mental and physical health, maternal behaviours, complex social conditions, healthcare quality and working and environmental conditions [85].

Despite various studies pointing to the importance of these risk factors, social disadvantage is a fundamental cause of exposure to these risks. Furthermore, social disadvantage remains a significant, direct cause of inequality in pregnancy and reproductive health that is not entirely explained by these intermediary factors. It is critical to focus on changeable social and economic factors, such as reducing poverty, to address these inequalities.

Research from Australia shows that household income supplements to low-income families can benefit children's development and maternal mental health[110]. Moreover, adopting a life course approach that encompasses pregnancy and reproductive health can help decrease inequalities in maternal (and child) health and well-being, pregnancy, and early childhood, ultimately leading to improvements in health for all.

Recommendations

Successful strategies to address the intergenerational transfer of social disadvantage need to focus on addressing inequalities in maternal health. There is no quick fix. These will likely need to involve co-ordinated combinations of preventative public health, social care, welfare, and education interventions to improve family income, pregnancy outcomes, parental health, particularly mental health (see chapter 8); and education; alongside system strengthening for maternity, midwifery, health visiting and early years services, with investment proportionate to levels of need.

Below we outline some key areas for policy action and some examples of promising initiatives to reduce inequalities in maternal and reproductive health.

- The government must address regional inequalities in family livelihoods and health and other services to remove inequalities in the social determinants of health which underpin many regional inequalities in pregnancy outcomes for women in the North of England. Addressing poverty, deprivation, and income inequality is the key to solving health inequalities for mothers and children
- Policy recommendations emphasise the necessity of removing the two-child limit policy and increasing funding for reproductive and sexual health services, especially in regions marked by high poverty and food insecurity rates. Targeted support initiatives tailored to vulnerable households with three or more children, along with efforts to collect data on food insecurity during pregnancy, are proposed to better inform interventions and policy decisions
- Policy must prioritise joined up and comprehensive preconception, pregnancy, and postnatal care for women, extending beyond childbirth. While a small number of maternal deaths in the UK stem from obstetric conditions, deaths from mental health-related causes comprise nearly 40% of deaths within the first year after birth, with maternal suicide being the leading direct cause during this period [111, 112]. To ensure improved maternal health outcomes, it is key for women with complex co-morbidities, more prevalent in the North, to have holistic care throughout the maternal journey, from pre-pregnancy through to the postnatal period [112]
- The government should address inequalities among women of different ethnic backgrounds to reduce maternal healthcare and healthcare access inequities [112, 113]
- Public health policy in maternal care should look beyond biomedical factors. Initiatives should embrace holistic approaches, confront societal and structural racism, and address broader disparities. Collaboration with local communities is essential for successful implementation of such initiatives
- Regional authorities and organisations in the North should consolidate resources for proactive outreach campaigns. These campaigns should raise awareness about entitlements and social tariffs (such as the Healthy Start programme), actively support individuals in accessing them, and address the associated stigma. The 'No time to wait' report explains how capturing even a small percentage of the estimated unclaimed benefits and social tariffs could significantly bolster assistance for low-income families in the North, thereby stimulating local economic growth [114]. Established campaigns like the Social Navigators scheme in South Tyneside effectively support families facing financial challenges, helping them access welfare benefits and debt services. Expansion is recommended
- The government should expand the 'Baby Box' initiative that has been implemented in Scotland and the North East. Scotland's Baby Box Scheme (SBBS) is a national programme offering a box of developmentally appropriate essential items to all pregnant women in Scotland intended to improve infant and maternal health. This initiative successfully reduced infant and primary carer tobacco smoke exposure, and increased breastfeeding among young mothers in Scotland [115]. Funding from the North of Tyne Combined Authority will extend the program to 750 parents across Newcastle, Northumberland, and North Tyneside, starting January 2024. Government funding should expand this programme across the North
- The government should explore reinstating the 'Health in Pregnancy' grant, which provided a £190 one-time payment to pregnant women from 25 weeks onwards, equivalent to three months of Child Benefit. Research suggests that this grant led to decreased rates of LBW, particularly benefiting younger mothers in deprived areas, and that these improvements were not solely attributed to antenatal care, nutrition, or smoking habits, indicating a potential reduction in prenatal stress as a contributing factor [116, 117]

Chapter 7
Sexual health

Authors: Rebecca S Geary, Malcolm Moffat, Holly Hope, and Judith Rankin

Summary

- Outside London, the three northern regions had the highest rates of new diagnoses of sexually transmitted infections (STIs) and Gonorrhoea among people accessing sexual health services in 2022.
- Spending on sexual health advice, prevention, and promotion has declined dramatically since 2013-14 in almost all English regions. Regions in the North have seen a 26-28% decrease, however the North West, North East and Yorkshire and the Humber remain three of the top five highest spending regions, potentially reflecting higher STI burden in these regions
- Yorkshire and the Humber, the North East and North West have some of the highest overall contraception prescribing rates (460.0, 396.6 and 400.9 per 1000 women years respectively compared with 384.4 per 1000 person-years for the South)
  - o These numbers potentially hide inequality in access to different forms of contraception across the North: Yorkshire and the Humber has the second highest usage of long-acting reversible contraception, whilst rates in the North East and North West are among the lowest in England
- Primary care prescribing rates for emergency hormonal contraception were lower in the North West (3.85 per 1000 women-years), North East (4.53) and Yorkshire and the Humber (4.53) than the South (4.91), potentially reflecting better access to contraception overall in northern regions
- The repeat abortion rate among pregnant young people has been increasing nationally, but was highest in the North West in 2021, with all three northern regions in the top five across England
- Women in the three northern regions experienced the highest rates of recorded sexual offences in 2021/22, with the North East and North West having the first and second highest rates and Yorkshire and the Humber the fourth
  - o We note that this might reflect greater efforts by police forces to promote reporting and recording of sexual offences, or greater rates of offences

Context

Sexual health is fundamental to the overall health and well-being of individuals, couples and families. It is also critical for the social and economic development of communities and countries [118]. Sexual health-related issues are wide-ranging, encompassing sexual expression, relationships, and pleasure, as well as negative consequences or conditions such as: STIs and reproductive tract infections and their adverse outcomes, unintended pregnancy and abortion, sexual dysfunction, sexual violence and harmful practices (such as female genital mutilation). Sexual health is also closely connected to reproductive health, with complications from untreated STIs including infertility [119]. The UK has had notable successes in improving sexual health such as the HPV vaccination programme almost eliminating cervical cancer incidence in young women in England [120], and falls in new HIV diagnoses [121]. Despite these successes, the UK is experiencing increases in common STIs like chlamydia, and large increases in syphilis and gonorrhoea[122], which have returned to the high levels reported prior to the COVID-19 pandemic. The burden of STIs is not evenly distributed, and some communities are disproportionately affected [123]. Alongside this, public health grant allocations in England have been cut by 24% in real terms per capita between 2015–16 and 2021–22.

This grant is paid to local authorities from the Department for Health and Social Care's budget to provide vital preventative services to support health including drug and alcohol and sexual health services, as well as broader public health support [124]. The third largest cuts have been seen to sexual health services, following services aiming to stop smoking and adult drug and alcohol services [125]. Cuts to public health budgets have disproportionately affected the Midlands and North of England, with the North enduring per-person cuts 15% higher than the average for England, and the worst affected area in the country being the North East, with a cut of £23.24 per person[126]. In this chapter we present evidence of regional inequalities in sexual health.

Sexually Transmitted Infections

In 2022, of the regions outside London, the three northern regions had the highest rates of new diagnoses of STIs (excluding chlamydia among under 25s) and gonorrhoea among people accessing sexual health services in 2022 (Table 7.1 and Table 7.2 127). STI detection rates in primary care (2016-2018) for any STI were lower in the North (3.55 per 1000 person years) than the South (4.67 per 1000 person years). The same pattern was seen for chlamydia, HIV, genital herpes and genital warts but not gonorrhoea, where case rates were higher in the North than the South (0.06 vs 0.03 cases per 1000 person years). The contrasting results from specialist sexual health services and general practice may reflect different service mixes between regions, as we have presented STI testing service use data, not population STI prevalence.

Spending on sexual health advice, prevention, and promotion has declined dramatically since 2013-14 in almost all English regions (Figure 7.1)[128]. Regions in the North have seen a 26-28% decrease whilst the North West, North East and Yorkshire and the Humber remain three of the top five highest spending regions, potentially reflecting higher STI burden in these regions.

Contraception

The continuous decline in age at first sexual intercourse and an increase in the age at first cohabitation and becoming a parent means that, on average, heterosexually active women in Britain have about 30 years of their life where they need to avert an unplanned pregnancy [129]. Long-acting reversible contraception (LARC) in the form of injections, implants and intrauterine devices has the potential to reduce unintended pregnancies. Contraceptive method is an issue of personal choice, but an

increase in the provision of LARC can be considered a proxy measure for wider access to the range of possible contraceptive methods.

Yorkshire and the Humber has the second highest LARC usage of all regions in England. In contrast, rates in the North East and North West are among the lowest in England, with rates declining in the North West (Table 7.3). These data exclude contraceptive injections for three reasons: injections rely on timely repeat visits so have a higher failure rate than other LARC methods; they are easily administered, not requiring the resources and training of other LARC methods; and injections are outside local authority contracts. However, the regional pattern in primary care (general practice), which accounts for most of the contraceptive injection provision, is similar between 2016 and 2018. The highest contraception prescribing rate for any method is in Yorkshire and the Humber (460.0 per 1000 women years).

There is also a 5% higher contraception prescribing rate in the North than the South (405.6 vs 384.4 per 1000 person-years). The North East and North West had some of the highest overall contraception prescribing rates (396.6 and 400.9 per 1000 women years respectively), suggesting that the proportions of contraceptive types prescribed differs between northern regions and other parts of the country. In contrast, primary care prescribing rates for emergency hormonal contraception (EHC) were lower in the North West (3.85 per 1000 women-years), North East (4.53) and Yorkshire and the Humber (4.53) than the South (4.91). This potentially reflects better access to LARC for Yorkshire and the Humber, as well as access to oral contraceptives and injections across the three northern regions reducing need for EHC in the North.

Many factors influence contraceptive choice, however, availability and accessibility of services, particularly for LARC which require seeing a health professional, will impact which methods can be used. Most English regions have seen a decline in local authority spending on contraception functions since 2013-2014 but these have not been equally distributed [128]. The largest percentage declines in local authority spending on contraception per head have been in Yorkshire and the Humber (31%) and London (34%). Funding per head in the North East (£3.83) and the North West (£3.72) was substantially higher than in most other regions in 2021-22 (lowest at £2.16 in the South West in 2021-22) (Figure 7.2).

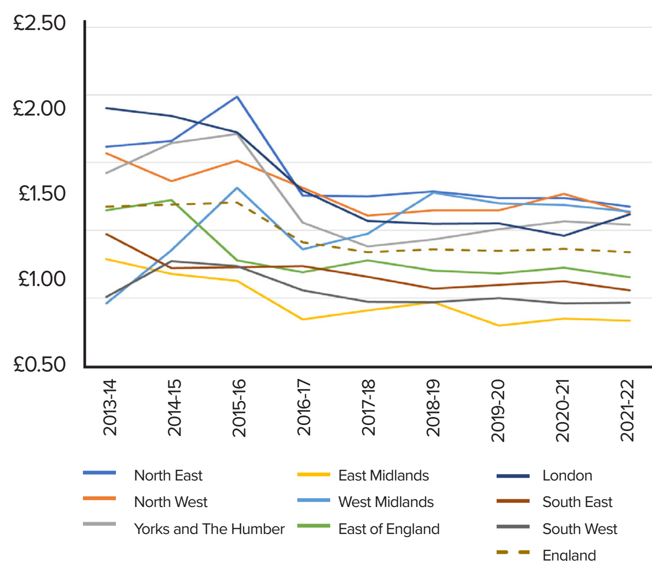
Postnatal Contraception

The 2022-23 North East and North Cumbria Postnatal Contraception (PoCo) Study survey collected the experiences of postnatal contraception care amongst women who had completed a pregnancy in the previous three years [130]. The period after having a baby is a key opportunity for contraception care because an interpregnancy interval of less than 12 months increases the risk of preterm birth, low birthweight, stillbirth and neonatal death [131, 132]. In addition, almost 1 in 13 women presenting for an abortion or delivery in the UK had conceived within a year of a previous birth [133]. More than 2,500 women responded to the survey, which found that only 15.5% of respondents accessed the most reliable LARC methods during the 8-week postnatal period, and almost one in five women (18.8%) indicated that they had been unable to access their preferred contraceptive type. In accounts of their postnatal contraception experiences, women described services that were difficult to access, that often provided inadequate information about contraceptive options and side effects, and that tended to place the onus for contraception uptake on women (Figure 7.3). Women also described experiences of care that sometimes felt forced or coercive.

Repeat Abortion

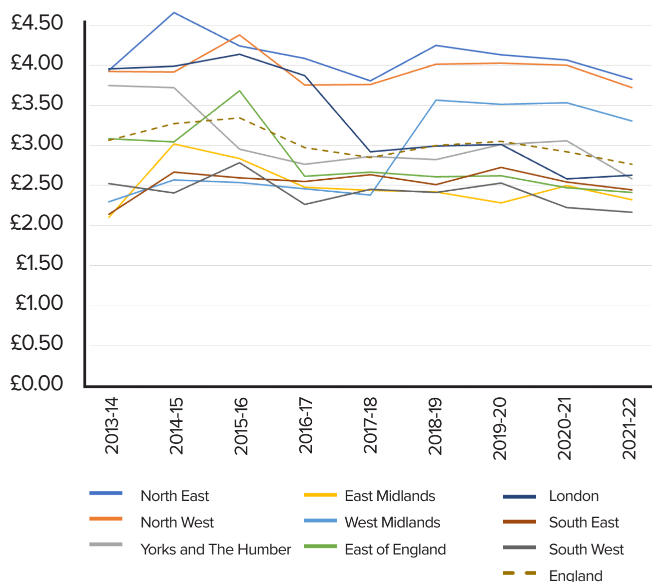
Repeat abortion can be an indicator of lack of access to good quality contraception services and advice, lack of access to a preferred contraceptive method, as well as problems with consistent and correct use of a method [134]. There is large variation in rates of repeat abortions across local authorities. The proportion of women who had a repeat abortion in 2021 ranged from 29% in the City of London to 54% in Knowsley in the North West of England [108]. Such variation could reflect

Figure 7.1. Total local authority expenditure on sexual health advice, prevention and promotion by Region in England



Notes: Source data are taken from the Local authority revenue expenditure and financing collection [124].

Figure 7.2. Total local authority expenditure on contraception per head by Region in England



Notes: Source data are taken from the Local authority revenue expenditure and financing collection [124].

many factors, including random variation, differing demographics, or the impact of local policy decisions and differential funding cuts. More than a quarter of abortions in under 25-year-olds in England are repeat abortions. The repeat abortion rate among pregnant young women has been increasing nationally, but was highest in the North West in 2021, with all three northern regions in the top five (Table 7.4)

Access to reproductive health services

Regular cervical smears are crucial for older women who did not benefit from the national vaccination programme which, since 2019, offers HPV vaccination to all children between the ages of 11-13 years. Women in the North are accessing these services as often or more frequently than women in the South. The highest primary care cervical screening rate in 2016-18 was in Yorkshire and the Humber (133.4 per 1000 person years), which also had the lowest rate of abnormal tests (4.09 per 1000 person years). Cervical screening rates were 127.1 per 1000 person years in the North West, 126.4 in the South and 124.1 in the North East. Abnormal

Figure 7.3. Experiences of postnatal contraception care

Table 7.1. New STI diagnoses per 100,000 in 2022.

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated; → No significant change; ↑ Increasing & getting worse; ↑ Increasing & getting better; ↓ Decreasing & getting worse; ↓ Decreasing & getting better

New STI diagnoses (excluding chlamydia aged under 25) per 100,000 2022 — Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	280,330	496	494	498
London region	↓	103,049	1,171	1,164	1,179
North West region	↓	33,118	446*	441	451
Yorkshire and the Humber region	↓	20,534	375*	370	380
North East region	↓	9,745	368	361	376
South East region	↓	32,402	349*	345	352
West Midlands region	↓	20,220	340	335	344
East Midlands region	↓	16,548	339*	334	344
South West region	↓	17,785	311	307	316
East of England region	↓	19,386	305	301	310

Notes: data from GUMCAD [123].

Table 7.2. Gonorrhoea diagnostic rate per 100,000 in 2022

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated; → No significant change; ↑ Increasing & getting worse; ↑ Increasing & getting better; ↓ Decreasing & getting worse; ↓ Decreasing & getting better

Gonorrhoea diagnostic rate per 100,000 2022 — Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	82,592	146	145	147
London region	→	33,728	383	379	388
North West region	→	9,840	133*	130	135
Yorkshire and the Humber region	→	6,598	120	117	123
North East region	→	3,110	118	113	122
West Midlands region	→	6,042	101	99	104
East Midlands region	→	4,627	95*	92	98
South East region	↑	7,523	81*	79	83
South West region	→	4,185	73	71	76
East of England region	→	4,223	67	65	69

Notes: data from GUMCAD [123].

smear test rates were 5.03 per 1000 person-years in the South, 4.81 in the North West and 6.30 in the North East (all per 1000 person-years).

Sexual Offences

Violence against women – particularly intimate partner violence and sexual violence – violates women's human rights and is a major public health problem [135] The Office for Health Improvement and Disparities' Population Health Analysis Team publish a violent crime: sexual offences indicator using Home Office crime data and ONS population data. These data are published to enable focus on interventions that are effective and evidence-based, including prevention and treatment, to be considered alongside criminal justice measures. This indicator is not restricted to sexual offences against women, excludes exposure and voyeurism, does not include crimes that have not been reported to the police or incidents that the police decide not to record. However, it does demonstrate wide variation in rates of sexual offences recorded across England.

People in the three northern regions experienced the highest rates of recorded sexual offences in 2021/22, with the North East and North West having the first and second highest rates and Yorkshire and the Humber the fourth (Table 7.5). Action taken by police forces to improve their compliance with the National Crime Recording Standard is likely to have resulted in the increase in the number of sexual offences recorded. Further research is needed to understand whether the higher rates of sexual offences recorded in the North of England reflect a higher population burden, or greater police action against such offences.

Conclusion

The World Health Organisation views sexual health as not merely the absence of disease but recognises the importance of having pleasurable and safe sexual experiences free of coercion, discrimination, and violence [137]. This avoids framing sexual health exclusively in terms of the prevention of adverse sexual health outcomes. However, publicly available public health data (as presented here) are still mostly limited to HIV, STIs and repeat abortions.

The limited availability of data on sexual health more broadly may limit evaluation of ambitious sexual health strategies that prioritise sexual wellbeing. Data that describe inequalities in these sexual health outcomes by population subgroups are also needed to better understand and address population need. Increased recognition of the importance of sexual violence as a negative impact on sexual and mental health is reflected in the availability of data, but data on sexual wellbeing and satisfaction are not available outside specialist surveys. There is also, generally, a lack of research on inequalities in sexual health, particularly research that takes an intersectional approach.

Health disparities affecting women and girls were key driving forces for creating the first Women's Health Strategy for England.

We have shown that women in the North of England experience higher rates of STI diagnoses than those in the rest of England (excluding London), young women (<25 years) in the North are more likely to have had a repeat abortion than in other parts of England, and rates of recorded sexual offences are higher in the North than in the rest of England. Provision of LARC in the North East and North West are among the lowest in England, although overall contraceptive prescribing rates are higher in the North than the South. For some of these conditions we can confidently state that women in the North of England are experiencing greater negative sexual health consequences than those in the rest of England. However, for STIs, up-to-date population prevalence data are lacking, meaning we are limited to data on rates of diagnoses among sexual health service attendees.
This may reflect greater population STI burden (a negative situation), or better funded, more accessible sexual health services testing more people at risk of acquiring STIs (a positive situation). Updated population prevalence estimates will be available from the forthcoming fourth wave of the National Survey of Sexual Attitudes and Lifestyles to disentangle

this question. Data may be produced locally to evaluate sexual health strategies in the North that focus on reducing the inequalities in sexual and reproductive health across communities [138].

Women's sexual and reproductive health needs are complex and vary across a woman's life course. These health needs are currently met by a range of providers and professionals in a variety of venues, including general practice, gynaecology, maternity, community sexual health services, and genitourinary medicine services.

The complexity of this care landscape has often meant that provision is not well-integrated, with inequalities in accessing services and in sexual and reproductive health outcomes [139]. Funding cuts, workforce issues and gaps in training provision and fragmented commissioning between the NHS and local authorities have contributed to increasing challenges in service access, with substantial regional variation.

The Women's Health Hubs model may overcome some of these challenges [139-141], but we recommend robust evaluation to ensure these hubs reduce, rather than widen, inequalities in service access and sexual and reproductive health outcomes.

Recommendations

- Women's experiences highlight opportunities to provide more comprehensive and patient-centred contraception care in abortion and maternity settings, ensuring uptake of the most effective contraceptive methods. This uptake is currently low in the North East and North West.
- Improved data collection on sexual health more broadly is essential for the development and evaluation of ambitious sexual health strategies that prioritise sexual wellbeing. Currently, publicly available regional data on sexual health are limited to HIV, STIs and repeat abortions. While these are important endpoints, they fail to encompass the full scope of sexual health.
- Data that describe inequalities in sexual health outcomes by population subgroups of interest are needed to better understand and address population need.
- Sexual offences statistics should be disaggregated by gender and an additional indicator including exposure and voyeurism should be created given growing arguments on the importance of these offences as a gateway to more serious sexual offences.

Acknowledgments
We thank Dr Christopher Grollman for his analysis of the Department for Levelling Up, Housing & Communities Revenue Outturn: Social Care and Public Health (RO3).

Table 7.3. Total prescribed LARC excluding injections rate/1000 in 2022

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	44.1	44.0	44.3
South West region	→	-	58.3	57.8	58.7
Yorkshire and the Humber region	→	-	52.9	52.5	53.3
South East region	↓	-	50.6	50.3	51.0
East Midlands region	↓	-	47.1	46.7	47.6
East of England region	↓	-	43.8	43.4	44.2
North West region	↓	-	40.6	40.3	41.0
North East region	→	-	39.3	38.8	39.9
West Midlands region	→	-	38.2	37.9	38.6
London region	↓	-	33.2	33.0	33.5

Table 7.4. Under 25s repeat abortions (%) in 2021

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	21,158	29.7	29.4	30.0
North West region	↑	3,734	31.9	31.1	32.8
London region	↑	3,901	31.6	30.8	32.4
West Midlands region	→	2,679	30.8	29.8	31.8
North East region	↑	1,002	29.2	27.7	30.8
Yorkshire and the Humber region	↑	2,075	29.0	28.0	30.1
East of England region	↑	1,925	28.9	27.8	30.0
South East region	↑	2,869	28.7	27.8	29.6
East Midlands region	↑	1,560	27.5	26.4	28.7
South West region	↑	1,422	25.5	24.4	26.7

Notes: Data are from the Office for Health Improvement and Disparities, Abortion Statistics [104].

Table 7.5. Rates of sexual offences (excluding exposure and voyeurism) per 1,000 population in 2021/22

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	170,543	3.0	3.0	3.0
North East region	→	9,221	3.5*	3.4	3.6
North West region	→	25,094	3.4*	3.4	3.4
West Midlands region	→	19,206	3.2*	3.2	3.3
Yorkshire and the Humber region	→	17,608	3.2*	3.2	3.3
East Midlands region	↑	15,496	3.2*	3.1	3.2
East of England region	↑	18,370	2.9*	2.9	3.0
South East region	→	26,872	2.9*	2.9	2.9
South West region	→	15,938	2.8*	2.8	2.9
London region	→	22,381	2.5*	2.5	2.6

Notes: Data are from the Office for Health Improvement and Disparities' Population Health Analysis Team.

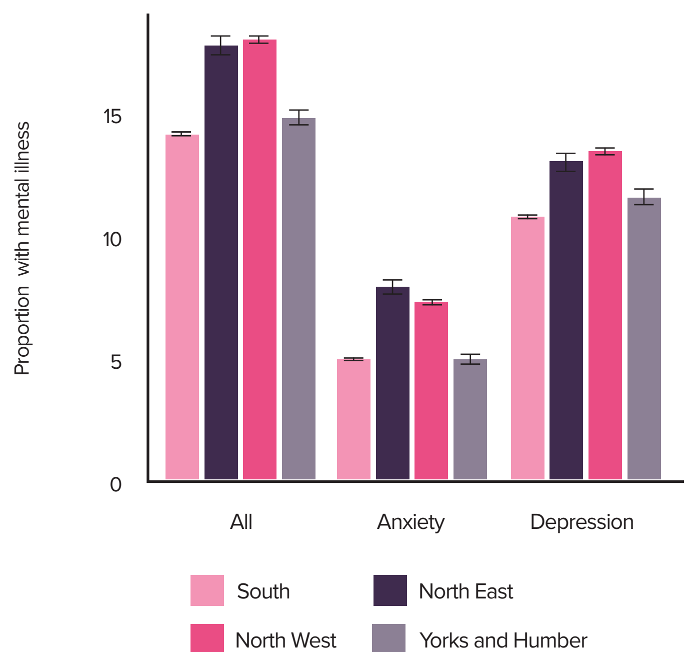
Chapter 8
Mental health

Authors: Dr Holly Hope, Dr Oluwaseun B Esan & Prof. Kathryn M. Abel

Summary

- In our cohort of 1,092,166 women aged 16 to 65 from 2008 and 2018, the prevalence of mental illness was higher in the North West, North East, and Yorkshire and the Humber than in the South of England.
- For mental illnesses affecting less than 1% of the population, bipolar disorder and schizophrenia have higher prevalence in the North West and North East than in the South and Yorkshire and the Humber; eating disorders are the only low prevalence mental illness occurring in a higher proportion of women in the South.
- The proportion of women with a diagnosis of mental illness who were receiving a treatment for their mental illness was lower in the North West and North East than in the South and Yorkshire and the Humber, likely indicating a treatment gap between regions.
- In contrast, the referral rates into NHS Talking Therapies (formerly known as Improving Access to Psychological Therapies, IAPT) services were higher for the North West and North East and Yorkshire commissioning regions than for the South West, South East and London.

Figure 8.1. Proportion of our cohort of 1,092,166 women aged 16 to 65 with mental illness living in the North West, North East, and Yorkshire and the Humber, compared with those living in the South of England



Context

The importance of improving mental health care is well known. The NHS Five Year Forward View for Mental Health (February 2016)[142] "set out a ten-year journey for the transformation of mental health services." This commitment was echoed by the 2019 NHS Long Term Plan with adult mental health services selected[143] as a focus for, "better care for major health conditions".

The need for better mental health care remains with nearly 1 in 5 women in the adult population currently experiencing mental illness. Mental health can be measured using surveys[144], or by counting the number of people diagnosed with a mental illness[145]. Whatever metric is chosen, mental illness is more common in women than men[146]. Common mental illnesses, such as depression, anxiety[147, 148] and self-harm are increasing over time in women, particularly among younger women[149].

Women with severe mental illness, such as schizophrenia or bipolar disorder, are 2.6 to 6.9 times more likely to die before the age of 75 than women who have never been diagnosed with a serious mental illness, demonstrating the link between mental and physical health. Although, more men with severe mental illness die prematurely than women, UK trends indicate that excess deaths are increasing faster in women than men[150].

Becoming pregnant and giving birth are times when women are especially likely to develop a new mental illness[147]. 1 in 4 women enter pregnancy with two or more long-term conditions with mental illness, accounting for 70% of this burden[151]. Women and girls aged 15 to 24 are particularly vulnerable to developing a new mental illness[152] and self-harming after pregnancy[153].

The latest confidential enquiry into maternal deaths reported that mental health accounted for 40% of 311 deaths in pregnancy and the first postnatal year 2019-2021. Suicide remains the most common direct cause of death in pregnancy and the first 42 days after birth[154].

The Five Year Forward View for Mental Health has provided additional funding for mental health services which has led to the expansion of mental health services since 2017[142]. This includes provision of psychological therapies for common mental illness and perinatal mental health services. In this chapter, we examine the regional differences in prevalence of mental illness in women and access to mental health care and services.

Regional differences in prevalence of mental illness in women

We used a cohort of 1,092,166 women aged 16 to 65 observed between from 2008 and 2018, to estimate the 2-year prevalence of mental illness with 95% confidence intervals in the North East, North West and Yorkshire

and the Humber and compared these estimates with women living in the South of England (London, South East and South West) (Figure 8.1). We used primary care health records to measure prevalence. In this cohort (2008-2018) we were able to use an algorithm that intelligently maps and matches symptoms, diagnoses and medications across each type of mental illness to give the most accurate picture of mental health burden. Overall, nearly 1 in 5 women were living with a mental illness in the North West (18.2%; 95% CI 18.1% - 18.4%) and the North East (18.0 %; 95% CI 17.6% - 18.4%). Rates were slightly lower in Yorkshire and the Humber (15.1%, 14.7% to 15.4%), but still higher than women in the South of England (14.4%; 95%CI 14.3% -14.5%). When we looked at types of mental illness, we saw the same pattern with women in the North experiencing higher rates of depression and anxiety (Figure 8.1). Overall, trends over time were similar across regions, with a gradual increase in mental health need over this ten-year period, and the North West and North East consistently experienced higher health burden than other regions. How trends were affected by the pandemic is covered in the next section.

This was also the case for rarer mental illnesses such as schizophrenia and bipolar disorder that affect less than 1% of the population (Figure 8.2). These mental illnesses persist over time, tend to be more severe and are more likely to prevent a person from getting on with their everyday life. Notably, even though the percentages are small, there are significantly more women in the North West (0.31%; 95% CI 0.28% - 0.33%) living with schizophrenia compared to the South (0.22%; 95% CI 0.21% - 0.24%). More women in the North East and the North West were diagnosed with bipolar disorder. The only type of mental illness where rates were lower for women in the North West than the South was eating disorder.

Increased rates of mental illness in the North were observed across all deprivation, ethnic and age groups (Figure 8.3). For women living in the top 20% most deprived areas in the South (IMD-5, Figure 8.3) the overall prevalence of mental illness was 15.6% (95% CI 15.8% - 16.1%), compared to 19.2% (95% CI 19.0% to 19.4%) in the North West and 18.4% (95% CI 17.9% - 18.8%) in the North East.

Women aged 30 to 39 years had the highest rates of mental illness, and rates were higher for women in the North West (21.0%: 95% CI 20.8% - 21.2%), North East (20.6%: 95% CI 20.2% - 21.1%) and Yorkshire and the Humber (17.3%: 95% CI 16.9 - 17.7%) than the South (16.7%: 95% CI 16.6% - 16.8%). In the UK, this is also the age when most women have their first child [109]. Giving birth and mental illness are linked, so it is not surprising this group had the highest overall prevalence.

Women from White ethnic groups had the highest rates of mental illness compared to women from Asian, Black, Mixed and unknown ethnic groups. The reasons for this are complex and are discussed later in the chapter. However, despite the reduced prevalence within primary care, the prevalence of mental illness among women from Asian, Black, Mixed and Other ethnic groups was higher in the North West and the North East, but not Yorkshire and the Humber, compared to the South of England. Unfortunately, reporting of ethnic group is incomplete, although the level of missingness did not vary by region and we can therefore report the regional differences. However, the absolute prevalences for different groups may be inaccurate and are not reported. Recording of ethnic group is improving; this should mean we can estimate prevalences of mental illness for different ethnic groups more accurately in the future.

Mental health and the COVID-19 pandemic

Mental health, as well as accessing treatment and therapies for mental health, was affected by the COVID-19 pandemic [155]. Records show an initial drop in primary care presentations in March 2020. This is despite increased reporting of psychological stress in representative population surveys [156], examined in detail in a secondary analysis of the monthly nationally representative population survey - Understanding Society, the UK Household Longitudinal Study (UKHLS) [144]. This analysis suggested that women's mental health, and particularly the mental health of young women and women with young children, was most affected. As many as 4 in 10 women reported symptom counts high enough to indicate

Figure 8.2. Proportion of our cohort with low prevalence mental illness living in the North West, North East, and Yorkshire and the Humber, compared with those living in the South of England

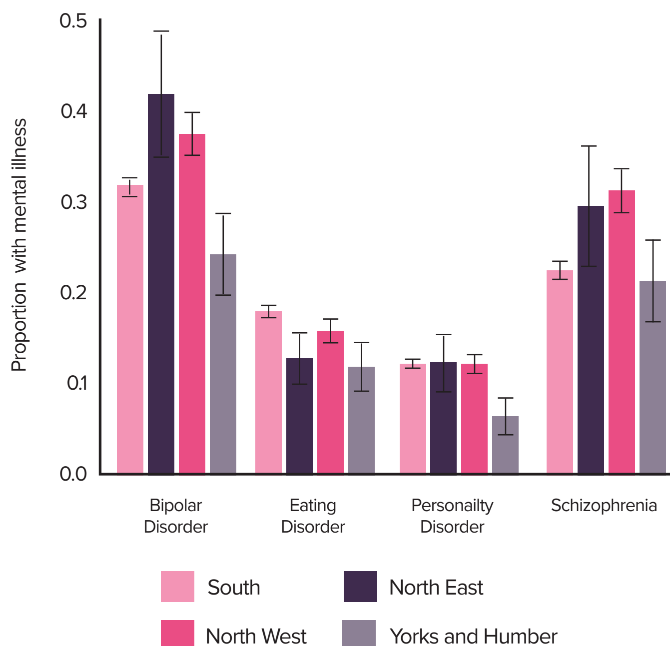
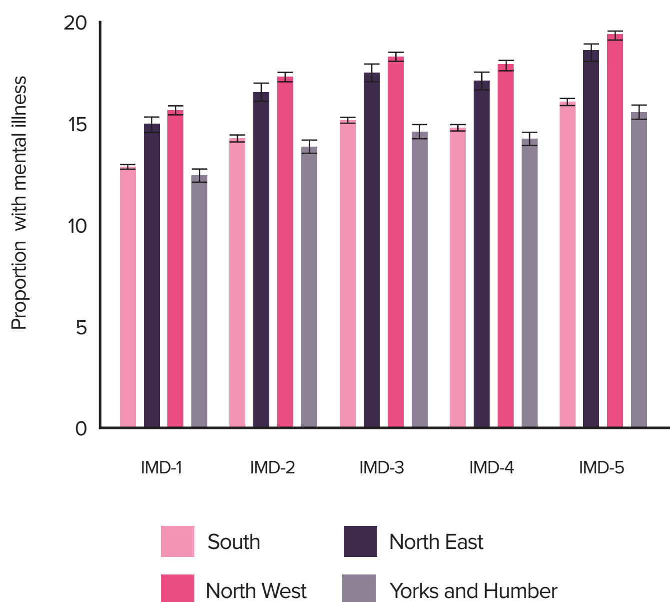


Figure 8.3. Proportion of our cohort with mental illness living in the North West, North East, and Yorkshire and the Humber, compared with those living in the South of England by Index of Multiple Deprivation (IMD) quintile



probable mental illness – the highest scores ever recorded in UKHLS. However, most women recovered rapidly as the pandemic continued and, by 2021, were presenting at levels expected pre-pandemic [156].

Accessing mental health services and therapies

Given the higher rates of mental illness reported for women in the North, we used our Women in the North Cohort, to investigate whether women living in this region were treated at higher rates compared to women elsewhere. Regional differences in demographic factors such as poverty, deprivation and ethnic diversity might explain regional differences in rates of mental illness. Importantly, if there are no regional inequalities in care, then there will be no differences in the proportion of women needing

treatment who are getting treatment. If there are such differences, these are more likely to be modifiable by changes in policy, practice and services; including the provision of outreach and culturally sensitive services.

We calculated the proportion of women with a diagnosis of mental illness who were receiving a treatment for that mental illness (Figure 8.4). Our data showed that 54.2% (95% CI 53.3% - 55.1%) of women in the North West and 54.2% (95% CI 51.7% - 56.8%) of women in the North East with a diagnosis of depression were also currently prescribed antidepressants. This was lower than the prescribing prevalence for women in the South (59.9%: 95% CI 59.8% - 60.3%) and women living in Yorkshire and the Humber (57.3%: 95% CI 55.2% - 59.4%). For women with an anxiety disorder, 26.7% (95% CI 20.2% to 29.3%) of women in the North West and 25.3% (95% CI 20.4% - 30.1%) of women in the North East were prescribed an anxiolytic, which is less frequent than women in the South (36.5%, 35.6% to 37.3%) and women in Yorkshire and the Humber (36.8%: 95% CI 32.6% to 40.8%). For women with bipolar disorder and schizophrenia, prescribing rates were lower, but not significantly so, for women living in the North West and North East compared to the South of England and Yorkshire and the Humber.

Reduced prescribing for depression (North West & North East 54.2% vs. South 59.9%) and anxiety (North West 25.3%, North East 26.7% vs. South 36.5%) in the North West and North East might reflect less severe depression and anxiety; but we believe this is more likely to indicate under-treatment or 'a treatment gap', and a regional health inequality for women with common mental health conditions in the North of England.

Referral rates for Talking Therapies

If we consider non-drug therapies for mental health symptoms since the Five Year Forward View for Mental Health in 2017 [142], we find that all the regions we explore achieved their investment goals. This means that wherever women live in the North of England, there is greater access to talking therapy services for common mental conditions, and to specialist perinatal services for women with serious mental illness. This is good news for women in the North.

Using information collated by Public Health England between 2021 and 2022 [157], we examined the referral rate for women into the NHS talking therapies for anxiety and depression, at the regional commissioning level, using Census 2021 female population estimates as the denominator.

Referral rates were high in all regions, but highest in the North West (Figure 8.5). Not all referrals are eligible for talking therapies, and not all women take up therapy when it is offered. However, women in England clearly desire rapid access to mental health services: of women who were eligible, 70% completed their treatment (range 69 to 71%).

The target is for 50% of women to have recovered by the end of the treatment, meaning that, at the end of treatment, they were no longer above the threshold for needing talking therapies. Notably, recovery rates in 2021-2022 approached this target in the North West (N= 35,111, 48%), South West (20,180, 43%), South East (36,365, 50%) and exceeded the target in the North East (32,170, 51%) and London (38,900, 52%).

Hopefully, sustained funding of these services will ensure that women are able to continue to access an appropriate talking therapy quickly and prevent deterioration in their mental health. We also need to consider other inequalities; currently women from Asian and Black ethnic groups have lower recovery rates than women from White ethnic groups [158].

Many women with more complex and serious problems are not eligible for talking therapies, and it is unclear what happens next for these women, but there is some evidence that this varies widely across talking therapy providers [159]. How women are referred, screened and communicated with is not standardised and this may mean some women with urgent and serious mental health needs, particularly those who self-refer, fall between the cracks.

Figure 8.4. Proportion of our cohort with a diagnosed mental illness also prescribed psychotherapeutics

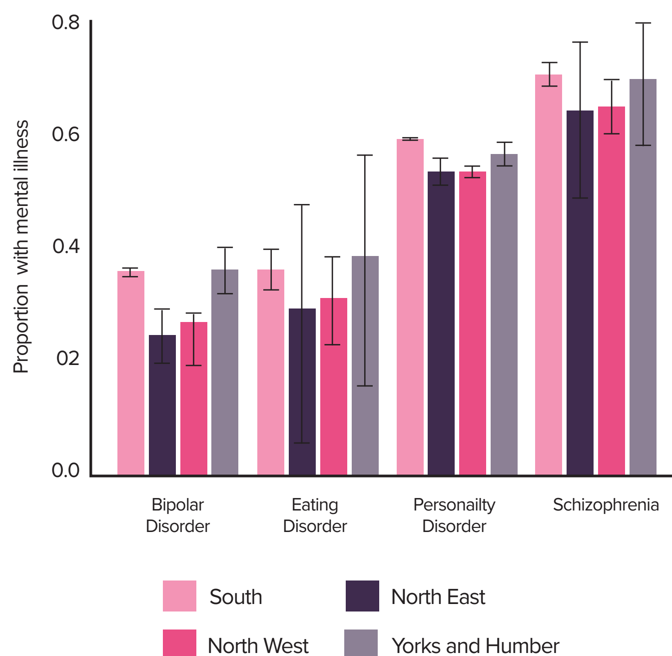
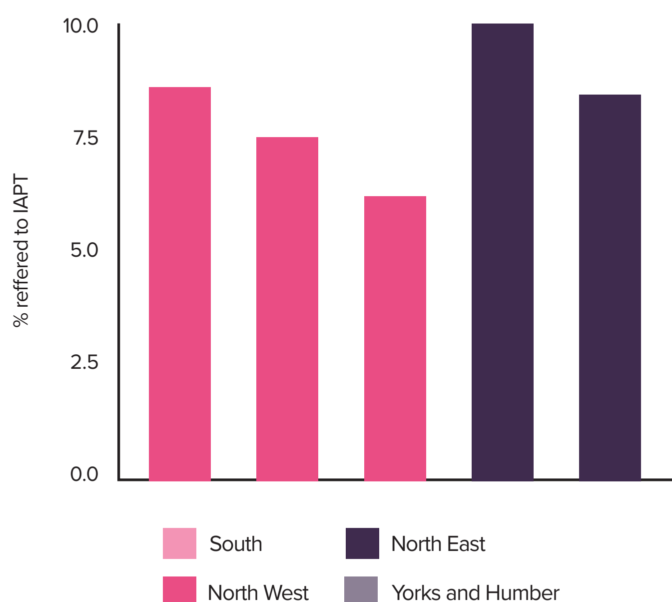


Figure 8.5. Referral rates for women into the NHS talking therapies for anxiety and depression at the regional commissioning level during 2021 and 2022



Access to perinatal mental health services

Perinatal mental illness (PMI) during pregnancy and the first postnatal year affects 1 in 5 women; and suicide is one of the leading causes of maternal death in the same period [154]. The NHS Long Term Plan aimed to expand specialist community perinatal mental health (PMH) services following a cost-benefit analysis estimating that reducing the human and economic costs of PMI had the potential to save £8.1 billion [154]. In March 2024, an evaluation of the rollout of improved PMH services reported that in regions with these services, women with pre-existing mental illness had lower relapse rates after birth [160]. However, they also report a small significant increase in stillbirths and neonatal deaths where a community perinatal mental health team was available at the onset of pregnancy compared to no team, (165 [0·5%] of 30,980 women vs. 151 [0·4%] of 38,693 women; adjOR 1·34, 95% CI 1·09–1·66; p=0·0063) as well as for

babies born small for gestational age (2227 [7·2%] of 31,030 women vs 2,542 [6·6%] of 38,762 women; adjOR 1·10, 1·02–1·20; p=0·016). These findings are complicated to interpret and may be by chance. As a result of gaps in data availability, access to PMH services was measured by the service's availability in a region where a woman had secondary mental health care records, which may not adequately capture the primary care mental health burden [160, 161].

However, the implication is that adverse neonatal outcomes are not adequately addressed by improving perinatal services for mental health. This has important consequences given what we know about the numbers of at-risk mothers with multiple long-term conditions and co-morbid mental illness at conception. The evaluation highlights a need for integrated care among mental health, primary care, obstetrics, neonatal and maternity services. The maternal medicine network, launched in 2021, aims to link multidisciplinary teams for the management of complex pregnancies, regionally[5]. This new service model, integrating mental and physical health into maternity care and health visiting, is expected to generate nearly £500 million in net benefits over ten years[2]. Joined-up care is crucial to ensure women receive comprehensive support and avoid adverse outcomes.

Inequalities in access to perinatal mental health services

Limited by data on regional access to services, a recent report by the Maternal Mental Health Alliance used freedom of information requests received from 47 out of 51 NHS trusts in England to examine regional variation in available services fulfilling the NHS Long-term Plan [162]. They reported the following regional variations:

- Provision of care from pre-conception to 24 months after birth varied across NHS Trusts, both in the North and South, with approximately equal number of Trusts not providing the service
- Provision of support for women with complex postnatal post-traumatic stress disorder syndrome/personality disorder diagnosis is widespread; only two trusts in the North (North York and Yorkshire and Lancashire) did not have funding to provide the service
- Provision of psychological therapies, including parent-infant, couples, co-parenting and family interventions was also widely funded; only three Trusts in the North (Cumbria, Northumberland and Tyne & Wear, Tees, and North York & Yorkshire) did not have funding to provide the service. A similar number of Trusts in the South also did not have the funding for the service

Critical data gaps also exist in differences in access of services by ethnicity and other sociodemographic factors, despite long-standing acknowledgment of inequalities in access and outcomes [161]. A recent rapid review commissioned by the NHS Race and Health Observatory (RHO) reported that women who identified as Black African, Asian (including all sub-groups) and White Other were significantly less likely to access community mental health services than the White British group [163].

Lack of access is not always a result of poor uptake of services, but may result from a mix of complex factors such as healthcare professionals being less likely to ask ethnic minority women case-finding questions, language barriers, low awareness of services, fear of stigma and of having children removed by social services, lack of culturally appropriate or compassionate care, lack of cultural awareness training for staff, as well as religious views not taken into account [163].

These barriers to services are not new [164]: a recent scoping review to identify policy interventions that might tackle ethnic health inequalities reported that only one promising intervention for women with perinatal mental illness - a culturally adapted group cognitive behavioural therapy for postnatal depression in South Asian women living in the North West [163, 165]. This intervention was reported to reduce scores on a depression scale and was accepted by the women in both the feasibility[166] and exploratory RCT [167]. The multi-site trial is awaiting results [168].

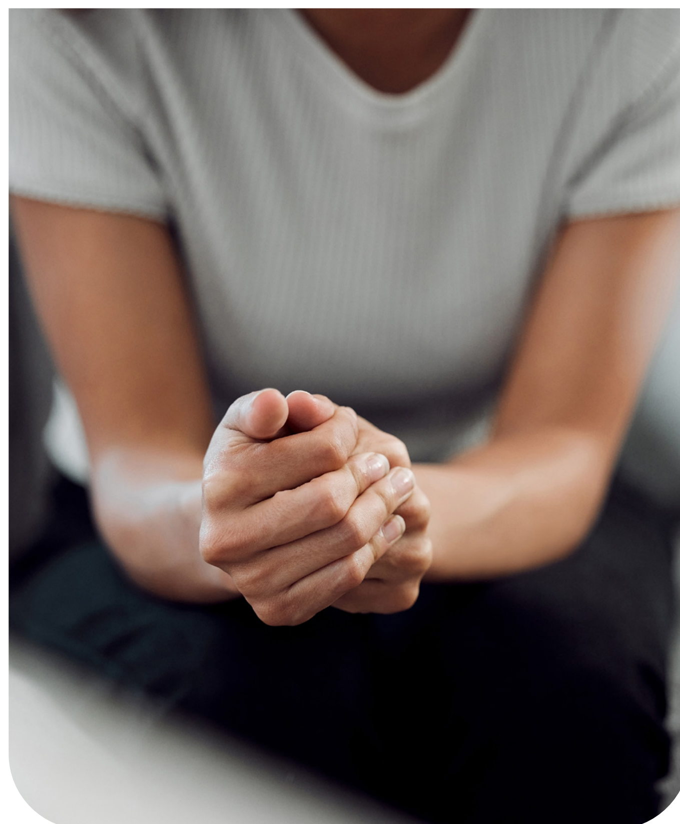
Conclusions

Significant and clinically meaningful differences remain between the numbers and health care access of women with mental illness in northern regions of England compared to the geographical South. Some of these differences relate directly to poverty and deprivation being concentrated in northern England; this should be considered carefully in responses to the regional inequalities. Other differences appear common to regions across the country such as ethnic inequalities in accessing services, strikingly apparent in poorer maternity outcomes for Black women.

In spite of this, much progress has been made to improve mental health services since the NHS 5 Year Forward Plan was published in 2016. The following recommendations seek to continue improvements by addressing mechanisms behind the inequalities we report between regions of the same country.

Recommendations

- Consistently high rates of mental illness are found across all demographics of women living in the North. However, these women appear to access both medical and talking therapies differently to women in the South. More research is needed to understand the causes of these differences to better and more equitably meet the needs of women.
- Talking therapy services in the North of England appear to be successful as low intensity interventions and are well accessed by women who need them. Resources are required to streamline referral for significant numbers of remaining women with more serious problems who are not eligible for talking therapies so they can access appropriate help.
- Prompt research into the 'active' ingredients of perinatal mental health services is needed, so that best practice can be shared as these services start to expand rapidly and regionally.
- Significant health inequalities need regionally specific solutions including staff training in cultural sensitivity to tailor, trial and deliver effective mental health interventions that meet the needs of women in the North from Black and South Asian backgrounds, in particular.
- Routine data collection on ethnicity and other key demographics needs to become standard in health records to reduce missingness and deliver better information for service development.



Chapter 9
The impact of domestic violence

Authors: Hayley Alderson, Ruth McGovern, Luke Munford and Nicole Westmarland

Summary

- Domestic Violence and Abuse (DVA) is a gendered crime that disproportionately affects women living within the North of England.
- Many children in the North are exposed to domestic violence - incidents of DVA are higher for individuals living in single parent households with one or more children compared to those living in a no-children household.
- Child victims and survivors of DVA are more likely themselves to be victim to, or perpetrate, DVA.
- Mothers are often held responsible for protecting their children, despite the perpetrator's/father's responsibility for the abuse and protective responses made by mothers in an attempt to minimise the impact of DVA on their children are often overlooked.

Context

Domestic violence and abuse (DVA), often also called domestic violence or intimate partner violence, is defined by the United Nations as "as a pattern of behaviour in any relationship that is used to gain or maintain power and control over an intimate partner." DVA can take a variety of forms, including physical, mental, economic or sexual abuse. Although DVA can and does happen to anyone of any race, age, gender, or socioeconomic background, we know that victims are predominantly women, with 1 in 4 women experiencing a form of domestic abuse in their lifetime. In the UK women in the North of England are disproportionately affected by DVA. In this chapter we explore the prevalence of DVA in families in the North and the effect that it has on victims and survivors.

Prevalence of violence and abuse in the North of England

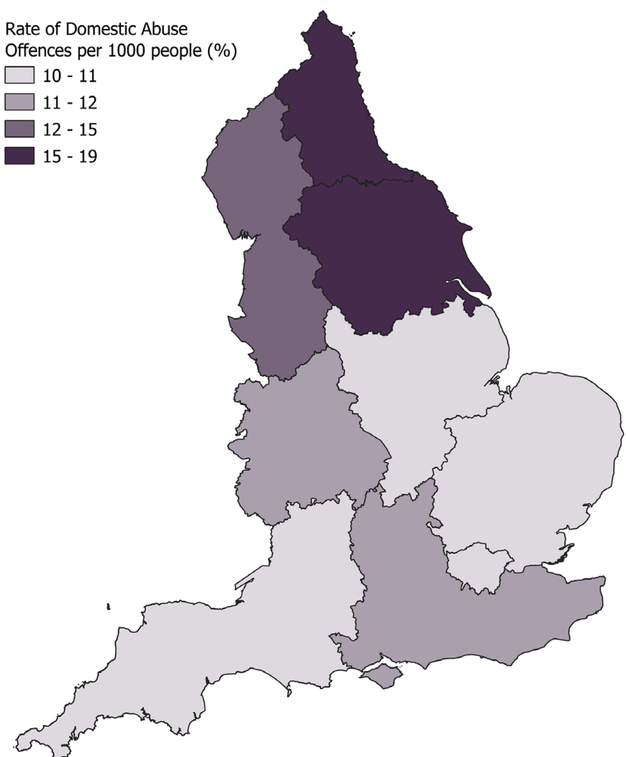
It is difficult to rely on police data in relation to violence against women and girls due to under-reporting and/or under-recording. There also exists limitations in self-reported data. The data we do have show that DVA is a gendered crime that disproportionately affects women living within the North of England. The Crime Survey for England and Wales 2019 showed that the highest levels of DVA related crimes were recorded in the North East region, with all three northern regions having rates of DVA well above the English and Welsh average (Figure 9.1)[169]. We note that similar patterns are seen in more recent data, however the data sets are incomplete either due to COVID-19 or a survey error which resulted in missing data (year 2023).

The effects of violence and abuse on families

Many children in the North are exposed to domestic violence. In around a third of all cases of intimate partner violence, there was at least one child under the age of 16 years living in the household[170]. Incidents of DVA

Figure 9.1. Rates of all domestic abuse-related offences per 1,000 population, by region, in the year ending March 2019

Notes: the black dashed line is the English average (=13 per 1,000 population). Bars coloured in purple represent rates more than 10% above the English and Welsh average. Data are from the Office for National Statistics[169].



were higher for individuals living in single parent households with one or more children compared to those living in a no-children household[171]. The introduction of the Domestic Abuse Act in January 2022 marked the start of children being officially recognised as victims of domestic abuse. This is in response to significant evidence documenting the harmful life-long effects of experiencing DVA[172].

The risks to children exposed to DVA start from conception. Pre-natal exposure increases the risk of miscarriage[173], low birth weight of the infant[173] and neonatal death[174]. The risk continues post-birth, with child victims and survivors going on to experience mental health problems in adulthood[175, 176]. The impact of witnessing DVA on children can differ depending on gender, with boys displaying externalised behaviours such as aggression and girls experiencing internalised behaviours such as depression and/or anxiety[178] in addition to experiencing childhood trauma symptoms[179, 180]. When considering the impact of DVA on children, statistics show that DVA is identified as a risk factor in statutory social care needs assessments[171]. Domestic violence is the most commonly identified risk in 'child in need' assessments, with the North of England having the highest rates of concerns relating to a child due to domestic violence. The Child Safeguarding Practice Review Panel data show that DVA was a significant feature in fatal child death incidents and serious incident notifications reported by Local Authorities. The father was identified as the perpetrator and mother as the victim in nearly three quarters of incidents[181].

Figure 9.2. Children in need per 10,000 children, by region, in 2023

Notes: the black dashed line is the English average (=342.7 per 10,000 children). Bars coloured in purple represent rates more than 10% above the English average. Data provided by the UK Government 182.

Analysis of the 2023 statistics on children in need across England shows that:

- In approximately a third of cases of intimate partner violence, there was at least one child under the age of 16 years living in the household.
- Incidents of DVA were higher for individuals living in single parent households with one or more children (18.6%) compared to those living in a no-children household (4.2%).
- Of the 403,090 children in need assessments completed in the year ending March 2023, 51% identified domestic abuse as a risk factor.
- In 160,140 (39.7%) of child in need assessments, concerns were identified that the parent was a victim of DVA; 57,550 (14.3%) identified the child as a victim of DVA; and 25,710 (6.4%) identified an 'other person' as a victim.
- It is estimated that there is an average of 692 assessments a day featuring domestic abuse as an issue faced by children.

The figure of 403,090 children in need across England equates to a child in need rate of 342.7 per 10,000 children. However, there is considerable regional variation (Figure 9.2). The North East had the highest rate (467.4 per 10,000 children) and the North West (386.8 per 10,000 children) the second highest rate. The rate in Yorkshire and the Humber (349.7 per 10,000 children) was also above the English average. The rate in the North East was almost twice as high than in the East of England, the region with the lowest rate (245.1 per 10,000 children).

- DVA was a feature of 42.6% of serious incident notifications reported by Local Authorities (where a child has died or is seriously harmed), with the father being identified as the perpetrator and mother as the victim in 74% of incidents
- Of the 206 fatal child death incidents reported, DVA was a feature in 41%
- 87% have of mothers subjected to repeat care proceedings, i.e. with two or more children removed from their care, have experienced DVA

The response from supporting services

Those who have experienced violence and abuse need access to tailored services. Unfortunately, there is a 'postcode lottery' across the UK in terms of access to services[183]. Although some improvements have been made, the funding and commissioning of services is often done piecemeal, in a reactive rather than proactive manner, leaving gaps in service provision. Women and girls living in rural areas, which make up a large part of the North, often have more difficulties in accessing services.

The North East and Cumbria previously benefited from services and research funded through the Northern Rock Foundation's Violence against Women and Girls programme. The loss of this programme is still felt amongst frontline workers and researchers – not only financially but also in the way that research-based policy and practice was developed and supportive networks created.

In families, despite safeguarding concerns relating to DVA being frequently identified in statutory 'child in need' assessments, the response from supporting services is a major area of concern. It has been shown that services engage in destructive and less than proficient domestic violence practice which blames the adult victim[184], for example holding the mother responsible for protecting the child despite the perpetrator's/father's responsibility for the abuse[185]. Protective responses made by mothers in an attempt to minimise the impact of DVA on their children are typically overlooked. In the North, and elsewhere around the country, services are trying to move away from such victim-blaming practices. Improved approaches would move away from maternal deficit models and ensure the needs of both the adult and child survivors are supported throughout their recovery[186].

When DVA takes place within the family, it is often occurring alongside poverty, deprivation, mental ill-health, and substance misuse. All these disadvantages are prevalent amongst women within the North East region[187], and these co-occurring risk factors can be viewed as indicators of increased harm to children. Safeguarding approaches suffer competing priorities between delivering child focused (children's social care) and adult focused services[188]. Instead, safeguarding approaches which focus on the family as a unit and as its individual members (adult and child victims and perpetrators) are recommended[189 190].

To reduce violence against women and girls, we need prevention work. This work should build upon transforming harmful gender norms that are prevalent in different ways across all Northern communities[191], and should involve men and boys in developing and delivering content. A much more ambitious, joined up approach with longer term planning is needed to ensure access to high quality support services alongside a serious commitment to prevention work. Without this, prevalence rates are likely to remain high. One area in the North that is taking this approach is Greater Manchester, who launched their Ten-Year Gender-Based Violence Strategy in 2021, with the ambition of seeing a radical transformation by 2031.

Recommendations

- Services should continue to move away from victim-blaming practices that are often evident when DVA occurs within families with dependent aged children.
- Services should offer needs-led and trauma-informed care that focuses on the recovery needs of both the adult and child victim/survivors of DVA.
- Integrated commissioning needs to occur to ensure services have capacity to take a family safeguarding approach to respond to the needs of both the adult and child victim whilst simultaneously addressing the behaviour of the perpetrator.
- There needs to be sustainable investment in services to tackle DVA and recognise the part that DVA plays in children entering children's social care which features disproportionately in the North of England.
- To see a reduction in prevalence rates, there needs to be a far greater focus on transforming harmful gender norms. More ambitious, multi-agency planning to end violence against women and girls is needed, such as the approach being taken by Greater Manchester.

Chapter 10
Marginalised women

Authors: Michelle Addison, Kelly Stockdale, Steph Scott, Dawn Harrison, Lisa Boyack; Kate O'Brien, Christina Cooper, Jane McDermott, Jennifer Greenlaw, Carolyn Snell, Nicholas Pleace, Anna Browning, Sara Anderson, Kat Jackson, Ruth McGovern, Nicole Westmarland, Catherine Mead, Mary Laing, North East Spicy Coffee Collective, Nasima Akhter, Oluwaseun Esan, Natalie Bennett, Clare Bambra; Lauren Powell

Summary

- We cannot paint a complete picture of how the social determinants of health impact outcomes for marginalised northern women due to the notable lack of health data about the lived realities of marginalised northern women. We present the available data and stress the need for more research to understand the scale and scope of the health problems marginalised women of the north are facing.
- Women from North with experience of the justice system are likely to also be involved with other systems and support services, they frequently juggle 'a maze' of different services, including criminal justice services, drug and alcohol recovery services, social care, mental health, homelessness, domestic and sexual abuse, and healthcare systems.
  - o In 2019, all of the police areas with the ten highest rates of female imprisonment were in the North of England, the Midlands or in Wales. In 2022, nine of the ten police areas with the highest rates of female imprisonment were in the North of England.
- Women's homelessness therefore is 'invisible problem' since women are much more likely than men to exhaust all social avenues before resorting to rough sleeping, often alternating between sofa surfing and nights on the streets.
- Of the recorded deaths per 100,000 from alcohol-specific causes in 2021, women in the North East (13.9), North West (13.8) and Yorkshire and Humber (11.7) had the highest rates of deaths in women in England.
- The North East of England has the highest rate of children being taken into care in the country (113 per 10,000) followed by the North West (96 per 10,000). This compares to the national average of 70 children per 10,000.
- The proportions of trans women from the North East and North West of England who described themselves as disabled with 'day-to-day activities limited a lot' was 16.1%, and 'with activities limited a little' was 19.1%. These proportions compare to 10.0% and 9.5% with 'day-to-day activities limited a lot' and 12.2% and 11.3% with 'activities limited a little' in age-standardised data for women in the North East and North West respectively.

Context

This chapter focuses on women in the North of England who are marginalised and the impacts this has on their health and wellbeing. In simple terms, marginalisation is to treat a person, or group of people, as though they are not important, belonging only on the edges of society. In reality, marginalisation refers to more than exclusion from a particular group or environment – whether this be political, economic, social, employment, or educational. It encompasses the myriad ways in which certain individuals, groups, and communities are stigmatised, overlooked, underheard, and underserved for reasons related to identity and contextual factors – often by those more powerful in society.

We are concerned about the marginalisation of women in the North, the needs of which are under-researched. In this chapter we bring together the latest research and expertise, demonstrating how being treated as insignificant or peripheral is harmful to health, unjust and requires further attention from researchers and policymakers.

We discuss key health issues, barriers to accessing support systems, and health outcomes across a range of marginalised groups. These include: women who have experience of the criminal justice system, women who use drugs and/or alcohol, women who experience homelessness, those that engage in sex work, or are care leavers. We also consider violence against women and girls. We identify problems impacting women who are sexually minoritised, women who are neurodivergent, and women who are ethnically and racially minoritised, and how health outcomes are affected for these groups. We have highlighted particular issues impacting subsets of women who are marginalised. However we wish to emphasise that these are overlapping and intersectional – and therefore amplified for certain women.

In writing this chapter our contributors identified a notable lack of health data about the lived realities of marginalised Northern women. In this regard Northern women are also extremely marginalised in research. We therefore know very little about how the social determinants of health impact outcomes for marginalised northern women. We are only able to present a partial picture here, providing insights and observations where the data allows. For this reason, we wish to echo the call made in the Women's Health Strategy for England (2022) for more research to understand the scale and scope of the health problems women of the north are facing.

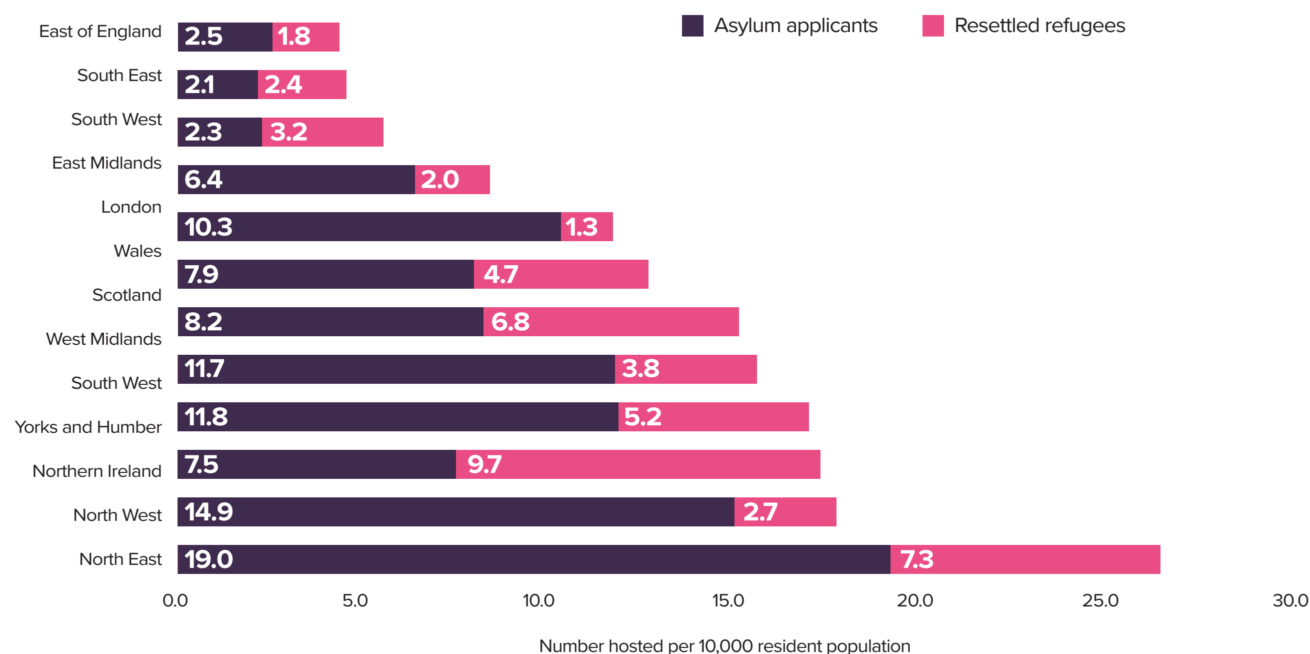
Living as a minoritised ethnic woman in the North

No one-size fits all

Ethnicity is a complex phenomenon that encompasses genetic factors influenced by environmental, behavioural, and sociocultural factors. Ethnic minority women in England encompass a diverse range of backgrounds including Asian (such as Indian, Pakistani, Bangladeshi, Chinese, Other Asian), Black (African, Caribbean, Other Black), Mixed/Multiple ethnic groups (White and Asian, White and Black African, White and Black Caribbean, Other Mixed/multiple ethnic groups). With ongoing discussion around categorisation, the recent census free-text description of ethnicity included 287 categories, demonstrating heterogeneity within broad classification [192]. Yet, as we have seen when analysing the effects of COVID-19 [193], administrative records such as death certificates do not record ethnicity, and other records often have a high level of missing data, making these minoritised men and women "invisible" to the system.

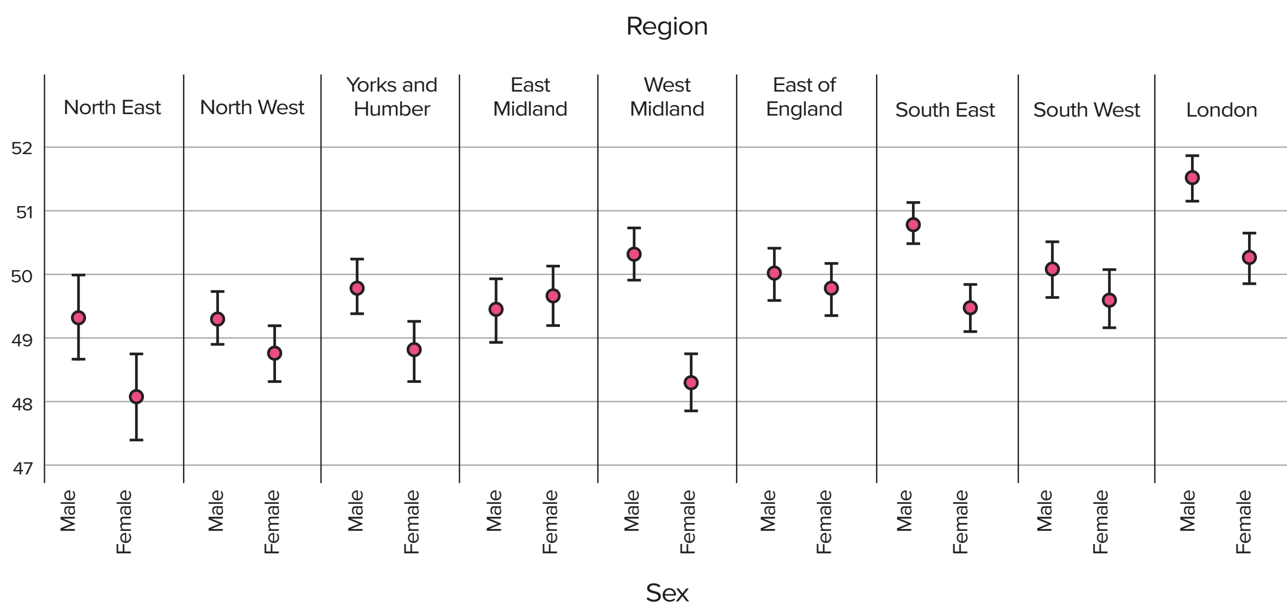
In relation to health, ethnicity is also often used to understand the impacts of interpersonal and structural racism, including the effects on socio-economic status. Taken together, these all affect the health and wellbeing

Figure 10.1. Number of asylum applicants and resettled refugees in the UK by region of residence per 10,000 population as of December 2021-22



Source: Figure from the Migration Observatory analysis of Home Office Immigration Statistics22, Section 95 support by local authority (Table Asy_D11), and Resettlement by local authority (Res_D01). Population estimates: Office for National Statistics, Population estimates for the UK: mid-2020 [208]

Figure 10.2. Mean SF12 physical component score (PCS) indicating health-related quality of life among female and male residents across regions



Note: Authors' analysis of the UKHLS data 2020-2021, adjusted for complex survey design, & weighting allowing national representativeness [271].

of minoritised ethnic groups. Genetic predisposition, cultural practices, and socioeconomic deprivation that are common across a particular ethnic group provide some explanation of ethnic patterns in health risks [194, 195]. There are ethnic inequalities in diagnosed ill health, for example with Pakistani, Bangladeshi and Black Caribbean groups having higher prevalence of some cardiovascular diseases compared with the White British group [196]. Type 2 diabetes is 2-4 times more prevalent among South Asian and Black groups; hypertension is highly prevalent among African-Caribbeans; and South Asians generally have increased risk coronary heart diseases [197, 198].

Gender norms and traditions vary across cultures [198, 199]. This may lead to ethnic group-specific gender inequalities, influencing their dietary habits, physical activity levels, health literacy, decision making capacities, and treatment seeking behaviours, and can negatively affect health of minoritised ethnic women [199-201]. Although gender norms create some expectations around role of women, they cannot be generalised to all individuals for the group.

Wang and Coulter found that Pakistani, Bangladeshi, Indian, and Black African women were expected to take larger share of housework and caring responsibilities, while such expectations were less among Black Caribbean, and White British population [199]. This still needs careful interpretation as Black African as a category actually include residents

of different countries and therefore a combination of cultures. Better education level or exposure to different cultures or value systems positively influence attitude towards gender equality. Gender inequality compounded by socioeconomic inequality may negatively affect health of women [198, 201].

Socioeconomic inequalities influencing health inequalities

Several researchers have acknowledged that ethnic health inequalities are largely explained by socioeconomic inequalities, which is an important phenomenon to consider when investigating ethnic inequalities in health [194, 195, 200, 201]. For example, research suggests that socioeconomic deprivation, along with multiple long term conditions, partly explain inequalities in COVID-19 infection and mortality negatively affecting Bangladeshi, Pakistani, and Black ethnic groups [193, 194, 202, 203]. While Bangladeshi and Black Africans have higher odds of living in a deprived neighbourhood [195], Bangladeshis who had financial adversity had two times higher predisposition to obesity related non-communicable diseases than those who considered them to be better-off [204]. Pathways to obesity can vary due to migration status, cultural characteristics, and structural drivers such as racism influencing socio-economic characteristics [205].

North-South divide

Funding for health services and resources for socioeconomic development are unequally distributed, and are inverse to the demand in the northern regions [49, 204, 206]. This may lead to the health needs of women from minoritised ethnic groups in the North being amplified. Persistent North-South health divides have been reported. While people in the North have the highest health care needs. Four conditions (chronic pain, alcohol problems, cardiovascular disease, and chronic obstructive pulmonary diseases) are linked to the majority (83%) of the inequalities (difference between regions with highest level of illness in the North East vs. lowest levels in the East of England)[196]. Despite this, preventive services aiming to reduce risks of non-communicable diseases, such as NHS Health Check in 2018-2019 [207,] remains low (<25%) in the northern regions.

When comparing regional ethnic diversity, census data show that the North East is the least diverse, with 90.6% of the population "White" [192]. There are subtleties, however. Following the implementation of the Asylum Act 1999 and the concomitant "dispersal policy" aimed at reducing the responsibility of hosting asylum seekers in London and the South East, the northern regions of England have assumed a disproportionate burden of asylum seekers and resettled refugees [208]. This highlights the need for nuanced approaches to equitable resource allocation and support systems to ensure integration and welfare for vulnerable populations including the asylum seekers.

Health of women from minoritised ethnic groups

Unsurprisingly, minoritised ethnic women struggled to access health care during COVID-19 due to structural, environmental and cultural factors [206]. Both the physical and mental health of minoritised ethnic groups can be affected by existing structural and socio-economic inequalities [199, 200]. However, health outcomes for minority ethnic women are likely to be impacted by the specific and unique intersection of racism and misogyny that they experience [199-201, 209]. For example, a recent mixed methods study among minoritised ethnic women in North West England documented systematic injustice in care provisions, which paid limited or no attention to religious or cultural needs [85].

To further investigate these inequalities at the intersection of gender and ethnicity, we analysed the difference in physical and mental health between White British and minoritised ethnic groups using data from the survey Understanding Society [210] (calendar year data for 2020-2021). During 2020-2021, women in the northern regions had lower SF12-PCS score (indicating poorer physical health) (Figure 10.2) compared to the

Figure 10.3. Prevalence on indicative clinical depression (assessed using SF12 mental component score)

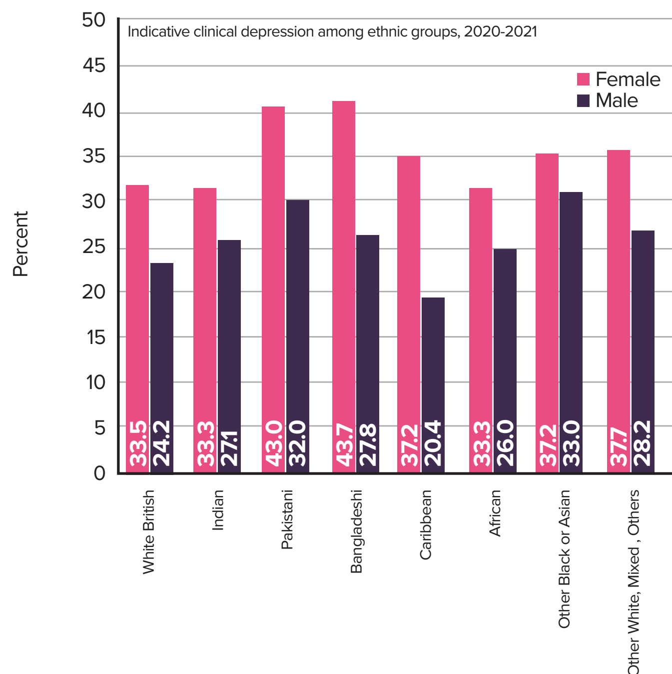
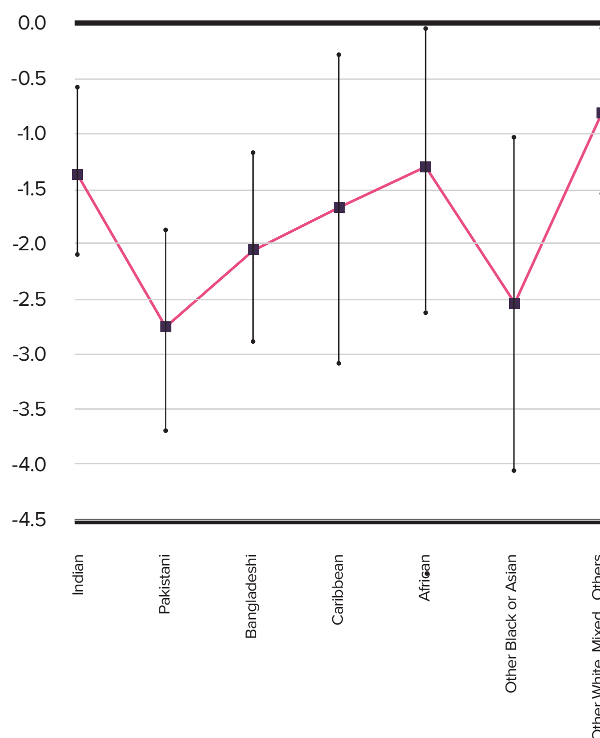


Figure 10.4. Mean difference in SF12-PCS among minoritised ethnic women, adjusted for demography, region, socio-economic, and access to smart phone status



status of women living in southern regions.

In terms of mental health, we found that the prevalence of indicative clinical depression varied statistically significantly across ethnic groups ($p<0.001$) (Figure 10.3). While women generally fared worse than men, indicative clinical depression was most prevalent among Pakistani and Bangladeshi women. The final Generalised Liner Model (GLM) examining inequalities in physical health (SF12-PCS) took account of age, sex, marital status, ethnicity, region, education, employment and having a

smart phone (a proxy for digital literacy). When gradually building the final model, northern regional differences were no longer statistically significant after the step when socioeconomic status variables were added to the model. This implies that regional differences in physical health are explained by regional differences in socioeconomic status.

Compared to the average SF12-PCS score of the White British men and women, average scores remained statistically significantly lower (negative) among most ethnic groups. The difference was highest among Pakistanis, followed by Africans, and Bangladeshis (Figure 10.4).

Sexual and gender minority women

Over the last 15-20 years, good quality evidence has slowly revealed the considerable health inequalities experienced by sexual and gender minority women [211, 212]. The inclusion of sexual orientation and gender identity in the UK Census 2021 for the first time has been a major step forward. Although limited data are currently available from the 2021 Census, there are some that are useful. According to the Census 2021, there were 3,809,340 women who identified as straight or heterosexual and 140,877 who identified as lesbian, gay or bisexual in the North East and North West of England, 3.3% of the total female population.

Data on sexual orientation, disability and health status in the UK Census 2021 have not yet been published by sex. However, it is possible to calculate the proportions of trans women in the North East and North West who have disabilities, and to describe their general health status. The proportions of trans women from the North East and North West of England who described themselves as disabled under the Equality Act with 'day-to-day activities limited a lot' was 16.1%, and 'with activities limited a little' was 19.1% [213]. These proportions compare to 10.0% and 9.5% with 'day-to-day activities limited a lot' and 12.2% and 11.3% with 'activities limited a little' in age-standardised data for women in the North East and North West respectively. The proportions of trans women group in the five health categories and the age-standardised data for women in the North East and North West are shown (Table 10.2). It can be seen that the general trend is for trans women to have worse self-assessed health.

Elliott et al published an evaluation of the English General Practice Survey (n=2,169,718 in total, 1,021,541 women) by gender and sexual orientation [211]. The weighted percentages reporting fair or poor health status was 24.9% (95%CI 23.6 to 26.2) in lesbians and 31.6% (95%CI 30.0 to 33.3) in bisexual women, compared to 20.5% (95%CI 20.4 to 20.6) in heterosexual women. Both differences were statistically significantly worse for sexual minority women.

Indicator: A widely used generic measure of 12-item Short-Form Health Survey (SF12) 1, 2, which collected data on physical functioning, role limitations due to physical health problems, bodily pain, general health vitality, social functioning, role limitation due to emotional problems, and mental health -psychological distress and wellbeing, reflecting quality of life was used. The results are summarised for SF12-Physical component summary (SF12-PCS) and SF12-Mental component summary (SF12-MCS), which both uses six item questions.

Source of data: We analysed Understanding Society (also known as the UK Household Longitudinal Survey - UKHLS) data from 44,839 England residents for 2020-2021.

Analyses: Descriptive results for SF12-PCS and SF12- MCS are shown as means, with standard errors or 95% confidence intervals, and percentage, as appropriate.

- A higher SF12-PCS or a higher SF12-MCS score means better physical or mental health, respectively. To estimate percentage of respondents with indicative of clinical depression, a score of SF12-MCS of ≤42 was considered positive cases.

- To examine how physical health (SF12 PCS) varied across region, sex and ethnicity when adjusted for demographic, socioeconomic and proxy of health literacy (use of smart phone), we used a generalised linear model that accounted for complex survey design and relevant weighting to allow national level representation of ethnic groups was used.

- Compared to the physical health status of the White British groups (measured by SF12-PCS), a negative difference for an ethnic group indicated worse health and positive difference indicated better physical health. A p-value of <.05 was considered statistically significant.

Table 10.1: Difference in SF12-PCS among men and women from minoritised ethnic groups, in comparison to status of White British group

Ethnic group	Unit difference, 95% confidence intervals	P-value
Pakistani	-2.6 (-3.3; -1.9)	<0.001
African	-2.1 (-3.7; -0.4)	0.016
Bangladeshi	-1.8 (-2.7; -1.0)	<0.001
Indian	-1.7 (-2.3; -1.1)	<0.001
Caribbean	-1.2 (-2.2; -0.3)	0.014

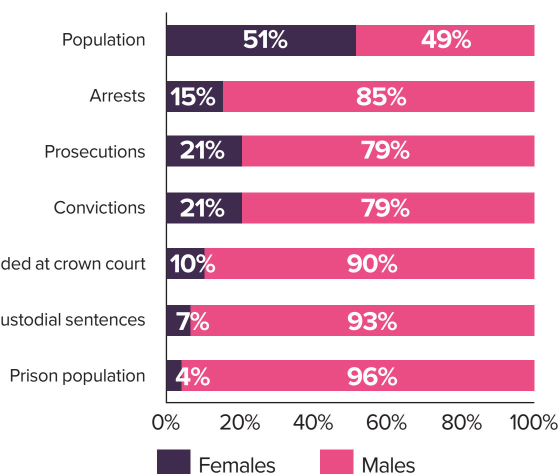
Note: Authors' analysis of UKHLS data, 2020-2021 [210]

Table 10.2. Proportions of women and their ratings of health

	Trans women in North East and North West	Women in the North West of England	Women in the North West of England
Very good health	31.1%	44.5%	46.5%
Good health	37.7%	33.6%	33.1%
Fair health	20.5%	14.9%	13.8%
Bad health	8.2%	5.5%	5.1%
Very bad health	2.4%	1.6%	1.5%

Note: Data are from the Office for National Statistics [274].

Figure 10.5. Proportions of males and females throughout the criminal justice system, 2021, England and Wales



There is a higher prevalence of certain long term health conditions amongst sexual minority women than heterosexual women after adjusting for deprivation, ethnic group, region, and age [214]. For example sexual minority women have higher prevalence of angina or heart problems; arthritis or joint problems; asthma or chest problems; blindness or severe visual impairment; deafness or severe hearing impairment; diabetes; epilepsy; kidney or liver disease; long-term back problem, and long-term neurological problems.

A recent systematic review showed that UK lesbians and bisexual women, including trans women, have worse health experiences. This includes barriers to access and service uptake and poor health outcomes. Significant barriers included heteronormative and cis-normative assumptions, negative responses to coming out, ignorance and prejudice from healthcare professionals, and barriers to raising concerns or complaints [215]. For example, negative responses were frequently reported in the context of coming out during cervical screening.

de Blok et al conducted a retrospective cohort study of adult transgender people who visited the Amsterdam University Medical Centre gender identity clinic [216]. They found that, during 50 years of follow-up, 8-10% of transgender women died, which was higher than expected compared with general population men (SMR 1·8, 95% CI 1·6–2·0) and general population women (SMR 2·8, 2·5–3·1). Cause-specific mortality in transgender women was high for cardiovascular disease, lung cancer, HIV-related disease and suicide.

Indices for Multiple Deprivation and the Office for National Statistics identify the North of England as one of the most socioeconomically deprived areas in England. The recent report by the Institute of Health Equity has shown that people die earlier than they otherwise would have done in more deprived areas of the UK compared to the least deprived area [217]. It is likely that the health inequalities evidenced in this report in sexual and gender minority women will be worse for those living in the North although there is currently limited information for northern LGBTQ+ women regarding health inequalities. One of the biggest health inequalities we can identify regarding sexual and gender minority women of the North is a lack of data. The inclusion of sexual orientation and gender identity in the Census 2021 for the first time is a major improvement, but we look forward to the inclusion of sexual orientation and gender identity in routine data collection wherever sex and ethnicity data is being collected.

'Storychair'

The 'Storychair' programme is a creative collaboration between social justice charity Changing Lives and the School of Design at Northumbria University and is supported by the North East Probation Service. It also brings together a number of arts and cultural institutions such as the National Trust and Newcastle Cathedral to question how those spaces and venues feel for the women we support.

Born from a conversation whilst exploring the crypt which historically is a place you would have gone to say goodbye to the dead, the women also wanted a space to leave behind old narratives they no longer wanted told about them. The eight week programme sees the women explore seven universally accepted ways to tell any story using two characters, the eighth week offers the opportunity for reflection and hope about what they now want their stories to be.

The actual chair was designed by the women themselves and represents their stories so far, the seat has a solid base as many of the women felt they had not yet experienced this. There are twists and turns in parts of the chair representing life's paths at times, some thinner and some thicker depicting how some experiences leave more of an impact on you than others.

The National Trust's Gibside site donated the wood from a 200 year old turkey oak tree which had fallen during the storms in the North East, the site was once owned by Mary Ellenor Bowes who's story resonated with the women for many reasons.

Organisations can opt to host the magnificent chair which unlocks access to a toolkit, whilst the Story Chair programme may never be repeated the skills which were used to design and deliver the programme can be … we all have stories to tell.

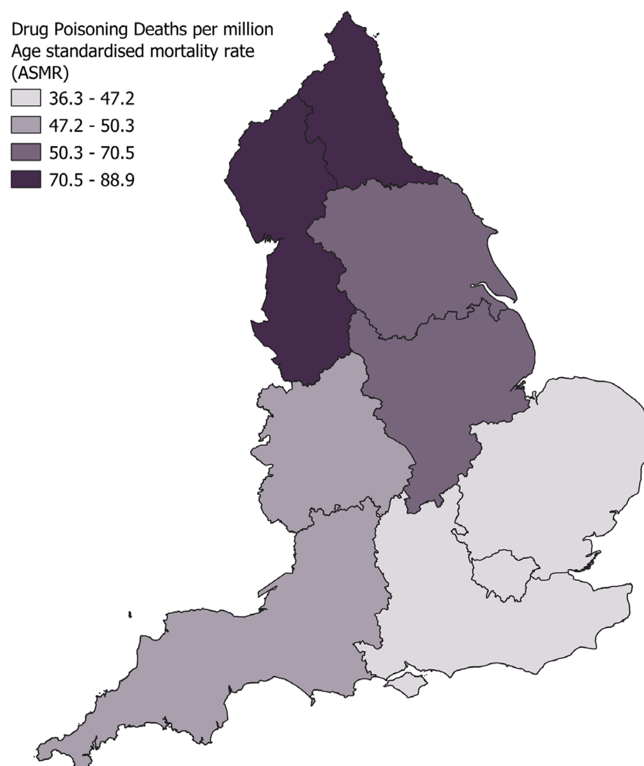
Women who have experience of the criminal justice system

Women make up a small proportion of people who encounter the criminal justice system at every stage from arrest through to custody in England and Wales (Figure 10.5) [218]. Over half (53%) of all prison sentences given to women in 2022 in England and Wales were for less than six months, despite widespread recognition that short prison sentences are ineffective and cause further harm [219, 220]: 44% of women leaving prison in England and Wales are currently reconvicted within one year [219]. Female prisoners face distinctly different challenges to their male counterparts

Table 10.3: Age-standardised mortality rate for deaths (per million) related to drug poisoning, by sex, for countries and regions of England registered 2022

Region	Males	Females
North East	197.9	72.6
North West	165.7	88.9
Yorkshire and the Humber	162.5	70.5
East Midlands	114.2	58.4
West Midlands	95.4	47.5
East	82.4	47.2
London	78.1	36.3
South East	88.7	46.9
South West	110.0	50.3
England	112.0	55.0

Note: Data are from the Office for National Statistics [215].



and often become involved with the criminal justice system as a result of poverty, homelessness, and substance misuse [221].

Women in the criminal justice system are more likely to report experiencing physical disability and mental health needs compared to the general population and to male prisoners [218, 222]. On arrival in prison 76% of women in prison report having mental health problems compared to 51% of men, and nearly twice the proportion of women (40%) enter prison with a drug and/or alcohol problem compared to men (22%) [223]. Meanwhile, female prisoners face distinctly different challenges to their male counterparts and often become involved with the criminal justice system as a result of poverty, homelessness, and substance misuse [221]. Many women in prison have been the victim of more serious offences than the offence(s) they have been sentenced for, including emotional, physical, and sexual abuse [222]. It is estimated that 60% of women in prison have experienced some form of domestic and/or violent abuse and over half have experienced emotional, physical, or sexual abuse as children . In relation to suicide and self-harm, a 2022 report from His Majesty's Inspectorate of Prisons highlights that almost double the proportion of women than men reported feeling suicidal while in custody. Rates of self-harm and suicide have also increased for female prisoners over recent years, and in 2021 the number of instances of self-harm per self-harming individual was over twice as high for females as for males [225]. The prison environment can also exacerbate health inequalities for Black and racially minoritised women who are less likely to have their physical and mental health needs recognised [226].

Women who are justice-involved in the North are likely to be disproportionately disadvantaged by their postcode. Despite this, we know very little about the specific experiences of women who are justice-involved in the North of England. There are very little publicly available regional data, particularly in relation to re-offending, resettlement, and additional systems use, rendering this population hidden and seldom

10.1: Urban Village Medical Practice – Homeless Health Service

Homeless women suffer the worse health inequalities of any inclusion health group. They often suffer 'tri-morbidity': poor physical and mental health, and substance misuse issues. Homeless women also experience a high prevalence of sexual violence, intimate partner abuse and control.

Since 1999 Urban Village Medical Practice (UVMP) has provided Manchester's only specialist GP-led homeless primary care service. UVMP is a large general practice with approximately 13,000 patients based in Ancoats, Manchester.

The UVMP homeless service has been successful in registering and providing specialist primary care support for a proportion of Manchester's estimated 3,000 homeless people. They currently have around 850 homeless patients registered at the practice, with about a third being homeless women. The team often work with women who have experienced sexual assault, who are engaging in sex work or offering/being coerced into transactional sex for food or accommodation.

During the pandemic UVMP purchased a clinical van to improve their outreach offer and improve access to health care for homeless women. The team of three nurses visit women's hostels, day centres and a park on the streets to provide meaningful health interventions to women. The nursing team can provide vaccinations, smears, wound care, sexual health screens, contraception including fitting contraceptive implants. The team can provide most things that can be done by a nurse in the GP surgery.

Homeless health care works best when relationships are enabled to flourish. The mobile van has enabled the outreach nurses to take high quality health care to where people feel comfortable and to where they can target those who need it most. Their wide skill set equips them to address patients' health concerns whilst retaining a focus on opportunistic preventative health interventions such as vaccinations, STI and BBV screening, cervical screening and the provision of contraception. A clean and private environment supports the development of trust and enables patients to maintain their dignity at all times.

The positive impact of providing health care in a way that makes people feel valued and cared for raises expectations of health care going forward and increases confidence in seeing the nurse team and engaging with other services in the wider GP practice.

10.2: Fuel Poverty and Homelessness: the extremes of the 'cost of living' crisis

Our research team: Carolyn Snell, Nicholas Pleace, Anna Browning, and Sara Anderson, all based in the School for Business and Society at the University of York, set out to understand the impact of the 'cost-of-living' crisis on homelessness services. Existing evidence suggests that homelessness, poverty and destitution have gendered effects [4], and our findings were no different.

We identified three specific issues that women were facing, often leaving them in vulnerable, precarious situations. These issues related to: increasingly constrained housing choices and a lack of alternatives; the impact of underfunded homelessness services on those using them; and the impact of working in these underfunded services.

Increasingly constrained housing choices: The study showed that women are left in difficult and unpleasant living situations due to a lack of viable, affordable options, especially if they have children. For example, Sophie* and her husband were having a rough patch in their marriage, but she couldn't afford to leave without needing to declare herself homeless and move with her children to hostel accommodation, which she was not prepared to do. Some were also limited in their housing choices due to a lack of independent transport.

The impact of underfunded homelessness services on those using them: As homelessness services faced even tighter budgets, one impact was tougher eligibility criteria for temporary accommodation and access to services. For example, supported housing staff described a situation where a pregnant woman was refused temporary housing as she could not prove she was unhoused:

'She's a pregnant lady. She's incredibly vulnerable, and she needs to be in temporary accommodation. But they still turned her away. I really don't get it. she ended up sleeping in a shop doorway."
The impact of working in these underfunded services: Retaining staff and being unable to uplift wages was discussed throughout our research. A supported housing manager explained the hardships faced by some of her staff, who are predominantly women in the care sector:

'Being in a charity staff are really underpaid, and the cost-of-living crisis really affects the staff, like leaving the charitable sector to work elsewhere, just so they can earn more money... [the] cost-of-living payments won't go to people that are working.'
In extreme cases, the cost-of-living crisis meant some women working in lower-paid sectors, including the homeless sector, were considering sex work as a way of supplementing a limited income, where there was no further available help.

heard. What we do know is that Police Force Area data from 2019 and 2022 demonstrates significant geographical variations in rates of women's imprisonment across England and Wales. In 2019, all of the police areas with the 10 highest rates of female imprisonment were in the North of England, the Midlands or in Wales. In 2022, 9 of the 10 police areas with the highest rates of female imprisonment were in the North of England.

Importantly, those who have contact with the justice system are likely to also be involved with other systems and support services. Women from North East England with experience of the justice system have overwhelmingly highlighted that they experience 'fragmented' and 'siloed' service provision. They frequently juggle 'a maze' of different services, including criminal justice services, drug and alcohol recovery services, social care, mental health, homelessness, domestic and sexual abuse, and healthcare systems [225]. Specifically, the Dismantling Disadvantage report found 44% of women were currently in contact with three or more support workers at once, and one woman reported being in contact with seven services simultaneously. Women with experience of the most complex combinations of disadvantage – including contact with the justice system - are much more likely to have children, leading to fears around child removal [225]. Meanwhile, women also flagged being unable to attend services due to the cost of travel. For women on probation, who need to comply with requirements and attend appointments, non-engagement can have serious consequences; for example, a "breach" of the terms of their licence on probation can lead to potential recall to prison.

"By the time women are criminalised, many of them have already been excluded from or let down by public services, including children's and adult's social care, health and educational services, and as survivors". Dismantling Disadvantage[3]

Voluntary, community and social enterprise practitioners who support justice-involved women typically access data via Probation Hubs. Practitioners in North East England highlighted the following regional concerns in response to this data:

- Several areas of northern England have the lowest school attendance in the country. Over half of the cases related to school attendance prosecuted nationally are prosecuted in North East England. This risks bringing civil matters into a criminal justice space and is potentially linked to other 'crimes of survival' such as non-payment of council tax and electricity.
- Fears around child removal for justice-involved women may be particularly exacerbated in the North of England which has higher proportions of child poverty and children living in lone parent families, which tend to be headed by women.

The Ministry of Justice has invested in women's services, and women-only services are delivered in trauma informed spaces. However, probation sites are not gender specific with women being instructed to attend probation offices and substance use services as part of their order/licence. Here, female service users continue to highlight fears around safety, inclusion, stigma, and belonging.

In her landmark review of the 12 women's prisons in England in 2007, Baroness Corston recommended that they be overhauled to create a woman-centred, trauma-informed 'therapeutic environment' with specialist staff and resources suited to meet women's individual needs. Seventeen years on, little has changed. A recent All-Party Parliamentary Group report found that prison compounds women's victimisation and can often be re-traumatising [226]. Practices such as strip-searching, physical restraints, drug inspections and segregation compromise trauma-informed ways of working, particularly when performed by male members of staff [227]. Updated findings in the 'Women's Review' of 2023 found that drug treatment services in women's prisons, where emphasis is on abstinence[223], do not meet the needs of women whose drug use is driven by past trauma. The review also concluded that women's prisons were ill-equipped to provide the necessary treatment and care for women with acute mental health illness, or to provide specialist interventions for women who have experienced trauma, including sexual and domestic abuse.

Most women leave prison without a safe and sustainable place to live [228]. Nationally, less than half of women (47%) will have settled accommodation on release from prison, and 1 in 10 will be homeless or sleep rough [219]. Although data are not collected regionally, it is likely that these figures

Idle Women: Arts-Led Support for Marginalised Women and Survivors of Gender Based Violence and Abuse

Idle Women are an arts, environment and social justice project who offer psychosocial support and group work combined with life and employment skills development through art, horticulture, driving lessons, translation services, mechanics workshops, camping, cooking and, above all, friendship and solidarity. Through a busy schedule, they carry out intensive relational work and have acquired a nuanced understanding of pressing issues that affect the lives of the women who take part in their activities: health and healing, migration and settlement, cultural change across generations, aspirations to education, employment and independence, racism and inter-community tension and the importance of cultural heritage.

Idle Women have adopted the nickname of the women who operated canal haulage boats during the second world war[301]. Dubbed the 'land girls of the waterways' recruits worked long hours for low wages and a subsistence diet. Beyond a few specialist interest groups, they have been forgotten. However, In 2015 the arrival of their namesakes on a narrowboat on the Leeds and Liverpool Canal re-kindled their spirit. Rachel Anderson and Cis O'Boyle were in retreat from the London Arts scene. Their boat, named after mill worker and suffragist, Selina Cooper, moored in the post-industrial canal environment, while engaging women through arts residencies and activities.

At first, they attracted some unwelcome abusive attention. Determined not to be intimidated, they set about building local partnerships with other arts programmes (Pennine Lancashire's Super Slow Way) and also with local women's organisations. A long-term working relationship, was formed with Humraaz, a Blackburn-based refuge and support centre for minoritised women and girls. Realising that Idle Women offered something radical and creative – beyond normal support services - Humraaz has continued to refer survivors and to second an experienced staff member for one day a week.

An ongoing research partnership with UCLan has aimed to account for why Idle Women distinctive approach 'works' as it does. Through the use of arts sensitive methods, their work has been documented and evaluated and the change processes that it sets in motion have been explained and shared with other organisations and groups.
It is worth adding that this unique project, led by white, educated, feminists from the cultural sector confounds easy assumptions about the 'relevance' of arts-led work to working class women from canalside estates and disadvantaged, vulnerable minorities. Idle woman have worked imaginatively with the differences between women who take part in their projects to create a thriving, vibrant and increasingly self-confident community. In 2024, responding to the interests of members in health and herbalism, they will open their award and crowd funded Physic Garden in Nelson, Lancashire as a women's space to learn, work, play and heal and, sometimes even perhaps remain idle[302].

are much higher in the North of England, not least because of the acute shortage of approved premises for women on licence in the region.

There are also fewer women's centres in the North of England, and no specialist residential centres offering trauma-informed and therapeutic-based alternatives to prison for women, such as Hope Street in Southampton and Trevi House in Plymouth. Across England, women leaving prison face huge challenges accessing specialist support services, such as mental health services, drug treatment, domestic and sexual violence services, and support around parental rights, and maternal mental health.

These are vital health-related services for women leaving prison and yet they have been subjected to harmful austerity measures. Ongoing cuts in spending on public services and inadequate funding for the charitable sector have been felt deepest in the North of England; disparities in regional health and wealth have a significant impact on criminalised women in the North of England, many of whom have multiple unmet needs[187]. Supporting the findings of the 'Female Offender Strategy'[229] there is an urgent need to redirect resources to Women's Centres and other specialist community-based women-centred mental health and social care services, and this is especially the case for the North of England.

Women experiencing homelessness

The latest data show that 309,000 people living in England were without a suitable home in December 2023[230]. This is a stark increase of 14% in a single year. Of these 279,390 are in temporary accommodation housed under a statutory duty of care, 20,000 are in hostels or supported accommodation, over 5,000 live in other temporary accommodation, and over 3,000 are sleeping rough[230, 231].

The majority of those living in temporary accommodation are families, with women making up 60% of the total. Almost half (49%) of those living in temporary accommodation have been there for more than two years. There has been a steady rise in homelessness across the North East of England, with the greatest increases seen in Stockton-on-Tees, Newcastle upon Tyne, and Northumberland. In the North East 18,340 people were assessed as being statutorily homeless in 2022/23, with 65 people shown to be sleeping rough on a single night, and 229 across the month of June. Of those sleeping rough, 83% identified as male, and only 15% as female, with 2% identifying as other or preferring not to say[231]. It is widely acknowledged that many homeless people are missed from these counts, particularly women.

For women, visibility on the streets at night is too dangerous. Many seek quieter spaces, sleeping by day, using public transport systems, sofa surfing, or resorting to relationships of need[232, 233]. Women are much more likely than men to exhaust all social avenues before resorting to rough sleeping, often alternating between sofa surfing and nights on the streets – women's homelessness therefore is an invisible problem. While indoor homelessness has often been viewed as safer than rough sleeping, for women it can be equally risky. Evidence nationally[232] and locally[233] suggests that some women find themselves in relationships which at a surface level appear as mutually consenting romantic or sexual partnerships, but which are grounded in transactional trade-offs e.g. sex in return for a place to stay[234].

Increased drug and alcohol use and physical violence are a frequent feature of such relationships[234]. These difficult and traumatising relationships facilitate negative cycles of homelessness and significantly impact on women's health and wellbeing.

The average life expectancy for a person experiencing homelessness is 43 years of age for women and 45 for men. This compares to national averages of 83 years of age for women and 79 years of age for men in the general population[235]. Evidence from the Agenda Alliance Changing Lives 2023[187], shows that the average age of women who are known to have died while accessing homelessness services in the North East is 37 years of age, down from 47 years pre-pandemic.

These early and avoidable deaths are underpinned by a complex range of unmet needs including poverty, housing, domestic abuse, debt, mental and physical ill health, and substance abuse. Removal of children from the family home was also identified as a core contributing factor in experiences of homelessness for women, with the North East highlighted as having the highest rate of referrals to child services in England. A key finding reported by Changing Lives is that women are dying early, at least in part, due to neglected social, economic and health needs, let down by multiple services[187]. This is a particular issue where a dual diagnosis of poor mental health and substance misuse are present.

Better connected services working collaboratively and specialist training in trauma informed services, are identified as key areas for action by women living in the North East, with siloed services, long waiting lists, uncoordinated care, and the need to tell and retell traumatising stories identified as key issues for women seeking help.

Over the next three years, research funded by the Arts and Humanities Research Council and led by Cooper and Lhussier at Northumbria University, aims to bring together key stakeholders across all levels of the system to address homelessness across the North East and Cumbria. Through this research the team will foster collaborative working in the region, expand trauma informed approaches, incorporate creative health approaches to support posttraumatic growth, and challenge stigmatising narratives in partnership with people with lived experiences. Learning from successful models nationally and building on regional strengths, such as the work of changing lives, the project aims to deliver systems level change in the region.

Women, alcohol and illicit drug use

Women from the North of England, like elsewhere, commonly report that they begin and continue to use substances to cope with gender-based trauma[5] and to escape from other adverse life experiences[6]. Officially recorded rates of heavy alcohol consumption[236] and illicit drug use[237] in women in the North of England are similar to women in the South of England. Nonetheless, women in the North of England experience greater rates of morbidity and mortality directly related to alcohol and illicit drug use than women in the South. In alcohol research, this is known as the alcohol harm paradox whereby people in more deprived areas experience alcohol's most negative effects[238].

A recent study exploring 'deaths of despair' (encompassing deaths attributable to drug and alcohol misuse and suicide) in both women and men in England, shows that living in the North of England is associated with significantly higher risk of mortality from these preventable causes [239]. Of the recorded deaths per 100,000 from alcohol-specific causes in 2021, women in the North East (13.9), North West (13.8) and Yorkshire and Humber (11.7) had the highest rates of deaths in women in England [7]. There is an even more pronounced North-South divide in drug-related deaths in women. As Table 10.3 illustrates, there were more reported drug-related deaths per million women in the North West of England in 2022 than there were for men in London, and the South East[8].

Excess mortality and morbidity from substance misuse can emerge from the toxic effects of the substances on the body[240]. Alcohol and illicit drug use are associated with multiple physical health conditions in women. Some of these are gender specific including increased risk of breast cancer from alcohol use, ovulation and menstrual difficulties, sexually transmitted infections, and risks to the child in pregnancy[5]. Substance misuse may also indirectly lead to physical ill health, as women may not prioritise their own physical health when they are using substances. Crucially, women often present later for substance use treatment, and do not access other health care, because of the significant stigma they experience seeking care whilst balancing family and maternal responsibilities[241].

Alongside physical ill health, mental health conditions commonly co-

occur with substance misuse in women: high rates of mental ill health are reported by women (and men) entering substance use treatment [243]. As women in the North of England experience poorer mental health than women in the South of England [244], it is likely that co-occurring conditions are a significant problem for women in the North. Nationally and internationally, formal care for co-occurring substance use and mental ill health is inadequate; mental health care and substance use treatment services are not joined up, and people who use substances are often denied access to mental health care until they are abstinent [245]. This approach overlooks many contextual factors that are complexly bound up with drug use. Recent qualitative research in the North East illustrates that further barriers to accessing help for co-occurring substance use and mental ill-health are poverty, stigma and rurality [246]. As many women attribute their substance use to their mental health, and mental ill health can also emerge from substance use, addressing mental health alongside substance use is a key unmet need to address in this population [240].

Women who are care leavers

In 2022/23, 83,840 children in England were in state care [247]. This is an increase of 2% from the previous year and continues the two decades of year-on-year increase in the number of children being taken into care, resulting in a 'care crisis' [248]. The North accounts for 28% of the child population, but 36% of the children in care. The rate of children in care per 10,000 of the child population is 93 in the North, compared to 62 in the rest of England.[249]

The North East has the country's highest overall care rates, followed by the North West. Yorkshire and the Humber has the fourth highest rate after the West Midlands.[249]

The North East of England has the highest rate of children being taken into care in the country (113 per 10,000) followed by the North West (96 per 10,000). This compares to the national average of 70 children per 10,000.[249]

The North records extreme outliers for high care rates. In Blackpool 1 in every 52 children is in care, in North East Lincolnshire, the figure is 1 in 57 and in Hartlepool, one in 63. 21 of 31 local authorities with more than 1 in every 100 children in care were in the North. Of these, 14 have consistently exceeded the 1% thresholds since 2019. [249]
Rising child poverty in the North appears to be a major driver for care entry. Whilst some of these children leave care at a young age and are reunified with their families, many leave care when they reach 18 years old. These care leavers face challenges as they make the transition from care to independent adult life. They are often required to navigate multiple transitions simultaneously, and at an earlier age than their non-care experienced counterparts. Further, care leavers often lack the social and familial support that their peers without care experience often benefit from and consequently experience high levels of social instability, isolation and loneliness. Despite some care leavers showing considerable resilience and achieving success in their lives, many have poor outcomes in areas such as education, health, offending behaviour and homelessness [250].

Whilst there is a lack of research examining gender differences relating to care leaver outcomes and experiences, the traditional risks associated with the transition from care may be experienced as more pronounced by young women [251]. This is in part explained by young women often experiencing traumatic events before, during and after care. These events affect their mental health and wellbeing and how they experience care. Women who have experienced care as children experience high levels of sexual and reproductive vulnerability. Compared to boys, girls are almost five times as likely to experience sexual abuse: 38% of girls subject to a serious incident notification were sexually abused compared to 8% of boys [252]. Girls in care are more likely than their peers become sexual active at a young age [253] and they are particularly vulnerable to sexual exploitation [254]. Women who are care experienced are more likely to get a sexually transmitted infection and 2.5 times more likely to become pregnant as a teenager.

Becoming a parent can be a key transition for female care leavers, with the potential to be a positive and stabilising experience [255]. However, female care leavers are more likely to become pregnant at a younger age [256], and experience poor pregnancy related outcomes [257]. These having a low-birth weight baby and experiencing symptoms of post-natal depression. They are more likely to smoke during pregnancy and be a single parent. Care experienced women often report feeling stigmatised by services who they perceive as judging them based upon their experience of care [258].

These young women are more likely to come to the attention of child protection services [256] have a child enter care and experience recurrent care proceedings [259]. In 2016/17 there were 2,447 babies in England

Vulnerable women, support and the care system

"My daughter was removed from my care twice in her childhood. First time because of 'neglect' and the second time, domestic abuse. Neglect is a big word, and while meaning a lot of things, it also means nothing. What it meant for me and my daughter was that I was a teenage mum who was also a drug addict and didn't know it. Neglect in my case was leaving her with a babysitter while I went out partying. She was safe but I wasn't. By the time she was removed the second time, my life was suffering the effects of chronic addiction and domestic abuse. I have never intentionally harmed my daughter but our lives were filled with a social, emotional and physical ill health that needed support.

"Like cancer needs chemo, my drug addiction needed treatment. Like diabetes needs insulin, I needed domestic abuse intervention. Like infection needs antibiotics, my social isolation needed friends and loved ones. I was not a bad person doing bad things, I was a sick person needing to get well.

"When I went through this I had no advocacy. Nobody there to tell me what things meant and what the consequences were for agreeing to legal orders I didn't understand. I didn't have an advocate who could help direct me to the treatment I needed and so my daughter and I lived separately for almost all of her childhood.

"Today my life is very different, I'm four years clean and sober. I'm completely free from domestic abuse, in fact I'm in a very supportive and loving relationship today. I have friends and loved ones in my life. I attend college and have aspirations to support women in a professional role in the future. I actually already do that today by working as a volunteer with REFORM and other charities to raise the voice of women and show them where to get the help it took me far too long to access. And, most importantly of all, my daughter lives with me today.

"Things need to change. Rather than a punishment style of intervention in families where social workers perceive risk and harm to children, there needs to be a health perspective which recognises people are suffering with a curable condition. Viewed through a health lens we could provide the support needed to keep families together. *So* often we complain that women are 'repeating the cycle'; why are we not recognising that the state is now repeating its own failed cycle and needs to change."

Kirsty, REFORM volunteer.

subject to a care order within the first seven days of life. These babies are said to have been 'born into care'. In 2016/17 the North East had the highest rate of babies born into care (104 per 10,000), followed by Yorkshire and Humber (66 per 10,000) and the North West (62 per 10,000) this compares to 48 per 10,000 national average. 24% of all mothers who have experienced the removal of a child will return as respondents in future care proceedings. Many of these mothers are themselves care experienced; 42% of mothers who experience repeat care proceedings and 22% of fathers who experience repeat care proceedings are care leavers.

Little is known about what interventions are effective at supporting the social and emotional wellbeing of care experienced mothers. A recent study suggests support for care experienced parents to 'build their informal village of support' [258] in recognition of the lack of (family) support available to many care leavers [260]. Additionally, this study recommended that the 'corporate parenting role' held by children's social care should be extended to midwives and health visitors and care leavers should have access to effective mental health support [258].

Sex workers

Cis-gender and trans women sex workers have complex and intersecting health needs. Sex work is deeply heterogenous, therefore the health inequalities and exclusions experienced by sex workers are diverse. Potter et al. note that the health needs of street-based sex workers are often associated with addiction, homelessness, and domestic violence [261]. Mainstream provision is largely unable to meet the needs of this group as it is commonly inflexible and not trauma informed. Spectra, a not-for-profit whose mission is to, 'deliver supportive, knowledgeable, non-judgemental peer-based services to under-served communities' comment that key issues for sex workers accessing their services included negotiating disclosure about sex work with practitioners, being unable to access vital information about testing and treatment for Hepatitis C, problematic gendered eligibility for vaccinations, and experiencing intersectional discrimination in services [262].

Health inequalities experienced by all sex workers are exacerbated by criminalisation [263], as in England and Wales where many aspects of sex work are criminalised. For example, sex workers are prohibited from making the safer choice of working together and indoors via brothel keeping laws, and street sex workers are criminalised via solicitation laws [264]. The significant health inequalities sex workers face cannot be extricated from the often violent, structural and intersectional discrimination that they face in their day to day lives [265]. Such inequalities are exacerbated for the most marginalised sex workers, those who are trans, racialised , migrants, use drugs and those living in poverty [266]. In addition, National Ugly Mugs [267], a national UK charity working with sex workers to provide safety tools and support, report that the health needs of sex workers are often complexly related to other factors including (but not limited to) chronic illness, addiction, and mental health needs [268].

As of February 2024, National Ugly Mugs (NUM) had 9567 members, 85% of which are active sex workers, with 20% being based in the North [269]. In 2023, 585 reports of harm against sex workers were submitted to NUM, and over a third of these reports were from sex workers in the North. Most reports in 2023 came from the North West, including Cheshire, Cumbria, Greater Manchester, Lancashire and Merseyside. The most common forms of harm were boundary pushing, malicious communications, stalking and harassment, physical assault, contact with a dangerous person, sexual assault, rape and condom removal without consent or condom refusal. Only 11% of sex workers reporting to NUM were willing to report to violence to the police [270]. The trauma of harm is closely linked to poor health outcomes for sex workers. Cunningham et al report that women sex workers, have the greatest risk of homicide of all occupational groups [271]; we know also that sex workers are at disproportionate risk of violence, including sexual violence [268, 272].

Harms experienced against sex workers contribute to significant adverse health outcomes for sex workers, especially poor mental health [272, 273]. NUM also reports a high percentage of disability amongst their membership [269]. This was especially visible in their work on racial justice [274]. More generally, they also report that sex workers are suffering from mental health conditions related to minority stress, poverty, disclosing depression, anxiety, suicide. Cis-gender and trans women sex workers experience stigmatisation and discrimination from statutory services [268, 275]. Participatory research in the North East, found that the experiences of sex workers accessing local support services were profoundly shaped by their stigmatised identities [276]. Participants felt judged by their GP, chemist - 'looks at me like crap' - and nurses due to their sex work. The North East Sex Work Forum also reported significant health inequalities experienced by street-based sex workers including feeling unheard in services, inflexible service times affecting access and inconsistent support. This was coupled with mental ill health impacted by additional intersecting disadvantages including homelessness, poverty and domestic abuse [277, 278].

The North East Spicy Coffee Collective (NESCC), a collective of sex workers in North East England, report experiences of stigmatisation, prejudice and barriers to care when accessing health services, identifying that services often fail to recognise the complex needs of sex workers [279]. Their membership has felt 'belittled, patronised and vulnerable' in health care spaces. Members of their collective have been asked inappropriate questions by healthcare workers including how much they charge for their services and unnecessary questions about genital piercings. NESCC report significant barriers to accessing pre-exposure prophylaxis for HIV (PrEP) despite the important harm reduction role it plays for full service sex workers.

They report great difficulty in accessing the often expensive sexual health certificates, which are required by pornography studios, with many clinics reporting they don't know what these are. One member of NESCC had to contact six clinics in the region before she was able to access a certificate. Another member was told they could only be screened every three months, which contravenes standard adult industry requirements of a test within the last 28 days.

Outside of NHS services, some third sector organisations report success in supporting women sex workers in the North with their health needs. Manchester Action on Street Health [280] reached [609] women, including [284] street sex workers, [171] women who use drugs, and 84 survivors of violence via their service in 23/24. In supporting the sexual health of sex workers in Manchester, MASH distributed 27,000 condoms, had 416 sexual health interactions and 408 needle exchange interactions. 88% of women felt that their health had improved after engaging with MASH. Alongside NUM, MASH note that the cost of living crisis and poverty are significantly impacting health, and are having a 'ripple effect' [280]. MASH are seeing increased needs for support around homelessness, mental health and both sexual and domestic violence.

Women and neurodiversity

Little attention has been given to the level of inequality experienced by neurodiverse females in the North compared to the South. This needs to change so we can determine the scale of the problem and support required. Recent figures indicate that this inequality is likely to exist. For example: neurodiverse young people face inequality in educational contexts [281-283], and we know that young people in the North of England already have poorer education outcomes than those in the South[284], raising the prospect of intersectional inequalities. However there is a dearth of information that allows for a more granular picture of inequalities amongst neurodiverse women in the North.

Neurodiverse girls and women with attention deficit hyperactivity disorder (ADHD) and autism present unique challenges that are underrepresented in research. It was previously assumed that boys and men comprised the vast majority of autistic people.[285], and the diagnostic criteria are based on research focusing on presentations seen in young boys, rather than quite different female presentations [286, 287]. Despite work aiming to understand sex and gender differences in neurodevelopment

and to improve the diagnosis of neurodiverse women and girls [288-290], many women are diagnosed with ADHD and/or autism late in life. This contributes to neurodiverse girls and women being misunderstood by society and diagnosticians which can contribute to low self-esteem and can exacerbate marginalisation.[291]

Currently available evidence suggests that neurodiverse women and girls have a higher risk of a wide range of physical and mental health conditions [292]. Neurodiverse girls and women are more likely to self-harm and commit suicide [292], with autistic girls and women are twice as likely to attempt suicide as autistic males [293]. In addition 23% of women hospitalised for anorexia meet the autism diagnostic criteria [294]. Neurodiverse girls and women often present with higher instances of mental health conditions and social isolation and are more likely to mask their symptoms [292]. This can make their condition(s) difficult to detect and lead to diagnoses in girls and women being missed, delayed, or preceded with misdiagnoses of co-occurring conditions such as anxiety or depression [295] and a subsequent lack of or delay in much needed support.

Conclusions

Writing a chapter about marginalised women in the North of England and their experiences of health and social inequalities has highlighted the dearth of data available about their lives and health outcomes. As our contributing authors have shown, the experiences of these marginalised and minoritised women have too often been overlooked, minimised, or ignored.

Significant evidence gaps persist which must be addressed if health inequalities amongst these women are to be tackled. Nevertheless, the evidence that is available provides a glimpse of the significant harms that are being inflicted on marginalised women in the North by systems and structures that are stigmatising, poorly designed, over-subscribed and under resourced, resulting in poor health outcomes and widening health inequalities. This is unfair and unjust – women of the North deserve better.

Recommendations

Minoritised ethnic women

- We cannot successfully reach minoritised ethnic women and reduce existing health inequalities unless we acknowledge the complexities around ethnicity, create awareness and demand for services, as well improve service delivery and monitoring to ensure that services are delivered without racism and prejudice.
- The design of health research must include representation from minority ethnic groups[289], in order to provide insight on social and cultural contexts that can be associated with health conditions, reaching a particular group, or improving service uptake.
- Acknowledgement of the complex nature of the ethnic variations (e.g., heterogeneity across ethnic groups, gender, generation and education levels) can help communication strategies, improve service provision and reduce barriers in accessing health services.
- Adaptation of health services sensitive to the specific needs of women from minoritised ethnic groups is necessary (e.g., female-only spaces and family friendly service provision) to ensure that their needs are met respectfully and without prejudice.
- Increased offerings, and strategies to improve uptake of preventive health measures (e.g., NHS health checks, social prescribing in deprived regions) and community awareness initiatives are essential. to reduce risks of NCDs among minoritised ethnic men and women.
- Better recording of ethnicity in routine data on morbidity and mortality, monitoring of service quality by ethnicity, and easy access to such data for researchers are needed to identify vulnerability among minoritised ethnic groups.

Women who are justice involved

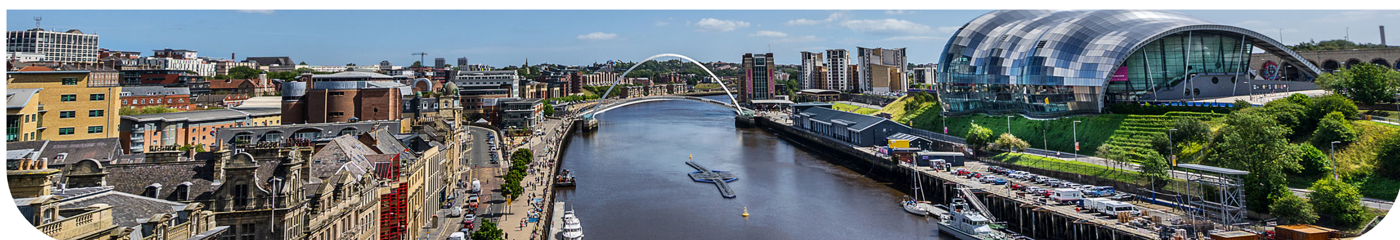
- It is imperative that regional data focusing on women in contact with all levels of the criminal justice system be made publicly available in order to explore geographical inequalities in re-offending, resettlement and access to services. At minimum, these data should be shared with practitioners who support justice-involved women in order to ascertain whether current interventions and initiatives are making a difference to practice and where further funding and expenditure should be prioritised.
- There is a pressing need to map how different systems overlap and integrate for the women who use them, particularly during release and resettlement. To ensure continuity of support, multi-agency, regional communities of practices need to be established comprising those who support and care for justice-involved women.
- All services for justice-involved women, including probation sites, should be gender responsive and prioritise prevention, diversion and resettlement.

Women who engage in sex work

- We recommend full decriminalisation of sex work to tackle health inequalities and access to care alongside pro-actively addressing stigmatisation of sex workers.
- Health services for sex workers should be trans inclusive, harm reduction centred, non-judgemental, compassionate; person-centred, asset-based (focusing on the strengths of patients/participants), rights based, and trauma informed.
- Funding should be made available to re-centre the expertise of sex workers, so peer-driven services can be developed to support the statutory and third sector offer. Training on sex work for those providing care to sex workers should be prioritised. This should be trans inclusive and non-judgemental.
- Barriers to resources which facilitate safer working practices should be tackled including (but not limited to) providing free sexual health certificates for adult performers and access to PrEP for full service sex workers.
- Leeds Sexual Health have a 'red umbrella card' system, facilitating fast-track, specialist and flexible services for sex workers. This approach should be considered regionally.

Women who are neurodiverse

- More work is needed to define the extent of inequality in neurodiverse girls and women so we can determine the scale of the problem and support required.
- Tailored support for neurodiverse girls and women is needed to assist with key transitions including from school to university and education to the workplace.
- More work is needed to work towards wider spread inclusive education for neurodiverse girls and women. For example, leading charity ADHD Foundation offers guidance to achieve an ADHD Friendly Schools award to help schools support their pupils with ADHD to achieve their potential [296].



Chapter 11
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